

challenged in the courts, the courts shall independently decide all relevant questions without according any presumption in favor or against the actions.

**Appeals of Agency Orders ("race to courthouse" problem).**—When agency actions are challenged in two or more courts of appeals within ten days of their issuance, the Administrative Office of the U.S. Courts shall, by random selection, designate one court in which the record shall be filed.

**Intervenor Funding.**—Federal funds could not be used for public participation in agency rulemaking proceedings unless specifically authorized by law.

**TITLE II—CONGRESSIONAL REVIEW OF AGENCY RULES**  
(Amendments to Administrative Procedure Act)

**Submission and Review of Agency Rules.**—Agencies would be required to submit most rules of general applicability to Congress for a 90-day review period. The rules would be referred to one committee of primary jurisdiction in each House or to an ad hoc committee if more than one committee has primary jurisdiction.

**Congressional Action on Rules.**—Major rules could not take effect unless a joint resolution of approval is enacted within 90 days of continuous session of Congress; other rules could take effect unless a joint resolution of disapproval is enacted within the 90-day period, and could take effect sooner if neither House has acted on a resolution within 60 days or if either House has rejected a resolution.

**Committee Consideration of Resolutions.**—In the case of major rules, resolutions of approval must be introduced by the chairman (or his designee) of the committee to which the rule is referred within one day after the rule is received, and the committee would be required to report the resolution not later than 45 days after receipt of the rule, or would thereafter be discharged of the resolution. Other rules would be subject to joint resolutions of disapproval which the committee could report at its own discretion or would be required to report if a "motion for consideration" is filed within 25 days after the rule is received and is signed by one-fourth of the membership of the House involved not later than 30 days after the rule is received. If the committee has not reported such a resolution within 45 days after receipt of the rule, the resolution would be discharged.

**Floor Consideration of Resolutions.**—Resolutions reported or discharged would be referred to the appropriate calendar of the House involved, a motion to proceed to their consideration would be privileged and, if adopted, debate on major rules resolutions would be for two hours, and for other rules resolutions, one hour. If one House receives a resolution from the other House and has not reported or been discharged of its own resolution within 75 days after the rule is received, the resolution of the other House would be placed on the appropriate calendar.

**TITLE III—REGULATORY OVERSIGHT AND CONTROL AMENDMENTS TO HOUSE RULES**  
(Amendments to the Rules of the House)

**House Regulatory Review Calendar.**—A Regulatory Review Calendar would be established in the House to which all joint resolutions of approval and disapproval would be referred once reported or discharged from committee. The Calendar would be called on the first and third Monday and second and fourth Tuesday of

each month after the approval of the Journal. Priority consideration would be given to resolution for rules whose review period would expire before the next calling of the Calendar. Motions to proceed to the consideration of a resolution would be nondebateable except for resolutions discharged pursuant to a "motion for consideration" signed by one-fourth of the membership, in which case the motion would be debated for twenty minutes.

**Regulatory Appropriations Riders.**—The present House rule restricting the offering of limitation amendments to appropriations bills would be amended. At present such limitation amendments can only be offered after other amendments are disposed of and only if the House votes down a motion that the Committee of the Whole rise. Under the proposed rule change, limitation amendments could be considered during the initial amendment process with respect to regulations for which a resolution of disapproval has not been considered by the House, or has been passed but not enacted, during the specified review period.

**Oversight Improvements.**—Committee would be required to formally adopt oversight plans at the beginning of a Congress and their funding resolutions could not be considered until the plans have been submitted to the Government Operations Committee. Committees would also be required in their final oversight reports to relate their actual oversight activities and accomplishments to their original plans. The Speaker could create special ad hoc oversight committees, subject to House approval.

**THE TOWN THAT WAS POISONED**

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Oregon (Mr. WEAVER) is recognized for 60 minutes.

Mr. WEAVER. Mr. Speaker, I have a strange and terrifying tale to tell the House. It is about a town that was poisoned. This town has a population of 10,000. When the poison struck, over 700 were taken violently ill. There were, in fact, 715 confirmed cases of poisoning. Another 117 had severe symptoms. Over 45 hospitalized. A pregnant woman and her husband were poisoned; her baby born soon after had the effects of the poison. Fortunately, no one died.

The poisoning was investigated thoroughly by county, State and Federal health authorities. The investigation pointed directly to the food from salad bars in eight restaurants in the town. Another two restaurants without salad bars were implicated, although fewer cases from these two restaurants were reported. The poisoning occurred in two waves in September of 1984, with an astronomical 450 cases reported on the weekend of September 23.

The poison was salmonella typhimurium. The town was The Dalles, OR. To dramatize for you how unusual this outbreak of poisoning was, let me cite some figures:

The Dalles has not had a single case of reported Salmonella poisoning since

1978. Before 1976, only one or two cases a year were reported.

The entire State of Oregon has reported salmonella cases ranging from 250 to 400 a year. The Dalles outbreak had 715.

Figures from the Federal Center for Disease Control in Atlanta, GA, for the entire country for the years 1979, 1980 and 1981 show only one outbreak of Salmonella larger than that in The Dalles, and that of 1,200 cases stemming from pork eaten at a festival in Georgia. The CDC figures include only those outbreaks investigated by the CDC. Most of the outbreaks listed by the CDC run about 20, with the range between 10 and 200. There are an average of 40,000 cases of reported salmonella in the United States each year. The small town of The Dalles had about 2 percent of such cases in 1 year.

Most significant of all—highly significant—The Dalles outbreak did not come from one food source from one site nor did it occur at one time. The sources of The Dalles outbreak were eight salad bars. And the outbreak came in waves.

Salmonella is not easy to catch, like the common cold or flu. It is difficult to pass from one person to another in ordinary encounters. It almost always occurs from eating food that has been contaminated, improperly cooked, or left out of the refrigerator too long. Salmonella feeds on protein and usually occurs in meat, poultry, eggs, fish, milk or cheese. Not green lettuce salad.

Salmonella typhimurium is one of the most common types of salmonella. It can cause typhoid fever in mice. In humans, it is extremely discomforting and can be dangerous (it can kill, but most often does not). Salmonella does not like the acid in our stomachs but it thrives in our intestines where it erupts and causes diarrhea, fever, chills, headache, nausea, vomiting, fainting, hematochezia and abdominal cramps. It is a bacteria that can grow at room temperature but reproduces at a most rapid rate at body temperature.

Let me now relate to you the horror-ridden story of the town that was poisoned. The Dalles is the county seat of Wasco County, OR. It is situated on the Columbia River about 60 miles east of Portland. It is a farm town, surrounded by orchards, with wheat and cattle ranches in the dry southern reaches of the county. The big aluminum smelter in The Dalles was recently closed. Directly across the river is the State of Washington. It is a quiet, conservative town.

On September 17, the Wasco County Health Department received a call from a person who complained of gastroenteritis after eating in a popular restaurant in The Dalles. In the next 4

days the local health authorities received at least 20 more complaints involving two restaurants. On September 21, salmonella typhimurium was isolated from a stool sample of one of these restaurant patrons. The resultant publicity in the local news media caused hundreds of others to report their illness. State health investigators were called in and the Federal Center for Disease Control was contacted and asked to participate. A full-scale investigation was on.

The health authorities interviewed and checked the hundreds of people who complained of salmonella symptoms; and they interviewed and checked hundreds who did not. The statistics began to show that those who had eaten at salad bars in eight restaurants were far more likely to have become infected; in fact, the salad bars seemed the only common denominator. Few of those who had not eaten at the salad bars suffered from the illness. With that lead, the Food and Drug Administration investigators and other officials began checking the sources of supply for the salad bars.

They found no common source for any of the food articles on the various salad bars. The lettuce came from different suppliers, as did the other vegetables. The salad dressings were from different wholesalers. Each item was traced back, some even to the growers. The puzzled investigators even checked the kale that was used decoratively on one salad bar. A shipment of canteloupe from a farm across the river in Washington State was suspected but nothing was discovered.

There were no other similar outbreaks of salmonella in other communities either in the vicinity of The Dalles or, for that matter, in all of Oregon or Washington. I think that bears repeating. This huge outbreak of salmonella was isolated in one town, and it had no common food source. Indeed, the outbreak had no common site. It sprang up and then erupted simultaneously from eight different restaurants and from the salad bars of those restaurants.

Even so, both water systems serving The Dalles were thoroughly checked and no evidence of salmonella was found.

The food handlers were suspected. Most of the perplexed health authorities involved in the investigation continue to believe that in some way, somehow—no one knows how—the food handlers were the cause. Almost all of the 325 food handlers employed in the 10 restaurants were interviewed and later interviewed again. About 100 had been infected. The 26 food handlers who showed positive salmonella culture in their stools denied having been ill. I can understand the health officials turning to the food handlers as the source; there is no other place

to look. Everything else has been investigated and nothing found.

But the food handlers came down with salmonella poisoning at the same times the patrons of the restaurants did. One or two handlers came down a day or two before patrons became ill in one or two restaurants, but the figures are imprecise. And at one restaurant the patrons became ill before the food handlers.

And no one has been able to discover how all the food handlers got salmonella in the first place. There were food handlers in almost all the restaurants who became ill about the same time. How did all of them happen to get salmonella? They were the victims of the poisoning just like the patrons. They ate at their restaurants, and they were poisoned too.

And why was it only the salad bars which were almost the entire sources of the poisoning?

As an incubator, raw vegetables are not ideal for salmonella. Salmonella feeds on protein. Health authorities can remember only one instance of an epidemic arising from a vegetable, some sewage contaminated celery back in 1974. But records list few other instances not occurring in protein sources. So salad, lettuce salad, would be a most unlikely source for any Salmonella development, certainly not one that poisoned 715 people. Yet no statistical evidence could be found to implicate other foods more commonly associated with salmonella. In one restaurant involved in the first wave 49 patrons of the period September 11 to 15 were interviewed. Seven reported becoming ill within 1 week after they had eaten there. All seven had partaken of the salad bar; but only 17 of the 42 who denied being ill had eaten salad. And two heads of lettuce from that restaurant were analyzed and no salmonella was found.

Actually there were a number of suggested sources of the salmonella. In one restaurant, people who ate the lettuce were unaffected but the macaroni and potato salads at the salad bar apparently were contaminated. In another restaurant, salmonella was found in the blue cheese dressing, but none in the mix used to make the dressing, pointing to contamination in the restaurant during preparation; or after preparation. The fruit garnish in one restaurant was associated with the poisoning. And two restaurants which had no salad bars were implicated, though with few confirmed cases.

The first wave of the outbreak occurred on September 10 and 15 percent of the cases emanated from a 3-day period; it was the second wave that was explosive and just like an explosion, it hit hard and was quickly over; but about 600 confirmed cases of salmonella poisoning occurred in that terrifying second wave which began

September 21 and ended a few days later.

The epidemic in The Dalles is one of the largest outbreaks of salmonella poisoning in our history for the size of the population in which it occurred. A proportional outbreak in Los Angeles would have 350,000 people ill! If there had been one source, hot dogs at a high school football game, chicken at a big country barbecue, then it would have been explainable though most unusual. But there was not a single source. All evidence pointed to contamination on the premises of the eight restaurants.

But the natural place to find salmonella—poultry, eggs, milk, meat, fish—were never implicated. The interviews of affected persons never traced back to such foods; if food handlers had infected salad bars, why had they not infected the more likely foods? Of course food handlers came down with salmonella in larger numbers than the rest of the population; almost all of them ate in the restaurants they worked in. And they were investigated far more intensely than the general population.

But one startling fact sends all this conjecture spinning.

One restaurant, the Portage Inn (which was one of the first two restaurants implicated) had banquet facilities and frequent large private banquets were given there. These banquets had salad bars all of their own in their private banquet room; the same foods and dressings were provided the banquets as the regular salad bar in the main restaurant. The same food handlers prepared and served the food, including salad bars, for the banquets as for the main restaurant.

But no person who ate at the restaurant only as a banquet patron came down with salmonella.

Let me repeat that. Banquet guests in the private banquet room, eating from a salad bar prepared by the same food handlers who prepared the salad bar in the main restaurant, and serving the same food as the main restaurant salad bar, did not come down with salmonella while patrons of the main restaurant at the same time did come down with salmonella. In large numbers.

If, during the periods of the outbreaks, you had turkey or a ham sandwich, you did not get salmonella. Hundreds of people who ate at the salad bars did. If you had a pizza from Shakey's or Pietros, you did not get salmonella. But if you ate at their salad bars you had a good chance—dozens did—of coming down with salmonella. If you ate salad at a banquet at the Portage Inn you did not get salmonella poisoning. But if you ate at the salad bar in the main restaurant you had a very good chance of severe illness. If you were an employee of one

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of the implicated restaurants you had a very good chance of getting salmonella infection. But even the health authorities who assumed that the food handlers were the cause could find no evidence of any kind to determine how the food handlers got salmonella in the first place. Except by eating at the salad bars.

Consider the outbreak. Eight salad bars in one small town within a 2-week period were the primary source of 715 confirmed cases of salmonella. Indeed, in the second wave when, within a few days, about 600 people were poisoned. The salad bars accounted—according to the best statistical evidence—for most of the infections. Then consider that there are about 50,000 salad bars in restaurants in the United States according to the National Restaurant Association and none of them have been pinpointed as the cause of any salmonella outbreaks. They all have food handlers just as likely or unlikely to contract and pass on salmonella as the food handlers in The Dalles. But only eight salad bars in the United States—out of those 50,000—caused one of the largest eruptions of salmonella in our history. All in one small town within a 2-week period.

The Dalles is not in my congressional district but it is a town I particularly like. When I first read of the salmonella outbreak and the investigation it appeared so strange I became most interested. I talked with the health authorities involved in the investigation almost daily. I poured over the statistics as I received them. I analyzed them thoroughly. I rechecked my facts with the authorities. I talked with other people in The Dalles, including several of the restaurant managers. I came to the conclusion that the town had been poisoned.

I have nothing but the highest commendations for the health authorities involved. They were courteous and patient. They were extremely careful and thorough. They never violated confidences and I was given, by them, only statistical data and no names.

Their feeling—that the food handlers are the cause—is understandable. I believe they can point to nothing else. For there is no direct, concrete evidence that the salad bars were deliberately contaminated. It is not job of the health authorities to postulate answers from circumstantial evidence. Because I believe the crime is so horrendous, and the dangers so great, I believe it is my job to do so.

Let me repeat. There is no direct, concrete evidence of deliberate sabotage of the food in The Dalles. But the circumstances are so overwhelming in pointing to such deliberate contamination that—though I have agonized over the decision—I can only conclude, and very positively conclude, that sabotage did take place.

Is it possible to use salmonella for mass poisoning? It certainly is. Salmonella is quite easy to culture. Under the right conditions it grows quite rapidly. It can be transported easily in liquid. However, culturing salmonella and storing it and determining the proper mix for transporting it would best be done by a medical laboratory with trained lab technicians.

If one wanted to undertake a mass poisoning with salmonella, where would one go? The obvious places, where a customer of a restaurant comes in contact naturally and without suspicion with the food many of the other patrons will eat: the salad bars. A small vial of salmonella culture could be used to sprinkle the liquid in the salad dressings or salad mixes or on the lettuce or other foods on the salad bar as one helped themselves.

Who would do such a terrifying thing? Who would poison a whole town; or at least 715 of its citizens? Whoever did could not have known how many people they would poison, or whether someone might die from the poisoning. But the massive assault on the people of The Dalles was that: a massive assault, almost a war on the town. Who would want to do it? And who would have the capability to do it?

Is there a madman lurking in The Dalles? The poisoning was an insane act, an act of violent hatred, carried on with subtle means. There must be such a person or persons with the motive and ability to assault this town, for it actually happened.

#### RAJNEESHUPURAM

A group of people arrived in Wasco County in 1981. They are the followers of a native of India who calls himself the Bhagwan Shree Rajneesh. This man has attracted a worldwide following. They bought a 70,000-acre ranch in the southern end of the county, built a town called Rajneeshpuram, and began developing the property. There are now about 2,000 adherents living in the town. They call themselves Rajneeshes.

The relations between the Rajneeshes and the adjoining ranchers has not been very good. There have also been conflicts between the Rajneeshes and the Wasco County authorities over such things as building permits and sanitation facilities. These and other conflicts have caused the establishment of the Rajneeshes to become a statewide issue.

Beginning in early September 1984 the Rajneeshes began recruiting from throughout the United States down and outers who lived on the skid roads of major cities. These street people began showing up, transported in buses by the Rajneeshes, around September 5. On the next day Rajneesh officials announced details of their program to bring 1,000 homeless to Rajneeshpuram. As the street

people poured in, other residents of Wasco County became aroused. Among other things, they feared that the Rajneeshes would attempt to register and vote the street people in the coming election; possibly even elect county commissioners favorable to the Rajneeshes. Large protest meetings were held in The Dalles and other places. The issue became very hot and heavy, with both Rajneeshes and other Oregon citizens saying some very harsh things about each other.

The person who spoke for the Rajneeshes most frequently was a woman called Ma Anand Sheela, the personal secretary of the Bhagwan. On September 18 press reports quoted Ma Anand Sheela saying to a rally:

You tell your Governor, your attorney general and all the bigoted pigs outside that if one person on Rancho Rajneesh is harmed I will have 15 of their heads, and I mean it. You have given me no choice. Even though I am a nonviolent person I will do that.

Ma Anand Sheela has been photographed wearing a holster with a revolver in it.

On the next day, September 19, Ma Anand Sheela was again quoted in newspapers: "Wasco County is so bigoted it deserves to be taken over."

There were a number of reports of people who threatened to come to Rajneeshpuram with shotguns. But there were no reports of people who actually did. Nor were there reports of any Rajneeshes who were harmed by outsiders. Nor were there any reports of Rajneeshes harming anyone else.

One of the things that first aroused my concern about the Rajneeshes was a statement I saw the Mayor of Rajneeshpuram make on a TV program. He said: "If we are forced to we will take over Oregon. If we are forced to." Recently the same man, Swami Krishna Deva, was quoted by the Associated Press as saying: "If we need to take arms to battle bigotry, we will."

The Rajneesh Medical Corporation has a well equipped medical laboratory at Rajneeshpuram.

A final story. This story was told to the Subcommittee on Mining, Forest Management and BPA which I chair at a hearing I conducted in Portland, OR in December 1984. It is related by County Judge William Hulse of Wasco County.

On August 29, a few weeks before the salmonella outbreak, the three county commissioners of Wasco County drove down to Rajneeshpuram to make an inspection. They drove into Rajneeshpuram where they were stopped and asked to continue their inspection in a Rajneesh vehicle. As they got in, Ma Anand Sheela came to the van and said to them: "Snakes should sit in the back seats."

Judge Hulse continued: When we returned to our car, a tire was flat. The Rajneeshes agreed to fix the tire and



as we waited by the car, someone from the Rajneesh medical laboratory brought us out a pitcher of water and three cups. We thanked her and drank the water. The tire was fixed and we drove back to The Dalles. Within about 8 hours I became violently ill, with some sort of stomach and bowel upset. Later I went to the hospital. I was in the hospital 2 days. The doctor said I might have died. Another county commissioner came down with what appeared to be the same thing, though he was not hospitalized. The third commissioner was considered by us to be sympathetic to the Rajneeshes. He did not get sick."

Mr. Speaker, I conclude my story by calling for an intensive police investigation of the salmonella outbreak in The Dalles.

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Mr. Speaker, I have a letter which is the preliminary report of the health authorities investigating the Salmonella outbreak in The Dalles, to Dr. John A. Googins, M.D., State epidemiologist, Department of Human Resources, Oregon State Health Division, Portland, OR.

It begins: "Dear Dr. Googins, thank you for inviting the Centers for Disease Control to participate in investigating the September 1984 outbreak of Salmonella typhimurium in The Dalles."

Mr. Speaker, I would like the balance of this letter included in the RECORD at this point, and I ask unanimous consent to do that.

The SPEAKER pro tempore. Without objection.

CENTERS FOR DISEASE CONTROL,  
Atlanta, GA, January 18, 1985.

JOHN A. GOOGINS, M.D.,  
State Epidemiologist, Department of  
Human Resources, Oregon State Health  
Division Portland, OR.

DEAR DR. GOOGINS: Thank you for inviting the Centers for Disease Control (CDC) to participate in investigating the September 1984 outbreak of Salmonella typhimurium in The Dalles. It was a pleasure to work with the highly motivated members of your division and of the Wasco-Sherman Public Health Department. This letter is to summarize the preliminary findings of our investigation. A complete report will follow.

#### INTRODUCTION

On September 17, 1984, the Wasco-Sherman Public Health Department received a call from a person who complained of gastroenteritis after eating at a popular restaurant in The Dalles. In the next 4 days they received at least 20 additional complaints involving two restaurants. On September 21, Salmonella typhimurium was isolated at the Oregon Public Health Laboratory from a stool sample of one of these patrons. There were anecdotal reports of widespread illness among employees in both establishments, as well. CDC was contacted on September 25 and was asked to participate in the investigation of this outbreak. Following subsequent publicity, hundreds of affected patrons telephoned to report illness. Illness was not limited to patrons of the two initial-

ly reported restaurants, but involved employees and patrons from 10 independent establishments. A total of 715 persons met a clinical case definition (below) or had a positive stool culture for Salmonella typhimurium. The dates of onset of clinical illness were between August 28, 1984, and October 26, 1984. Almost all gave a history of having eaten at a restaurant in The Dalles within 72 hours prior to illness. Of those cultured, 342 were found to have Salmonella; all but 3 of 275 were identified as Salmonella typhimurium on further testing. The other 67 isolates were not serotyped. The remaining 373 persons met the clinical case definition of diarrhea and at least three of the following seven symptoms: fever, chills, headache, nausea, vomiting, hematochezia, and abdominal cramps. An additional 117 people reported an acute gastrointestinal illness but did not meet the clinical case definition. At least 45 persons were hospitalized. No fatalities were reported.

The epidemic curve was biphasic. The first wave, accounting for approximately 15 percent of the total cases, began on September 10 and peaked on September 15 with 17 culture-confirmed cases. The second wave began abruptly on September 22 and peaked on September 24 with 71 culture-confirmed cases. This curve rapidly falls off with fewer than 2 percent of culture-confirmed cases reported after September 28. Eight of the 10 implicated restaurants were associated with culture-confirmed cases in the second wave only; the other two restaurants were associated with confirmed cases in both waves.

An initial investigation by local health officials suggested that having eaten at a salad bar was associated with illness. This observation led to the recommendation on September 25 that the restaurants in The Dalles voluntarily discontinue salad bar service. This action was associated with the subsequent abrupt decline in new cases.

#### METHODS AND RESULTS

##### 1. Investigation of Patron Illness:

Information on illness in restaurant patrons was obtained primarily through a passive surveillance system. Initial reports came from unsolicited phone calls from ill patrons. Press releases encouraged reporting. Additional cases were reported from local and regional laboratories. Ill patrons were interviewed by telephone or in person regarding demographic data, nature of illness, risk factors for gastrointestinal infection, and foods eaten at any restaurants in the 3 days prior to onset of symptoms. We attempted to obtain similar information for well members of dining parties, to provide a comparative basis for estimating relative risks. Standardized questionnaires with comprehensive lists of foods available at each restaurant were administered when possible.

No other common exposure was identified among these ill patrons of restaurants. Local residents who became ill were geographically scattered by residence and appeared to be equally likely to live in either region served by the two water sources for The Dalles. Thus, the subsequent investigations focused on food consumption in restaurants.

There were 10 restaurants where at least one case of patron illness was confirmed by stool culture. Eight of these restaurants had salad bars. Food-specific attack rates were analyzed for four restaurants where we had enough complete food histories from both ill persons and controls. These four restaurants accounted for 274 patron cases (38 percent of the total number of cases).

Attack rates were highest for salad items in all four restaurants; lettuce was the only item whose consumption was consistently associated with illness. In one restaurant, potato salad, bean salad, and macaroni salad were associated with illness even in patrons who had not reported having consumed lettuce.

##### 2. Investigation of Restaurant Employees:

Employees of implicated restaurants were interviewed during the outbreak and then again afterward. The initial interviews resembled the patron interviews; the second set of interviews was part of a systematic survey that included controls from six unaffected restaurants. More specific information collected included work duties, restaurant patronage, and recent diarrheal illness.

All employees from implicated restaurants were required to submit a stool sample for culture. Those with a positive culture or a history of recent gastrointestinal illness were excluded from work until two consecutive stools were negative.

There were 325 employees working in the 10 implicated restaurants during September. Of these, 307 (94 percent) were interviewed in depth. Seventy-four (23 percent) reported a diarrheal illness. Sixty-six (20 percent) were culture-positive for Salmonella typhimurium; this group includes 26 employees who denied any illness. Of the eight restaurants where culture-positive patrons were documented from the second wave only, seven had at least one employee with early onset of disease (on or before September 20). In one restaurant, the work history of a salad maker with culture-proven, early onset illness coincided with patron exposure. In another establishment, multiple salad makers became ill early on; no single employee's schedule coincided with the epidemic curve, but the combination of the ill employees' schedules did.

Detailed information was available on 47 ill employees. Only one of 16 early cases reported eating at one of the two restaurants associated with the first wave. Comparing the 16 early to 31 late cases of diarrhea, among employees, there were no differences with respect to age, sex, consumption of raw eggs or milk, number of restaurants patronized, or in number of meals eaten at other restaurants. Thus, although the early onset of illness in employees in most of these restaurants suggests that they introduced Salmonella typhimurium, the sources of their infections remain obscure.

##### 3. Restaurant Inspections:

All implicated restaurants were inspected by sanitarians. There were no significant time-temperature violations for holding food. Sanitary inspections revealed minor violations of hygienic food-handling practices in some restaurants, but none of these violations could plausibly have caused this large outbreak in multiple restaurants.

##### 4. Food Sources:

Local health department sanitarians and Food and Drug Administration representative sought out the distributors and original suppliers of foods used in all implicated restaurants. There was no single food item or supplier common to all 10 restaurants or even to the first two establishments implicated. Many of these distributors served large geographic regions in the West, yet only one additional outbreak was recognized in this time interval, and did not appear to be related.

To explain the appearance of Salmonella typhimurium in the first restaurant, several leads were pursued:

a. Five employees who were ill with Salmonella typhimurium were interviewed during the outbreak and then again afterward. The initial interviews resembled the patron interviews; the second set of interviews was part of a systematic survey that included controls from six unaffected restaurants. More specific information collected included work duties, restaurant patronage, and recent diarrheal illness.

b. This restaurant was visited on September 25 and 26. The restaurant was visited on September 25 and 26. The restaurant was visited on September 25 and 26. The restaurant was visited on September 25 and 26.

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a. Five employees of this restaurant, three who were ill with culture confirmed *Salmonella typhimurium* gastroenteritis, reported drinking raw milk or consuming raw milk products from an uncertified dairy in Washington. An on-site inspection of the dairy by Paul Williams, D.V.M., Oregon State Health Division, revealed unsanitary practices, including washing milk pails in untreated pond water. However, cultures of raw milk, cow feces, and pond water were negative for any *Salmonella* species.

b. This restaurant used local produce occasionally. One farm providing cucumbers and tomatoes on September 9 and 20 was inspected by an epidemiologist and a sanitarian. They discovered that a nearby trailer court had a history of septic tank malfunctions in early September, but found no gross signs of contamination of the adjacent vegetable patch at the time of their inspection. Samples of soil and tomatoes were submitted to the Oregon State Laboratory; cultures were negative for *Salmonella* species. A second farm provided cantaloupes to the restaurant on September 20, but complete harvesting precluded meaningful findings from this inspection.

Samples of two lots of lettuce from each of two restaurants involved in the second wave of illness were submitted to the Oregon Department of Agriculture. They showed no evidence of contamination by any *Salmonella* species. Cultures of several food items from another restaurant were obtained. *Salmonella typhimurium* was cultured from a sample of blue cheese dressing only, but not from the dry mix used to prepare it. Given that the sample was obtained well into the epidemic, it is likely that the dressing was contaminated during or after its preparation.

#### 5. Water Supply Investigation:

There was no epidemiologic evidence to indicate water contamination as the source for this outbreak. Records of routine surveillance by the local water company showed no increase in coliform counts during September. Supplemental samples were collected from five of the implicated restaurants, and no *Salmonella* was cultured from any of these sources.

#### 6. Special Studies:

a. The restaurant accounting for the largest number of cases also had a busy home delivery service. All items on the menu were routinely delivered except salad. Telephone interviews of over 120 people consuming delivery orders disclosed no illness except where there were other potential exposures at an implicated restaurant. This study provided further evidence supporting salad as the vehicle of the outbreak.

b. Several restaurants had banquet facilities. Although a number of groups had been served during the outbreak, illness was not reported from any of them. These banquets had salad bars prepared by each restaurant's usual personnel and from the usual ingredients, but the salad bars had fewer items, and perhaps more importantly, were taken down within a short period of time. In contrast, most of the other salad bars remained open as long as the restaurant was open.

c. The first wave of illness at the first affected restaurant was investigated using the original waitress food order slip and records available for patrons who had charged their meals to their rooms. A total of 49 such patrons who had eaten from September 11 to 15 were contacted and their clinical status ascertained. Seven (14 percent) reported a diarrheal illness in the week after their

meal. All seven, versus 17 of the 42 who remained well, had eaten food from the salad bar ( $p=0.004$ , FET, 2-tailed). For statistical analyses, we pooled food histories from this group with those from other patrons of the restaurant and found that lettuce and salad dressings were not associated with illness. Consumption of sliced fruit was of borderline significance. Consumption of any mixed salads, e.g., macaroni, was highly significant (11/15 ill vs. 11/43 well,  $p=0.002$ , FET, 2-tailed).

#### SUMMARY

1. A large outbreak of diarrhea due to *Salmonella typhimurium* occurred in The Dalles in late September 1984.

2. During this time, only one outbreak was recognized in the Northwest outside of The Dalles.

3. Amplification and transmission appears to have occurred at 10 restaurants via contamination of one or more salad items.

4. No single source for food items or single distributor common to all or most of the implicated restaurants was identified.

5. At most restaurants implicated, food handlers were identified with gastroenteritis and onset of illness prior to exposure of patrons, suggesting that the food handlers may have contaminated the salad bars.

6. The food items implicated were uncooked and likely to be handled during their preparation without rewashing prior to serving.

7. There was no epidemiologic evidence to suggest deliberate contamination of foods.

8. Sanitary practices in implicated restaurants were not found to be grossly deficient.

9. The public health actions of the Wasco-Sherman Health Department appear to have been very effective in terminating the outbreak.

#### FURTHER INVESTIGATIONS

1. Plasmid profile studies of *Salmonella typhimurium* isolates are being performed to test the hypothesis that a single isolate was responsible for disease acquired at multiple restaurants. These studies will also allow comparison with strains collected elsewhere and may shed light on how *Salmonella typhimurium* was introduced into the community.

2. The Oregon State Health Division will conduct studies of temperature changes in foods held on salad bars.

3. Complete data analysis in cooperation with Centers for Disease Control is in progress.

#### RECOMMENDATIONS

1. Continued exclusion from work of culture-positive food handlers until they have had at least two consecutive negative stool cultures.

2. Continued surveillance for new cases of salmonellosis.

3. Further emphasis on hygienic practices in public food-handling establishments.

Sincerely yours,

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#### SETTING THE RECORD STRAIGHT ON THE FINANCIAL STATUS OF THE GREAT PLAINS COAL GASIFICATION PROJECT

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Connecticut [Mr. McKINNEY] is recognized for 30 minutes.

● Mr. McKINNEY. Mr. Speaker, recently the chairman of the Government Operations Committee on Environment, Energy and Natural Resources, Mr. SYNAR, asked GAO to review certain aspects of the financial viability of the Great Plains coal gasification project. We have heard statements today that the Great Plains project is being overfunded by the Synthetic Fuels Corporation and that the Federal Government is giving a windfall to the owners of Great Plains.

To rebut those contentions I would like to quote a paragraph from the cover page of the GAO report:

According to GAO's assessment of SFC's proposed assistance, a lower amount of assistance could achieve the same results if Great Plains' partners could fully use certain tax credits and if energy prices and other assumptions remained the same as those SFC used in April 1984. Since April 1984, however, several changes have occurred, such as a continued decline in energy prices. An August 1984 SFC analysis indicates that the decline in energy prices offset the effect of the increased tax credits. Other changes have also occurred, but SFC analyses subsequent to August 1984 showing the impact of these changes were not available to GAO. If all changes since April 1984 were incorporated into GAO's analyses, the results could be different.

Mr. Speaker, the implication that the owners of Great Plains will, as a result of the prospective SFC financial assistance agreement, earn a 54.5-percent rate of return is so outrageous as to be ludicrous on its face. This is particularly so when the GAO report itself, from which the statement is taken, indicates that, with respect to Great Plains, such a computation is misleading, has little value, and is not the way the project should be measured. GAO says:

We believe that Great Plains should not be measured using the incremental rate of return because that return excludes most construction costs and attributes all future profits to the latest incremental investment made.

A light-hearted analogy might be to picture three men straining to pick up a car but they can't lift it. A fourth man comes along, grabs a bumper, and the car is lifted. Do we say how strong that fourth man is because he lifted the car? Of course not; obviously, he