Co-Chair (US): I think that another suggestion about the network and what it can do, as a trusted network, is to lead by example. We can lead or influence other networks through our collective efforts. Public health response has many different components and communication is one of those critical components.

Japan: Informal communications are useful as Japan is very interested in other countries' activities and sharing information before it is published or announced is most valuable.

Co-Chair (Germany): I think we should continue to meet on a face-to-face basis and our senior officials should support us.

UK (Dr. Lightfoot): Patrick had mentioned the use of exercises and this suggestion would be a very valuable one to consider. Exercises are not easy to implement but would be very useful for GHSAG communicators to be joined by technical experts and engage with journalists.

Co-Chair (US): We had engaged in a number of pandemic-related table-top exercises in the past and the most recent of these exercises was implemented on the theme of adverse reactions to vaccinations.

Co-Chair (Germany): I would like to thank everyone for their input. We could perhaps pick-up the topic of exercises once again on Thursday. I will write up a report and distribute it to you all.

Day 2 AGENDA

Meeting Chairs:

Klaus Riedmann, Federal Ministry of Health, Germany
Bill Hall, Department of Health and Human Services, United States

Wednesday, March 3

Generic Preparedness

1) Derive generic plan from known agents: Anthrax and Ricin - (with the support of Nigel Lightfoot)

2) Derive a generic plan for the first 12-24 hours in an event with an unknown agent; the Uncertainty phase (with the support of Patrick Brasseur/Marika Valtier)

9:30 a.m.	Discussion of overall goals and expectations for generic preparedness communications planning within GHSI
	Review of 2008 GHSAG Anthrax and Ricin Workshops (Nigel Lightfoot)
10:45 a.m.	*Break*
11:00 a.m.	Discussion
12:00 p.m.	*Lunch*
1:00 p.m.	Review of Uncertainty Phase planning work (Patrick Brasseur)
2:30 p.m.	*Break*
2:45 p.m.	Discussion
4:30 p.m.	*Close*

SUMMARY

Dr. Hall, Co-Chair (US), welcomed participants to the second day of the meeting, explaining that discussions in the morning would cover Ricin and anthrax, with the afternoon being devoted to discussions on the uncertainty issue.

Dr. Riedmann, Co-Chair (Germany), reminded participants that the issues that would be discussed in the meeting are new issues and that the aim is not to come up with concrete proposals, but to table issues. He invited Dr. Lightfoot to make his presentation on the results of the Ricin and anthrax workshops.

Review of 2008 GHSAG Ricin Workshop (Nigel Lightfoot)

Dr. Lightfoot: Castor plants can be found widely around the world. In the London Ricin incident in 2003 the security services had engaged in listening and watching operations, which led to a covert operation. On Sunday morning of January 5, 2003 police found acetone and 20 castor beans in addition to £14,000 in a room occupied by Kamal Bourgass. Seven people were arrested.

After the operation had been discovered questions arose about whether efforts had been made to use the Ricin that had been accumulated by the group of terrorists. The National Health Service (NHS) Direct phone service was used to assess whether Ricin had been used in any way on the population, which proved not to be the case.

After the Ricin incident a press conference was held by the police with a health expert present. It was very important to reassure the public about the threat of Ricin and to stress that Ricin is not a weapon of mass destruction, and the presence of a health official helped to reassure the public. The working group meeting of GHSAG discussed the quantities of Ricin that could be accumulated and it was concluded that the maximum quantity that could be prepared was sufficient to kill only 20 persons. It is therefore only of limited use as a weapon, but its potential to cause alarm is much greater.

Co-Chair (US): How close to real time is the availability of the data on the NHS Direct service?

Dr. Lightfoot: It takes about 24 hours for information to be reported.

US (Dr. Rutz): What would be some other ways of getting people to ingest Ricin?

Dr. Lightfoot: It can be by ingestion or inhalation, but it is difficult to produce large amounts of Ricin. There was an incident in which a Bulgarian dissident in London was assassinated using a pellet containing Ricin.

Co-Chair (Germany): The Paris workshop concluded with deliverables for 2009. Have there been any new developments since the report of 2008?

Dr. Lightfoot: Work has continued and it has been realized that the identification of Ricin is very difficult. It is impossible to measure Ricin in the human body, because once it is ingested it is chemically converted to other substances. Germany has engaged in research that shows that pasteurization does deactivate Ricin.

Co-Chair (Germany): It seems that there is only a short time available for medical countermeasures if a person has been infected. On the other hand, from the perspective of public health, there is not much that can be done if detection is too late. For me the most alarming aspect is the widely available nature of castor beans and the potential for creating confusion between law enforcement and public health. It seems that the psychological aspect of Ricin is the largest threat.

UK (Dr. Graham): Can I ask about the anti-toxin, which the report states should be available by 2010?

Dr. Lightfoot: The Ricin anti-toxin may soon be available, but when you look at the pathogenesis of Ricin an anti-toxin may only be useful in a laboratory accident, etc. One of the questions we need to address is whether we want information about Ricin in the public domain.

Co-Chair (Germany): I wonder whether public health services would be able to detect Ricin immediately. In the case of anthrax it has taken health experts time to realize that the anthrax virus is the cause of illnesses and the same would be true for Ricin, given its rarity.

Dr. Lightfoot: The most important step is for law enforcement and public health officials to have good communication channels.

US (Dr. Rutz): In the US autopsy rates are at historic lows and that is unlikely to change unless Ricin attacks or similar were to escalate considerably. Ricin has potential as a

"weapon of mass disruption," and a response to the alarm created by a Ricin incident is most important.

Co-Chair (Germany): I would note that there is a low probability that the public health sector would detect Ricin poisoning and even if it were able to detect Ricin it would entail the public health sector referring the incident to the law enforcement side. From the communications perspective the question we must address is whether we go public as public health communicators.

Dr. Lightfoot: We have an agreement with the police in the UK that public health comes first. The police would not stop us from going public if there was a threat to public health. In order to deal with Ricin effectively it is essential for law enforcement and public health sectors to work together.

Co-Chair (US): I think where some of the challenges arise is the degree of information that can be provided from a law enforcement perspective. With regard to the question of whether to go public or not, it is inevitable that we go public. In the US there are frequent "white powder" incidents and the media is very quick to pick up on these. We have to consider when we go public and how we go about doing it. In many of the "white powder" incidents it is the local law enforcement departments that are involved and local health services and these kinds of incidents do not require a federal/national response.

US (Dr. Rutz): Even though you cannot pinpoint Ricin using diagnostic measures, the demise of a previously healthy person from multiple organ failure, etc., would surely create a few questions among medical professionals. Another question to address in the event of a Ricin incident is do we need to highlight the need to check that food packaging has not been tampered with?

Dr. Lightfoot: I think that would be alarmist and should be left in the realm of food safety and standard hygiene.

UK (Dr. Graham): I think we should think about key messages to work through in a response to a Ricin incident. A joint press conference between law enforcement and public health officials is a very good idea, but we need to consider what generic information we would provide to the public.

France: In the case of a terrorist attack we could imagine that a few persons would be attacked in a number of locations in a city. However, I do not think it is a good idea to inform the public immediately, as it would create a panic.

Dr. Lightfoot: I agree with what you are saying, but it is important not to be put on the back foot by the media reporting beforehand on incidents.

UK (Dr. Graham): It is important to manage the understanding of the general public and provide accurate information.

US (Dr. Rutz): I think our default position needs to be one of disclosure, given our status as communicators. People rarely tend to panic, unless they feel that they are being lied to. We can deal with public anxiety if we give people credit for being able to understand the information we provide.

Co-Chair (US): I think the question is not if we disclose information, but how we disclose it. It is essential to respond according to the severity of the situation.

Dr. Lightfoot: That is a very good point. In such cases it could be useful to have a matrix that could be applied depending on the degree of response that is required.

UK (Dr. Graham): I think we can agree that with regard to the issue of "how" a response is made, it should be on a case-by-case basis, but we could consider the creation of a matrix for various response scenarios.

Dr. Lightfoot: I think the creation of a matrix presents a set of options for how to proceed. We also need to consider about what information the public needs to know in response to various incidents.

If one of the terrorist organizations contacted the media and announced that they would be implementing Ricin attacks in random cities, this would present a national problem and would require a coordinated response.

France: We all agree that we have to make a response, but the question is at what point we should start to communicate. Can we implement a type of guidance that details when communication should be implemented?

Co-Chair (Germany): From the GHSAG perspective, an isolated case of Ricin poisoning is not significant, but multiple poisonings would require a response and we should consider how that would be implemented.

Co-Chair (Germany): We need to have parameters that would assess the degree of threat presented by any particular incident.

Dr. Lightfoot: I think there needs to be information available for professionals and GHSAG could unify the message we provide to professionals.

US (Dr. Rutz): A Ricin incident would be unusual enough to be raised by the media and law enforcement and public health coordination is essential.

Co-Chair (US): I agree that from a media perspective a Ricin incident is novel, but we would not issue a large amount of information about Ricin to the public as the threat is very limited and over-provision of information would alarm the public.

The public have very little of understanding of biological agents and in 2004 we put together a project anticipating an anthrax attack. We anticipated that local media would not understand the facts and misreport them and the efforts to correct the initial misunderstanding would be time consuming. Information sheets on all biological agents were prepared to be provided to all media organizations in the hope that they would refer to these and therefore provide accurate basic information. We have also prepared another document that presents processes for responding to biological agent incidents.

US (Dr. Rutz): Since 9/11 the public has become more receptive to imminent or possible threats.

Dr. Lightfoot: The Risk Management and Communications Group have got to finish off their work on Ricin. We could provide feedback to the Risk Management group on our discussions, stressing the point that it is not necessary to take large-scale media steps in response to isolated incidents, which would be reassuring for ministers, etc. We could also mention the importance of ensuring that the media is reporting accurate information about a specific agent or incident.

Co-Chair (Germany): I feel that the creation of a matrix would also be useful as a generic tool.

Dr. Lightfoot: I agree that a generic plan is a good idea, but it is first important to provide some specific cases that would provide reference for a generic plan.

Co-Chair (Germany): I think that the US has taken come very concrete steps in terms of providing information on biological agents and with the permission of the US we could use those documents.

Co-Chair (US): We would be happy to share the materials we have developed.

Break

Review of 2008 GHSAG Anthrax Workshop (Nigel Lightfoot)

Dr. Lightfoot: The workshop was held two years ago and we need to find an output for this piece of work. The problems presented by anthrax are very different to those presented by Ricin. Anthrax is an animal disease and was fairly common among people working in contact with animals. Anthrax spores survive for a very long time and this presents a problem for prolonged contamination. Anthrax is easy to grow. In Tokyo, Aum Shinrikyo attempted to release anthrax spores but used a vaccine strain which failed to result in contamination. Inhalation anthrax has a mortality rate of 65-85%, but there is no person-to-person spread.

The UK worked on anthrax in WWII, using cattle cakes and cluster bombs. They also released spores in the underground system and found that they traveled tremendous distances. Al Qaida has announced that they seek to use anthrax as a weapon, and one of the questions is why they have not yet tried. The only two countries that have anthrax vaccines are the US and the UK.

The US did a lot of work on anthrax, but stopped its biological program in the 1970s. In 1979 the Sverdlovsk incident in the Soviet Union caused a number of deaths from inhalation anthrax, killing people up to 4km away and animals up to 50km away. The Sverdlovsk incident showed that the incubation period was up to 43 days. Although Iraq signed the Biological Weapons Convention in 1972 they continued to developed biological weapons.

In October 2001 there was a report of a case of inhalation anthrax in a white 63-year old male in Florida. This was the first case in 25 years. There was also a case in the UK, which created alarm in the media.

In the case of a covert release of anthrax the initial recognition of an anthrax attack would be difficult as people would have moved about during the incubation period. If antibiotic intervention were to be implemented promptly it could save a significant number of people, but antibiotics must be taken for 60 days if a person who has not been vaccinated has been infected.

If anthrax was released over a city it would infect many people, and several hundred people would be expected to visit a local hospital. In this situation individual patient care would not be viable and pressure on health care would be acute. The first priority would be to identify where the anthrax was released, through reverse epidemiology, but this is difficult given that people will have moved around during the incubation period. It is also important to give detailed information to people with regard to measures for anthrax spores which would be attached to people's clothes and bodies, etc.

Co-Chair (Germany): With regard to antibiotics, has the regime recently been changed from 60 to 100 days?

Dr. Lightfoot: That is possible, but in the panic following an attack it would not really be an immediate and pressing issue.

Co-Chair (US): Would there be a danger of ingested anthrax in the vicinity of food markets, etc?

Dr. Lightfoot: Yes, that would be a danger and it would be important to advise the public to eat tinned food and take precautions to prevent ingestion.

WHO: How long would it take to find the location of the anthrax release using reverse epidemiology?

Dr. Lightfoot: It would take approximately 24 to 36 hours.

US (Dr. Rutz): If people carry anthrax on their clothes would the danger of those spores be from cutaneous or inhalation anthrax?

Dr. Lightfoot: It is anticipated that the danger would be from cutaneous anthrax.

Co-Chair (Germany): As you say, anthrax is not transmissible from person-to-person, so it would be limited to persons infected from an initial event. However, you would need infrastructure in place to deal with the infected persons, and the provision of psychological care is also important. If anthrax is released in a large city the response is very difficult, so what do we communicate to the public in such circumstances?

Dr. Lightfoot: It would be important to work to reduce risk and emphasize that the antibiotics do work, etc.

US (Dr. Rutz): It would also be important to make efforts to avoid stigmatization of infected persons.

Co-Chair (US): The traumatization effect of an anthrax attack is incredibly large. Even people who are not living in the infected area would be worried by watching the television.

Dr. Lightfoot: It would also be the case that infected persons would have moved around and be in a variety of different locations that would raise uncertainty further.

US (Dr. Rutz): At the time of the "white powder" incidents in the US in 2001, did these events in the US have an effect on the public in other countries?

Dr. Lightfoot: Absolutely. It caused chaos in the UK, even though there was not a single positive case.

Co-Chair (Germany): An anthrax attack is more like an act of warfare in psychological terms. I am not sure whether we, with our public health view, could handle such an incident from a communication perspective alone. I think the psychology would be similar to that following the 9/11 attacks.

Dr. Graham: Do you have any idea of whether an attack would be likely to be covert or overt?

Dr. Lightfoot: I think that the likelihood is that it would be a covert attack.

Dr. Graham: I think we should start with educational and instructional messages. Are there any specific measures that we have in place concerning instructions to infected persons about what to do, where to go, whether to evacuate, etc.?

Dr. Lightfoot: We are solidifying these responses measures now.

Japan (Dr. Saito): We held a field exercise last month about a response to a Sarin attack. We have some experience in providing psychological support in the case of earthquakes and in the Sarin attacks of 1995. We also engaged in a national level exercise that anticipated an anthrax attack on Tokyo and one of the issues we faced was how to contain the contamination (in the event of an overt attack in an enclosed space).

US (Dr. Rutz): I think communication expertise is required in this situation more than any other. We need to be able to demonstrate compassion and understanding in response to a covert attack.

Dr. Lightfoot: This would involve training for personnel.

US (Dr. Rutz): We would have to select the best spokespeople to present the government response to such issues.

Co-Chair (Germany): Another problem within the anthrax scenario is what to do with the area of the city that is contaminated and how to reduce stigmatization of people who live in the vicinity.

Dr. Lightfoot: In such a situation you would need the best spokespeople in place, and other measures, such as taking over a television station to provide constantly updated information.

Co-Chair (Germany): I agree that we need the best spokespeople in place to provide compassionate and accurate information. In many situations it would be expected that the mayor of the city would respond, but questions arise of whether the mayor would be able to make an appropriate response. Do we need to consider training for mayors?

Dr. Lightfoot: There are going to be many people talking in such situations and the important thing is to have a core medical team in place to provide accurate and timely information.

US (Dr. Rutz): There are already a number of training programs in place to help public officials make an appropriate response in the event of an emergency.

Co-Chair (Germany): I think the question for us is how we develop a response guide for anthrax, and what scenarios it should include (covert/overt, inside/outside a building, etc.).

Dr. Lightfoot: As a response to an overt incident the exercise implemented by Japan recently would be a useful reference point. However, a covert attack would prove to be overwhelming to all services and processes as we know them would effectively cease to function.

UK (Dr. Graham): I think we should think about identifying who we would need to communicate to in the early days after a covert attack. There are many different people who need to be contacted and we need to prioritize who needs to be contacted first.

US (Dr. Rutz): Japan has an awful lot to teach us about risk communication. Very much of our work is based on a western mindset and therefore the experiences of Japan would be very instructive and provide an additional and welcome perspective.

Co-Chair (US): I agree with Dr. Graham about addressing different audiences. In the case of the anthrax incidents in the US we had difficulty in communicating to people the difference between the "flu-like symptoms" of anthrax and actual seasonal flu.

Co-Chair (Germany): We need to have certain logistics planned and in place prior to an attack.

UK (Dr. Graham): We also need to have a clear message why certain people are eligible to receive a vaccine and why others are not and why certain actions are being prioritized.

Dr. Lightfoot: We must be careful to provide a message to people that is consistent with what they have already been doing, including washing the spores off clothes and bodies.

It is important that we discuss these issues openly within GHSAG and that discussions do not go beyond the confines of the group.

Lunch

Review of Uncertainty Phase planning work (Patrick Brasseur)

Dr. Brasseur: Our objective was to make a draft strategic communications plan. Uncertainty is the state of having limited knowledge, where it is impossible to exactly describe an existing state or predict future outcomes. Risks and crises are invariably marked by high levels of uncertainty. Communicators have to act whether or not they can be certain and give the necessary information based on the uncertainties of risk assessment. There is a real need to acknowledge, explain and cope with uncertainty and to better prepare the population for the evolution of message.

With regard to the H1N1 pandemic experience in France, there were many uncertainties to face, including the virulence of the virus, epidemiological situation, safety of vaccines, and the number of shots required. The public often perceived uncertainty as a sign of health authority incompetence. Changes in recommendations were barely understood by the public. The public authorities should have worked to present uncertainty in a more positive way and should have thought more about organizing who should take the floor to address uncertainty.

In the uncertainty phase of a CBRN event, the strategic objectives of communication are to protect people and prevent the worsening of the health situation, reassure and avoid panic, and preserve public authorities' credibility and legitimacy to communication (preservation of people's trust in authorities).

The challenges and prerequisites of communication are to:
- Make sure the necessary health information is given to protect people, even though they could interfere with the investigations.
- Guarantee transparent communication to the population taking into account all the uncertain issues.
- Ensure coherent communication at all levels (harmonized messages and identified spokespersons' roles)
- Communicate in a proactive way, on a regular basis and closely to the demands, but not under the pressure, of media and public opinion in order to prevent the development of rumours and disinformation (especially on the internet) and to fill the gaps.

In terms of the next steps the GHSAG is presented with a number of questions and decisions:

- Should we adopt a global approach (work on the objectives, general principles of communication) and/or a technical one (work on template sanitary recommendations to guide the immediate local communications)? How could we link them?
- Should the work be inter-ministerial or limited to health?
- Any requests/expectations for the workshop that is planned to be held in autumn 2010?

Co-Chair (Germany): Thank you for an excellent condensation of your paper.

US (Dr. Rutz): I wanted to zero on the communication objectives, which I don't think anyone can argue with. I think where education comes in here is how to achieve the communication objectives. In developing materials for educating people on risk communication, I hope that we can agree that we should not sugar coat threats and instead be honest about the efforts we are undertaking. We need to engage in a very careful approach in order not to lose credibility.

Co-Chair (Germany): I liked your paper very much because it addresses the dilemmas we sometimes face in communications issues. It is important not to be dogmatic in following rules and regulations. I would strongly wish to go on working on this paper.

UK (Dr. Lightfoot): This paper is an excellent start and it chimes with a lot of things we were talking about this morning. It would be important to address specific issues in parallel with this paper as they would fit into its framework. With regard to the question "should the work be inter-ministerial or limited to health?" the reality is that law enforcement and security officials have already been engaged. It would be a good idea to make a recommendation about which governmental sectors could be included in discussions. The workshop in the autumn is going to be very important and perhaps it would be useful to develop some scenarios for the workshop in order to get people into a working mode.

Dr. Brasseur: One of the difficulties we have faced with this draft paper is that when we show it to experts in other sectors (energy, security, etc.) we have experienced difficulty in making them understand about strategic communication objectives.

UK (Dr. Lightfoot): We need to do some groundwork to promote understanding about this strategic communications plan.

Co-Chair (Germany): What is the feeling within the group about how we should proceed with this paper?

Dr. Brasseur: I think this paper provides us with the opportunity to do something new in the group. We should attempt to share our knowledge.

Co-Chair (US): The strength of GHSAG is that we have the capability for all our countries to work together and move forward together. Working on this document for our own benefit does not bring the same level of benefit as it would if other sectors were brought in and our expertise shared with technical experts and other groups.

UK (Dr. Lightfoot): I think it would be extremely useful to issue this paper as an excellent academic resource that can be distributed to other sectors.

Co-Chair (Germany): Another question is what is the difference between "uncertainty" and "generic"? My feeling is that with this paper we are moving towards the creation of a generic plan. The question is whether France would be willing to accept that we advance towards the creation of a generic plan using this paper.

Dr. Brasseur: Yes.

US (Dr. Rutz): This is a subject that lends itself to the creation of a generic plan.

Co-Chair (Germany): We have been tasked with the creation of a generic plan for CBRN events.

Co-Chair (US): You develop a generic plan by looking at specific scenarios and identifying generic issues that are common to measures for dealing with different agents or incidents.

US (Dr. Rutz): Are we going to acknowledge or deny the presence of uncertainty in our message? I ask this question because there are a number of situations in which we would deny uncertainty in our position as communicators.

UK (Dr. Lightfoot): I wonder whether it might be useful to go through some of the issues that Patrick has asked us to consider.

Co-Chair (Germany): I think we can focus both on the issue of uncertainty and also on the creation of generic plans for risk communication. The generic plan is a clear deliverable for this group.

Dr. Brasseur: I prefer the option of moving towards the creation of a generic plan. We definitely need a generic plan in order to be able to explain to other groups about our work and risk communication strategies.

Co-Chair (Germany): The generic plan is one deliverable, but it may be useful to include a chapter on uncertainty, incorporating some specific issues.

WHO: It is important to involve the academic community when assessing uncertainty and gain expert opinion as a basis for our communications.

UK (Dr. Lightfoot): The uncertainty paper as written by Patrick is an excellent start and we should consider its further development, because in my opinion it is already near completion.

Co-Chair (US): Are you saying that we use this as an extra part to a generic plan?

UK (Dr. Lightfoot): Yes.

Co-Chair (US): As a generic plan and the inclusion of specific examples it would also function as a teaching document.

UK (Dr. Graham): I think we should use the paper by France as an introduction and add annexes as required that enumerate various examples.

Dr. Brasseur: We can work with the technical experts on the technical and communication challenges I have laid out in the paper.

UK (Dr. Lightfoot): If we have a paper at a certain stage of development we could give it to the other groups and ask them for their opinions from their own perspective.

Dr. Brasseur: What could we do in the workshop in the autumn?

UK (Dr. Lightfoot): I think the workshop would ideally be one that is scenario-based.

US (Dr. Rutz): A scenario-based workshop would enable us to identify what types of uncertainty exist and what is necessary to communicate in terms of bona fide uncertainties vs. fabrication.

UK (Dr. Lightfoot): I think it is very worthwhile putting technical experts on the spot in a scenario-based workshop.

Co-Chair (US): We had the same experience with our table-top exercises. I think a workshop like our exercises would be difficult to organize in terms of logistics, but it would be very useful as a cross-fertilization exercise.

UK (Dr. Lightfoot): We did a similar exercise for pandemic flu in GHSAG and it provided a valuable lesson for the technical experts.

Break

Co-Chair (Germany): What we have remaining to do today is to clarify the outcomes from this morning's session and the previous session. We need to work on specific communications recommendations or plans for anthrax and Ricin and also for a generic plan for dealing with uncertainty. How do you want to proceed with the development of the paper drafted by France?

Dr. Brasseur: I would like to receive your comments on the paper and I will redraft it on the basis of your comments. We could then exchange the paper via e-mail and use it to prepare for the workshop in the autumn. With regard to the workshop I would need some help in arranging it. We should also identify what we want to achieve in the workshop.

Co-Chair (Germany): As there is a Working Group Chairs and Liaison meeting in mid-April we could provide a draft of the paper to that meeting.

UK (Dr. Lightfoot): It is important to provide the draft to that meeting in April as it provides a statement that we are engaged in concrete work. We also need to ask Didier for his opinions.

Co-Chair (Germany): In terms of a time line, as everyone has already received the paper, would it be acceptable to agree to provide comments on the paper to Patrick by close of business on 19 March? (*Participants agreed*)

UK (Dr. Lightfoot): We would use the workshop as the final testing for the document. We would ask for technical experts to be available at the workshop, which would be scenario-

based and include televised interviews with technical experts. If we need some injects for scenarios, where would we get those from?

Co-Chair (US): I would like to return to the issue of whether our work should be inter-ministerial or limited to health, particular for the autumn workshop?

UK (Dr. Lightfoot): I think that for the workshop we should stick to people from the health sector as the workshop will be a new exercise.

Co-Chair (Germany): How shall we proceed with the work on the matrix and the specific recommendations/guidelines for dealing with anthrax and Ricin? The US will provide us with the URL of the materials it has created on various agents.

Co-Chair (US): We will provide that information to you and would ask that you check them and see if their content is applicable to GHSAG.

Co-Chair (Germany): I volunteer to start work on the matrix.

Presentation on Polonium 210 – Uncertainty and the Challenges of Communication

Dr. Lightfoot: This presentation concerns the death of Alexander Litvinenko who was poisoned on November 1 and who died on 24 November. The source of the poisoning was the Pine Bar at the Millennium Hotel, although it had been originally thought to be the Itsu Sushi Bar. Litvinenko was a Russian dissident and a former KGB/FSB agent. He was working with other dissidents in London. He became ill on November 1, and was admitted to Barnet Hospital. He was transferred to University College Hospital and tested for Thallium poisoning, which proved negative. There was difficulty in making the diagnosis and so the Health Protection Agency was consulted for advice. A urine sample was taken and examined at the Atomic Weapons Establishment and a massive amount of Polonium 210 was detected.

Polonium 210 is normally a solid metal at room temperature. It dissolves readily in dilute acids to form salts and decays by the emission of alpha particles. It is naturally occurring in plants and foodstuffs and in cigarette smoke. Polonium is a material that is extremely toxic per unit of weight.

In the Litvinenko case the exposure to Polonium 210 came on November 1, but the Health Protection Agency only started responding on November 23. Measures included

communicating with the public early, monitoring hospitals and public places, asking the public to contact NHS Direct, initiating 24-hour urine samples and establishing a help line.

The Chief Executive of the Health Protection Agency held a press conference and explained that Polonium 210 was only harmful if ingested. Given the extended period of time between the incident and its discovery the Russian people involved had moved around and there were various locations that had been contaminated. The bar staff at the Pine Bar of the Millennium Hotel were found to have elevated levels of Polonium 210.

HPA was asked for information on the safety of public transport and other locations. Press conferences were held daily and the media and the public were told what the HPA did know and also what it didn't know. There was also an international context as the people who had stayed in the same hotel rooms as the Russians came from all over the world.

WHO: What did you tell the public about the risk?

Dr. Lightfoot: Our stance was to refer to the situation as being of minimal risk.

Co-Chair (Germany): Did you only address public health issues?

Dr. Lightfoot: Yes, the police were being approached separately by the media.

France: At what moment did you announced that the risk was "minimal."

Dr. Lightfoot: The period of uncertainty was eight days and our press release stated that anyone who had visited the Itsu Sushi Bar during a certain period should contact NHS Direct. We were very fortunate in that the press knew nothing about Polonium 210 and there were no "talking heads" about Polonium 210.

UK (Dr. Graham): I think that because we provided a constant stream of communication updates, the media were kept informed and satisfied.

US (Dr. Rutz): What would you say was the impact on the various media (tabloid, quality press, television, etc.)?

Dr. Lightfoot: Generally the press was compliant, mainly because there was very little information available.

Japan (Dr. Saito): Were there problems with disclosure of Litvinenko's name?

Dr. Lightfoot: There was some discussion about disclosing the name of the patient to the police with regard to privacy issues, but I made the decision to tell the police from a public health perspective.

Co-Chair (Germany): Thank you very much for your presentation. I had heard about this story previously but it was very interesting to hear it again from the perspective of uncertainty. I would like to thank Nigel for his inputs at the meeting today.