

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF COLUMBIA

IN RE: INVESTIGATION INTO  
THE DEATHS OF THOMAS MORRIS  
AND JOSEPH CURSEEN

: MISC. NO. 09-402  
:  
: (UNDER SEAL)  
:

**FILED**

**MAR 10 2011**

Clerk, U.S. District & Bankruptcy  
Courts for the District of Columbia

ORDER

Upon the *ex parte* Motion of the United States for entry of an Order authorizing unsealing of the Report of the Expert Behavioral Analysis Panel, which has been redacted of all protected mental health information, as set forth specifically below, and for good cause shown, the Government's Motion is hereby GRANTED.

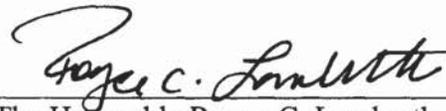
And it is further

ORDERED that the redacted portions of the report not be publicly released until further Order of this Court;

And it is further

ORDERED that the foregoing Motion and Order be unsealed at this time, but Attachment C remains sealed.

SO ORDERED this 4<sup>th</sup> day of March, 2011.



The Honorable Royce C. Lamberth  
Chief Judge,  
United States District Court  
For the District of Columbia

Copies to:  
Rachel Carlson Lieber  
Assistant United States Attorney  
555 4<sup>th</sup> Street NW  
Washington, DC 20530  
(202) 252-6621

**FILED**

**MAR 14 2011**

**IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF COLUMBIA**

**Clerk, U.S. District & Bankruptcy  
Courts for the District of Columbia**

**IN RE: INVESTIGATION INTO : MISC. NO. 09-402**  
**THE DEATHS OF THOMAS MORRIS : :**  
**AND JOSEPH CURSEEN : :**

**ORDER**

Upon the *ex parte* Motion of the United States for entry of an Order authorizing substitution of Attachment to the Report of the Expert Behavioral Analysis Panel, and for good cause shown, the Government's Motion is hereby GRANTED.

And it is further

ORDERED that the original Attachment D be replaced by the Attachment D appended to the instant motion.

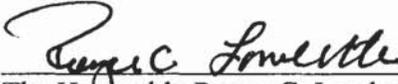
And it is further

ORDERED that the redacted portions of the report not be publicly released until further Order of this Court;

And it is further

ORDERED that the foregoing Motion and Order be unsealed at this time, but Attachment C remains sealed.

SO ORDERED this 14<sup>th</sup> day of March, 2011.

  
\_\_\_\_\_  
The Honorable Royce C. Lamberth  
Chief Judge,  
United States District Court  
For the District of Columbia

Copies to:  
Rachel Carlson Lieber  
Assistant United States Attorney  
555 4<sup>th</sup> Street NW  
Washington, DC 20530  
(202) 252-6621

# **EXHIBIT D**

# Report of the Expert Behavioral Analysis Panel

*About the Research Strategies Network:*

The Research Strategies Network is a nonprofit educational organization that conducts research and educates the public, including government officials, community leaders, and others, concerning: national security; international affairs; counter-terrorism; public safety; and other important public policy issues.

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[www.researchstrategiesnetwork.org](http://www.researchstrategiesnetwork.org)

# Report of the Expert Behavioral Analysis Panel\*

\*Report contains mental health information the Panel was authorized to review pursuant to Court Order.

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# Amerithrax Case:

## Expert Behavioral Analysis Panel

*Chair*  
Gregory Saathoff, MD

*Vice-Chair*  
Gerald DeFrancisco

*Panel Members*  
David Benedek, MD  
Anita Everett, MD  
Christopher P. Holstege, MD  
Sally C. Johnson, MD  
J. Steven Lambert, MD  
Ronald Schouten, MD, JD

Joseph C. White

*Special Assistant*  
J. Patrick Walsh

August 23, 2010

The Honorable Chief Judge Royce C. Lamberth  
United States District Court for the District of Columbia  
333 Constitution Ave N.W.  
Washington, DC 20001

Dear Chief Judge Lamberth:

Pursuant to your Federal Court Order, the Amerithrax Expert Behavioral Analysis Panel is now submitting its Final Report. Panel Members remain cognizant that materials related to this report remain sealed at this time and therefore we have maintained strict confidentiality regarding their contents. This Report is submitted without dissent and represents a consensus of the views of all Panel Members.

We would like to acknowledge the tremendous guidance that we have received from leaders who have been responsible for serving on recent major independent panels and commissions. Former Secretary of the Army John O. Marsh, Jr., former U.S. Attorney General Edwin Meese III, and former U.S. Senator Charles S. Robb have all provided us with the benefits of their past experiences. Their guidance in assisting the Panel with their own "lessons learned" has been of inestimable value. As a consequence, the Panel remains in their debt.

Throughout this process, the Panel has also been fully aware of the tragic consequences of these attacks on victims and their families. As a tribute to them and with humility, we have consciously attempted to focus on recommendations we believe to be most important, and whose implementation can make the greatest difference toward preventing a similar attack in the future.

Respectfully yours,



**Gregory Saathoff MD**  
Executive Director  
Critical Incident Analysis Group  
University of Virginia School of Medicine



**Gerald DeFrancisco**  
President  
Humanitarian Services  
American National Red Cross

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## Contents

I. EXPERT BEHAVIORAL ANALYSIS PANEL MEMBERS.....	II
II. EXECUTIVE SUMMARY.....	1
III. FINDINGS .....	15
IV. RECOMMENDATIONS .....	18
V. INTRODUCTION .....	21
A. A Note Regarding the Investigation.....	21
B. Statement of Purpose .....	21
C. Methods.....	24
D. Types of Materials Examined.....	26
E. Summary of Psychiatric Treatment.....	27
VI. CASE NARRATIVE .....	31
VII. BEHAVIORAL ANALYSIS AND INTERPRETATION .....	107
APPENDICES	
APPENDIX I - DIAGNOSTIC CONSIDERATIONS .....	137
APPENDIX II - BIOSAFETY AND BIOSECURITY (PERSONNEL RELIABILITY PROGRAMS) .....	168
APPENDIX III - VIOLENCE AND RISK- ASSESSMENT.....	211
APPENDIX IV - COMMITMENT LAW IN MARLYAND.....	223
APPENDIX V - CONFIDENTIALITY OF MEDICAL RECORDS.....	236
APPENDIX VI - TOXICOLOGY.....	246
APPENDIX VII - DR. IVINS AND THE AMERICAN RED CROSS .....	262
ATTACHMENTS	
ATTACHMENT #1: Victims of Anthrax: The Five Fatalities .....	271
ATTACHMENT #2: Frederick News-Post Letter Submitted Fraudulently by Dr. Ivins as That of KKG Sister #2 .....	274
ATTACHMENT #3: A September 18 Anthrax Letter .....	276
ATTACHMENT #4: Biographies of Panel Members .....	277

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## I. Expert Behavioral Analysis Panel Members

### *Chair*

#### **Gregory Saathoff, MD**

Executive Director, Critical Incident Analysis Group  
University of Virginia School of Medicine

### *Vice-Chair*

#### **Gerald DeFrancisco**

President, Humanitarian Services  
American National Red Cross

#### **David Benedek, MD**

Professor, Department of Psychiatry  
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#### **Anita Everett, MD**

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#### **Sally C. Johnson, MD**

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#### **J. Steven Lamberti, MD**

Professor, Department of Psychiatry  
University of Rochester Medical Center

#### **Ronald Schouten, MD, JD**

Director of the Law & Psychiatry Service  
Massachusetts General Hospital  
Harvard University School of Medicine

#### **Joseph C. White**

Senior Vice President, Chapter Operations  
American National Red Cross

#### **J. Patrick Walsh**

Special Assistant and Coordinator to the Panel and its Operations

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## II. Executive Summary

In September and October 2001, a series of letters containing *Bacillus anthracis* was mailed to targets in the media and Congress. As a result, 22 individuals became infected and five died.

Over the next eight years, the United States Department of Justice (DOJ) conducted one of the most complex, far-ranging and expensive investigations in the history of law enforcement. This investigation, code-named Amerithrax, eventually identified the mailer as Dr. Bruce Ivins, a microbiologist at the United States Army Medical Research Institute of Infectious Diseases (USAMRIID).

In July 2009, Chief Judge Royce C. Lamberth of the U.S. District Court for the District of Columbia authorized a report from the Expert Behavioral Analysis Panel. Chief Judge Lamberth authorized the Panel to examine "the mental health issues of Dr. Bruce Ivins and what lessons can be learned from that analysis that may be useful in preventing future bioterrorism attacks." The Panel was granted access to the Amerithrax investigative materials as well as the sealed psychiatric records of Dr. Ivins. The Panel was asked to provide insights into how the country can be better defended from such attacks and to provide a better understanding of Dr. Ivins himself. In particular, the Panel was asked to offer, based on the available materials, a better understanding of Dr. Ivins' mental state before and after the anthrax mailings, his possible motives — and the connections, if any, between his mental state and the commission of the crimes. The Panel was aware that it was not being asked to be the final arbiter of whether or not Dr. Ivins was responsible for the attacks, or to conduct a peer review of the doctors and therapists who provided care to Dr. Ivins over the years.

The Panel thus undertook its work with no predispositions regarding Dr. Ivins' guilt or innocence and in fact without even a focus on that issue. The Panel's review of the sealed psychiatric records, however, does support the Department of Justice's (DOJ's) determination that he was responsible. Dr. Ivins was psychologically disposed to

## II. Executive Summary

undertake the mailings; his behavioral history demonstrated his potential for carrying them out; and he had the motivation and the means. The psychiatric records offer considerable additional circumstantial evidence in support of the DOJ's finding.

### MEANS AND OPPORTUNITY

Dr. Ivins acknowledged that he was the sole custodian of the "RMR-1029" flask that held the anthrax used in the attacks, and had unrestricted and unobserved access to the "hot suites" where work with anthrax could be conducted anytime day or night. From his own laboratory writings we know that the quality and spore concentration of the anthrax he produced matched that contained in the letters. In addition, he had the equipment necessary to produce the non-weaponized<sup>1</sup> dried spores found in the letters. Some of his colleagues have contended that USAMRIID, where he worked, lacked the sophisticated equipment capable of producing the dried spores within the short time period in which the evidence suggests they were produced; but he, notably, never made that case. In fact, he named many of his colleagues, including his two technicians, as possible anthrax mailers.

Dr. Ivins also had the opportunity to commit the crime. His extensive, unexplained weekend and nighttime hours in the hot suite coincided with the period prior to the mailing of the anthrax letters in September and October. These odd hours enabled him to evade whatever supervisory oversight and observation by colleagues might have occurred. His secretive behavior in the hot suite mirrored his long-established habit of making secret, night-time drives to faraway locations — many much more distant than Princeton University, the location from which the letters were mailed. Dr. Ivins could not account for his activities during the windows of time when the letters were mailed. A man like him, who had committed repeated acts of breaking and entering as well as burglary without having been caught,

## II. Executive Summary

would have little difficulty mailing the letters late at night or early in the morning without being seen.<sup>2</sup>

### **A TRAUMATIC, DAMAGING CHILDHOOD**

To most of his colleagues and acquaintances, Dr. Ivins was an eccentric, socially awkward, harmless figure, an esteemed bacteriologist who juggled at parties, played the keyboard at church and wrote clever poems for departing colleagues. That is precisely how Dr. Ivins wanted them to see him. He cultivated a persona of benign eccentricity that masked his obsessions and criminal thoughts. That self, which he described in detail to his therapists, [REDACTED]

[REDACTED] Other evidence shows that Dr. Ivins was also exploitive and manipulative — clever in enlisting others in his schemes without their knowing, willing cooperation.

But Dr. Ivins, a meticulous scientist, was also very careful about the ways in which he shared information about himself. Only his doctors and therapists heard about [REDACTED] and, with one known exception, his criminal break-ins. And even with these mental health professionals, he could be skilled in his deceit. In his self-disclosures to his employer, too, he was canny — acknowledging some mental health issues but omitting and distorting others, in a manner that enabled him to evade real scrutiny. A lack of communication, in general, between the mental health professionals Dr. Ivins saw over the years and between them and his employer also played a role in his successful compartmentalization of his behavior.

Dr. Ivins thus managed to keep his obsessions and [REDACTED] thoughts, key aspects of his true self, hidden from public view for most of his life.

In the Panel's view, the previously sealed records afford significant insight into how that real self was formed. The record indicates that

## II. Executive Summary

Dr. Ivins experienced a strange and traumatic childhood. Although his early experiences certainly do not exonerate him in any way, they do help explain the kind of character and worldview he developed. (Please see Case Narrative and Behavioral Analysis sections for a more thorough discussion of this subject.)

Dr. Ivins grew up in a family in which, there is ample evidence, his mother assaulted and abused her husband — stabbing him, beating him, and threatening to kill him with a loaded gun. It also appears that she physically abused Dr. Ivins as a boy, and that his father mocked him publicly as well. For these and other reasons, Dr. Ivins grew up with the deeply felt sense that he had not been wanted by his parents. This was later confirmed by a family member who described Dr. Ivins' mother's attempt to injure herself to end the pregnancy and his parents stated preference for a girl rather than another son.

Throughout almost his whole life, Dr. Ivins avoided confrontation. Instead, he learned to compartmentalize and conceal his behavior. As early as college, he was interested in "clandestine-type things," a classmate recalled. And as Dr. Ivins himself later reported, [REDACTED]

[REDACTED] Yet at the same time, he performed well enough academically to gain admission to graduate school.

## II. Executive Summary

### A LIFELONG OBSESSION

While an undergraduate at the University of Cincinnati, Dr. Ivins was turned down for a date by a student (referred to in this document as KKG Sister #1) who was a member of the Kappa Kappa Gamma (KKG) sorority. Although this woman has no memory of the incident or Dr. Ivins, the rebuff to his fragile self image appears to have triggered a lifelong obsession. It primed him to be hypersensitive to any future rebuffs from the same source — KKG.

As events unfolded, Dr. Ivins moved several years later to the University of North Carolina to do post-doctoral research, and met there a graduate student who had been a member of KKG, a woman referred to in this document as KKG Sister #2. Strongly drawn to her, he later told his psychiatrist that [REDACTED]

[REDACTED]

too much or too quickly — or both — for her comfort, prompting her to withdraw.

In that rebuff, Dr. Ivins [REDACTED] as he told a psychiatrist years later. [REDACTED]

[REDACTED]

Dr. Ivins engaged in a series of criminal acts against KKG Sister #2, including stealing her irreplaceable research notebooks and breaking her car window. He also broke into and trespassed onto a number of KKG sorority houses and offices, and stole various documents.

As the Narrative section of this report describes in greater detail, Dr. Ivins' obsession with the sorority and with KKG Sister #2 continued for three decades — it was still driving his behavior shortly before he died. It was characteristic of him that he declared in an Internet posting in 2007 that the sorority had declared a "fatwa" against him. Dr. Ivins routinely depicted himself as a victim — not only of KKG, not

## II. Executive Summary

only of his parents, but also of colleagues, Congress, the media, the FBI, USAMRIID Security and the Frederick Police Department. He often succeeded in persuading others that this view was accurate. In reality, however, he was more often than not the victimizer.

Dr. Ivins' attachment to KKG Sister #2 was so intense that shortly after leaving the University of North Carolina in 1978 [REDACTED]

[REDACTED]

As already noted, Dr. Ivins was often candid, albeit sometimes selectively so, with his psychiatrists and therapists. To his psychiatrist in 1978, [REDACTED]

[REDACTED] The impression he left in his one year of meeting with this psychiatrist was so powerful that when she first heard about the anthrax mailings in 2001, she immediately "worried" that he might be the perpetrator.

### WORK AT USAMRIID

Dr. Ivins joined USAMRIID in December 1980, and became one of the institute's top authorities on the anthrax vaccine, which was mandated for U.S. Armed Forces. His job entailed producing large batches of *Bacillus anthracis* that were tested on vaccinated laboratory animals, to see whether the vaccination would protect them. He was an expert in the bacteria's growth, purification, and spore-producing process.

In the early 1980s, KKG Sister #2 unknowingly moved into Dr. Ivins' neighborhood in Gaithersburg, Md. He quickly discovered her presence. Among various other acts of harassment, he wrote and signed her name to a letter to the editor of the local newspaper, defending the practice of fraternity/sorority hazing. After the letter was published, he sent a copy of it, as it appeared in the newspaper, to the mother of a student who had died during a hazing. The mother, who had become an anti-hazing activist, then furnished the letter to an

## II. Executive Summary

author writing a book on the subject. The entire chain of events not only led to great embarrassment for KKG Sister #2, but demonstrated Dr. Ivins' deviousness and willingness to use others, as well as the United States Postal Service, to accomplish his stealthy retribution.

In the 1990s Dr. Ivins developed intense emotional attachments to two technicians who worked in his laboratory, women known in this document as Technicians #1 and #2. In 1999, Technician #2 left the lab to pursue medical studies at a university in New York State. Her departure [REDACTED]

Once again Dr. Ivins was candid to his psychiatrist. [REDACTED]

Switching soon to another therapist, [REDACTED]

[REDACTED] His therapist became so alarmed that she sought legal advice from her practice's malpractice insurance carrier and made tentative inquiries with the local police department. She later quit the practice because the physician in charge, referred to as Dr. #3 in this report, did not share her concerns about Dr. Ivins' dangerousness.

Besides coping with his separation from Technician #2, Dr. Ivins was also dealing in 1999, 2000 and 2001 with various threats to the anthrax vaccine program. *Vanity Fair* magazine published a report linking the vaccine to Gulf War Syndrome, a condition with a wide range of acute and chronic symptoms that developed in veterans of the conflict. In August 1999, the Food and Drug Administration (FDA) shut down production of the vaccine by the one company licensed to produce it, after the company failed its FDA inspection. In February

## II. Executive Summary

2000, the House Government Reform Committee's national security subcommittee urged the Defense Department to suspend the anthrax program, and in May 2000, 35 members of Congress signed a letter asking the Secretary of Defense to stop it until a long-term study could be done regarding its safety. In June 2001, Senator Daschle, the Senate majority leader, sent a letter to the Department of Defense that heightened concerns about the safety of the vaccine. Also in June, the Department of Defense announced it was curtailing its vaccination program — the vaccine was beginning to run out.

As his own emails show, Dr. Ivins became concerned that his vaccine program was in jeopardy. On September 7, 2001, he wrote that he had just received his own anthrax vaccine injection but that supplies were dwindling "and when it's gone, there's nothing to replace it with. I don't know what will happen to the research programs and hot suite work until we get a new lot. ... Everything is in limbo."

### **DR. IVINS' MOTIVES FOR THE ATTACKS**

Investigators determined that the first anthrax letters were mailed on September 17 or 18, in the wake of the 9-11 attacks. It was not until October 4, however, that the first case of anthrax exposure was reported, and there was no immediate reference in that case to the victims' having received a letter. A second set of letters was mailed sometime between October 6 and October 9.

As the Analysis section of this report explains in greater detail, Dr. Ivins had multiple motives in launching what he later called [REDACTED] through the mail. The key themes were revenge, a desperate need for personal validation, career preservation and professional redemption, and loss. These themes guided him not only in making the attacks, but in choosing his targets and shaping his methods.

## II. Executive Summary

- *Revenge*

The attacks above all enabled Dr. Ivins to gain retribution against his various perceived enemies. Some of those enemies, like Senators Daschle and Leahy, had directly incurred his wrath; others, like the *New York Post*, which to him represented the media and New York City, appeared to have been symbolic stand-ins for broader targets. But in each case Dr. Ivins achieved one of his lifelong preoccupations — revenge. In 2000, he had told his therapist that [REDACTED]

[REDACTED] With the anthrax attacks, [REDACTED]

- *Personal validation*

The attacks also represented a way for Dr. Ivins to elevate his own significance. One day his program was under scrutiny and his career as an anthrax researcher imperiled. The next day his program and his skills could not have been more crucial to national security.

Dr. Ivins was also trying to impress KKG Sister #2. After an approximately 18-year hiatus, he wrote her an email “after the anthrax attacks” “to refresh his acquaintance,” as he later put it, on September 21, 2001 — shortly after the first set of anthrax letters were mailed but before they were discovered. With its references to biowarfare and anxiety, the email would soon cast him in her eyes, he appears to have hoped, as a prophet and as a defender of the nation. He joined the American Red Cross the next day, positioning himself with the greatest possible significance by referring — as he never had previously — to his expertise in “anthrax research” on the volunteer application.

- *Career preservation and professional redemption*

By launching the attacks, Dr. Ivins showed that anthrax was a threat and the vaccine he helped manage was necessary to protect the public. The attacks in this sense achieved their goal.

## II. Executive Summary

- *Loss*

In part, launching the anthrax attacks appears to have been an effort to inflate his importance with Technician #2 and potentially attract her back into his laboratory. In the aftermath of the attacks, physicians with research backgrounds in anthrax were in demand. Technician #2 conceivably could have returned to the laboratory — embraced by her peers as an authority and with only Dr. Ivins, her mentor, to thank.

### THE MAIL AS VEHICLE

Dr. Ivins had used the mail for decades as a means of harassment. The U.S. Postal Service provided him the opportunity to carry out his schemes anonymously, consistent with his longstanding preference.

When he decided to engineer his anthrax attacks, therefore, it was perhaps predictable that he would choose the mail as his vehicle.

In retrospect, it was also not surprising that he would choose anthrax as his weapon. Not only was he expert in its production and purification, but he referred to it with a morbid intimacy. On numerous occasions, including some prior to the attacks, Dr. Ivins suggested to various therapists that

Finally, given Dr. Ivins' obsessions and proclivity for careful planning, it was also like him to give very careful consideration to the specific site for the mailings.

All four of the recovered letters were sent on two separate occasions from the same mailbox, at 10 Nassau Street, Princeton, N.J., investigators determined. That box is nearly 200 miles from Dr. Ivins' home in Frederick, Md., but just 175 feet from 20 Nassau Street, the address of the KKG office at Princeton University.

## II. Executive Summary

The box thus appears to have represented to him the two key reservoirs of his obsession and rage. Dr. Ivins' statements to therapists and the FBI suggest that KKG represented authority and all the successful, talented, attractive people who had rejected him and inspired his rage. Princeton represented his father and perhaps his unmet college aspirations and the humiliation and rage wrapped up in these concepts for him. For him, dropping anthrax in this box appears to have represented both a conquest and a desecration — in short, payback.

The return address on the letters to Senators Daschle and Leahy was also significant. As discussed in greater detail in the analysis, the ZIP Code Dr. Ivins selected likely was related to his passion for codes and laden with associations for him.

### **SUICIDE**

Through a combination of good luck and his own fabrications and deflections, Dr. Ivins was able to avoid the focus of investigators in the first few years after the attacks. But by 2004, the tide was beginning to turn against him, especially as scientists developed new, more refined techniques for analyzing the genetic material in the *Bacillus anthracis* that was mailed. As the scrutiny of investigators ratcheted up and at last, the Federal Government prepared to indict him for the mailings, Dr. Ivins finally revealed his rage in a remarkable rant. At a group therapy session in July 2008, he bragged that he was procuring a gun and threatened to kill others and then be killed by police.

Reports indicate he was extremely dangerous and required involuntary treatment on a psychiatric ward at that time. In obtaining his involuntary commitment, Dr. Ivins' mental health professionals likely prevented a mass shooting and fulfillment of his promise to go out in a "blaze of glory." Dr. Ivins was not only homicidal, he had a specific plan, which there is no reason to think he would not have carried out.

## II. Executive Summary

He was thwarted, however, by his involuntary psychiatric hospitalization and the FBI's ensuing search and confiscation of his ammunition, body armor and a bulletproof vest.

At the time of his hospitalization, Dr. Ivins said he actually agreed that he presented a danger to himself and others. But he believed that because he had been involuntarily hospitalized, his full medical records would be provided to investigators. He believed, in other words, that his decades-long effort to conceal the truth about himself had reached a tipping point and was about to be shattered. This recognition, groundless as it may have been, likely contributed to his decision to commit suicide.

To make his suicide possible, he engaged in a final deception, persuading a psychiatrist that he was no longer dangerous to others or himself and that he was qualified for discharge from the hospital. Within a few hours of his discharge, he had purchased the additional acetaminophen he needed to kill himself. He swallowed it a few days later, dying before investigators could further assess the mental state and motives that led him to commit his unprecedented acts of bioterrorism.

### **SECURITY ISSUES**

Despite criminal behavior and sabotage of his colleague's research, Dr. Ivins was hired by USAMRIID and received a security clearance, allowing him to work with potential weapons of mass destruction. Moreover, he was permitted to remain in the hot suite with anthrax — in position to potentially carry out more attacks — for nearly seven years thereafter.

These developments took place in large part because his medical records, which contained highly relevant information that likely would have disqualified him from employment, were not obtained and his treating clinicians never interviewed.

## II. Executive Summary

The failure to obtain them apparently resulted from these main causes:

- Dr. Ivins' self-disclosures featured key medical and psychiatric omissions;
- Investigatory follow-through was lacking;
- Information requested was not always provided;
- Dr. Ivins' treating psychiatrist lacked both an awareness of the full contents of the medical record and an appreciation of the stakes involved in assessment.

The Panel believes that part of the explanation for these failures may lie in the shifting security landscape. Beginning in 2001, the rules governing security at USAMRIID began to change, with Biological Personnel Reliability Program (BPRP) procedures slowly supplementing those established under Army security programs. The evolutionary nature of this shift may have delayed discovery of problematic information.

But familiarity, the Panel believes, played a much greater role in the failure of the systems to operate. Over the decades, Dr. Ivins' tenure at USAMRIID, combined with respect for him as a scientist, appears to have led to a degree of complacency toward him. His co-workers and supervisors had long since become accustomed to him and his eccentricities. Near the end, a threatened co-worker's expressions of fear led only to a supervisor's instruction to "hide in the hot suite" — and no other intervention. Familiarity may explain why those involved in the medical surveillance system did not follow through when information they requested: 1) either was not provided at all; or 2) was provided and suggested the need for additional inquiry.

## II. Executive Summary

### RECOMMENDATIONS

As a result of this review, the Panel has offered 10 findings and 14 recommendations. They are listed and explained in the following section.

### End Notes for Executive Summary

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<sup>1</sup>Greenemeier, L. (2008). Seven Years Later: Electrons Unlocked Post-9/11 Anthrax Mail Mystery. *Scientific American*. Retrieved from <http://www.scientificamerican.com/article.cfm?id=sandia-anthrax-mailing-investigation>.

<sup>2</sup>Former CIA counterintelligence officer and convicted spy Aldrich Ames repeatedly used a mailbox in Georgetown to provide information to enemy agents without being detected at the site of the box — in this case a postal collection box located at 37th and R Streets, NW that was essentially identical to the Princeton N.J. collection box used by the anthrax mailer. In order to request meetings with the KGB, Ames would leave horizontal chalk marks above the USPS logo.

### III. Findings

1. Dr. Ivins had a significant and lengthy history of psychological disturbance and diagnosable mental illness at the time he began working for USAMRIID in 1980. [REDACTED] that would have disqualified him from a Secret level security clearance had they been known. Such disqualification would have prevented him from having access to anthrax prior to and after 2001.
2. Information regarding his disqualifying behaviors was readily available in the medical record and accessible to personnel had it been pursued under mechanisms that existed prior to and after 2001.
3. Relevant information in the medical record, including pertinent psychiatric history, did not become available during the security clearance process as a result of a several factors:
  - Dr. Ivins made critical omissions in his self-reports;
  - Background medical record investigators did not pursue inconsistencies in Dr. Ivins' reporting;
  - Background medical record investigators did not request and review available medical records;
  - Background medical record investigators did not follow up on incomplete responses by treating clinicians;
  - Background medical record investigators did not clarify information through direct interview;
  - Treating clinicians did not report significant information known directly to them or available to them through ancillary therapist notes in the medical record.
4. It was not privacy law that prevented the flow of healthcare information between Dr. Ivins' private psychiatrist and

### III. Findings

USAMRIID — information that would have disqualified Dr. Ivins from a security clearance and access to select agents prior to the mailings or afterwards. Dr. Ivins had signed multiple waivers of his right to health information privacy. It is possible, however, that healthcare providers *viewed* privacy law as a barrier to disclosing information of concern about Dr. Ivins.

5. The Department of Justice (DOJ) did not seek or obtain authorization and therefore did not review or have access to comprehensive psychiatric records during the course of the investigation of Dr. Ivins. Federal investigators requested access to medical records, but the U.S. Attorney's Office within the DOJ viewed privacy law and its relationship to mental health and medical records as a significant legal barrier to obtaining them during the course of the investigation.
6. While he was employed at USAMRIID, routine drug and alcohol testing was not performed on civilians, like Dr. Ivins, who worked within secure USAMRIID laboratories.
7. Dr. Ivins' [REDACTED] [REDACTED] contributed to numerous episodes of impaired behavior within the work setting. The impairment and its cause were not detected or formally evaluated because [REDACTED] [REDACTED] were not performed.
8. Despite Dr. Ivins' long-term involvement in psychiatric treatment and work-related monitoring of his psychiatric issues, treatment and management interventions fell short of directly addressing his risk of harm to others until July of 2008. Even at that time, risk assessment with regard to self and others did not appear to adequately take into consideration the potential significance and imminence of his legal situation.

**III. Findings**

9. Many of the civilian mental health professionals who treated Dr. Ivins prior to 2001 (Dr. #1, Dr. #2 and Therapist #1) did not know that he had a security clearance and would have advised against it had they been consulted. However, even after recommending involuntary hospitalization for Dr. Ivins because of his suicidality and homicidality, the psychiatrist who treated Dr. Ivins from 2000-2008 continued to take the position that Dr. Ivins should have full access to agents such as anthrax.
10. Failures in supervision, documentation, and communication allowed Dr. Ivins to avoid scrutiny before and after the anthrax mailings.

**IV. Recommendations<sup>2a</sup>**

1. Personnel Reliability Program measures that allow for requisition of medical records should be utilized. Consent to release of the employee's complete records should be made a condition of continued access and security clearance.
2. All possible measures should be taken to ensure the privacy of medical information, with information disclosed only on a "need to know" basis and with strict penalties for inappropriate disclosure.
3. Serious deficits in judgment, cognition, and behavior can occur with a variety of medical and psychiatric diagnoses and also in the absence of diagnoses; the vast majority of violence and other criminal behavior occurs in the absence of a major mental illness. Medical records may contain documentation of deficits in judgment and cognition as well as of disqualifying behaviors. Therefore, where security procedures call for review of medical records, review of those records should occur in all cases and not be predicated on the reported presence or absence of specific symptoms or diagnoses.
4. For those to be newly enrolled in Personnel Reliability Programs, requests for records and their reviews should be all-inclusive. Subsequent requests and reviews for records should extend to all available records for the previous five years or the entire period since the last complete record review, whichever is longer. Subsequent to detailed review of the records, the treating clinician providing these records should be interviewed to determine the completeness of the records. If additional notes and materials exist, and if there have been contacts with additional clinicians, these notes and materials should also be reviewed, and clinicians contacted.

**IV. Recommendations**

5. The Personnel Reliability Program process should include a longitudinal review of all medical questionnaires to detect discrepancies and inconsistencies. Any that are detected should be followed up.
6. Because institutions that deal with Biological Select Agents and Toxins (BSAT) evolve in their response to national security imperatives, the need for additional inventory control and other security measures within facilities should be evaluated on an ongoing basis.
7. Routine drug screening should continue to be mandated for all persons working within BSAT laboratories. The types of drugs screened in such programs should be reevaluated each year by an expert advisory board.
8. Background investigators should be trained thoroughly to recognize red flags that relate both to counterintelligence and mental health issues and to respond to those indicators with thorough investigations.
9. Information from treating clinicians should be regarded as important but not dispositive when questions of security clearance and fitness-for-duty are considered. All fitness-for-duty evaluations and medical reviews should be conducted by clinicians who have had no treatment or other relationship with the subject of the investigation. These clinicians should also receive specific training in conducting fitness for duty evaluations in high security settings.
10. Requests for information from treating clinicians should include a detailed written and verbal description of the significance of the information requested and the potential consequences to national security of inaccurate and incomplete information. A clinician providing this information should be asked to sign a form acknowledging this discussion and certifying the accuracy and

## IV. Recommendations

completeness of the information provided. The treating clinician should be given the option of recusing himself or herself from making the assessment, deferring to an independent evaluator. Release-of-information forms signed by the employee should contain a waiver indemnifying the clinician from civil actions resulting from passing on appropriate concerns in good faith.

11. Requests for reports recommending return to the workplace should be accompanied by a description of the person's essential job duties as well as potential security risks. The healthcare provider completing the report should sign an acknowledgment that he or she has reviewed that information and that his or her recommendations regarding job performance are based on that review.
12. Every facility in which work is done with high-risk materials or in which security issues are otherwise implicated should have an employee wellness program. The program should facilitate and encourage assistance for any employee demonstrating high levels of stress, signs of substance abuse, or other indicators of distress. Support for these programs — and their success — should be a core measure of job performance for supervisory personnel, including laboratory directors and principal investigators.
13. Steps should be considered to promote the flow of protected healthcare information between military and civilian care providers when indicated.
14. Facilities working with high-risk materials must ensure that supervision, documentation, and communications within and between agencies are given the priority that they deserve.

### End Note for Recommendations

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<sup>2a</sup>Recommendations for Personnel Reliability and Biosurety Programs are covered in greater detail in Appendix II.

## V. Introduction

### A. A NOTE REGARDING THE INVESTIGATION

The Amerithrax investigators — who came primarily from the FBI and the USPS — required vital assistance from dedicated scientists at USAMRIID as well as other specialized laboratories in the United States. As a result of previous investigations and membership in the same scientific community, many of these investigators and scientists had already established collegial relationships. Moreover, while USAMRIID scientists were actively assisting the investigation, the circumstances required that these same scientists undergo investigative scrutiny from the FBI and the USPS.

The complexity of these relationships posed an unprecedented challenge for both scientists and investigators and resulted in tensions that increased as the investigation wore on. The challenge was further intensified when the investigation began leading in 2005 to a particular laboratory at USAMRIID. Serious questions began to be raised about the behavior and contradictory statements of Dr. Bruce Ivins, a senior anthrax researcher at USAMRIID. The Panel's review of the evidence in this case made clear that in spite of these tensions, both groups retained their professional dedication.

### B. STATEMENT OF PURPOSE

Dr. Ivins' security clearance allowed him to work with potentially dangerous biological agents, including *Bacillus anthracis* (anthrax). Because of the potential lethality and national security implications of these agents, those working with them are required to obtain security and medical clearances, including disclosure to USAMRIID concerning current or past psychiatric or significant medical treatments. As part of his annual occupational medical reviews, Dr. Ivins had reported on many occasions that he had received outpatient psychiatric treatment as early as 1978 for what he described, primarily, as job-related stress.

## V. Introduction

Although the medical records would have been available to USAMRIID investigators responsible for security clearances, they were not obtained, even though Dr. Ivins signed appropriate waivers. None of these records, however, were available to federal investigators assigned to the anthrax attack investigation. While Dr. Ivins was still living, the only psychiatric records available to them dated back no further than 1997; the laws, regulations, and customs protecting patient privacy and confidentiality blocked or were perceived as blocking investigators from obtaining more. Moreover, even the records the government did obtain, in 2006, were limited. Secured through a grand jury subpoena, they not only began at 1997, but featured only automated insurance-related information — the names of doctors Dr. Ivins had visited from 1997 to 2006; the code names of the diagnoses they had offered; and the names and dosages of prescribed medications that had been billed to his health insurance.

Reflecting, again, the legal issues and concerns that surround medical confidentiality, none of the mental health professionals who were treating Dr. Ivins while the investigation was under way were interviewed until after a group therapy session in July 2008. In that session, Dr. Ivins made explicit homicidal statements. He had arranged to obtain firearms, he said, and he threatened to shoot several people, including co-workers.

The two therapists who led that group therapy session were alarmed. One of them contacted Dr. Ivins' psychiatrist, who was out of town. After hearing what had happened, the psychiatrist instructed one of the therapists to file an Emergency Petition for psychiatric assessment. Dr. Ivins was involuntarily transported to Frederick Memorial Hospital on July 10, 2008. In accordance with State of Maryland procedures, Dr. Ivins was then examined by two physicians, who concurred that he should be hospitalized immediately. He was transferred the next day to a psychiatric hospital, Sheppard Pratt in Towson, Md.

## V. Introduction

Because the emergency petition is a public court document, and because the petition referenced Dr. Ivins' own statements that he was already a suspect in the Amerithrax investigation, local police notified the FBI. On July 11, FBI investigators interviewed, for the first time, both the therapist who had sought the emergency petition and her supervisor, the other therapist who was present in the group meeting where Dr. Ivins had made his explicit threats. Later, the FBI also interviewed Dr. Ivins' psychiatrist, who had authorized the petition.

Dr. Ivins was discharged from the psychiatric hospital on July 24. Shortly thereafter, while at home, he deliberately ingested a lethal quantity of acetaminophen. He died in the hospital on July 29, 2008.

After Dr. Ivins' suicide, the Department of Justice obtained a court order allowing the FBI's Behavioral Analysis Unit's consultant psychiatrist, Dr. Gregory Saathoff, to review Dr. Ivins' complete psychiatric records, which had been under seal. This request was based on the belief that these records might contain valuable information, previously unavailable to investigators, that could help investigators better understand Dr. Ivins' motivations and behavior. The request was not made to help buttress the case against Dr. Ivins, but rather to achieve a better understanding of him.

After receiving hundreds of pages of records dating back over three decades, Dr. Saathoff concluded that the case was so grave and complex that the review should not be conducted solely by him, but by an independent multi-disciplinary panel. He asked the Department of Justice for authority to form such a panel and to share the records with its members. The Department of Justice concurred with his request and placed it before a Federal judge.

After considerable consultation with authorities in their disciplines, Dr. Saathoff specifically proposed a panel of experts with backgrounds in psychiatry, psychology, medicine, law, and network and systems

## V. Introduction

analysis. The panel members he proposed were all independent and impartial; none had treated or known Dr. Ivins, who had died a year earlier; none, indeed, had had any involvement with the case.

In September, 2009, Chief Judge Royce C. Lamberth of the U.S. District Court for the District of Columbia issued an Order authorizing this independent Panel of experts to examine "the mental health issues of Dr. Bruce Ivins and what lessons can be learned from that analysis that might be useful in preventing future bioterrorism attacks." (Because of other obligations, however, two of those selected — prominent psychologists who had expertise in systems issues and violence research — decided they could not take part. They made this decision before any sealed materials were shared and before the Panel's first meeting.)

Investigators in this case relied on new microbial forensic techniques developed by government, academic, and private-sector scientists to address these specific attacks. Because these techniques were new, the FBI requested the formation of a separate commission through the National Academy of Sciences to evaluate "the reliability of the principles and methods used by the FBI, and whether the principles and methods were applied appropriately to the facts." At the time of this report's completion, that report has not yet been released.<sup>2b</sup>

## C. METHODS

The Panel conducted a multidisciplinary review of Dr. Ivins' sealed mental health records dating back three decades. The Panel was also given access to the entire investigative file. Thus, in addition to the sealed mental health records, the Panel also reviewed professional and personal emails; notes from FBI interviews with people in Dr. Ivins' past, going back to his boyhood; documents from the American Red Cross and USAMRIID; and more. These documents eventually amounted to thousands of pages.

## V. Introduction

Because it was only given authority to review the documentary record, the Panel conducted no new interviews of its own. The material it examined contained numerous interviews and references regarding Dr. Ivins' family, friends, acquaintances and colleagues. This material was often very helpful in understanding not only Dr. Ivins as an individual but also his social and professional environment. Because of the personal nature of this material, the Panel took pains to safeguard the privacy of those referenced in the interview documents. Information that could be used to identify others has been minimized in this report, except when absolutely necessary to understand Dr. Ivins and crucial decisions regarding his care.

The Panel approached its work from two perspectives. First, it sought a comprehensive understanding of the mental health, behavioral, medical and toxicological issues. Second, it looked at systems — and specifically, how they could be altered to improve safety and security.

The Panel met face-to-face for approximately 15 days over a five month period from September 2009 through January 2010. Panel members also communicated regularly through scheduled conference calls, which continued until this report was completed. U.S. Postal Service investigators and FBI investigators were available to answer questions about materials relating to the investigation but were not considered Panel members and were not present during the periods of independent panel discussion and analysis.

In producing this report, panel members did not seek and did not receive guidance from the FBI, U.S. Postal Service or any other U.S. government agencies. The report was not reviewed by any government official prior to its completion. Except for reimbursement for travel, lodging and meals, Expert Panel Members received no compensation for any of their time on this project or the resulting work product — this report.

## V. Introduction

### D. TYPES OF MATERIALS EXAMINED

This report's posthumous analysis of Dr. Ivins' mental state and behaviors was conducted through a thorough review of material from multiple sources. As noted above, these sources included emails, USAMRIID files, American Red Cross documents, and psychiatric records. They also included confidential and non-confidential investigatory interviews with friends, family, colleagues, and mental health professionals who treated Dr. Ivins over the course of three decades. These sources of information complement one another and, in aggregate, provided a basis for developing an understanding of Dr. Ivins' mental functioning.

Emails sent and received by Dr. Ivins are especially valuable — they reveal Dr. Ivins' own understanding of his psychiatric care and his behaviors as they relate to his mental functioning. From the fall of 1999 to 2002, Dr. Ivins regularly accessed and monitored email exchanges between his two assistants without their knowledge. One of those women, who will be referred to as Technician #1, was first hired in 1988, and remained in his laboratory at USAMRIID under his supervision until 2002. The other, who will be referred to as Technician #2, had worked in his laboratory as a summer intern in 1994 before joining full-time in 1997. She left Dr. Ivins' lab in 1999 to attend medical school in New York State.

FBI interviews of Dr. Ivins himself, which took place at various times from 2002 to 2008, were also helpful in understanding his behavior and motivations. An additional perspective is achieved through review of relevant FBI interviews of family, friends and associates dating back to childhood. While these interviews were conducted during Dr. Ivins' life, the interview process with mental health professionals was completed after his death.

Psychiatric records — most notably documentation from psychiatric outpatient sessions and hospitalizations dating back to 1978 — have

## V. Introduction

provided critical and remarkable information. This information had been deemed confidential during Dr. Ivins' lifetime, accessible only to his medical providers and off-limits to investigators. The information remains confidential, and became available to this panel only as a result of a federal court order in 2009, well after Dr. Ivins' July 2008 death. These medical records, combined with FBI interviews of treating outpatient and inpatient mental health professionals, permit a more complete understanding of Dr. Ivins, his motivations, and his behaviors before, during, and after the anthrax attacks of September-October 2001.

## E. SUMMARY OF PSYCHIATRIC TREATMENT

Dr. Ivins had a long history of treatment by mental health professionals, dating back to his post-doctoral work at the University of North Carolina-Chapel Hill (UNC) in 1976-1978. By his own report, he visited a psychiatrist at least twice during that period; no records of that treatment, however, have been recovered.

After completing his work at UNC in the summer of 1978, Dr. Ivins was given the names of two mental health professionals in the Washington, D.C. area. [REDACTED]

[REDACTED] practitioner in suburban Maryland who will be known in this document as Dr. #1.

Dr. #1 retained her records of her treatment sessions with Dr. Ivins, and, in compliance with a federal court order, provided them to federal investigators. They show that she first assessed him on September 12, 1978, and continued to treat him, on an out-patient basis, for approximately one year, until the fall of 1979.

In the course of her treatment of Dr. Ivins, Dr. #1 noted that [REDACTED]

[REDACTED] Dr. Ivins [REDACTED]

## V. Introduction

[REDACTED]

Following his outpatient psychotherapy and medication treatment with Dr. #1, Dr. Ivins appears not to have requested or received any psychiatric care for about two decades. In 2000, however, [REDACTED] led him to seek out Dr. #1 again. By this time, however, she had retired. She referred him to another psychiatrist in suburban Maryland, Dr. #2.

In compliance with another federal court order, similar to the one sent to Dr. #1 and Dr. Ivins' other therapists, Dr. #2 consented to be interviewed by the FBI and provide his treatment records. They show that Dr. #2 conducted five treatment sessions with Dr. Ivins in the first half of 2000. In those sessions, Dr. Ivins revealed [REDACTED]

[REDACTED]

After the fifth session, Dr. #2 referred Dr. Ivins to Dr. #3, another Maryland psychiatrist, for reasons related to insurance coverage and location.

For the next eight years — from May 2000 until mid-July 2008 — Dr. #3 and his staff provided Dr. Ivins with individual psychotherapy, group psychotherapy, and medication management. The staff members who provided care other than medication management, which was provided by Dr. #3, were all therapists employed in Dr. #3's practice. They will be referred to here as Therapist #1, Therapist #2 and Therapist #3.

Early in his treatment in Dr. #3's practice, Dr. Ivins offered Therapist #1 [REDACTED]

[REDACTED]

## V. Introduction

[REDACTED]

[REDACTED]

Dr. Ivins was first diagnosed with [REDACTED] only during the last four months of his life, even though the email record [REDACTED] reveal that he was obtaining and using diazepam without a doctor's prescription as early as 1979 and abusing alcohol prior to 2001. [REDACTED]

[REDACTED]

The documentation related to Dr. Ivins' [REDACTED] from 1978 to 2000 and [REDACTED] thereafter is detailed. The outpatient records from 2000 to 2008, in contrast, feature scant documentation and substantial gaps, including the critical summer and fall of 2001. In an effort to fill these gaps, the FBI interviewed all outpatient and inpatient psychiatrists and therapists involved in Dr. Ivins' care during this period, and, to be thorough, before. Preliminary interviews with Therapists 1, 2, and 3, all from Dr. #3's practice, took place just before Dr. Ivins died, but most of the interviews took place only after his death, and only after court orders gave the FBI the authority to conduct them and to compel the clinicians to cooperate. These interview documents, as well as all other documentation, were reviewed by the Panel.

## V. Introduction

### End Note for Introduction

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<sup>2b</sup>Sharples, Fran. (2009). *Review of the scientific approaches used during the FBI's investigation of the 2001 Bacillus anthracis mailings*, retrieved from <http://www8.nationalacademies.org/cp/projectview.aspx?key=49105>.

**VI. Case Narrative****THE ATTACKS**

In September and October of 2001, at least five envelopes containing significant quantities of anthrax were mailed to addresses in the District of Columbia, New York City, and Boca Raton, Fla. The letters were addressed to people connected with the national media and also to the Capitol Hill offices of two U.S. Senators. The mailings were postmarked on two separate occasions. The first set, addressed to the media, were postmarked September 18, 2001. Inside the envelopes, the messages, printed without punctuation, read:

9-11-01  
THIS IS NEXT  
TAKE PENACILIN NOW  
DEATH TO AMERICA  
DEATH TO ISRAEL  
ALLAH IS GREAT

Three weeks later, letters postmarked October 9, 2001 were sent to Senators Tom Daschle and Patrick Leahy in Washington, D.C. These contained a slightly longer message with a more dire warning that now identified the agent. The message read:

9-11-01  
YOU CAN NOT STOP US.  
WE HAVE THIS ANTHRAX.  
YOU DIE NOW.  
ARE YOU AFRAID?  
DEATH TO AMERICA.  
DEATH TO ISRAEL.  
ALLAH IS GREAT.

The two envelopes addressed to Capitol Hill contained the same fictitious return address, which read, "4th GRADE," "GREENDALE SCHOOL," "FRANKLIN PARK NJ 08852." The ZIP code on the envelopes

## VI. Case Narrative

did not correspond to Franklin Park, N.J., however, but rather to Monmouth Junction, N.J.

At least 22 people contracted anthrax as a result of the two mailings. Eleven of them contracted inhalational anthrax and 11 others cutaneous anthrax. Five of the inhalational victims, including two U.S. Postal Service employees, died: Robert Stevens; Thomas L. Morris, Jr.; Joseph P. Curseen, Jr.; Kathy T. Nguyen; and Otilie Lundgren. (For more information on the victims, please see Attachment #1.) In addition to these identified victims many more people were exposed to anthrax spores released from the mailings, the Centers for Disease Control (CDC) and other governmental and academic institutions determined. These people received mandatory treatment with the antibiotic Ciprofloxacin and avoided serious illness.

Anthrax is the name of both a type of bacteria, *Bacillus anthracis*, and the disease it causes.<sup>3</sup> Although there are 89 known strains of the bacteria, the CDC and organizations assisting it determined within a couple of weeks that just one — the Ames strain — had been present in each of the deceased and had caused the infections. The CDC determined that the Ames strain had been present in the threat letters, as well.<sup>4</sup>

In the course of the federal investigation that followed these attacks, four of the five envelopes known to have been mailed were recovered. All four were 6 1/2 inch federal eagle envelopes bearing a postage frank containing the image of an eagle in the upper right-hand corner. Investigators determined that these specific envelopes contained an unusual printing defect, and identified them as having been purchased at post offices in either Maryland or Virginia. The investigation further revealed that although the letters had been mailed on two separate occasions, all four of the ones that were recovered had been dropped in the same mail collection box, at 10 Nassau Street, in Princeton, N.J. The letters had all been postmarked at the Hamilton Township Regional

## VI. Case Narrative

Postal Facility in Hamilton, N.J. — the first group on Sept. 18, 2001, the second on Oct. 9, 2001.

### INVESTIGATION

In 2001, Dr. Ivins was a 55-year-old senior microbiologist in the Bacteriology Division at the United States Army Medical Research Institute of Infectious Diseases (USAMRIID). A 21-year veteran of the institute and a co-author of numerous scientific papers, he was an expert in *Bacillus anthracis* — and specifically its growth, purification, and “sporulation,” the process by which spores are produced and released. Now, in 2001, he essentially supervised quality control for the nation’s best defense against anthrax — a commercially produced vaccine given to members of the U.S. Armed Forces. He produced large batches of *Bacillus anthracis* that were tested on vaccinated laboratory animals, to see whether the vaccination would protect them.

In the immediate aftermath of the attacks, Dr. Ivins joined in the investigation. At the government’s request, he and his colleagues tested samples to help explain how the anthrax used in the attacks had been processed. He also presented himself to authorities as someone who could help identify the perpetrator. In the months of November, December and January, he repeatedly said the anthrax used in the attacks resembled that worked with by a former colleague. During that period, he also provided a spore-production diagram to a subordinate that implicated a current colleague. In good faith, this subordinate provided this erroneous information to investigators, who took it seriously.

Over the years, Dr. Ivins identified several current and other former colleagues as suspects, including, ultimately, his two closest former colleagues, Technicians #1 and #2. The individuals he identified often differed according to whether he was speaking with investigators or colleagues. At one point, Dr. Ivins even gave — [REDACTED]

**VI. Case Narrative**

[REDACTED] as the potential mailer. That Dr. Ivins never named [REDACTED] to the investigators or anyone else can perhaps be explained as an effort to deflect attention anywhere and everywhere. (For its own reasons — the FBI had no way of knowing what Dr. Ivins was telling his therapist at that time — investigators [REDACTED]  
[REDACTED]  
[REDACTED]

The information Dr. Ivins provided was taken seriously because of his stature in his field — investigators checked out the people he suggested. But the individuals themselves had no way of knowing that Dr. Ivins was naming them to investigators. He maintained professional and cordial relations with them all.

Moreover, Dr. Ivins tried to publicly embarrass co-workers who were cooperating with the FBI, even as he was providing names. Early in the investigation, a USAMRIID supervisor who had been out of town for a few days returned to find a poster on her office door that branded her an “FBI rat,” she told investigators. The supervisor “believed that Ivins put the sign up out of jealousy because he was no longer involved in the anthrax investigation like she was,” the investigators noted. Dr. Ivins later admitted that he had been responsible.

One person the anthrax mailer could not be, Dr. Ivins indicated, was himself. In November, 2001, he told his former Ph.D. advisor that the anthrax used in the letters was “weapons grade, so clean and so pure that nothing he had ever done was so good.”

In a case replete with circumstantial evidence, however, it is worth taking note of Dr. Ivins’ language to describe the anthrax in the letters. In a report dated March 12, 2002, he offered a scientific description that was very similar to one he had entered in his own lab notes on October 22, 1997 to describe the spores he used in his own research.

## VI. Case Narrative

In its independent scientific analysis, Sandia National Laboratories demonstrated that the mailed anthrax spores were non-weaponized.<sup>5</sup>

In the aftermath of the attacks, Dr. Ivins also sought at times to offer more benign or far-fetched explanations for what had happened. In October 2001 he contacted a colleague at the CDC to suggest the unusual idea that the first victim, Robert Stevens, might have contracted inhalational anthrax by drinking water downstream from an infected animal carcass. And as late as 2003, Dr. Ivins offered explanations that reflected a primitive rather than sophisticated origin for the outbreak, contradicting his own earlier written assessment that the anthrax spores were of high quality. In February of 2003, he told investigators that he "was recently at Home Depot and saw the many different grades of sandpaper that they sell which made him think about the use of sand in purifying B.A. A pasty block of spores can be shaken with sand of varying coarseness to achieve very pure or fine spores. Ivins advised [investigators] that Iraq has very fine sand."

But as eventually became clear, Dr. Ivins did more than offer investigators blind alleys.

To mount a systematic hunt for the source of the anthrax in the envelopes, federal investigators created an inventory of anthrax in circulation by issuing subpoenas for more than 1,000 anthrax samples at domestic and international laboratories. The subpoenas provided written instructions about how the samples were to be collected and prepared, including the type of agar or media to be used.

One of those who received a subpoena was Dr. Ivins. In February 2002, he prepared and submitted eight samples, two from a batch he developed in 1997 and labeled "RMR-1029" (the label refers to the "Reference Material Receipt" used to document the specimen) and others from different batches. Dr. Ivins followed the specific instructions concerning the agar on which the non-RMR-1029 samples were prepared, but he disregarded them for the RMR-1029 samples.

## VI. Case Narrative

That was in spite of the fact that the instructions had not only been written in the subpoena, but had been repeated to him personally by an FBI agent who was also a Ph.D. microbiologist. Disregarding both directives, Dr. Ivins used an agar he had prepared himself for the RMR-1029 samples, instead of the standard, commercial product specified.

Shortly thereafter, government officials developed a new technique that they hoped would help them identify the source of the anthrax used in the attacks. Analysis of the anthrax found in the mailings indicated the presence of certain distinctive mutations, which amounted to genetic markers. Through a collaboration of government, academic and private-sector scientists, the investigators resolved to develop sophisticated new genetic tests that would enable them to make better identifications of these mutations. In essence, the mutations would serve as fingerprints that they hoped would lead them to a source.

The new technique was spelled out in classified briefings, including one held at USAMRIID and attended by Dr. Ivins.

In April, after the classified briefings, government scientists examined Dr. Ivins' February samples and realized they had been prepared incorrectly. As a result, they discarded the four samples they were supposed to analyze and asked him to resubmit.

This time he followed the instructions regarding the agar, but, for reasons he never explained, made the labeling inconsistent by renaming the spores. Instead of calling them RMR-1029, he labeled them "Dugway." Although this was the name of a facility that had assisted in production of the spores, its adoption here was a highly unorthodox departure from standard scientific procedure.

## VI. Case Narrative

In any event, government scientists tested these new, April 2002 samples and found them negative for the four genetic markers they had preliminarily identified.

What the scientists did not recognize — what was not understood for several more years, when scientific advances made the insight possible — was that Dr. Ivins had deliberately altered his April submission in a manner that minimized the potential for identifying mutations. He had effectively smudged the evidence, and done so in a way so sophisticated that no one recognized it.<sup>6</sup> As a result, the trail of evidence leading to Dr. Ivins remained cold. Investigators focused elsewhere, especially on Dr. Hatfill.

Had investigators been more suspicious of Dr. Ivins, they might have been more concerned about something else that happened in April 2002. He acknowledged that he had swabbed portions of the office just outside the hot suite that month, and also in December 2001, in tests for anthrax. Moreover, many of the swabbings had tested positive, and he had followed up by cleaning the appropriate areas.

In both instances, Dr. Ivins had flagrantly violated procedures, which called for: 1) his seeking approval to have the swabbings performed; 2) an independent third party to conduct the swabbings; and 3) a third party again to disinfect the affected areas once the swabbings had been cultured and confirmed the presence of anthrax.

Dr. Ivins, however, had a well-earned reputation for independence and eccentricity. Investigators therefore treated this incident — like his failure to use the right agar in the February submission — as simply more evidence of his unorthodox ways.

In fact, far from inspiring skepticism, Dr. Ivins continued to win approbation from some quarters, including the U.S. government. On March 14, 2003, he and two of his colleagues at USAMRIID received the Decoration for Exceptional Civilian Service, the highest

## VI. Case Narrative

award given to Defense Department civilian employees. The award recognized their service in helping to solve technical problems in the manufacture of the anthrax vaccine.

As time passed, however, more questions about Dr. Ivins arose.

Scientists had continued to refine their new techniques for identifying genetic mutations in the spores. Of the more than 1,000 anthrax samples that had been collected, only eight had proved to contain the four mutations that the scientists were now fixed on as their markers. All of the laboratories that provided those samples identified the original source from which their own spores had been cultivated, as the RMR-1029 flask at USAMRIID controlled by Dr. Ivins.

Yet the April 2002 submission of samples by Dr. Ivins had proved negative. How could that be?

In April 2004, investigators decided to bypass the sample process and obtain the actual RMR-1029 flask, rather than trusting Dr. Ivins again to provide a sample from it.

The flask was stored in USAMRIID's Building 1425, in a "hot suite," a small, windowless, bio-containment room to which access was tightly restricted. Only those individuals who had been approved by the USAMRIID Security, Safety, and Special Immunizations Program could gain entrance. These people had passed the required background checks and obtained the required training and medical protection (vaccination and/or personal protective equipment (PPE)). Many of them had a Secret security clearance.

An FBI agent accompanied Dr. Ivins to the hot suite and, as he later recalled, asked him for his anthrax. Dr. Ivins and the FBI agent, a Ph.D. microbiologist, entered a walk-in cooler filled with hundreds of flasks and beakers, and Dr. Ivins brought out two samples.

## VI. Case Narrative

The agent then asked Dr. Ivins whether that was all the anthrax he had. It was, Dr. Ivins said. The agent then specifically asked about the RMR-1029 flask.

Dr. Ivins walked back into the cooler and returned with a standard, one-liter vessel, and labeled with a black Sharpie. The anthrax inside was in liquid form. Unlike the two samples he had readily volunteered, Dr. Ivins had held back the RMR-1029 — surrendering it only when specifically requested.

Later, Dr. Ivins' technicians reported that they had never seen the flask. He had been its sole custodian and presumably had kept it concealed in the cooler.

Soon, anthrax from the seized RMR-1029 flask was tested with the more sophisticated assay techniques that scientists had been developing. The question was whether the anthrax from the flask would show the same genetic markers as the anthrax used in the mailings.

The preliminary results returned that summer of 2004 were positive.

But that confirmation raised a question of its own. Why would the RMR-1029 from the flask have tested positive when the April 2002 samples did not? The February 2002 samples had, as noted, been discarded, but they would presumably have come from the same flask as the April 2002 samples, and therefore should have tested negative as well.

At that point, the investigation took another of its many remarkable twists.

As previously noted, the analysis of the different samples of anthrax represented a collaboration between government and academic and private-sector scientists. Although government analysts had discarded their four February 2002 samples from Dr. Ivins, government officials

## VI. Case Narrative

had forwarded his other four samples to a senior academic researcher, Dr. Paul Keim. It was this researcher's job to screen the anthrax samples collected from the laboratories that held them to determine whether they were Ames strain. And problems with agar notwithstanding, Dr. Keim had not discarded Dr. Ivins' samples as government investigators had assumed. He had put them in the laboratory cooler.

They had remained there until early 2006, when Dr. Keim asked the government investigators what he should do with them. The investigators asked that the samples be tested.

The results came back soon: Positive.

Dr. Ivins now found himself the subject of intense federal scrutiny. The interest investigators had once focused on Dr. Hatfill began to shift to him. They re-interviewed his associates and re-examined the interviews he himself had provided. By late 2006 they had him under periodic surveillance. In the spring of 2007 they began monitoring his computer. By the fall of 2007 they had installed Global Positioning System (GPS) devices on his cars. And in October 2007, federal investigators obtained a warrant to search his home and lab to gather additional information. According to their Application and Affidavit in Support of the search warrant:

- (1) At the time of the attacks, Dr. Ivins was the custodian of a large flask of highly purified anthrax spores that possessed certain genetic mutations identical to the anthrax used in the attacks;
- (2) Ivins had been unable to give investigators an adequate explanation for his late night laboratory work hours around the time of both anthrax mailings;
- (3) Ivins had claimed that he was suffering serious mental health issues in the months preceding the attacks, and told a

**VI. Case Narrative**

coworker that he had "incredible paranoid, delusional thoughts at times" and feared that he might not be able to control his behavior;

(4) Ivins was believed to have submitted false samples of anthrax from his lab to the FBI for forensic analysis in order to mislead investigators;

(5) At the time of the attacks, Ivins was under pressure at work to assist a private company that had lost its FDA approval to produce an anthrax vaccine the Army needed for U.S. troops, and which Ivins believed was essential for the anthrax program at USAMRIID; and

(6) Ivins sent an email to a colleague, a few days before the anthrax attacks warning that "Bin Laden terrorists for sure have anthrax and sarin gas" and have "just decreed death to all Jews and all Americans," language similar to the anthrax letters warning "WE HAVE THIS ANTHRAX ... DEATH TO AMERICA ... DEATH TO ISRAEL."

After the warrant was issued, Dr. Ivins continued to attempt to divert suspicion to colleagues and ultimately suggested that his two former technicians may have been responsible for the mailings. But continued investigation revealed additional discrepancies in Dr. Ivins' statements, as well as suspicious behaviors that he could not explain.

By early July 2008, he and his attorney had received notification: The U.S. government was preparing to indict him for a potentially capital offense.

## VI. Case Narrative

### Long Hours in the "Hot Suite" — with Reading Material

Dr. Ivins' work with anthrax took place in a USAMRIID "hot suite" — or high-security laboratory — in USAMRIID's Building 1425. Designed for pathogens that could be used against the United States in biowarfare, the Biosafety Level 3 (BSL-3 or simply B3) hot suite is a group of rooms connected by a central hallway. One of those rooms contains a large cooler that holds specimens, including anthrax. Another room is a laboratory, containing a sink, cabinets, and an autoclave. A third contains an office that was used by Dr. Ivins and his assistants. A lyophilizer — a piece of equipment that could be used to dry anthrax and convert it to the form used in the mailings of September and October, 2001 — was in the hallway.

Access required specific electronic badge authorization — a privilege held in September and October of 2001 by just 14 people with the requisite skills and abilities. Entrance and egress required an effort. To get in required that one disrobe completely and put on a scrub suit and protective footwear. To get out required a thorough shower. There are no windows. Eating and drinking are forbidden.

Most researchers did not spend time in the hot suite unless it was necessary. In the words of one of Dr. Ivins' supervisors, hot suites are "a terrible place to work."

Beginning in mid-August, 2001, Dr. Ivins significantly changed his work schedule and dramatically increased the time he spent in the suite. Between September 11 and October 8, 2001 alone, he accessed the suite outside of normal business hours on 15 different days, automated entry data shows. These visits included late nights and weekends.

Hours like this were not characteristic of other researchers, and when questioned about them, Dr. Ivins admitted that his professional duties did not require them. He had used the B3 suite to get away from his family, he explained.

Dr. Ivins' own writings do not support this claim. Before and after this period, he sometimes wrote long emails discussing family problems as well as his daily activities. During the six-week period before the mailings, however, his personal writings did not refer to

**VI. Case Narrative****Long Hours in the “Hot Suite” — with Reading Material  
*continued***

greater difficulties at home. In fact, at least one email reflected favorably on family relationships and accomplishments. And although his day-to-day conversation with Technician #1 and emails to Technician #2 were filled with personal and often banal information, he never referred to his extraordinary hours in the suite to either of them. Neither woman knew a thing about the extreme change in his work pattern, which ended — as abruptly as it had begun — shortly before the second set of letters was postmarked on October 9.

Uninviting as the hot suite was, Dr. Ivins and some of his colleagues sometimes took reading material there that was unrelated to their research.

A colleague noted that one periodical to be found there was the *National Enquirer*. Although it was brought in by one of Dr. Ivins' technician assistants, Dr. Ivins occasionally referred to the publication himself in emails and in conversations, and once joked that he might someday be the subject of one of its headlines: “Paranoid Man Works with Deadly Anthrax.”

Among the recipients of the first set of anthrax letters was the parent company of the *National Enquirer*, American Media Inc. (AMI), then based in Boca Raton, Fla. The address of the parent company at that time — the address to which the letter was sent — was the former address of the *National Enquirer* itself, as listed in the back issues that had piled up in Dr. Ivins' office. One copy of the paper was found in the hot suite. The letter caused the death of photographer Robert Stevens, the first of the five fatalities from the mailings.

Dr. Ivins also brought non-scientific reading material into the hot suite. A witness recalled that Dr. Ivins had a subscription in his name to the American Family Association (AFA) Journal, and would bring issues into B3, where they would accumulate. Dr. Ivins would sometimes discuss the contents of the journal with subordinates at work, the witness said. Investigators later learned that beginning in

**VI. Case Narrative****Long Hours in the "Hot Suite" — with Reading Material  
*continued***

1993, "Mr. and Mrs. Bruce Ivins" had made 11 different donations to the AFA.

In October 1999 the AFA Journal ran a story about a lawsuit the AFA Center for Law and Policy had filed on behalf of parents of students at the Greendale Baptist Academy in Greendale, Wis. The suit involved a fourth grade student, and involved an alleged violation of the parents' Constitutional rights by the State of Wisconsin. Specifically, the suit alleged that the Department of Human Services had interviewed the student about alleged corporal punishment at school without telling the school's staff why the interview was to be conducted and without allowing the parents to be present. A month later, "Mr. and Mrs. Bruce Ivins" made their first contribution to the AFA in about two years.

The anthrax envelopes mailed to Capitol Hill to the offices of Senators Daschle and Leahy both carried the return address "4th Grade, Greendale School."

**SUICIDE**

Through his attorney, Dr. Ivins formally requested the additional legal assistance the U.S. government offers defendants in federal capital cases. Within two days of that filing, however, on July 9, 2008, Dr. Ivins made a series of violent threats at his group therapy session. He told the group therapy session attended by two therapists that he had arranged to procure a Glock handgun. He said he had made a list of people — co-workers and at least one person acquainted with his family — whom he would kill.

As a result, and on the advice of Dr. #3, one of the two therapists attending the session initiated the process for civil commitment. On July 10, Dr. Ivins was sent involuntarily to Frederick Memorial Hospital

## VI. Case Narrative

for a psychiatric assessment. The next day he was transferred to Sheppard Pratt Hospital in Towson, Md. on an involuntary basis.

Dr. Ivins was discharged from Sheppard Pratt on July 24. Within hours, he had paid two visits to a Giant Eagle store near his home to buy Tylenol PM, among other items. Five days later, he died of a lethal overdose of that drug's pain-killing ingredient, acetaminophen.

### **COMPREHENSIVE PERSONAL, SOCIAL AND PSYCHIATRIC BACKGROUND**

*The following review of Dr. Ivins' life is based on a comprehensive review of multiple sources: psychiatric records dating back 30 years, USAMRIID documents, American Red Cross documents, court orders, Dr. Ivins' email exchanges with friends and associates, his FBI interviews, and FBI interviews with USAMRIID colleagues, family, friends and associates.*

### **DEVELOPMENTAL HISTORY**

The youngest of three boys, Bruce Edwards Ivins was born April 22, 1946 and reared in southwest Ohio, in Lebanon, where his father, Randall, owned and managed the Ivins-Jameson Pharmacy. The Ivins family traces its American roots to 17th century New Jersey. Bruce Ivins' great-great-grandfather Thomas Ivins was born in what was then known as Monmouth, N.J., before moving to Ohio in the 19th century.

For reasons whose significance will become clear later in this narrative, it is important to note that Bruce Ivins was aware of this family genealogy. In a file where he kept important papers, he saved a letter, dated August 26, 1986, from a paternal relative. This letter specifically related the genealogy of the Ivins family, and listed Thomas Ivins and his father, Barzillai, whose ancestors had also been born in Monmouth, N.J.

According to a family acquaintance interviewed by the FBI, it was Dr. Ivins' grandfather, Wilbur Ivins, who established the family

**VI. Case Narrative**

pharmacy in Lebanon, and who maintained it until his son Randall assumed ownership and operation. Randall, in turn, operated the pharmacy until the early 1970s. Randall, a graduate of Princeton University, was a licensed pharmacist.

Mary Ivins, Dr. Ivins' mother, was a homemaker who also helped her husband in the pharmacy. During the last month of his life, Dr. Ivins described himself as having been a [REDACTED]

[REDACTED] At another time he also reported that his aunt informed him that he had been an unplanned pregnancy, and that his mother had attempted to abort him by rolling down the steps.

He had not been wanted, Dr. Ivins made it clear to others. And to the extent that his parents had wanted a child, it was a girl: They already had two sons.

[REDACTED] In a March 2005 interview with investigators, Dr. Ivins said that when he was about 10, the family did take a trip; he "traveled through the town of Princeton with his parents, circa 1956, on a family vacation which included a tour of historic sites..." Later, as the investigation intensified, he denied to the FBI having ever set foot in Princeton.

Dr. Ivins' disclosures to the FBI concerning his childhood contain some highly unusual features. In a February 2008 interview, he reported that he had developed his lifelong fascination with blindfolds at the age of five or six, when he began blindfolding his stuffed animals and teddy bears. He also said his "obsession snow-balled over the years and eventually took on a sexual focus." [REDACTED]

**VI. Case Narrative**

[REDACTED]

[REDACTED]

[REDACTED] In retrospect, he suspected [REDACTED] s brothers, however, have disagreed with this assessment, and she had no known history of psychiatric hospitalization.

Family and friends recalled that Mary Ivins could be extremely aggressive. In the last month of his life, [REDACTED]

[REDACTED] Often, he reported, she physically abused his father. This report is corroborated by residents of Lebanon who knew the family. According to one acquaintance there, on one occasion Mrs. Ivins urgently contacted her husband's physician. "I think I killed Randall," she reported. When the doctor came to the house, Randall Ivins answered the door "covered in blood," having been beaten "with a broomstick."

Others from Lebanon recalled that Mrs. Ivins struck her husband on the head with a "frying pan," stuck a fork in her husband's hand, ran her husband "out of the house with a broom," and "got into fistfights" with him, leaving him with "a black eye" at least once if not on several occasions.

Dr. Ivins told others that witnessing the physical violence his mother perpetrated on his father subjected him to extreme emotional distress. In a March 24, 2003 email to a colleague, he recalled:

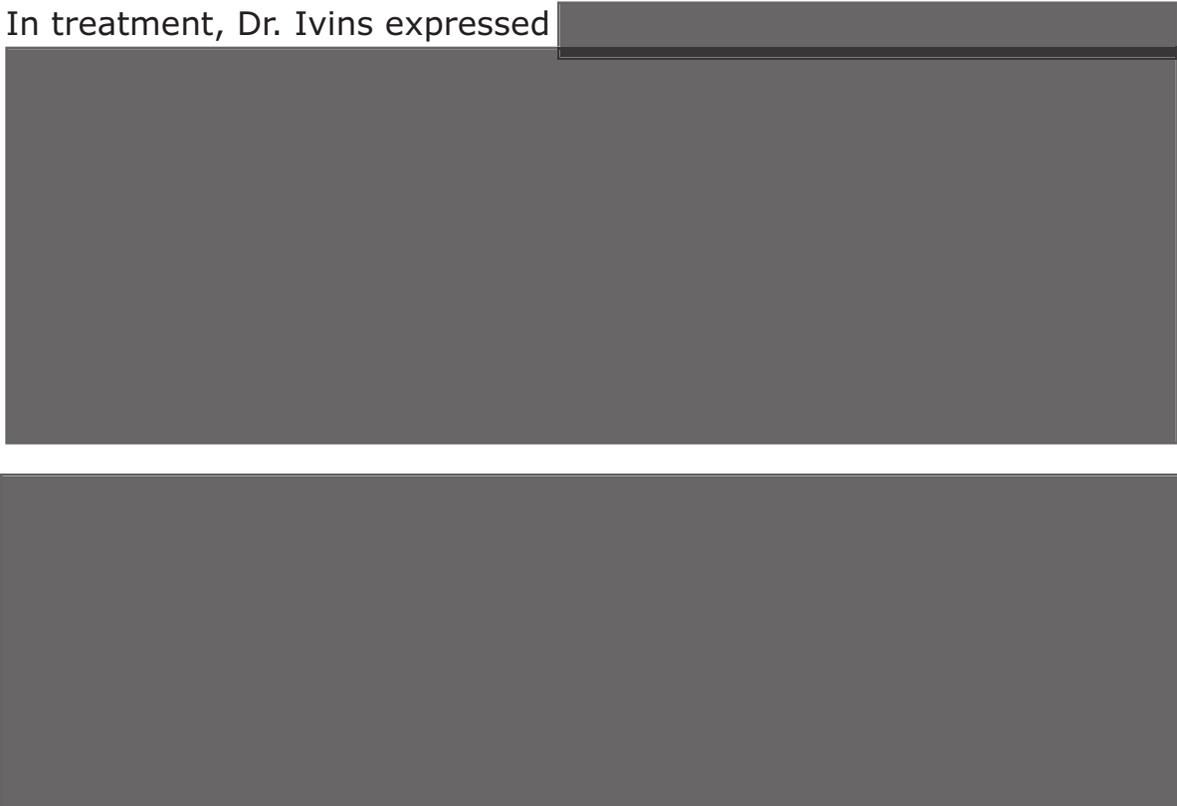
In all my years I never remembered her saying please or thank you to my father, and I never heard her say a SINGLE kind thing about him...lots of nasty things, but nothing kind. I also

## VI. Case Narrative

saw her physically assault him (and draw blood) on occasions. Then she bought a gun and loaded it, and that was the scariest of all.

In contrast to his mother, Dr. Ivins' father was, by his son's account, extremely passive. A childhood acquaintance also reported that the father sometimes treated his son with a distinct lack of kindness — with severe, public teasing. The acquaintance recalled that Dr. Ivins was, as a boy, an avid coin collector. His father, the acquaintance said, once played a prank on him — in the presence of this acquaintance — by gluing a roll of pennies together, preventing his son from looking at them. The acquaintance also recalled that the father referred to Dr. Ivins with the name "Snivi" — "Ivins" spelled backwards. "It was not used as an affectionate term," the acquaintance noted. "It was more to irritate him." The name was also given to a home remedy product sold in the pharmacy.

In treatment, Dr. Ivins expressed



## VI. Case Narrative

[REDACTED]

Both of Dr. Ivins' parents are deceased. His mother died of bladder cancer in 1970, when he was 24 years old and still a student at the University of Cincinnati. His father continued living for a while in Lebanon, but was ultimately moved to Frederick by Dr. Ivins and his wife due to failing health. He lived in a separate house in their neighborhood until his death from cardiovascular disease and prostate cancer in 1985.

It was a lonely childhood. [REDACTED]

[REDACTED] He was seven years younger than his next-older brother. According to an acquaintance who knew the family, Dr. Ivins' and this brother had some commonalities in temperament, and the two brothers vacationed together as adults at least twice. Dr. Ivins did not have a close relationship, however, with his eldest brother. In August 2008, National Public Radio reported that this brother believed Dr. Ivins was indeed the anthrax mailer.<sup>7</sup>

### EDUCATION

Bruce Ivins was a strong student in high school — he was selected as a member of the National Honor Society — and performed especially well in science. Socially, however, classmates described him as awkward. He had no close friends, his brothers and high school classmates recall, and he did not date. He himself later recalled his high school years as unhappy, and he attended no reunions. However, he did engage in numerous extracurricular activities while a student. His high school senior class yearbook, the 1964 Trilobite, includes photographs depicting his participation in track, music, drama, and photography, as well as the yearbook itself.

One classmate described Dr. Ivins as "driven and intense." He wanted to attend his father's alma mater, Princeton University, she recalled, because it was part of the Ivy League. But he was outshone by at least

**VI. Case Narrative**

some of his classmates, [REDACTED]

After high school, Bruce Ivins attended the University of Cincinnati, where he spent 12 years — 1964 to 1976 — earning a B.S. degree, M.S. degree, and Ph.D. in microbiology. Over the course of those dozen years, he exhibited some [REDACTED]

His freshman year was the best year of his life, he later said, but it appears that he soon began suffering symptoms of stress. He told Dr. #1 [REDACTED]

Dr. Ivins' social arrangements at the university did not include fraternity membership; he lived in dormitories and apartments with roommates. By his own description, however, he developed an "obsession" with a female sorority, Kappa Kappa Gamma (KKG). A national women's fraternity, KKG had been established in 1870 at Monmouth College in Illinois. As an undergraduate, Dr. Ivins later told FBI interviewers, he asked a KKG sorority member, who will be referred to here as KKG Sister #1, for a date. She declined. Forty years later, in January and February 2008, he told the FBI that he viewed this perceived slight as the start of an obsession that greatly influenced his behavior for the rest of his life.

During his years at the University of Cincinnati he also developed a strong interest in guns — to the extent that he fired them in residential buildings on several occasions. [REDACTED]

**VI. Case Narrative**

Another time, he said, [REDACTED]

[REDACTED]

recalled that in an apparent jest, Dr. Ivins brought a gun to his graduate thesis defense, placed it on the table, and asked if there were “any questions.”

A friend from those days, interviewed in 2007, described him as “eccentric, sensitive and unusual” and as “march(ing) to his own drummer.” This friend, a classmate, recalled that if one of Bruce’s roommates ate his food, he would refer to pills in his possession, and say — in a threatening manner — “you wouldn’t want me dropping this in your water.” The classmate said Ivins depicted himself as knowing “evil” and “clandestine-type things, and was intrigued to know things that no one else knew about. ... Ivins felt that he knew these things [pharmacology, chemistry] better than anyone else and could use his knowledge to intimidate his roommates into respecting him since he wasn’t very physical or verbal.”

While at the University of Cincinnati, Dr. Ivins met his future wife, a much younger woman, at a church function. Born and raised as a Presbyterian, he converted to her religion, Catholicism, at about the time of his marriage, in 1975.

**PATHOLOGICAL ATTACHMENT TO A MICROBIOLOGIST ASSOCIATED WITH KKG**

After earning his Ph.D., Dr. Ivins moved in 1976 to the University of North Carolina-Chapel Hill to do post-doctoral work.

One of his advisors, many years later, could still recall his being “fixated” on sorority secrecy. She had never been a member of KKG, but he nonetheless pressed her to reveal her secret handshakes and initiation rites. She remembered telling him “that it was none of his business or to just go away.”

**VI. Case Narrative**

Dr. Ivins did eventually let the subject drop with this advisor. Another woman at UNC, who will be known in this report as KKG Sister #2, was less fortunate.

Then in her mid-20s, KKG Sister #2 had joined the sorority as an undergraduate at UNC. Now, as a graduate student, she held an advisory role there. She and Dr. Ivins shared neither office space nor advisors nor research interests. Nonetheless, Dr. Ivins read materials on her desk, he told FBI interviewers in 2008, and in so doing learned of her KKG connection. Soon, by his own description, he became obsessed with her.

"Because she was a member of KKG," he told investigators, "[he] paid close attention to all aspects of [KKG Sister#2's] life, and he would periodically ride by her house without making contact with her. Ivins still remembers details about [KKG Sister #2], such as the make and model of the car she drove."

Dr. Ivins' obsession with KKG Sister #2 would make her a defining character in his life, influencing his personal and professional behaviors in many ways. He later told his psychiatrist [REDACTED]

The object of these attentions, however, felt uncomfortable with his intrusive behavior, especially after he gave her a long letter expressing his admiration and divulging personal details from his childhood. As a result, she distanced herself, [REDACTED]

**VI. Case Narrative**

Dr. Ivins' obsession with KKG Sister #2 was significant enough that he also burglarized the KKG house in Chapel Hill while they were both living there — [REDACTED] Talking to investigators 30 years later, in February of 2008, he could still recall one of the break-ins in vivid detail. According to investigators' notes of that interview, Dr. Ivins:

entered the house at night through a first floor bathroom window which was located behind a shrub. Although there were several lights on inside, [I] knew nobody was there as those lights were always left on. Using a small pen light to help [me] see, [I] went upstairs and looked for anything which was locked and may contain secretive sorority documents or materials. There was a hallway closet which was locked, so [I] used a coat hanger or some similar object to open the door. Inside the closet [I] found the "Cipher" and some documents regarding KKG rituals. The Cipher was a document encased in glass, and it referred to a book of ritual which [I] also looked for but did not find. In an unlocked closet directly across from that which

**VI. Case Narrative**

contained the Cipher were some blindfolds made from torn bed sheets. [I] assumed the blindfolds were used for the KKG initiation, but did not take them." Dr. Ivins said he "left after spending about an hour in the house, taking with [me] the Cipher and ritual materials."

Because of his intense and persistent need to take revenge on KKG Sister #2, Dr. Ivins, later told his psychiatrist [REDACTED]

[REDACTED]

[REDACTED] KKG Sister #2 questioned Dr. Ivins about their disappearance, but he denied any knowledge. Ultimately, as he later revealed [REDACTED] to the FBI, he deposited the notebooks, without postage, in a public collection mailbox, where they were found and returned to her.

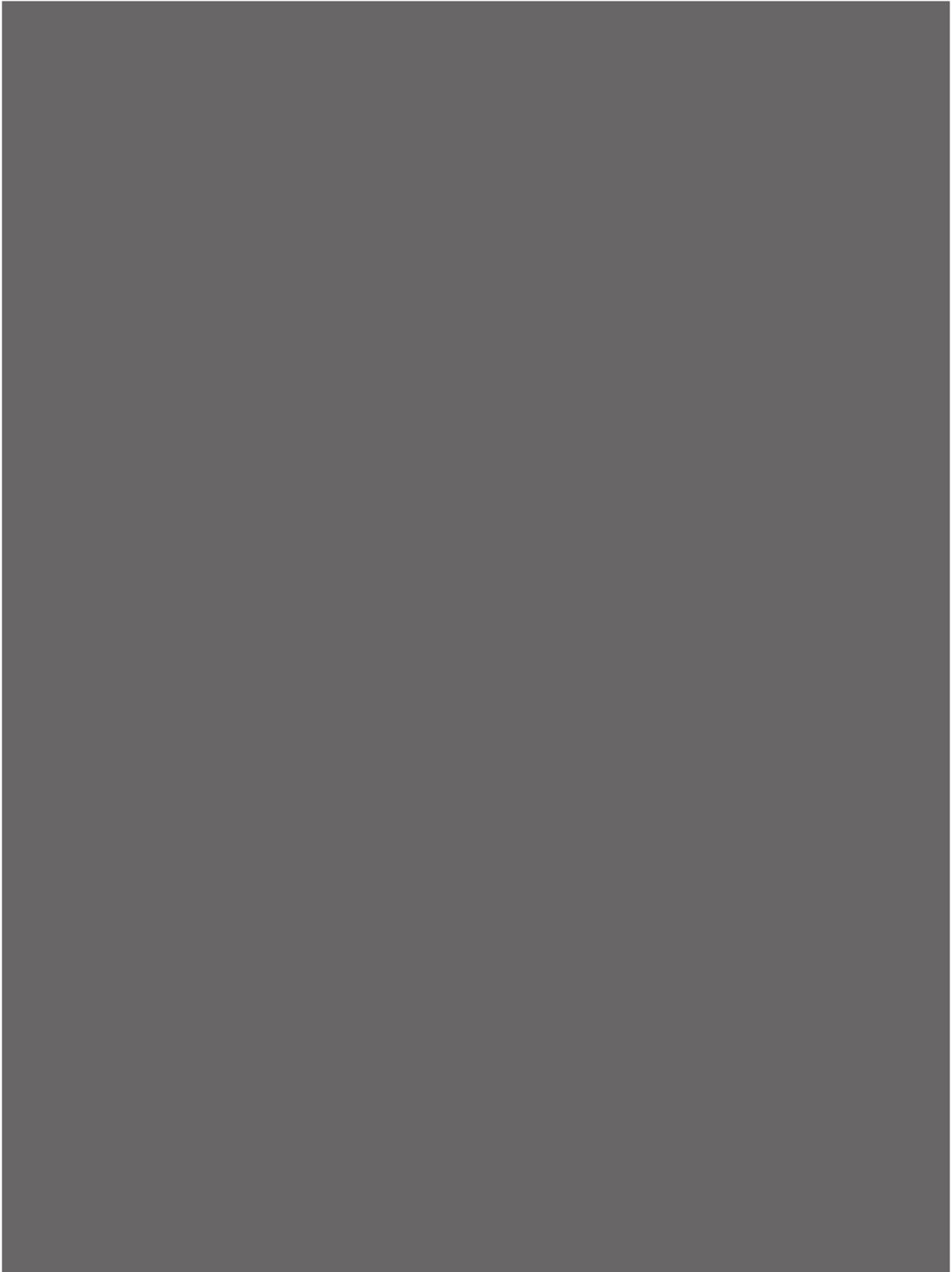
After completing his post-graduate training and moving to Maryland,

[REDACTED]

[REDACTED]

[REDACTED]

**VI. Case Narrative**



**VI. Case Narrative**

Regardless, Dr. Ivins left an impression on his psychiatrist. More than two decades later, when Dr. #1 heard about the anthrax letter attacks and their possible relationship to Fort Detrick, her first thought was of him. She "worried" that "the mailer was Ivins," she later told the FBI. She went so far as to try to compare the writing on the envelopes shown in the media with the handwriting she had from him on file. Finding no samples of his printing, however, she could not draw any conclusions. She also called the psychiatrist who had treated him in 2000; that doctor, although [REDACTED] did not, nevertheless, share her concerns. She decided to drop the matter.

[REDACTED]

[REDACTED] Dr. #1 indicated that, had she been asked, "she would not have recommended Dr. Ivins to obtain a security clearance and would not have allowed him access to weapons of mass destruction. ...

"[Dr. #1]," the notes add, "said that Dr. Ivins was very much alive in her head and she would never forget him."

\* \* \*

In the early 1980s, corporate and governmental job opportunities for scientists abounded in Maryland. Leaving UNC, KKG Sister #2 moved in with her fiancé, who, by coincidence, lived in the very same neighborhood as Dr. Ivins. Although she had previously felt threatened by Dr. Ivins, [REDACTED] and she was entirely unaware of his presence in the area.

## VI. Case Narrative

He, however, quickly learned of hers: to the FBI he later acknowledged that he tracked her entire professional career, and needed only Directory Assistance to find her in Gaithersburg.

During the night of November 28-29, 1982, according to a police report, the letters "KKG" were spray painted on the sidewalk outside her residence and on the window of the car she drove. KKG Sister #2 strongly suspected Dr. Ivins, but when she confronted him after a chance encounter, he denied any role. In interviews with the FBI in January and February of 2008, Dr. Ivins admitted he had been responsible.

### A Profound and Abiding Obsession

Once Dr. Ivins' obsession with the Kappa Kappa Gamma (KKG) sorority and KKG Sister #2 took hold of him, it never let go.

During the late 1970s, Dr. Ivins conducted research at the Library of Congress to identify KKG locations that were within driving distance of his places of residence in Maryland. Using directories of universities and colleges as well as telephone books, he located KKG sorority houses or offices at UNC in Chapel Hill; the University of Virginia, in Charlottesville; the University of Maryland, in College Park; West Virginia University, in Morgantown; and the University of Tennessee, in Knoxville.

By 1983 he had visited them all, making round trips of 50 to 368 miles, always within a 24-hour period. Dr. Ivins denied ever traveling to the KKG site in Princeton, N.J., from which the anthrax letters were mailed, but the round trip distance there from Frederick, about 390 miles, is significantly less than the 576 miles he acknowledged making on two separate nights for another purpose. The two 576-mile trips will be discussed at another point in this report.

Dr. Ivins' family was unaware of his long-distance drives to visit sorority facilities. This is not entirely surprising. With the exception of his visit to the University of Tennessee, where he combined his KKG office visit with a job interview, he made the trips at night.

**VI. Case Narrative****A Profound and Abiding Obsession *continued***

It appears that he did not use his gasoline credit cards while on these trips and, as he told the FBI in 2008, he turned back his car's odometer to conceal the extra mileage.

By his own admission to [REDACTED] the FBI in 2008, Dr. Ivins burglarized the UNC sorority house, stealing its "cipher" and ritual material. He used the cipher to decode the KKG written ritual documents. He also told the FBI he had broken into the KKG sorority house at West Virginia University in Morgantown because it was close enough to drive to during the night. Having forced open the lock of a filing cabinet, he stole the sorority's ritual book.

Discussing these events with the FBI, Dr. Ivins likened the ritual book to the "Holy Grail." It gave him a "source of power," he said; he could use it to exact revenge upon KKG Sister #1, the young woman who had refused to go out with him as an undergraduate. When interviewed by the FBI in 2008, KKG Sister #1 had no memory of Dr. Ivins.

After copying the ritual book, Dr. Ivins said he returned it to the sorority by mail, falsely claiming that he was a member of a fraternity and wanted to return what a fraternity brother had stolen. Nonetheless, Dr. Ivins told the FBI, he still felt a need to visit KKG facilities, if only to walk on their property. It is important to note that the KKG property itself, and/or its contents, were the objects of his obsession — not the young women who lived or worked at the sorority buildings. The Panel found no evidence that he approached or stalked undergraduate sorority members, or represented a sexual or physical threat to them. His interest seemed to reside more in knowing where the facilities were located and what they looked like. He therefore apparently preferred to approach them when they were unoccupied. For example, he visited the KKG house at the University of Virginia, he told investigators in February, 2008, but did not enter it or burglarize it. Instead "he merely walked around the outside of the house before returning home."

**VI. Case Narrative**

In 1980, while at the University of Tennessee at Knoxville for a job interview, he visited the KKG administrative building. To his surprise, he found four sorority members meeting there. Starting a conversation about the sorority's secrets and rituals, he displayed such extensive knowledge — in particular, by singing a secret song — that the young women became disturbed and called campus security, Dr. Ivins told the FBI in 2008. He was escorted off the property. He also recalled that a security officer at the University of Maryland had telephoned him at home and accused him of breaking into the Maryland KKG house and stealing its ritual book — and had told him that he knew about his visit to the University of Tennessee. Indeed, more than 20 years later, Dr. Ivins still remembered the security officer's name. FBI agents were able to locate the man, who confirmed he had worked in security at the university at the time, but could not remember the specific incident.

In the early 1980s, Dr. Ivins made claims that seemed aimed at harming KKG Sister #2. In April 1982, he wrote her a letter expressing interest in her career and suggesting an opportunity for collaboration between her employer and USAMRIID. Although she apparently answered cordially and professionally (a 1983 letter she wrote alludes to this response), he nonetheless followed up with a letter to her supervisor in which he claimed she had not replied. This failure, he wrote the supervisor, had jeopardized the potential for a financially beneficial arrangement.

Over the years, he also developed multiple aliases, one of which was the name of her husband. Using this name, he obtained two separate Post Office (P.O.) Boxes. He used the first, from 1981 to 1985, to mail KKG ritual books he had copied. He used the second, from 1993 to 2005, to order pornography relating to bondage. Neither KKG Sister #2 nor her husband knew of these activities.

In the early 1980s, Dr. Ivins also created a fictitious persona to seek revenge on KKG by revealing its secrets. Adopting a female variant of

## VI. Case Narrative

the name of KKG Sister #2's husband, he depicted himself as a former KKG sorority member and placed classified ads in *Mother Jones* and *Rolling Stone* magazines. He offered in these ads to send free copies of the KKG ritual book he had stolen to anyone who requested — anyone, that is, except for KKG representatives who might be attempting to retrieve their books. Because he kept the addresses of KKG facilities across the country, he knew who the latter would be.

As use of the Internet grew, Dr. Ivins also contributed to web sites and even created a blog about KKG. He also submitted negative entries about it to Wikipedia.

On the [www.abovetopsecret.com](http://www.abovetopsecret.com) website on December 21, 2005, he wrote the following under the pseudonym "Jimmy Flathead":

It's a common misconception that "Kappa Kappa Gamma" stands for "Key to the Kingdom of God." Actually, it stands for "Kalon K'Agathon Gnothi," which is Greek for "Know the Beautiful and the Good." KKG is big on the virtues of Plato: "The Good, The True, and The Beautiful." The organization is one of the oldest women's fraternities in the country, founded in 1870 at Monmouth College. Famous alumnae include Ashley Judd, Jane Pauley and Kate Jackson.

—Jimmy Flathead

Again under the Jimmy Flathead pseudonym, Dr. Ivins placed derogatory information about KKG on the Wikipedia site, and threatened to place more of it after previous postings were removed. One sorority leader described him on Wikipedia as a "bully" and "KKG basher;" in turn, he threatened to reveal more confidential information. The sorority considered legal action, but KKG leaders later told the FBI that they had decided it would not be worth the expense.

**VI. Case Narrative**

In late 2006, however, Dr. Ivins was on a different tack. On Nov. 8, he attempted to promote the name of KKG Sister #2 on Wikipedia's KKG page. Using the pseudonym "jf" (Jimmy Flathead), he wrote:

Could ... [KKG Sister #2] be added back to the list of Notable Kappas? Although she doesn't have her own Wikipedia page, an internet search will reveal that she is a brilliant and highly respected research scientist. I would suggest that perhaps having a Wikipedia page may be too stringent a requirement for inclusion in the "Notable Kappas" list. If ... [KKG Sister #2] was removed for reasons other than not being in Wikipedia, I would hope that those reasons could be shared with the rest of us. — jf

Months later, on Feb. 20, 2007, Dr. Ivins was back on the attack. In a note to the website [www.abovetopsecret.com](http://www.abovetopsecret.com), he made an explicit link between KKG and Islamic terrorism, a link that also exists in the anthrax letters (please see analysis section). Using the address of goldenphoenix111@hotmail.com, he wrote:

... Kappas are noted for being lovely, highly intelligent campus leaders. Unfortunately, they labeled me as an enemy decades ago, and I can only abide by their "fatwah" (sic) on me. I like individual Kappas enormously, and love being around them. I never choose an enemy, but they've been after me since the 1960's, and REALLY after me since the late 1970's. At one time in my life, I knew more about KKG than any non-Kappa that had ever lived. Unfortunately I've forgotten a lot. I've read the history of KKG that was written several decades ago about its founding ..."

## VI. Case Narrative

### Contact with Media and Legislators, and Contempt for New York

Over many years, Dr. Ivins wrote letters to Congressional Representatives and U.S. Senators, in addition to leading figures in the media. He also showed a strong hostility toward New York City.

Among those he wrote were Maryland Senators Barbara Mikulski and Paul Sarbanes, but he did not confine himself to his home state. Colorado Congresswoman Patricia Schroeder received his written congratulations for her daughter's graduation from Princeton ("my late father's alma mater") and for her 30 years of marriage. New Hampshire Senator Warren Rudman also received letters.

On March 24, 1987, he sent a letter addressed to Brandon Tartikoff, NBC Television, 30 Rockefeller Plaza, New York, NY 10112 — the same address used for the anthrax mailing to Tom Brokaw — concerning a proposal to develop a mini-series about the Challenger Space Shuttle. He also contacted CBS and ABC about this idea. Writing back from the same 30 Rockefeller Plaza address, a representative of NBC's law department informed him, in what appeared to be a pro-forma rejection, that his unsolicited program submission "has not been read by anyone at NBC."

Dr. Ivins also wrote several letters — none of them published — to Newsweek magazine. On January 2, 1992, he commented on a university's attempt to block Army-funded research on anthrax at the university. "To some, apparently," Dr. Ivins wrote, "protecting soldiers from disease is more morally repugnant than molesting children." On Nov. 19, 1997, he wrote to the editor: "The U.S. human anthrax vaccine is not 'experimental.' It has been an approved, licensed vaccine for over 20 years." Between those letters, on April 10, 1996, the arrest of the Unabomber Theodore Kaczynski also moved him to write. He sent the magazine's editor a letter referencing an article it had published entitled, "Probing the Mind of a Killer."

In addition to his antagonism toward KKG, Dr. Ivins also displayed hostility at times toward New York City. After the 9/11 attacks, Dr. Ivins sent a witness an email reading: "This is so

**VI. Case Narrative****Contact with Media and Legislators, and Contempt for New York *continued***

like New York. They get all the attention; what about the poor people in the Oklahoma City bombing?" The same witness said she believed Dr. Ivins hated New York because of some prior experiences there. She said Dr. Ivins had referred to having been treated aggressively by a waitress, having witnessed an unsympathetic response to a mugging, and having been given a soft mattress in a hotel room, requiring him to sleep on the floor. [REDACTED] a colleague, said Dr. Ivins "hated the New York Yankees and thought people from New York were elitist and didn't like them much." This colleague also noted that Dr. Ivins "does hold grudges."

**TWO DECADES WITHOUT PSYCHIATRIC TREATMENT**

During the two decades between 1980 and 1999, Dr. Ivins is not known to have sought psychotherapy or to have received psychotropic medications. During these years, [REDACTED] and, by his own account, he was occupied with family, work, and church. Throughout, he worked at USAMRIID and, beginning in 1981, lived in a small Cape Cod style home on Military Road, within walking distance of his place of work in Fort Detrick.

His obsession with KKG continued, however. He stopped visiting sorority houses and offices in the early 1980s, but he maintained his focus on KKG Sister #2. Through both decades, it appears that he monitored her career. In addition to the 1982 letter to her employer, mentioned above, he sent *The Frederick News-Post* newspaper a letter, published May 9, 1983 — in her name, and with her home address attached. [See Attachment #2] The letter strongly defended the practice of hazing. After KKG Sister #2 protested, the *News-Post* sent her a letter of apology, but it did not publish a retraction.

Apparently intent on further embarrassing KKG Sister #2, Dr. Ivins soon went a step further: Within three weeks he re-contacted the mother of a college student who had died in a 1978 hazing incident.

## VI. Case Narrative

Dr. Ivins had first written this woman in 1982, after she had become known as an outspoken critic of hazing and had been interviewed by Tom Brokaw on the "Today Show." (Brokaw, it is worth adding, noted in that interview that his co-host Jane Pauley was a KKG alumna.) On May 29, 1983, Dr. Ivins provided this woman with a clipping of his fraudulently signed letter. The woman gave the letter to the author of several books on hazing, who then referred to KKG Sister #2 by name in a book he was writing. The book also quoted a KKG official as saying that KKG Sister #2 "does not speak for the organization and never has" and that "it is a 'most isolated' occurrence to have a sorority woman come out in favor of hazing, which is 'strictly prohibited' by the national [KKG organization]."

The statements Dr. Ivins fabricated in KKG Sister #2's name have continued to be referenced and attributed to her in scholarly works, such as the 2004 thesis, "Definitions of Hazing: Differences Among Selected Student Organizations." In fact, the letter triggered a libelous cascade of publications that led to a personal repudiation of KKG Sister #2 by the sorority's leadership and continuing damage to her reputation. Interviewed in 2008, Dr. Ivins admitted to the FBI that he had written the letter to the newspaper and had provided the clipping to the grieving mother. He said he could not explain why.

In 1986, the death of Christa McAuliffe, the teacher who died in the Challenger Space Shuttle explosion, apparently affected him deeply. He wrote two personal letters of condolence to her husband, Steven: on January 31, three days after the explosion, and again less than two weeks later, on February 11. He wrote about the accident to members of Congress, and he even wrote a song in her honor, which he tried to promote to the music industry. Those efforts failed; the letters of rejection were found in a file he kept at home. As noted above, his attempts to develop a television series based on the life of Christa McAuliffe were also rebuffed. Those letters of rejection also went in the file. Eventually, he gave the song to the late astronaut's family.

## VI. Case Narrative

Two significant relationships in Dr. Ivins' life developed during this period. Beginning in 1988, he supervised a female employee, referred to in this document as Technician #1, whom he considered a close friend for the rest of his life. Working with her daily, he came to rely on her both for her technical skills and their collegial relationship. In his email correspondence with her, he acknowledged an extreme dependence.

He also became dependent on another subordinate, who will be referred to here as Technician #2. This woman first worked with him as an intern in the summer of 1994. In the summer of 1997, after graduating from college, she rejoined him in his laboratory and remained there until the summer of 1999, when she left for medical school.

By his own account in emails [REDACTED] the years from 1997 to 1999 were extremely rewarding to Dr. Ivins, because of his friendship with his two technicians. He worked with them closely in the lab, collaborated with them on scientific papers and traveled with them to professional meetings in the United States and overseas. Although there is absolutely no indication of a sexual relationship with her or Technician #1, he developed a particularly strong bond with Technician #2, the younger of his female assistants. Unlike KKG Sister #2, who had been a peer and who worked in a separate lab at UNC, Technician #2 was 30 years younger than Dr. Ivins, and clearly subordinate to him in education and training.

By his own account and by the evidence of his behavior and emails, as well as third party observations, he became obsessed with her. At times the obsession took very odd turns that involved elements of stealth and surprise. For example, in the late 1990s, without her knowledge, he took her apartment key and, as he told the FBI in 2008, had a copy made. Knowing that a male friend of Technician #2's was about to visit her from overseas, he then instructed a subordinate to use this key to secretly gain access to the apartment and decorate it before his arrival. Technician #2, surprised and embarrassed that her apartment had been

**VI. Case Narrative**

entered and decorated without her knowledge, considered reporting the incident to police until her colleague admitted the intrusion and apologized for carrying out Dr. Ivins' plan.

Dr. Ivins also made a practice of attempting to be humorous by writing notes while purporting to be someone else. He expected others to know he was the author — as in this note to Technician #2, written sometime between the summer of 1997 and summer of 1999, in which he joked about anthrax and Islam:

To the Future [Researcher in Microbiology]  
Many congratulations to you. Allah smiles on all of your accomplishments. After your degree please come to my country and talk to us about your work at Fort Detrick. Please bring your anthrax strains with you when you come. Most sincerely,  
Saddam

As was his custom when someone departed USAMRIID, Dr. Ivins wrote a poem he recited at Technician #2's going away party in July of 1999. Then and on subsequent occasions, he expressed the hope that she would consider returning to USAMRIID after her medical training. The 1999 poem included the following lines:

She worked with nasty anthrax strains.  
Yes, there were quite a few.  
She was super in the lab, and super outside, too.  
Her work made us feel better 'bout that vaccine in our arm.  
It keeps us safe from anthrax and from bioterrorist harm.  
—Soon you'll leave these diehards, rooting for the O's.  
Since you're a Yankee fan forever, you can thumb your nose.  
Med school now awaits you. We're sure that you'll do great.  
Then you'll be a doctor- bet you can hardly wait.  
Want to work back here again? There won't be any fuss—  
We'll take up a collection to bring you back to us.

**VI. Case Narrative**

The poem went on to say that the lab will “miss you lots — more than you’ll ever know.”

The depth of Dr. Ivins’ obsession is more fully revealed by his behavior during Technician #2’s last week at USAMRIID. Accompanied by Technician #1, he covered Technician #2’s eyes with a blindfold he had designed and made himself. He then drove her to an adult bookstore, where she was escorted to shelves containing sex toys. Meanwhile, he had Technician #1 videotape the whole episode. In that videotape, a copy of which he gave her, Technician #2 referred to Dr. Ivins as having a “criminal mind.” Only later did Dr. Ivins learn that Technician #1 had forewarned Technician #2 about the plan.

As he had lied to KKG Sister #2 about the burglary and vandalism of her property, Dr. Ivins lied to Technician #2 about his role in this episode. Two years later, in an email dated September 19, 2001, he wrote Technician #2 that the plan was Technician #1’s idea: “I swear it was hers — I remember her very words when I was initially discussing the plan with her. She insists that she doesn’t remember. I also remember the planning, planning and more planning that went into it.”

After Technician #2 left his laboratory, in 1999, Dr. Ivins became interested in the email correspondence between her and Technician #1. Within a few months of Technician #2’s departure to New York, Dr. Ivins stole Technician #1’s password, by watching her from behind as she typed it, and began to regularly review the content of emails between the two technicians. This intrusion continued until the departure of Technician #1 in 2002. Dr. Ivins learned highly personal information about the lives of his subordinates as well as their attitudes toward him.

Even when he was angry with them and later, even when he was [REDACTED] Dr. Ivins’ day-to-day interactions with his technicians were superficially cordial — even affectionate. Neither technician knew he was secretly reading their email exchanges.

## VI. Case Narrative

In 2002, when they realized this and confronted him, he lied: He told them a USAMRIID-installed filter automatically forwarded him any emails that referred negatively to him as a supervisor. There was no such filter.

After Technician #2 left in the summer of 1999, Dr. Ivins' emails describe his sense of loss and even depression. He began taking SAM-e, an over-the-counter remedy for depression. His remaining female colleague, Technician #1, informed Technician #2 in emails that Dr. Ivins was taking the preparation and experiencing an initial benefit. The improvement, however, was short-lived. By early 2000, Dr. Ivins was again seeking psychiatric treatment [REDACTED]

### Mailing Packages in a Childish Hand

In a reflection of his obsession with Technician #2, Dr. Ivins liked to send her gifts and packages through the mail. In the course of their relationship, he sent her more than a dozen, most of them "care packages" containing items like candy and cold remedies.

Dr. Ivins would address the packages in a childish hand, in block printing. Although he knew that she would know when she opened them that he sent them, he sometimes went to great lengths to prolong her suspense. In a March 31, 2005 interview with the FBI, Dr. Ivins said he sometimes sent her packages from other cities "so she would not immediately perceive from the postmark that it was a package from him (which would have been indicated by a Frederick, Maryland postmark)." Dr. Ivins "advised that he went to this effort to add to the 'surprise factor.'"

Dr. Ivins also used "childish, block printing" in which "upper and lower case letters [were] mixed together" in sharing pornography and bondage materials with a male correspondent during the mid 1990s and early 2000s. Dr. Ivins used a false name — the name of KKG Sister #2's husband — in conducting the correspondence

Neither Technician #2 nor the male correspondent kept the packages or envelopes they received from Dr. Ivins, so they could not be

## VI. Case Narrative

### Mailing Packages in a Childish Hand *continued*

compared to the childish printing on the anthrax letters. But upper- and lower-case letters are also mixed in those letters, and Technician #2 said that certain letters in the anthrax notes particularly reminded her of the lettering Dr. Ivins had used on her packages.

### A Focus on Codes

Among Dr. Ivins' many interests, few ranked higher than secret codes.

His obsession with KKG was bound up in this fascination. At least one of his purposes in breaking into the KKG house at UNC in the late 1970s was to obtain the cipher — a decoding device for secret sorority rituals. Later, he broke into the sorority house at West Virginia University to steal the actual ritual book, which he compared to the "Holy Grail." These exploits were so important to him that, even though they were criminal in nature, he could not keep them entirely to himself. He told Technician #1, who in September 2002 wrote Technician #2: "He broke into a sorority house, while no one was there, to get the code book."

But Dr. Ivins was also interested in other kinds of codes, including those relating to DNA.

Dr. Ivins was particularly interested in Gödel, Escher, Bach: An Eternal Golden Braid, a complex book which defies easy description but which deals in part with hidden messages and codes, including DNA codes. Published in 1979, the book won the Pulitzer Prize. In a June 2008 interview with investigators, Dr. Ivins described the work, which is nonfiction, as "really cool" and volunteered that he first may have learned of it from KKG Sister #2 in the late 1970's or early 1980's.

Dr. Ivins liked the book enough to give a copy to Technician #1 in 2006. When interviewed by the FBI in 2008, however, Dr. Ivins initially expressed no memory of having given a copy of the book to his former colleague. He also claimed that he hadn't read the part of the book that dealt with DNA codes. He volunteered, however, that

## VI. Case Narrative

### A Focus on Codes *continued*

KKG Sister #2 "is a Gene Jockey who could answer any such questions about DNA."

On November 8, 2007, following their November 1 search of his home, the FBI had Dr. Ivins under surveillance. Shortly after 1 a.m., investigators saw him walk out his front door in his long underwear. After waiting a few minutes, he went back inside. Then, a few minutes later, a municipal garbage truck arrived and picked up his garbage. A few minutes later, Dr. Ivins came back outside, looked inside the garbage cart, closed the lid and pulled the cart back into his driveway.

Dr. Ivins never acted in a similar fashion during the other approximately 15 times the FBI watched him during trash pick-ups. There was every indication that he wanted to make sure that the trash had been picked up.

It was, and inside was Gödel, Escher, Bach, as well as an issue of *American Scientist Journal* containing an article called "The Linguistics of DNA," which also discussed DNA codes.

DNA is made up of chains of four different nucleic acids, which can be compared to four different letters. Three acids in a row code are sometimes known as a codon, referring to their role as code for the production of a given amino acid. Scientists have given each codon a three-letter abbreviation based on its sequence of nucleic acids, and each amino acid a one-letter abbreviation.

In the September 18 postmarked anthrax letters (See Attachment #3), the bolded letters "TTT," "AAT," and "TAT" correspond to the codons for the amino acids Phenylalanine, Asparagine and Tyrosine. The first letter of each amino acid, in turn, spells the name [REDACTED] Pat. In addition, the single-letter designations for each of these amino acids are F, N, and Y respectively.

Thus, TTT AAT TAT can be translated into both "PAT" and "FNY," or "F\*\*\* New York." Each message related directly to one of his technicians, to each of whom he was obsessively attached. Pat was the name of the technician who remained with him. New York was the place where Technician #2, the object of his obsession, had gone

## VI. Case Narrative

### Focus on Codes *continued*

to live, and toward which he had already harbored a deep-seated hatred.

### RETURN TO PSYCHIATRIC TREATMENT

[REDACTED]  
[REDACTED] Dr. Ivins sought psychiatric treatment again in January 2000. More than 20 years after seeing her in therapy for the last time, he contacted Dr. #1. She had retired, however, and therefore referred him to Dr. #2.

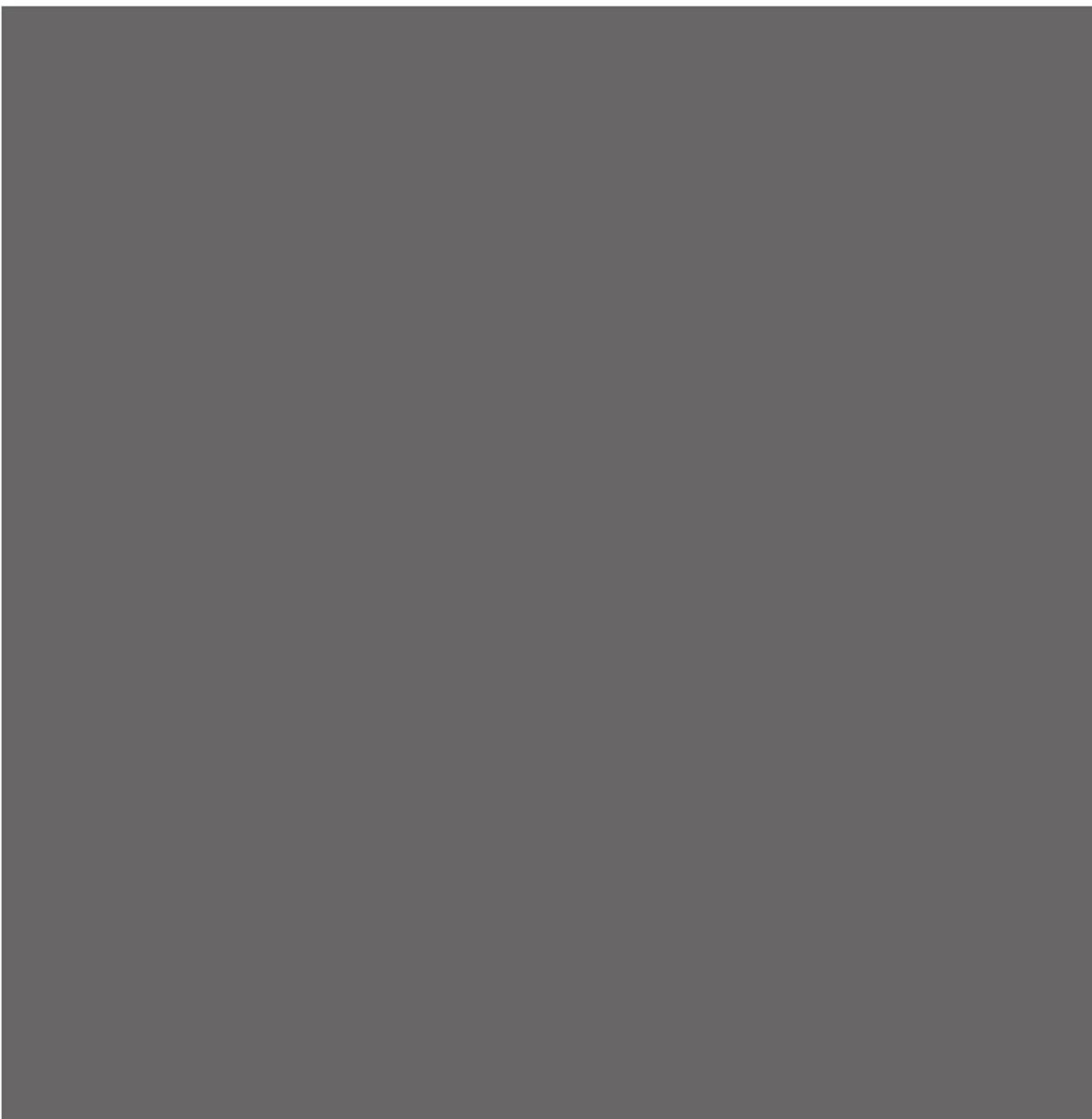
To Dr. #2, he admitted [REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED] When questioned in 2009 by the FBI, Dr. #2 echoed concerns of Dr. #1, saying specifically that if he had been asked, he would not have recommended that Dr. Ivins be given a security clearance to work with weapons of mass destruction.

[REDACTED]  
Dr. Ivins' emails from this period suggest severe difficulties. Some refer to abusive alcohol consumption. He was hiding empty bottles of alcohol from his wife, he informed Technician #2 in one message. In April, he wrote her about out-of-body experiences and a metallic taste in his mouth that "scares me a bit," and which in June he tied to paranoia.

## VI. Case Narrative

His therapist thought his symptoms “may be that of a paranoid personality disorder,” he wrote her in July. He also indicated that he would like to serve as a case study for her medical training, and that he did not want to see “PARANOID MAN WORKS WITH DEADLY ANTHRAX” as a headline in the *National Enquirer*.



She sought counsel about the risk of danger her client

**VI. Case Narrative**

posed — “dangerousness,” in risk assessment parlance — and about her duty to warn [REDACTED]. Her first step was to attempt to contact the director of the practice, Dr. #3. When this failed, because he was traveling, she sought legal advice from the malpractice insurance carrier for Dr. #3’s practice. [REDACTED]

[REDACTED] she had neither the legal duty to warn nor sufficient knowledge to be held liable. She also sought to consult with her local police department, but those efforts failed for the same reasons, she said.

[REDACTED] And from the summer of 2000 until near the end of his life, Dr. Ivins continued to receive treatment from Dr. #3 and members of his practice. Therapist #1, however, was no longer a member of that practice. She quit in 2000, because her concern about Dr. Ivins’ dangerousness appeared to go unheeded.

In early 2001, Dr. Ivins wrote Technician #2 that he was still having extreme difficulties:

I wish I could control the thoughts in my mind. It’s hard enough sometimes controlling my disorder. When I’m being eaten alive inside, I always try to put on a good front at work and at home, so I don’t spread the pestilence...I get incredibly paranoid, delusional thoughts at this, and there’s nothing I can do until they go away, either by themselves or with drugs.

## VI. Case Narrative

On March 4, he wrote her again, this time describing his feelings of isolation and his inability to confide even in his therapists:

The people in my [therapy] group just don't pick up on what I try to say. They are not into the kinds of problems I bring up... The psychiatrist is helpful only because he prescribes Celexa [citalopram]. He's not that easy to talk to, and he doesn't really pick up on my problems. The woman I saw before I went into group wanted to get me put into jail. That wasn't very helpful either. I'm down to a point where there are some things that are eating away that I feel I can't tell anyone.

In the summer of 2001, in response to [REDACTED] Dr. #3 doubled Dr. Ivins' dosage of the antidepressant citalopram to 60 mg.

As he revealed years later in an Internet posting, Dr. Ivins also developed an interest during this period with a television reality series, "The Mole," hosted by Anderson Cooper. The title role in that program belonged to a young woman named Kathryn Price. In the program's seventh episode, which first aired in February 2001, she was blindfolded while a professional stabbed the wall on either side of her head with knives that she thought — or appeared to think — he was actually throwing. More than seven years later and in the days leading up to the suicide, Dr. Ivins revealed to a correspondent on the Internet a graphic and detailed fantasy to murder Kathryn Price with a hatchet and to blind her with a ballpoint pen.

**VI. Case Narrative**

Despite his having treated Dr. Ivins for a much longer period than any other mental health professional, a review of Dr. #3's psychiatric records reveals only limited information for session content. Aside from insurance records indicating Dr. Ivins' attendance at weekly group therapy meetings, many meetings — both the weekly ones and individual medication-management sessions — were not documented.

In interviews with the FBI after Dr. Ivins' suicide, Dr. #3 also revealed that although records from Drs. #1 and 2 and Therapist #1 were in his possession, he had not read them. Despite Therapist #1's documented [REDACTED] [REDACTED] "he would not have read them" he said, "because they were too long." He said he also did not read typed notes if they were too long.

As he told the FBI in 2009, Dr. #3 thought Therapist #1 had over-reacted to the situation. FBI investigators gave Therapist #1's July 2000 therapy notes to Dr. #3 to read in their presence. [REDACTED]

[REDACTED] [Dr. #3] said, "If I'd read that, I would have had a different perspective."

[REDACTED]

Finally in 2009, he said he could now "understand why ... [Therapist #1] was so upset" (in 2000). [REDACTED]

## VI. Case Narrative

### CAREER CHALLENGES

In the two years prior to the fall of 2001, a confluence of problems ranging from vaccine production issues to media and Congressional criticism threatened Dr. Ivins' anthrax research and caused him both anger and anxiety.

As previously noted, Dr. Ivins' job involved quality control testing of the anthrax vaccine. The vaccine was given to members of the U.S. Armed Forces and had been used to protect American troops in the Gulf War in 1990 and 1991. Dr. Ivins had played an important role in its development.

In May 1999, *Vanity Fair* magazine published an article by Gary Matsumoto linking the vaccine to Gulf War Syndrome, a condition with a wide range of acute and chronic symptoms that developed in veterans of the conflict. Matsumoto questioned whether an adjuvant called squalene had been added to the vaccine and was responsible. An adjuvant is a substance added to a vaccine to increase its efficacy.

In 1999 and again in 2000, BioPort Corp., the Lansing, Mich.-based company that had the only license to produce the anthrax vaccine, failed Food and Drug Administration inspections. The failures blocked the company from shipping more vaccine.

In February 2000, the House Government Reform Committee's national security subcommittee urged the Defense Department to suspend the anthrax program, and in May 2000, 35 members of Congress signed a letter asking Secretary of Defense William Cohen to stop it until a long-term study could be done regarding its safety. Then, on February 7, 2001, Dr. Ivins got a personal rejection from the Federal Government. It denied his October 13, 2000 request to export anthrax spores to a colleague in Israel. The U.S. Department of Commerce Bureau of Export Administration denied the application on the ground that its approval would be "detrimental to United States foreign policy."

**VI. Case Narrative**

Although Dr. Ivins' job was not at risk the possibility appeared to exist that he might be reassigned to work on something other than anthrax. And his own words expressed the stress he felt.

**"LET WHATEVER HAPPENS TAKE ITS COURSE"**

In numerous emails to colleagues, Dr. Ivins expressed anger about the questions raised about squalene, with which he had experimented on monkeys in the laboratory. And by February 2001, he was expressing an awareness of his own dangerous capabilities. He noted in a Feb. 23, 2001 email that he enjoyed creating cynical slogans. "It actually kind of frightens me that I'm good at it, like there is some sinister monster waiting inside me for the right chance to escape." About this time, he also sent an email to a childhood acquaintance, in which he said that "he did not want to go to work anymore" and was experiencing "professional disillusionment." In an FBI interview, this acquaintance also recalled that Dr. Ivins was "against the administration, government and had issues with local politics."

Dr. Ivins' emails seemed to express an increased isolation and a certain fatalism toward his own inclinations. To Technician #2 on March 4, 2001, he wrote:

I'm down to a point where there are some things that are eating away that I feel I can't tell ANYONE. You are probably the easiest for me to talk to, but it is difficult for me to ask that you not tell anyone else what I say. That is a lot to ask for, and you may feel that you need to share it with others. (Obviously if someone says that he or she is about to commit a crime, you should share it with the right people.) Confidentiality is too much to ask of you, so perhaps I should just take the Celexa and let whatever happens take its course.

## VI. Case Narrative

Days later, on March 12, Dr. Ivins wrote Technician #2 about an upsetting experience with a security guard at USAMRIID:

This morning I was walking in and this big guard at the gate challenged me, demanding my ID, wouldn't accept it (!!!), and sent me over to the little guard house for further questioning and identification to see whether or not they would allow me to enter (!!!!!!!) I couldn't believe it! I was REALLY pi\*\*ed [(sic)]! The guy in the smaller shack was a little better. He looked at my badge, asked me where I was going and where I worked. Meanwhile, this other guy just walked right in the gate, jaywalked across the street, and neither guard said anything. I asked the second guard if I was going to get strip searched and he didn't particularly appreciate my comments, but I didn't appreciate getting treated that way. GRRRRR! ... so it's into the suite to harvest her spores."

As the year unfolded, the questions about the anthrax program only ratcheted up. The FDA's rejection of BioPort created an expectation that Dr. Ivins' division would assist in resolving the company's problems. Matsumoto, the author of the *Vanity Fair* piece, was now writing a book about the vaccine. He filed Freedom of Information Act (FOIA) requests for records he thought would prove the Army knew the vaccine was dangerous and, in response, Dr. Ivins' USAMRIID superiors asked him to provide detailed information from his laboratory notebooks. In an email sent two weeks before 9-11, Dr. Ivins wrote a superior: "Tell Matsumoto to kiss my ass."

Meanwhile, in June 2001, Senator Daschle, the Senate majority leader, sent a letter to the Department of Defense that heightened concerns about the safety of the vaccine. Also in June, the Department of Defense announced it was curtailing its vaccination program — the vaccine was beginning to run out.

## VI. Case Narrative

In numerous emails to colleagues, Dr. Ivins expressed the concern that his entire anthrax vaccine program was in jeopardy. On September 7, 2001, he wrote Technician #2 that he had just received his own anthrax vaccine injection. But supplies of the vaccine were dwindling, he said, "and when it's gone, there's nothing to replace it with. I don't know what will happen to the research programs and hot suite work until we get a new lot. ... Everything is in limbo." It was during this period that his time in the hot suite was greatly increasing.

### **"REFRESHING" HIS ACQUAINTANCE: 9/11 AND ITS IMMEDIATE AFTERMATH**

Dr. Ivins displayed strong emotional reactions to the terrorist attacks of 9/11. A family member recalled seeing him cry while watching the events on television. Four days later, during the period when he was still spending extraordinary amounts of time in the hot suite, he expressed his feelings in an email. He was "angry, very angry," he wrote. "Angry at those who did this, who support them, who coddle them, and who excuse them."

After September 16, Dr. Ivins did not re-enter the hot suite in the evening for nine days. The first anthrax mailing occurred on September 18. During the week that followed, there was no report within the government or the media that the letters had been received, nor that any individuals were experiencing anthrax-like symptoms.

Dr. Ivins resumed spending long and odd hours in the lab on September 25. On September 26, he sent Technician #2 an email indicating how different he was from others in his therapy group. (Dr. Ivins began attending group therapy sessions in Dr. #3's practice in 2000 and, beginning September 10, 2001, attended them for 14 consecutive weeks, according to billing records.)

Everyone but me is in the depression/sadness/flight mode for stress. I'm really the only scary one in the group. Others are talking about how sad they are or scared they are, but

## VI. Case Narrative

my reaction to the WTC/Pentagon events is far different. Of course, I don't talk about how I really feel with them — it would just make them worse. Seeing how differently I reacted than they did to the recent events makes me really think about myself a lot.

In this same Sept. 26 email to Technician #2, Dr. Ivins wrote, "I just heard tonight that Bin Laden terrorists for sure have anthrax and sarin gas. You should feel good about having received anthrax shots." Expressing a frustration with Congress and others, Dr. Ivins also wrote:

The news media has been saying that some members of Congress and members of the ACLU oppose many of the Justice Department proposals for combating terrorism...It's interesting that we may now be living in a time when our biggest threat to civil liberties and freedom doesn't come from the government but from enemies of the government.

As the FBI noted in seeking a search warrant of his home and lab six years later, this email — specifically referencing anthrax and Islamic terrorists — was written before public awareness of the mailings. The media first reported the anthrax attacks in the first week of October.

In the same email, Dr. Ivins told Technician #2 that he felt guilty about "not feeling guilty."

Dr. Ivins worked in the hot suite off hours for 10 consecutive days and nights. *Then came a break. On October 8 and October 9, a long weekend that concluded with Columbus Day, he spent no time there at all.* This period coincided with the window of time available for the mailing of the second set of anthrax letters. These letters, mailed to Senators Daschle and Leahy, were postmarked October 9, 2001. And as abruptly as they had started, Dr. Ivins' long and odd hours in the hot suite ended.

## VI. Case Narrative

### **DR. IVINS' BEHAVIOR BETWEEN THE MAILINGS AND THE FIRST REPORTS OF THE ANTHRAX ATTACKS**

For about 18 years since she moved from Gaithersburg, Md., in the early 1980s, KKG Sister #2 had had no contact with Dr. Ivins. On September 21, 2001, however, three days after the first letters were postmarked, she received an email from him at her place of work, in Seattle. He inquired about personal matters — her sons and their educational plans — which he had no way of knowing about, to her knowledge. He also offered a comment about his professional life: “since we are the primary BW [Biowarfare] research center in this country, we are all more than a bit on edge.” Then — that very day — he called her as well. His computer had not received a reply from her server, he told her, so he wanted to make sure she had received his email.

KKG Sister #2 found this sudden burst of communication disturbing.

In an interview with the FBI on January 16, 2008, Dr. Ivins said he had sent this email to KKG Sister #2 “after the anthrax attacks” in order to “refresh our acquaintance.” But at the time he contacted KKG Sister #2, no one else knew there had *been* an anthrax attack. Dr. Ivins’ first email to KKG Sister#2 came three days after the postmark date of the first anthrax letters and about two weeks before the media began to report the anthrax attacks, in early October. As we have discussed, the September 18 letters contained the bolded lettering that corresponded with DNA codons, described in the book, Gödel, Escher, Bach, that KKG Sister #2 had first brought to Dr. Ivins’ attention.

In the aftermath of the attacks, the American Society for Microbiology asked its members to contact authorities with the name of anyone who might have been responsible. Out of more than 40,000 members who received this request, only one responded, as far as the investigative team could determine. KKG Sister #2’s February 1, 2002 response to the Society’s request is quoted here in full:

**VI. Case Narrative**

I am a microbiologist and a professor at the University of Washington. I am a member of the American Society for Microbiology and received their e-mail appeal. I would like to speak to someone about a former colleague of mine who presently works with anthrax at Fort Detrick MD. When we were at UNC Chapel Hill in the mid 1970's, there were some very unusual behaviors that he exhibited that were repeated later in 1982-83. I believe that this individual is somewhat mentally unstable and has the profile of someone who COULD be capable of such an act. I certainly hope that I am wrong, and no one hopes more than I that this person is not involved in any negative way. I am very worried about being traced, as this person is particularly adept at computer snooping. I do not want to give out my home number or address for fear of my personal safety and that of my children. This person has recently contacted me via unsolicited e-mail to my work to show that he is working on anthrax. He was concerned that his computer did not receive a reply from our server and called to be sure that it was me. I spoke with him briefly but certainly do NOT have any personal relationship whatsoever. Please take this seriously, especially the confidential nature.

The FBI followed up on this email by interviewing KKG Sister #2 in early 2002. She reiterated her concerns. For a variety of reasons which have already been discussed, however, the authorities chose not to pursue Dr. Ivins as a suspect.

\* \* \*

The day after his initial email to KKG Sister #2, Dr. Ivins filled out an application to join the American Red Cross (ARC) as a volunteer. In that application, he identified himself in a way he never had previously, on dozens if not hundreds of forms, and never would again. Over the years, Dr. Ivins had routinely described his profession on personnel information documents as "Bacteriologist" or "Microbiologist."

## VI. Case Narrative

On September 22, 2001, however, — only four days after the first anthrax letters were postmarked and well before the media had reported them — he volunteered that he worked in “anthrax research.” On December 17, 2001, he also wrote, on an ARC Disaster Services Volunteer Information Form that he could provide assistance in response to a bioterrorism-related event: “I work at USAMRIID. Perhaps I could help in case of a disaster related to biological agents.”

The foreshadowings in his email to KKG Sister #2 and the ARC application are not the only places where Dr. Ivins initiated communication with others regarding the potential for bio-warfare attacks in the United States. On October 3, he sent Technician #2 the following email:

I remember mentioning to you the possibility that after you get your degree you might be interested in being an ‘on-call’ physician for any suspected BW attacks in the country...I’m hoping such an attack doesn’t happen, of course. On a more humorous note, if a BW ‘crop duster’ ever does buzz through your city, you can just look up in the sky, knowing your immune system is ready, and give him the finger...

### **“AN ABSOLUTE MANIC BASKET CASE”**

The first fatality in the anthrax attacks came October 5, 2001, with the death of Robert Stevens. In the days thereafter, media attention and public concern mounted — exponentially so after the discovery of the letters to NBC news on October 12 and Senator Daschle on October 15.

To at least one colleague, Dr. Ivins’ behavior in this period stood out. In an October 16 email, Technician #1 wrote: “Bruce has been an absolute manic basket case the last few days.”

Meanwhile, although she had left his laboratory in 1999, and although [REDACTED] he continued to maintain a

## VI. Case Narrative

relationship with Technician #2. He confided in her with frequent long emails. And in September of 2002, he made two separate long-distance night drives to her parents' house: the first to scout the location and the second to deposit a bottle of her favorite liqueur on their porch. Each of the round-trips covered almost 600 miles. Although he left the package without seeing her or revealing his identity, she knew he was responsible because of the nature of the gift and the way it was left. Ultimately, Dr. Ivins acknowledged to FBI interviewers that she had been right.

On December 15, 2001, he offered Technician #2 a description of himself in the following poem.

I'm a little dream-self, short and stout.  
I'm the other half of Bruce — when he lets me out.  
When I get all steamed up, I don't pout.  
I push Bruce aside, then I'm Free to run about.

Hickory dickory Doc — Doc Bruce ran up the clock.  
But something happened in very strange rhythm.  
His other self went and exchanged places with him.  
So now, please guess who  
Is conversing with you.

Hickory dickory Doc!  
Bruce and this other guy, sitting by some trees,  
Exchanging personalities  
It's like having two in one.  
Actually it's rather fun!

### **INVESTIGATION AND ANXIETY**

As already discussed, Dr. Ivins took many steps to deter investigators from developing an interest in him, but by 2004 suspicion of him was beginning to grow. In early 2005 the FBI obtained consent to search his home computer. The search of his office computer revealed that all

## VI. Case Narrative

### An Unreported Skin Infection

In emails he sent Technician #2 during the period of the mailings, Dr. Ivins reported that he had acquired a skin infection on his hand. The pain, he complained, was severe enough to make it difficult to play the keyboard in church.

According to insurance billing records, he sought help from his family doctor, who diagnosed cellulitis, a skin infection, and prescribed the antibiotic cephalexin. After about 10 days with no apparent improvement, Dr. Ivins contacted a different clinician, who treated him with a different antibiotic, doxycycline.

Because Dr. Ivins was a microbiologist who worked around the most dangerous types of bacteria, an unusual or resistant infection requiring antibiotic treatment by a private physician mandated his report of it in his yearly medical assessment. Specifically, he was required to "list illness, accidents, surgeries, hospitalizations, physician visits or fevers" since his last Special Immunization Program physical exam. In April 2002, Dr. Ivins dutifully reported that in early 2001 he had suffered an episode of chest pain and pneumonia, and had sought medical treatment.

Although the skin infection was an illness that required two separate antibiotic prescriptions from two different clinicians, he chose not to report either prescription or treatment. Although the first antibiotic, cephalexin, can be used to treat an anthrax skin infection, the second one, doxycycline, is the preferred treatment.

his emails from 2001 were missing from his hard drive archives.

On March 31, 2005, the FBI interviewed Dr. Ivins, and asked him, among other things, about the missing emails. He "advised that he was very surprised" and "insisted that he did not delete any batches of email from his computer pertaining to the year 2001." Investigators were able to retrieve many of the emails from the hard drives of other computers he used and from those of recipients.

The rising scrutiny took its toll on Dr. Ivins, enough to move him to tell

**VI. Case Narrative**

USAMRIID authorities he felt uncomfortable in the hot suite [REDACTED]

[REDACTED] USAMRIID asked Dr. #3 for a letter, which he supplied, recommending restriction from the suite. As a result, on April 28, 2005, Dr. Ivins was temporarily barred from his laboratory and allowed only desk and computer work. [REDACTED]

Within three months, however, Dr. Ivins had returned to the lab. In November 2005, he wrote an email to himself listing 12 reasons why Technician #1 and Technician #2 were the most likely suspects in the mailings. With a subject line that read "New Thoughts and Theories on the Anthrax Letter attacks," the email added their names to the list of co-workers he had already named as potential suspects. Learning of this email later, both technicians were shocked, in part because Dr. Ivins had remained overtly friendly at the time.

As the investigation progressed, Dr. Ivins attempted to dissuade close colleagues from cooperation. In May of 2007, he criticized [REDACTED] for stating that "it would all be over soon" and claimed in an email that embarrassing personal information would be revealed in any trial. This claim was interpreted as a threat.

The email also contained this apparent warning:

Do you realize that if anybody gets indicted for even the most remote reason with respect to the anthrax letters, something as simple as not locking up spore preps to restrict them from only people in lab — they face the death penalty? Playing any part, even a minor part such as providing information about how to make spores or how to make them in broth, how to

## VI. Case Narrative

harvest and purify...that could wind up putting one or more hapless persons on death row. Not pleasant to think about.

As the year drew to a close, investigators wanted to search Dr. Ivins' home. They obtained a warrant and searched it on the evening of November 1.

From monitoring his Internet searches, the authorities suspected they might find guns in Dr. Ivins' home. They were correct. The search recovered three handguns, a Taser, two stun guns, and homemade targets indicating that he had used his basement as a firing range.

### Assessing and Monitoring the Suspect

By late 2007, investigators knew that Dr. Ivins had a psychiatric disorder, and that they needed to consider it in their plans to search his home. As a result, they requested a joint assessment from the FBI's Behavioral Analysis Unit (BAU) and Dr. Gregory Saathoff, a psychiatrist.

The information available to the BAU and Dr. Saathoff, however, was quite limited. Periodically since late 2006, Dr. Ivins had been under occasional surveillance; the information available to the BAU and Dr. Saathoff for their assessment included the information from this surveillance and from searches of his Internet use and email correspondence. It also included insurance documentation that listed diagnoses and prescriptions filed with Dr. Ivins' insurance carrier from 1997 to 2006 — but not 2007. And notably, the review did not include access to any medical records, such as psychiatric records or interviews; there was no legal authorization to obtain such information.

The BAU assessment concluded that Dr. Ivins presented a risk of harm to himself and others. It based that conclusion on these factors: Dr. Ivins was a middle-aged white male with significant health concerns; he had a history of medication treatment for

**VI. Case Narrative****Assessing and Monitoring the Suspect *continued***

depression and anxiety; he had access to biological agents such as anthrax; based on his own emails and Internet searches, he had a family history of mental illness; he was approaching retirement; he had recently acquired weapons; he had expressed unhappiness in his marriage; and, as suggested by his own reports of misuse of addictive prescription medications, he had an apparent substance dependence disorder. On the other hand, an apparent longstanding relationship with his psychiatrist, as indicated by his regular attendance at therapy group meetings, suggested support in the face of anxiety related to the search — a counterbalance to his potential dangerousness.

Given this assessment, FBI investigators sought to minimize the stress likely to be associated with the search. They offered Dr. Ivins and his family the option of free lodging in a local hotel and to conduct the search after dark with the windows covered from the inside to minimize observation by neighbors. Dr. Ivins and his family took the government up on these offers.

During the search, and during an interview they conducted with Dr. Ivins earlier in the day in his office, investigators also listened to and observed Dr. Ivins carefully for statements or actions that suggested a threat to himself or others. They were prepared to immediately alert mental health professionals responsible for emergency assessment.

But although he expressed anxiety to investigators during the interview and search, Dr. Ivins did not appear to be in crisis and therefore did not require assessment for hospitalization.

Two days earlier, Dr. #3 provided his patient with a leave of absence for “medical illness” until December 1, 2007.

**VI. Case Narrative**

A week after the search of his residence, Dr. Ivins remained under surveillance. At about 1 a.m. on November 8, he was seen placing the book Gödel, Escher, Bach in his trash. As noted previously, this book deals with coded messages similar to the codes found in the anthrax letters. Wearing only his long underwear, Dr. Ivins was seen walking out of the house just before the truck's arrival. Shortly after the trash was collected, he walked back to the street to inspect the trash can and bring it back from the curb to just outside the house.

After the search Dr. Ivins took a temporary leave from his job and his volunteer work with the American Red Cross. His alcohol consumption increased. By December of 2007, [REDACTED]

According to Dr. #3, Dr. Ivins requested and received authorization to return to work in the biocontainment (hot) suite "up to 4 hours/day with supervision."

[REDACTED]

[REDACTED]

[REDACTED]

## VI. Case Narrative

Meanwhile, Dr. Ivins was providing the FBI with a better grasp of his obsession with KKG, with detailed accounts of his long drives to KKG offices and sorority houses in different states, his break-ins and thefts, his mailing of materials, his interest in codes and ritual books. During interviews on January 16 and February 13, 2008, he proved unable, however, to account for his whereabouts during the time of the 2001 anthrax mailings. He also admitted that his wife had not questioned him about his absences from home at night, when he was in the hot suite or making one of his long drives, and was apparently not even aware of how much time he had spent away from home.

Not long thereafter, he was apparently accusing the FBI of abusing him. This was a theme that had actually started a few years earlier. According to Technician #1, "as early as 2005, [Dr. Ivins] was convinced that the women living in the house next to him were FBI agents because they moved in really quick, then they left. She remembered he talked about it all the time." Dr. Ivins' suspicion was, in fact, groundless: No buildings in the neighborhood were ever used for surveillance.

But in 2008, Dr. Ivins evidently elaborated on the theme of FBI persecution. After he died, *The Washington Post*<sup>8</sup> recounted an episode related by an anonymous scientist. The scientist said that Dr. Ivins had told him confidentially that he and his family had been publicly pressured while shopping: "One day in March [2008], when Ivins was at a Frederick mall with his wife and son, the agents confronted the researcher and said, 'You killed a bunch of people.' Then they turned to his wife and said, 'Do you know he killed people?' according to the scientist."

In its exhaustive review of sealed and unsealed materials, in addition to interviews with FBI investigators involved in the case, the Panel could find no evidence that this event or any other public confrontations in fact took place.

Meanwhile, Dr. Ivins' close relationships with his two female former colleagues continued to erode. When Technician #1 confronted him about

## VI. Case Narrative

his earlier attempt to implicate her in the mailings, he responded with an email. The responsibility, he wrote her on March 11, 2008, belonged with "Crazy Bruce," a version of himself whom he described as periodically "paranoid, severely depressed and ridden with incredible anxiety."

### IMPAIRMENT

By late winter of 2007-2008, the combination of Dr. Ivins' medication addictions and heavy drinking was causing him to fall repeatedly.

One fall took place March 15 or 16, 2008, according to his wife. It resulted in a black eye that was still noticeable [REDACTED]

One or two days after that fall, on March 17, Dr. Ivins spilled "live vaccine anthrax strain used for the vaccination of livestock," on his trousers while cleaning the laboratory. After the spill, and in clear violation of USAMRIID policy, Dr. Ivins went home and washed and dried his contaminated trousers there. He informed supervisors following his return to the laboratory later that afternoon. Although the "potential hazard exposure" form was supposed to be filled out by his supervisor, Dr. Ivins apparently filled it out himself, and checked the box indicating that he should "return to regular duty." On a "near miss report" that Dr. Ivins filled out March 18, he placed responsibility for the spill on the carelessness of colleagues. He wrote that the "suggested procedure to prevent injury" should be "Don't clean up technicians' messes in BSC."

USAMRIID officials responded swiftly and decisively to this incident, documents indicate. On March 18, they "assigned [Dr. Ivins] to administrative duties immediately and for the indefinite future and deactivated his badge for laboratory areas of USAMRIID."

Now restricted from all laboratory areas of USAMRIID, Dr. Ivins wrote this email on March 19 to Technician #2, [REDACTED]

[REDACTED]:

## VI. Case Narrative

O Healer! O devoter of your life to the lives of others! I can hurt, kill and terrorize, but others place me with the vilest of vile...our pasts shape our futures and mine was built on lies and craziness, and depression, and thievery, and things that make an honest man and woman cry.

In the early afternoon of March 19, 2008, Dr. Ivins' wife found him in an unheated room at home, unresponsive. She called 911. Dr. Ivins was rushed to Frederick Memorial Hospital, [REDACTED]

[REDACTED] He denied his behavior was a suicide attempt, and was not admitted to the hospital.

**VI. Case Narrative**

[REDACTED]

[REDACTED] On April 24, 2008, investigators recovered from the Ivins' trash an apparently forged prescription under Dr. #3's name for atomoxetine 40 mg, which is generally used to treat attention deficit disorder with hyperactivity. When asked later by investigators whether he had ever prescribed this medication for Dr. Ivins, Dr. #3 said he had not.

[REDACTED]

[REDACTED] A June 23, 2008 search of Dr. Ivins' trash revealed that he had been receiving trazodone, a sedating antidepressant, from this doctor, who was neither Dr. #3 nor his primary care physician.

Dr. Ivins demonstrated increased anxiety during this period, and sought out his former colleague, Technician #1. On April 28, he dropped by her home on the pretext that he was in the neighborhood for American Red Cross work; in fact, he was still on leave from the Red Cross at that time. He did not find her there. Two days later he drove to her place of work, and claimed to have found "a piece of information that would prove that the letters did not come from anyone in his laboratory." She described him as "stressed and haggard." The information he promised was never forthcoming.

**VI. Case Narrative**

[Redacted]

[Redacted]

[Redacted]

[Redacted]

**VI. Case Narrative**

[REDACTED]

During the month of June, Dr. Ivins attended therapy sessions and spoke [REDACTED] the cost of his attorneys and his lack of memory for behaviors. On June 5, 2008, in answer to a question [REDACTED] he did not deny a role in the anthrax attacks, but said he did "not have any recollection of ever have doing anything like [sending the anthrax letters]...I can tell you," he added, "I am not a killer at heart.... Because I, I don't like to hurt people, accidentally, in, in any way.... And I, in my right mind wouldn't do it [laughs]." He also spoke about having no memory of his long nighttime drives, and said it worried him when he awoke in the morning with all of his clothes on and his car keys beside him. He claimed he was no longer consuming alcohol and had embarked upon a program of sobriety. His statements to the source represented the first time he had ever claimed to have engaged in purposeful behaviors, such as driving at night, without remembering them.

Later that month, on June 25, he also revealed again that his attorneys had told him that an indictment was "coming" and that he should be prepared to face the death penalty. On June 27, the Justice Department announced, in effect, that it had cleared Dr. Hatfill of suspicion by disclosing that it would pay him a multi-million dollar settlement. On Sunday evening, July 6, FBI surveillance observed Dr. Ivins walking on the street, talking to himself and "behaving erratically."

**DANGER TO OTHERS**

On Monday, July 7, Dr. Ivins sent an email to USAMRIID administrators questioning the need for a risk assessment "since I am no longer permitted in ANY laboratory areas whatsoever." Also on that day, his attorney filed a request with the Federal Court requesting additional legal help preparing for prosecution that could involve the death penalty.

## VI. Case Narrative

On that same date, Dr. Ivins posted the graphic fantasy of blinding Kathryn Price with a ballpoint pen or letter opener and killing her with a hatchet. He wrote:

Steve had a great chance to Kill (sic) Kathryn that would go down as the primo moment in reality TV. After the fake fainting he'd say, "Kathryn, do you know what a mole is? It's a blind useless animal that humans hate. And do you know what we do to moles? We kill them!" With that he should have taken the hatchet and brought it down hard and sharply across her neck, severing her carotid artery and jugular vein. Then when she hits the ground, he completes the task on the other side of the neck, severing her trachea as well. The "Blind" mole is dead and Steve is a hero among heroes! I personally would have paid big money to have done it myself. Maybe something really dreadful will happen to Kathryn Price. If so, she will richly deserve it! The least someone could do would be to take a sharp ballpoint pen or letter opener and put her eyes out, to complete the task of making her a true mole!

A day later, he contacted Ms. Price and attempted to arrange a meeting. Using the pseudonym Cindy Wood, he sent her an email in which he called himself her "biggest fan" and expressed interest in meeting with her personally. [REDACTED]

Also on July 7, 2008, a witness at USAMRIID contacted the FBI. The witness told investigators that Dr. Ivins was acting in a threatening manner while on site at USAMRIID, implying that he would take revenge against coworkers who were "diming" him out. The witness said she was concerned that Dr. Ivins was talking to himself as if "to a ghost," and would "go postal." She reported that a female employee felt threatened by Dr. Ivins, and asked her supervisor at USAMRIID for advice. The supervisor told her to "hide in the hot suites" because Dr. Ivins was

## VI. Case Narrative

restricted from access there and would be retiring at the end of the summer.

In response to the witness's call, the prosecution team grew more concerned about Dr. Ivins' safety. They promptly relayed her account of Dr. Ivins' threatening behavior to his attorney.

### **"YOU WILL SEE ME IN THE PAPERS"**

On the evening of July 9, 2008, Dr. Ivins attended his regular group therapy session, which was led by Therapist #2 and Therapist #3. In FBI interviews after Dr. Ivins' death, both therapists gave a similar account of the group meeting and Dr. Ivins' threats. Specifically, they noted that Dr. Ivins was agitated, and told the group that he would not go to death row. He had a hit list of co-workers that he would murder, he said. The FBI had already taken his guns, but a family member had acquired a Glock handgun for him and was bringing it to him.

Dr. Ivins monopolized the 90 minute session, they said. He wore a strange smile.

He had recently walked in crime-prone neighborhoods at night while carrying a sharpened object in his pocket, he said. While in the "ghetto" as he called it, he had imagined provoking an African-American youth into attacking him by calling out, "Come on, nigger boy!" He also expressed anger that the FBI was requesting a DNA sample from him, and reportedly shook his shoe over a new therapy group member, stating "Here's some DNA!" During the group session, he reportedly "discussed how to murder someone and not make a mess. He stated that other people made a mess and if you did it another way you would not make a mess. He did not provide details about how to murder someone, but was focused on not making a mess, because he did not like that."

Therapy group members were taken aback. According to the therapists at the session, who were interviewed later by the FBI, some asked

**VI. Case Narrative**

him, "If you are innocent, then why are you doing what you plan to do?" "Ivins did not reply and only smiled and was evasive. ... He thought he would be executed or go out in a 'blaze of glory' and be killed by police."

"Ivins said that during the next twenty-four hours he would not do anything, because he was not ready," the FBI notes on the interviews with the therapists continue. "The people in group therapy discussed Ivins and agreed that he wanted to be killed in a 'suicide by cop' scenario. ... After the session, one of the other therapy members heard Dr. Ivins say, 'You will see me in the papers.'"

That same evening, shortly after the group session ended, Therapist #3 attempted without success to call Dr. #3, who was out of town. She also contacted Dr. Ivins' attorney, "who agreed to have Dr. Ivins come down to his office first thing in the morning to talk to Dr. Ivins, evaluate his condition, and if necessary have him committed." On the morning of July 10, Dr. #3 called back Therapist #3, who reported Dr. Ivins' threats "to shoot co-workers and others that had wronged him." According to Dr. #3, Therapist #3 "was reluctant to contact authorities." The psychiatrist suggested that Dr. Ivins' attorney be contacted. When Therapist #3 did so, for the second time, the attorney tried to dissuade her from calling authorities to hospitalize Dr. Ivins, she said; the attorney, she later reported, said Dr. Ivins was "fine." That same day Dr. #3 also spoke with the attorney, Dr. #3 later told authorities; the attorney "pleaded" with him "not to call the authorities and just allow Ivins time to 'calm down.'"

In spite of the attorney's objections, Dr. #3 later told the FBI that after consulting a colleague, he "instructed [Therapist#3] to call the authorities on Ivins." Therapist #3 then informed the Frederick Police Department of the situation. Dr. Ivins was picked up at USAMRIID on the afternoon of July 10 and transported to Frederick Memorial Hospital, where he was independently evaluated and certified by two physicians as meeting the criteria for involuntary

## VI. Case Narrative

psychiatric hospitalization.

The following Crisis Management Note, dated July 10, 2008, provided an independent psychiatric assessment and led to Dr. Ivins' hospitalization at Sheppard Pratt, in Baltimore:



Also in the hospital record is a July 10, 2008 note by another doctor:



**VI. Case Narrative**

While awaiting assessment at Frederick Memorial in the early morning hours of July 11, 2008, Dr. Ivins called Therapist #3 and left two voice mails. In the first, he thanked her for “getting me arrested” and “roughed up,” thus “destroying the client-patient relationship so now the FBI can come and get all the information from you.” In the second, he said he had no interest in continuing to see her in treatment after his release from the hospital.

Dr. Ivins was moved to Sheppard Pratt on July 11, and remained there until July 24. During his stay there, Therapist #3 requested a restraining order to protect her from Dr. Ivins. Testifying in pursuit of the order, she described a third voicemail<sup>9</sup>, on July 12. In that call, Dr. Ivins reportedly said that because she had requested an assessment for possible commitment, the FBI now had access to his psychiatric file. He agreed that he required hospitalization because there was no less restrictive alternative and he was a danger to himself and others. But he felt disappointed and betrayed because, he claimed, he would have agreed to be hospitalized voluntarily. Contending again that he had been “roughed up” in a “terrible experience,” he said he had lost trust with her.

Dr. Ivins’ records at Sheppard Pratt show 



**VI. Case Narrative**

FBI investigators did not question any of Dr. Ivins' current or former mental health care providers until the Frederick police contacted the local FBI office to inform them they were dealing with a man who claimed to be a prime suspect in the anthrax mailings. The local FBI office referred the report to headquarters, which sent word to the investigative team. Thus it was, ironically, Dr. Ivins' own statements to the police during the commitment proceedings — identifying himself as a suspect in the mailings — that led the FBI to the Emergency Petition. And it was by reading that petition, which is a public document, that the FBI first became aware of Therapist #3.

The FBI contacted Therapist #3 on July 11. She described for investigators the group meeting that prompted her to contact authorities about Dr. Ivins' potential for dangerousness. Her report prompted investigators to seek another search warrant of Dr. Ivins' home. Executed July 12, 2008, this search recovered hundreds of rounds of ammunition, smokeless handgun powder, a bullet-proof vest and an improvised shield that could serve as body armor.



## VI. Case Narrative

[REDACTED]

[REDACTED]

[REDACTED] On the basis of these statements, and without the benefit of conversations with Dr. #3, Therapist #3, or other outpatient therapists who had treated Dr. Ivins, Dr. #5 prepared a one-page assessment in which he did not find Dr. Ivins to be an imminent danger to himself or others. Dr. Ivins, the psychiatrist wrote, [REDACTED]

[REDACTED]

[REDACTED]

During his two-week hospitalization, the case against Dr. Ivins advanced. He supplied the FBI with the DNA it had requested. On July 7, four days prior to his hospitalization, his attorney had asked the federal court to provide legal assistance for his defense, because it was a death-penalty case. On July 15, the court approved this request.

Dr. Ivins' wife [REDACTED]

**VI. Case Narrative**

[REDACTED]

[REDACTED] She also told an acquaintance that she felt the discharge was premature. [REDACTED]

[REDACTED]

On July 23, Therapist #3 spoke for about 20 minutes on the phone with Dr. #4, notes from an FBI interview show. She expressed her concerns about Dr. Ivins' dangerousness and requested that a commitment hearing be held to keep him hospitalized.

That same day, Dr. #3 met with investigators. Despite the fact that Dr. Ivins was currently hospitalized due to his severe homicidal and suicidal threats, Dr. #3 stood by his 2003 assessment — i.e., that Dr. Ivins "does not have a condition or treatment that could impair his/her judgment or reliability, particularly in the context of safeguarding classified National Security information or special nuclear information or material." He said he still had no personal knowledge to preclude Dr. Ivins from performing his job, or working with Weapons of Mass Destruction (WMD). That same day, Dr. #3 also spoke with Dr. #4 at Sheppard Pratt.

Dr. Ivins was discharged July 24, 2008. [REDACTED]

[REDACTED]

[REDACTED]

**VI. Case Narrative**

[REDACTED]

[REDACTED] Dr. Ivins' attorney, Dr. #4 reported, "had no concerns about Ivins' discharge."

Also on July 24, the District Court of Maryland for Frederick County issued the Peace (Restraining) Order Therapist #3 had requested against Dr. Ivins. Authorities went to USAMRIID to serve the order at 11 a.m. July 25, but were informed that Dr. Ivins "had been barred from the property."

**DANGER TO SELF**

Dr. Ivins' wife picked him up at the hospital the morning of his discharge from Sheppard Pratt and took him home. From 2 p.m. to 6 p.m. she worked at her job. She later said her husband had planned on going to the grocery store to "pick up a few things to eat" while she was gone. Recovered receipts and store surveillance video show that Dr. Ivins purchased Tylenol PM from the Giant Eagle food store at 1305 West 7th Street at 12:31 p.m. July 24 and then returned at 1:44 p.m. to pick up three filled prescriptions. Later, Dr. Ivins also went to the local library to access the Internet briefly before returning home.

Ms. Ivins later reported to a law enforcement investigator that she had left a note for her husband that expressed her concerns and her disappointment with her husband's behavior. She said she was out for much of the day and evening of Friday, July 25 — at the library, her work, the Fort Detrick pool and then Bingo. Returning that evening, she found a request he had written on the back of her note: He wanted her to let him sleep, because he had a headache. Going to bed Friday evening in a separate bedroom, as she later reported, she got up Saturday morning, went to the library to check her email, and in the afternoon went to the Fort Detrick pool. Sometime during this period, Dr. Ivins took an overdose that included a large quantity of acetaminophen.

Returning home late in the day that Saturday, Ms. Ivins checked on

**VI. Case Narrative**

her husband twice, at 7 p.m. and 9 p.m. and found him apparently sleeping. After going to sleep on a couch downstairs, she was awakened at about 1:00 a.m. Sunday morning, possibly by the sound of a fall upstairs. She found him lying on the bathroom floor, unresponsive. At 1:06 a.m., July 27, she called 911. She told the emergency operator that she had found a glass of wine near where he had been sleeping and was unsure whether he had consumed too much alcohol and fallen as a result. (The FBI, it might be noted, knew from its surveillance that Dr. Ivins was being taken by ambulance to a hospital, but its monitoring did not permit it to enter the house, and agents could not know his condition; nor did they have legal authorization, at the hospital, to find out.)



His condition eventually deteriorated, however, and the family requested that no special measures be taken to sustain him. He died at the hospital on the morning of July 29, 2008.

The Toxicology section of this report provides more detailed information regarding Dr. Ivins' use of medications, his substance abuse and the final days of his life. But in summary, a hospital note written on July 29, 2008 reported:



On July 31, 2008, the FBI conducted a search of the trash from the Ivins home. Agents found two empty boxes of Tylenol PM and a Giant Eagle

## VI. Case Narrative

receipt for a Tylenol PM purchase dated July 24, 2008. In addition to paper with handwritten names and notes relating to U.S. Senators, the FBI also found 45 discarded wedding photos of Dr. Ivins and his wife.

### End Notes for Case Narrative

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<sup>3</sup>Anthrax is one of 80 biological agents and toxins listed by the Centers for Disease Control (CDC) as Biological Select Agents and Toxins (BSAT) pursuant to the Public Health Security and Bioterrorism Preparedness Act of 2002.

<sup>4</sup>The United States Department of Justice. (2010). Amerithrax Investigative Summary. Retrieved from <http://www.justice.gov/amerithrax/docs/amx-investigative-summary.pdf>.

<sup>5</sup>Greenemeier, L. (2008). Seven Years Later: Electrons Unlocked Post-9/11 Anthrax Mail Mystery. *Scientific American*. Retrieved from <http://www.scientificamerican.com/article.cfm?id=sandia-anthrax-mailing-investigation>.

<sup>6</sup>Federal subpoena: (2002) Preparing and Shipping TSA slants for *B. Anthracis Ames*.

<sup>7</sup>Keyes, A. (2008). Ivins' Estranged Sibling Believes Anthrax Allegations. *National Public Radio*. Retrieved from <http://www.npr.org/templates/story/story.php?storyId=93250745>.

<sup>8</sup>Goldstein, A., Hernandez, N., & Hull, A. (2008). Tales of Addiction, Anxiety, Ranting: Scientist, Counselor Recount Recent Turmoil in Anthrax Suspect's Life. *The Washington Post*. Retrieved from [http://www.washingtonpost.com/wp-dyn/content/article/2008/08/05/AR2008080503747\\_2html?sid=ST2008080503796](http://www.washingtonpost.com/wp-dyn/content/article/2008/08/05/AR2008080503747_2html?sid=ST2008080503796).

<sup>9</sup>Dr. Ivins' tone in the voice mails was even and calm, but given his stated efforts to procure a gun and publicly stated intention to murder people on a list he had developed, the Panel agreed with the magistrate judge's decision.

## VII. Behavioral Analysis and Interpretation

### INTRODUCTION

In this section, the Expert Behavioral Analysis Panel will attempt to answer these questions:

- Do the sealed psychiatric records support or refute the Department of Justice's determination that Dr. Ivins was the sole mailer of the anthrax letters?
- What was the extent of Dr. Ivins' mental illness?
- In what ways did his mental illness influence his behavior?
- Did Dr. Ivins behavior in the last month of his life clearly warrant the involuntary hospitalization that he received?
- Was his death in July of 2008 clearly a suicide?
- If so, why exactly did he kill himself?

### THE QUESTION OF GUILT

This Panel was not asked to consider the question of Dr. Ivins' guilt in the anthrax mailings. Nevertheless, the Panel found that the material within the sealed psychiatric records supports the Department of Justice's determination that he was responsible for the mailings.



### PUBLIC MAN, PRIVATE MAN

For many of Dr. Ivins' colleagues and acquaintances, it is no doubt difficult to square the notion that the man they knew and the anthrax mailer were the same. The man known to many of his colleagues and

## VII. Behavioral Analysis and Interpretation

the Frederick community was a juggler at children's parties, a keyboard player at church, a generous, self-deprecating, eccentric who wrote clever poems for departing colleagues and who seemed cast more naturally in the role of victim than victimizer. He was eager to please, a Red Cross volunteer — and also, of course, an accomplished and respected scientist.

All this, of course, was true. But what was also true was that, by his own description, [REDACTED]

Dr. Ivins' entire life was bound up in concealment and deceit, in presenting a socially acceptable version of himself while cultivating another beneath the surface. His success in this enterprise accounts for the incongruity between what those who knew him witnessed and experienced and his covert behaviors throughout his life. It accounts for why:

- Many colleagues saw him as benign and regarded him as a friend. Yet privately, Dr. Ivins felt that aside from Technicians #1 and #2, he had no friends — and was identifying several of his colleagues as the anthrax mailer in an effort to divert suspicion from himself.

Indeed, while maintaining an ostensibly positive relationship with Technician #1 and sending her friendly and confidential emails, he also wrote himself an email suggesting 12 reasons why she and a colleague were "involved in the mailings." That other colleague was his closest confidant of all, Technician #2.

- Churchgoers might have taken him — the keyboard player at Sunday mass — for an enthusiastic Catholic. [REDACTED]

## VII. Behavioral Analysis and Interpretation

- His own wife might have thought he was asleep in their house, yet he was actually driving hundreds of miles at night and setting back the odometer to conceal the fact.

Mrs. Ivins had no knowledge of her husband's deep and abiding obsession with the Kappa Kappa Gamma sorority or KKG Sister #2. Nor did she know of other secrets. In an email to a former colleague, Dr. Ivins wrote that she "frequently criticizes me for how I look in public with respect to clothes that she doesn't think match ... I have a surprise for her, however. When I return I am going to change the civil service retirement option that gives me a considerable monthly income, but which ends when I die. I could choose an option which pays her a monthly check after I die and until SHE dies, but that would mean I'd get less while I was alive, I'm not getting a retirement pension so that she can live like a queen after I die."

And after he died, *The New York Times* reported a surprise provision in his will<sup>9a</sup>: Contrary to Catholic teaching, his ashes were to be scattered rather than buried. Should this provision not be carried out, he instructed, \$50,000 from his estate should be donated to the pro-abortion organization Planned Parenthood, instead of being allocated to his wife and children. His wife, it should be noted, was a devout, anti-abortion Catholic. He had devised a way to make her go against her principles no matter which option she chose.

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**VII. Behavioral Analysis and Interpretation**

Yet days earlier, the private Dr. Ivins had posted an extremely graphic, violent fantasy. He described his desire to blind and kill Kathryn Price, who was appearing on the Anderson Cooper reality television series "The Mole," with a hatchet. And he followed up the posting with an email, written under the pseudonym "Cindy Wood," through which he attempted to arrange a personal meeting with her. Portraying himself as an adoring female fan, he attempted to entice Ms. Price, a graduate of the University of Kansas and Stanford University, with an inviting email address — Stanfordhawker@yahoo.com. Later, investigators found in his trash the password for this account: "killkathrynprice."

These are only a few highlights in Dr. Ivins' decades-long record of concealment and deceit, which is described in greater detail in the Narrative section of this report. For purposes of this analysis, we want only to add the Panel's view that Dr. Ivins was aware of the unacceptable character he held within, a character [REDACTED] that he cultivated his eccentric persona. By referring to himself as "Crazy Bruce" he was able to gain a degree of latitude for his behavior. He was able to create the expectation that he would not always be reliable, consistent, or conventional, and that no one should therefore be surprised or suspicious if his behavior appeared deviant. This persona served him well; indeed, it probably played a role in helping to keep investigators off his track in the first few years after the attacks.

This is not to say that Dr. Ivins' eccentric persona was an entirely false character. The Panel does believe, however, that this version of Dr. Ivins' self provided him with the cover he needed, and that Dr. Ivins understood and exploited that fact.

Likewise, Dr. Ivins created and exploited the persona of victim, while casting others — his parents, brothers, wife, colleagues, the media, government, KKG, the FBI, the Frederick Police Department, and USAMRIID Security — as aggressors. This was again like him,

## VII. Behavioral Analysis and Interpretation

because paranoid tendencies were a core feature of his personality, resulting in his belief that he was being persecuted. And whether these claims of victimization were driven by this paranoid view of the world or were deliberate attempts to deceive, these statements shaped the way that others experienced him. They successfully concealed a core aspect of his behavior — his conduct as a predator and victimizer — and thereby helped foster sympathy and an aura of harmlessness. This impression was reinforced by the fact that Dr. Ivins often protested indirectly. Rather than confronting those he accused, he complained to colleagues, family and acquaintances, who often found his lies believable, and passed them on to others.

This pattern was seen again and again. After his suicide, it appeared that many of his colleagues viewed him as an innocent man hounded to death by the FBI. This view was in part informed by Dr. Ivins' own statements; as reported in *The Washington Post*<sup>10</sup>, Dr. Ivins told another scientist that he, his wife and son had all been approached at a shopping mall by FBI agents who accused him and harassed them. Based on review of his own interviews with the FBI and a review of the FBI's interviews with his wife, daughter and son, as well as extensive probing interviews with FBI agents and the prosecutor, the Panel found no evidence that this event at the mall ever even occurred. Likewise, Dr. Ivins' statements about warrantless searches of colleagues' cars and warrantless wiretaps of colleagues' phones were without foundation. So, also, were his claims that the FBI escorted him off the premises of a pond near Frederick in December of 2002; in fact a Red Cross supervisor had removed him from the site, a forensic crime scene. His repeated claims that the government had rented a neighborhood house to conduct surveillance were also false.

Dr. Ivins did not restrict his claims of victimization to the FBI during the investigation. Six months prior to the mailing of the anthrax letters, questioning by security officers at the USAMRIID gate

## VII. Behavioral Analysis and Interpretation

provoked his outrage and a sarcastic inquiry about whether he would be strip searched. He described the incident in an angry email: "I was REALLY pi\*\*ed (sic)!" he wrote. "... GRRRRR!" [REDACTED]

[REDACTED] But no formal or informal complaints were lodged, and the panel found no evidence to support that [REDACTED]

As we have seen, Dr. Ivins also claimed that he was the victim of KKG. He declared in a web site posting that the sorority had issued a "fatwa" against him and had been at war with him since his days in college. In fact, there had been only one combatant in this one-sided war — himself. Through vandalism, burglary and libelous letters, he had harassed the sorority and one of its members for more than three decades. The seed for his antagonism towards KKG appears to have been his having been turned down for a date by a KKG member while in college.

Dr. Ivins retained his skill at self-concealment to the end. In June, 2008, as noted, he told [REDACTED] that he could not remember sending the anthrax letters, and that he could not remember any of his long night-time drives. At that point, he was aware that he was in deep legal trouble.

With his explosion at the group therapy session of July 9, 2008, Dr. Ivins did publicly reveal his potential for violence and the extent to which his mental health had deteriorated. Yet even in his very last act, he demonstrated his skill at self-concealment. He persuaded a psychiatrist that he was no longer suicidal and could safely be discharged from the hospital. As we have seen, shortly after his discharge on July 24 he took a lethal overdose.

Still, Dr. Ivins did not successfully deceive everyone. One of his close colleagues reported a "sneaky" side. Another said he had a "criminal

**VII. Behavioral Analysis and Interpretation**

mind," because he was always thinking "what if" and "then." A witness reported that "Ivins always had loopholes in his stories, which was evident in his planning. He always had side notes, contingency plans or a way to cover his tracks which enabled him to have a way out of situations." As Dr. #1, the psychiatrist who treated him in the 1970s, noted:

[REDACTED]

But as this comment by Dr. #1 suggests, Dr. Ivins was nothing if not candid with certain therapists.

[REDACTED]

[REDACTED]

Had those in positions of authority known of his criminal behaviors, Dr. Ivins should not have been given a security clearance at USUHS or USAMRIID; nor, as bio-security rules were developed, should he have been permitted to conduct research on potential weapons of mass destruction. Indeed, had UNC officials known of his criminal behaviors, including some directed at one of its own graduate students, he likely would not have been allowed to complete his postgraduate training there.

## VII. Behavioral Analysis and Interpretation

### CHILDHOOD AND THE MEANING OF KKG

The roots of Dr. Ivins' behavior appear to have developed in his traumatic childhood. Although his early experiences clearly do not excuse his behavior, they do help us understand how he learned to see the world as so hostile.

Although his brothers deny that their mother suffered from mental illness, there is ample evidence from Dr. Ivins and from neighbors of Dr. Ivins' boyhood home that she was extremely abusive to her husband — stabbing him, beating him, and threatening to kill him with a loaded gun. This physical abuse was so extreme that on one occasion Mrs. Ivins believed she had killed her husband.

Although many of the details cannot be proved, it seems clear that as a boy, Dr. Ivins experienced the physical and emotional humiliation of his father by his mother. [REDACTED]

As noted in the Narrative, his father also mocked him publicly, and he grew up convinced that he had been unwanted by his parents. His aunt confided to him that his mother had attempted to abort him by rolling herself down the stairs.

Dr. Ivins identified with his embattled father, to the extent that he developed a plan to attend his alma mater, Princeton. We don't know whether it was because that university rejected him or because he was not deemed worthy of applying, but he did not realize his ambition of going there.

[REDACTED]

[REDACTED] His blindfolding of Technician #2 may relate to these childhood experiences [REDACTED] And any or all of these experiences may help account for his lifelong pattern of sexual arousal by women's undergarments, as well as his self-reported cross-dressing.

## VII. Behavioral Analysis and Interpretation

Dr. Ivins' mother's [REDACTED] were unusual, but so too were his mother's very public displays of domestic violence in the small-town, privileged milieu in which Dr. Ivins was raised. This public humiliation was painful for him and preceded [REDACTED]

[REDACTED] Frequently, public humiliation results in a profound sense of private shame, which can be followed by rage. That appears to be what happened in the case of Dr. Ivins. Indeed, members of the Panel, many with long experience in psychiatry, were struck with how often Dr. Ivins himself, [REDACTED]

Dr. Ivins grew up feeling rejected by his parents and powerless. He absorbed the sense that women, by contrast, were powerful — his mother physically dominated his father, and had his parents wanted a child at all, they would have wanted a girl. The resulting damage in his attachments to his parents and to his own self-concept may have created the foundation for future disturbed relationships.

All this was played out in Dr. Ivins' adult life. His feelings of powerlessness lent themselves to deceitful, covert, secret behavior patterns — to the "sneaky" behavior one of his colleagues described. He was a man who spoke about KKG having declared war on him. Rather than engaging in conventional warfare, he adopted "guerilla" tactics.

Powerlessness also led to fantasies of omnipotence — to thoughts of [REDACTED]

magnifying the sense of domination and control by the perpetrator,

**VII. Behavioral Analysis and Interpretation**

who is invisible, fate-ordering, godlike. Feelings of powerlessness may have also disposed Dr. Ivins to his love of surprise, an element that heightens impact. It was surprise that fed his fascination with blindfolds, with gifts delivered secretly in the night, with packages addressed in a disguised hand. Surprise was also an element in his plans [REDACTED] and in the anthrax mailings.

When KKG Sister #1 rejected Dr. Ivins' request for a date during his undergraduate years, the rejection cut Dr. Ivins to the core, perhaps because it seemed to confirm his experience of childhood isolation and validate what at some level he feared the most — that his parents had been right to reject him. Moreover, given his fragile sense of self, he would have presumed that she shared word of her rejection with her sorority sisters and friends — and thus once again, he would have been publicly humiliated. When, in his view, KKG Sister #2 initially showed him some measure of kindness, he may have seen her as the mother he had never had and a figure that could validate his worth.

[REDACTED]

payback to KKG Sister #2 and the sorority to which she had once belonged again and again.

KKG Sister #2's rebuff was also shattering to Dr. Ivins for the very reason that it was the second KKG-related rejection and trauma. Already hypersensitive to rejection, the first rebuff, painful as it was, left him even more vulnerable to the trauma of KKG Sister #2's rejection. KKG Sister #1's rejection had not only caused him immediate pain — it appears to have primed him to receive any future rebuffs from the same source as a grave threat to his self-esteem and sense of identity.

## VII. Behavioral Analysis and Interpretation

When Technician #2 left Dr. Ivins' laboratory, it was again devastating to him, because he found attachments so difficult to make. By his own account, he had been friendless as a child. As an adult, the dissolution of attachments evoked the abandonment and sense of rejection he had suffered from his parents and from his mother in particular. It is no coincidence that he sought psychiatric treatment after separation from KKG Sister #2 in 1978 and from Technician #2 two decades later.

He told Dr. #1 [REDACTED]

[REDACTED]

Dr. Ivins' relationships with certain successful and competitive women were skewed because he invested these women with omnipotent power and felt himself to be powerless in comparison. These women might be only dimly aware of his existence — as was apparently the case with KKG Sister #1 — or married to another man, as with KKG Sister #2. They might be 30 years younger, as with Technician #2, and trying to make their own careers in another city. None of that mattered. He could not let go. Because of the imbalance in the relationship, he had to prove his significance, or alternatively, exact revenge — two sides of the same coin.

In seeking revenge, as we have seen, Dr. Ivins targeted not only KKG Sister #2 but KKG the institution. His burglaries of KKG houses took place when women were absent. They were not the object of his obsession — rather, it was KKG as the symbol of authority that engaged and enraged him. From what we now know about his statements and actions, KKG appears to have represented a symbol of female authority. His decades-long war with KKG, the "fatwa" he described in 2007, was a continuation of the self-described "payback" to his long-deceased mother.

## VII. Behavioral Analysis and Interpretation

### SUBSTANCE ABUSE AND MENTAL ILLNESS

Because human behavior is so complex, it is helpful to examine it in the context of Dr. Ivins' own biology, personality and environment.<sup>11</sup>

Dr. Ivins believed that his mental problems were genetically related to his mother, whom he claimed suffered from schizophrenia. This belief is in dispute, however, because his brothers both report that she did not have a mental illness. Dr. Ivins also contended that both of his parents were alcoholics and that his mother was addicted to barbiturates.

A family history of addiction is relevant to Dr. Ivins' own significant history of substance dependence. [REDACTED]

[REDACTED] These medications are addictive, and we know that he took more of them than directed. His use of them grew over time, peaking in the last years of his life. These medications can impair judgment, particularly when combined with alcohol.

We know from emails to female confidantes that in 2000 Dr. Ivins drank heavily and hid empty bottles from his wife, but this period of alcohol abuse appears to have been temporary and did not result in the type of severe impairment he exhibited in the last six months of his life. His wife [REDACTED] blamed alcohol and medication dependence during those last months for his numerous falls, including the one that caused the black eye and left-side bruising that would have been visible to co-workers on March 17, 2008, when he spilled a live anthrax strain on his pants while at work. Instead of immediately reporting this incident to the suite supervisor and his supervisor as required, Dr. Ivins grossly violated procedure by leaving the laboratory and going home to wash his clothes. From that point on, he was barred from all laboratory space at USAMRIID, but his supervisors did not request either a medical or

**VII. Behavioral Analysis and Interpretation**

psychiatric evaluation. Just two days later, he was rushed to the hospital for intoxication and drug overdose after his wife found him unresponsive and called 911.



However, because of weight gain and other possible side effects, as well as periodic intervals of stability, his use of antipsychotics was not consistent. He also at times did not take his anti-depressants as directed. Colleagues reported that he sometimes isolated himself during periods of depressive symptoms, which they referred to as "black cloud days."

But Dr. Ivins did use antidepressant medication extensively, and he reported benefit from them when he did. 



 In the fall of 2001, a colleague referred to Dr. Ivins as a "manic basket case," and in December he wrote his poem about being two persons in one. While he may well have been energized during this period, it should be noted he was apparently functional in the

## VII. Behavioral Analysis and Interpretation

laboratory. He did not request nor was he referred by supervisors for psychiatric consultation. And he collaborated with colleagues in the analysis of the anthrax spores recovered from the anthrax mailings.

The main clinical concerns appear to have been his treatable symptoms of depression and anxiety, which can be biologically rooted, or situational conditions, as well as his alcohol and drug dependence. The Panel was unable to find any psychological testing that would have provided an objective picture of his intellectual abilities and psychological functioning. [REDACTED]

From a psychological standpoint, Dr. Ivins presented a rather complex picture that was remarkably consistent over time, until his alcohol and substance abuse created severe impairment in the last six months of his life. The [REDACTED] he expressed to his psychiatrist in the 1970s — [REDACTED] — share important similarities with those of his final days, when he posted thoughts on the Internet [REDACTED]

From the environmental and social standpoints the USAMRIID facility and certain of its employees were extremely important to Dr. Ivins. Employed there for almost 30 years, Dr. Ivins' professional identity was tied directly to USAMRIID. The Panel's review of his personal emails and FBI interviews with his laboratory technicians show that he particularly connected to them — and emotionally dependent on them for personal and professional validation. Physically located in the same neighborhood as his home, USAMRIID served as an anchor for him. Because of Congressional and media scrutiny, he felt by the summer of 2001 that his career as an anthrax researcher there could be in jeopardy. These environmental and social issues are further explored in the Motives and Targets section below.

## VII. Behavioral Analysis and Interpretation

The sealed psychiatric records offer insight not only into Dr. Ivins' behaviors, but also to the possible motivations behind those behaviors. In the Panel's view, these motivations did not arise solely from mental illness — i.e. they were not the result of delusions, extreme depression, or mania. Rather, they arose from the combination of his character-related symptoms and life events. These character-related symptoms, established since boyhood or youth, reflected a personality disorder that involved pathological attachments and preoccupation with revenge and anger. They were represented in the criminal behavior that Dr. Ivins displayed before his employment at USAMRIID. Had this behavior been known, it would have disqualified him from the opportunity to work in the secure setting of USAMRIID under the rules then in place. Had this pre-employment behavior — or later behaviors documented in 2000 — been known, those rules would have prevented him from obtaining a security clearance and from access to select agents.

### **MOTIVES AND TARGETS**

In carrying out the anthrax attacks of 2001, Dr. Ivins acted out of an extraordinary confluence of multi-layered motives. In addition to preservation of his career and life's work, the key themes appear to have been loss, a desperate need for personal validation and professional redemption, and most importantly, revenge. These themes guided him not only in planning and carrying out the attacks, but in choosing his targets and shaping his methods.

- *Revenge*

As a result of the various pressures described in the narrative, Dr. Ivins had genuine reason to be concerned that the anthrax vaccine program in which he had invested his professional identity was in jeopardy. But his fragile view of himself also led him to feel that criticisms of the vaccine were more than impersonal critiques of a longstanding DoD program. He experienced them as personal attacks.

## VII. Behavioral Analysis and Interpretation

In some cases, Dr. Ivins targeted his responses broadly and symbolically — in writing to *The National Enquirer*, for example, and its parent company, American Media Inc., he was targeting the media in general. “Tell Matsumoto,” he had written about one journalist, “to kiss my ass.” Sending anthrax to the *Enquirer* sent that message, in bold face italics.

In other cases, Dr. Ivins targeted very specifically. The *New York Post* represented the city he hated. Even more specifically, Tom Brokaw worked for NBC, the network that had rejected his idea for a mini-series about the Space Shuttle Challenger disaster. And perhaps more importantly, Brokaw had been the co-host of the Today Show with Jane Pauley, who was among the most famous alumnae of KKG of her generation, as Dr. Ivins himself noted in his Internet postings. Just as he had sought revenge in various ways against the husband of KKG Sister #2, Dr. Ivins sought it against the broadcast partner of this other KKG Sister.

Senator Daschle, as we have noted, had been a public critic of the anthrax program. Senator Leahy was viewed as a civil libertarian, whose sympathies concerning both anthrax vaccine and the kind of events that took place at the Greendale Baptist Academy in Wisconsin might be seen as suspect by Dr. Ivins.

Against all of them, the mailer sought to achieve literally “in your face” revenge.

- *Personal validation*

The attacks also represented a way for Dr. Ivins to elevate his own significance. One day his program was under scrutiny and his career as an anthrax researcher imperiled. The next day his program and his skills could not have been more crucial to national security. The downward trajectory of his career reversed in the most dramatic way.

## VII. Behavioral Analysis and Interpretation

One of his key audiences, as usual, was KKG Sister #2. It was clearly not by accident that after an approximately 18-year hiatus, he reached out to her between the time the first set of anthrax letters were mailed and the time they were discovered. In his September 21, 2001 email to KKG Sister #2, Dr. Ivins made reference to his presence at the “primary BW [bio-warfare] research center in this country” and commented that “we are all more than a bit on edge.” Having lit the fuse on his bombs, he was now positioning himself to be this all-important figure in two ways: both prescient and prepared. (On the other hand, it was an accident — and a supremely self-incriminating one, indicative of his increasing difficulty in concealing past behaviors — that in 2008 he told investigators he had contacted KKG Sister #2 “after the anthrax attacks.” On September 21, 2001, no one but the mailer knew there had *been* anthrax attacks. With most suspects, such a statement might be attributed to the vagaries of memory. But Dr. Ivins’ memory for events connected with KKG Sister #2 and KKG in general appears to have been perfect. Statements he made in the same 2008 interview, recalling events that took place decades before the September 21, 2001 email, were found to match up exactly with the facts.

The evidence for the place occupied by KKG Sister #2 in Dr. Ivins’ motives also lies in the DNA codons in the first set of letters. Dr. Ivins thought that KKG Sister #2 would understand them. During an interview with the FBI, he had falsely denied his own knowledge of this coded language. But he had bragged about KKG Sister #2’s: She “is a Gene Jockey who could answer any such questions about DNA,” he said.

By sending letters with codons, he was showing off to KKG Sister #2.

## VII. Behavioral Analysis and Interpretation

- *Professional redemption*

By launching the attacks, Dr. Ivins showed that anthrax was a real threat and the vaccine he helped manage was necessary to protect the public. The attacks in this sense achieved their goal. Soon after, the FDA placed the approval process for the vaccine on a fast track, problems with its potency notwithstanding. And Dr. Ivins even received the Exceptional Civilian Service Award from the Department of Defense.

It is important to note that the mailer might have been sincere in his beliefs about the anthrax threat and might have actually believed he was doing a public service by calling attention to the need for the vaccine in this manner. His various motives were obviously all severely misguided, but they were not all necessarily misanthropic.

- *Loss*

Technician #2's departure from Dr. Ivins' laboratory in 1999 to go to medical school in New York State represented a serious personal blow. In the poem he wrote to mark her departure, he had expressed the thinly veiled wish that she would return and that "[we will] miss you lots — more than you'll ever know." After she left, his emails described his sense of loss and even depression. By early 2000, he was again seeking psychiatric treatment for symptoms related to depression and anxiety, for the first time in 20 years.

Launching the anthrax attacks was in part an effort to inflate his importance with Technician #2 and potentially induce her return to the laboratory. Technician #2 had been inoculated against anthrax and had the skills to work with it. In the aftermath of the attacks, people like her were in demand. "I just heard tonight that Bin Laden terrorists for sure have anthrax and sarin gas," he wrote her on September 26, 2001, after the first letters were mailed but before they were reported. "You should feel good about having received anthrax shots." In the aftermath of the attacks, physicians with

## VII. Behavioral Analysis and Interpretation

research backgrounds in anthrax were in demand. Technician #2 conceivably could have returned to the laboratory — embraced by her peers as an authority and with only Dr. Ivins, her mentor, to thank.

“FNY,” the letters to the *New York Post* and Tom Brokaw had spelled out in the embedded codons. New York, the state he had long hated, had attracted Technician #2 and therefore taken her away. But the letters and the spores they contained could bring her back to USAMRIID — and him.

In interviews with investigators after Dr. Ivins’ death, Technician #2 herself reluctantly acknowledged that this motive had likely been instrumental in Dr. Ivins’ actions.

Understanding Dr. Ivins’ motives may also help explain why he sent two sets of letters. After the first set was sent, on either September 17 or 18, nothing happened publicly until October 4, when it was first reported that Robert Stevens had become ill in Florida with anthrax. Mr. Stevens’ death was reported the next day. But there were no reports of a letter having been received in connection with this death, and in fact the letter that infected Mr. Stevens was never found. Thus the mailer likely felt, even after Mr. Stevens died, that he was not achieving his purpose. Without public exposure of his letters, his effort to stir panic by linking the anthrax with the Islamic terrorists who had just attacked the United States was in jeopardy. And without that panic, he was less likely to induce Technician #2 to return to the lab, impress KKG Sister #2, or redeem the anthrax vaccine program. Without publicity for his letters, he was also being denied the satisfaction of knowing that the letters had reached their targets — that he had achieved direct, personal revenge. In short, the letters themselves — not only the anthrax they contained — were essential to the achievement of his motives. So he prepared and mailed a new set, to Senators Daschle and Leahy. Eventually, both sets of mailings were discovered and publicized.

## VII. Behavioral Analysis and Interpretation

### MAILING ANTHRAX

Dr. Ivins' methods in launching the attacks are also revealing.

Dr. Ivins used the mail for legitimate purposes, but throughout his adult life, he also used it for illegal and duplicitous activities. In fact, his use of the mail paralleled his depiction of himself as a dual personality with the ability to easily move back and forth between [REDACTED] people saw and the rage-filled, planner within.

As we have seen, Dr. Ivins took great satisfaction in folding into his plans and schemes the element of surprise. In his use of the mail, Dr. Ivins also found ways to indulge that fondness, and to enlist and manipulate others, entirely without their knowledge. In a world where trust is the norm, he succeeded by duping others, often through his methodical, sinister use of the mail.

*The Frederick News-Post*, for example, did not know that the letter it received about hazing did not come from the person whose signature was attached; the mother of the student who died in a hazing accident had no idea that the published letter to the editor she later received in the mail from Dr. Ivins came from anyone but the woman who allegedly signed it; nor did the author of a book on hazing who received a copy of that letter from that mother suspect a fraud. All these parties were not only links in Dr. Ivins' smear campaign against KKG Sister #2 — they were unknowing links, in a chain consistently forged by the Postal Service.

The Postal Service was also an unwitting instrument in delivering packages Dr. Ivins sent in a childish hand to Technician #2, under various aliases. But over the years, the Postal Service was more often a tool in his malicious attacks on KKG and KKG Sister #2.

In addition to his activities in connection with the hazing letter, he had dropped KKG Sister #2's stolen lab book in a mail collection box without postage. He had sent the KKG ritual book back to West

## VII. Behavioral Analysis and Interpretation

Virginia University through the mail. He had taken out a Post Office box under the name of her husband, and used it to receive bondage-related pornography. For decades he had successfully exploited the U.S. Postal Service — while also escaping detection.

When he decided to launch his surprise attacks, therefore, it was perhaps predictable for Dr. Ivins to choose the mail as his vehicle.

It was also understandable for him to choose anthrax as his weapon.

An expert in its production and purification, he also knew how to protect himself from it. He was vaccinated, and when he did, apparently, get a bacterial skin infection from handling it while preparing the mailings, he knew enough to get himself treated and cured, and also knew enough to omit providing this required information from the medical assessment he filled out for USAMRIID six months later.

But more than that, he displayed a kind of morbid intimacy with anthrax. On numerous occasions, including some prior to the attacks, Dr. Ivins suggested to various therapists [REDACTED]

Indeed, in 2005, in a self-protective move, he requested permission to be assigned out of the hot suite, because he did not feel comfortable being alone there with the deadly agent. The Panel agreed that it would be highly unusual for a scientist working with a weapon of mass destruction to consider using it as an agent for his own suicide — because use of such a weapon could trigger a large-scale catastrophe involving colleagues and perhaps others, as well as imperil the program itself. [REDACTED]

**VII. Behavioral Analysis and Interpretation**

Dr. Ivins was also comfortable with anthrax as his weapon because he



Finally, given Dr. Ivins' obsessions and proclivity for careful planning, it was also natural for him to give very careful consideration to the specific launch site.

As we have discussed, all four of the recovered letters were postmarked at the Hamilton Township Regional Postal Facility in Hamilton, N.J. Investigators tested all 622 public mail collection boxes in that district and found only one that tested positive for anthrax. That box is at 10 Nassau Street, Princeton, N.J.

That location puts it 197 miles from Dr. Ivins' home in Frederick, Md. It also places it at a site that, at least in the daytime, is not desirable for someone who wants to escape notice: Nassau Street is busy.

At night, when the letters were probably mailed, the site does offer more privacy. But many other mailboxes offer more. And what this site really offered Dr. Ivins was something far more important than practical utility. What the mailbox at 10 Nassau Street offered was symbolism. Just 175 feet from that box — closer than any other — is the KKG office of Princeton University.

In other words, the same mailbox Dr. Ivins chose on two separate occasions provided proximity to the two key reservoirs of his obsession and rage. KKG represented female authority and all the successful,

## VII. Behavioral Analysis and Interpretation

talented, attractive people who had rejected him and inspired his rage, as we have discussed. Princeton represented his failed college aspirations and his father and the humiliation and rage also wrapped up in both of these concepts for him. It is likely that dropping anthrax in that one — for him — uniquely well-located box was a kind of spectacular “gotcha.” It was a desecration, a poisoning, a payback in its own way, by a veteran plotter [REDACTED]. Hundreds of miles from some of his eventual victims, he was lighting the fuse on his bombs from what was probably the most supremely meaningful site he could imagine.

Besides the choice of the mailbox, the return address on Dr. Ivins’ letters to Senators Daschle and Leahy (the letters to the New York Post and Tom Brokaw bore no return address) is also significant. That return address was: 4th Grade, Greendale School, Franklin Park NJ 08852.

As we have already seen in the Narrative section of this report, “4th Grade, Greendale School” was most likely a reference to a story in a magazine Dr. Ivins read relating to a civil liberties case.

Franklin Park is a real town in New Jersey, not far from Princeton. Why he chose it is unknown; we have no information to shed light on that question. But Franklin Park’s ZIP code is in fact not 08852. That ZIP code belongs to a place called Monmouth Junction, N.J. About that name, we have a great deal of information.

On his father’s side, as we’ve noted, and as Dr. Ivins knew, the Ivins family came from Monmouth, N.J. (Note: Monmouth County, N.J. does not contain a municipality by that name; whether the Ivins family records that Dr. Ivins kept refer to the county or a farm community is unclear; regardless, they refer to “Monmouth, N.J.”) KKG, as also discussed, was founded at Monmouth College in Monmouth, Ill.

## VII. Behavioral Analysis and Interpretation

Dr. Ivins did not use the ZIP code of either of these places, however, because doing so would not have demonstrated the link between them. Code lover that he was, he appears to have come up with something much richer.

Dr. Ivins felt that his own identity, aspirations and resentments, were entwined in KKG. His decades of obsession demonstrated that entanglement.

By using the ZIP code of Monmouth Junction, Dr. Ivins may have been portraying in code the connection between KKG and his own identity. Monmouth Junction may have represented the union of father (Monmouth, N.J.) and mother (Monmouth College, KKG), i.e., himself. And it also represented his entanglement, his obsession with KKG.

In other words, in two inter-related ways, the Monmouth Junction may have represented Dr. Ivins himself. With the return address on his Senatorial letters, he appears to have revealed the identity — at the deepest level — of the mailer. Dr. Ivins, in short, signed his letters.

### **COMMITMENT AND SUICIDE**

The evidence indicates that Dr. Ivins was conscious of his guilt and took many steps over the years to conceal it. Realizing that investigators would be looking at his own laboratory as a possible source, he pre-empted them — not once, but twice. Contrary to USAMRIID rules, he tested his office for anthrax after the attacks and, when he found it, disinfected the office himself — also against the rules — without telling anyone until afterwards. His claim that he did the swabbings out of concern for his technician does not hold up; although the results confirmed the presence of anthrax, he chose not to inform her or supervisors until much later. In all likelihood, he did these things because he did not want the authorities to find evidence of the murder weapon at the scene of the crime.

**VII. Behavioral Analysis and Interpretation**

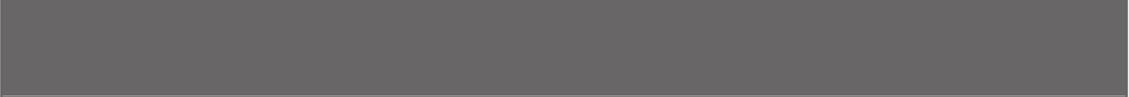
In an apparent attempt to conceal the murder weapon, he deliberately broke the rules in submitting his February samples of RMR-1029. Then, in submitting more samples in April, he broke them again — but in a different way designed to thwart the investigators' emerging new forensic techniques.

Dr. Ivins' efforts at deception appear to have been strategic. He purged only his 2001 emails. He named an ever-changing list of colleagues as suspects. He tested the anthrax used in the letters, and falsely claimed it was of a higher quality than anything he had ever produced.

For a long time, all these stratagems worked. For a long time, no one could have been further from being a suspect. He — the perpetrator — was providing scientific examination of the anthrax in the Daschle letter. He — the perpetrator — was being decorated by the Army in 2003.

But by 2004, some of the evidence, including the assays of his anthrax samples, was beginning to point his way. By March 31, 2005, he was being interviewed by the FBI and he knew — he said it himself — that he was "under suspicion," resulting in such severe anxiety that he had to request a temporary leave from the hot suite. By 2006 more evidence was accumulating against him. Although he had purged his own 2001 emails, his recipients kept many of theirs, and shared them with investigators. What they found was revealing. By 2007 his house was being searched and he was being re-interviewed by the FBI.

Some observers have suggested that Dr. Ivins' increasing abuse of alcohol and drugs near the end of his life was purely the consequence of prosecutors' harassment. That is not surprising, because Dr. Ivins openly attributed his substance abuse to the FBI investigation. In the Panel's view, that is a distorted assessment, and another example of Dr. Ivins' effective efforts to portray himself as a victim. In fact, he



## VII. Behavioral Analysis and Interpretation

deceit was being uncovered and his unexplained behaviors questioned, his anxiety rose. [REDACTED]

[REDACTED]

It was not just that he feared being indicted and executed. The man behind the [REDACTED] was being exposed. Clever and surreptitious his whole adult life, his anthrax mailings had in many ways been brilliantly successful. He had achieved what he likely felt was retribution against his enemies — KKG, Princeton, his mother, his father, the media, Congress, New York. He had positioned himself as a hero to KKG Sister #2, Technician #2, the Red Cross, his colleagues, the scientific community in general, and the Federal Government. He had apparently outsmarted everyone.

But now all his stratagems to evade detection began to point toward him rather than away. Now the swabbings, the naming of others as suspects, the erasure of emails, the false samples, the evidence from his own laboratory notebook that his anthrax matched the quality of that in the Daschle and Leahy letters — all began to show another picture. And perhaps Dr. Ivins began to sense that in the end he had himself been outsmarted and that the core self he had hidden so well was coming into the clearest possible public view. The man who so aggressively and maliciously exposed the secrets of others — who literally advertised his willingness to mail the secret KKG rituals to any third party — rapidly deteriorated as he realized that his own secrets were beginning to come to light.

[REDACTED]

[REDACTED] In June of 2008 he learned for certain that an indictment was coming, and on June 27, he learned that the Justice Department had reached a financial settlement with Dr. Hatfill. His behavior grew reckless and threatening. He became publicly intoxicated and taunted people in a minority neighborhood. He was so threatening to a female colleague at USAMRIID that she went to her supervisors; when

## VII. Behavioral Analysis and Interpretation

instructed to “hide in the hot suites,” a USAMRIID employee contacted FBI investigators instead and pleaded for some kind of intervention. (The resulting Department of Justice call to his attorney appeared to go unheeded.) Then he expressed his fantasies as real plans. He did it in the way that he was accustomed — in a therapy setting, [REDACTED]

[REDACTED] But this was a group, not a one-on-one session, and therefore rather public; regardless, his performance was too maniacal and convincing not to provoke a reaction. He smiled strangely as he discussed his plan for revenge, his therapists recalled. They had him involuntarily hospitalized.

In so doing, they almost certainly saved lives. Dr. Ivins had acquired ammunition and a bulletproof vest and body armor and had made arrangements to obtain a Glock pistol in addition to the rifle he already possessed. He had a list of people he wanted to kill. Now that he was being unmasked as the killer, he was going to shed his lifelong stealth and anonymity and go down with guns blazing — literally. Had he retained the means, there is every reason to think he would have carried out his plan. One of the group therapy members suggested that his plan sounded like a mass killing followed by “suicide by cop.”<sup>12</sup> Provoking law enforcement to kill him would force the hand of government and in its own way complete his narrative as victim. But because the therapists brought his threats to light, a chain of events unfolded that led to the disruption of his plan to obtain a pistol and to a search of his house. That July 12 search resulted in the confiscation of the rest of his arsenal — hundreds of rounds of ammunition, a bulletproof vest, body armor and smokeless handgun powder.

Meanwhile, Dr. Ivins appears to have thought that he was under assault in other ways too.

Through his attorney, Dr. Ivins had earlier requested and been provided with verbatim notes from his outpatient psychiatric record.

**VII. Behavioral Analysis and Interpretation**

He was therefore aware of [REDACTED] that had never been requested by his employer or seen by investigators. When he was involuntarily hospitalized, he became convinced that the FBI could now have access to this information because, he thought, the investigators would be given his entire psychiatric file. He expressed this conviction of betrayal to Therapist #3 in bitter voice mail messages that helped lead her to seek a restraining order [REDACTED]  
[REDACTED]

In fact, Dr. Ivins' fears were groundless. The FBI did conduct limited interviews with Therapist #2 and her colleague, Therapist #3, from the July 9 group therapy session, as a follow up to the Emergency Petition. It also spoke with his psychiatrist, Dr. #3, as well as Dr. Ivins' therapist from the year 2000, Therapist #1. But access to his psychiatric records and interviews with all known prior psychiatrists and therapists was provided to investigators only upon Federal court order months after his suicide. This information would never have been made available to prosecutors unless he had raised the issue of mental illness as part of a criminal defense.

Still, his phone messages to Therapist #3 and [REDACTED]  
[REDACTED] show that Dr. Ivins thought the FBI had the records. He thus would have believed that they would know about [REDACTED]  
[REDACTED]

Although it had no basis in reality, it likely was, in his imagination, yet another blow — a double blow, actually. Once again, he would have believed, it was turning out that in the end, he was the one being outsmarted. [REDACTED]  
[REDACTED]

The information would show

**VII. Behavioral Analysis and Interpretation**

that, in a very real sense, [REDACTED]  
[REDACTED]

Dr. Ivins knew that he was going to be indicted, likely convicted and go to prison and quite possibly be executed. He had lost the means to exact revenge while going out in a blaze of glory. Rather than ending his career as a hero in the battle against the threat of anthrax, he would face prosecution and quite possibly execution as the perpetrator of a treasonous attack on his own nation.

But he had a choice. He could accept the fate the authorities were preparing to deal him, or he could take the initiative. For a man for whom control had been a lifelong issue, this was probably not a difficult decision. [REDACTED]  
[REDACTED]

Dr. Ivins pulled himself together one more time. He persuaded the consulting psychiatrist at Sheppard Pratt that he had no intention of hurting anybody, himself included. As a result, he got himself discharged from the hospital.

Within hours of his release, he had bought the acetaminophen he needed to take his life. Then, knowing that the authorities could be knocking on his door at any time, he did not wait long — perhaps two days. Discharged on July 24, it was probably July 26 when he wrote a note to his wife asking her to let him sleep, thus ensuring that the drug would have time to take effect.

He was correct about one thing. His promise to group therapy that “You’ll see me in the papers” came true. Despite his failure to go down with all guns blazing, his death — and his role as the investigation’s chief suspect — made national news.<sup>12a</sup>

**VII. Behavioral Analysis and Interpretation****End Notes for Behavioral Analysis and Interpretation**

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- <sup>9a</sup>Shane, S. (2008). Another Twist in Case of Dead Anthrax Suspect. *New York Times*. Retrieved from <http://www.nytimes.com/2008/09/13/us/13anthrax.html>.
- <sup>10</sup>Goldstein, A., Hernandez, N., & Hull, A. (2008). Tales of Addiction, Anxiety, Ranting: Scientist, Counselor Recount Recent Turmoil in Anthrax Suspect's Life. *The Washington Post*. Retrieved from [http://www.washingtonpost.com/wp-dyn/content/article/2008/08/05/AR2008080503747\\_pf.html](http://www.washingtonpost.com/wp-dyn/content/article/2008/08/05/AR2008080503747_pf.html).
- <sup>10a</sup>Holstege, C., Neer, T., Saathoff, G., & Furbee, B. (2010). *Criminal Poisoning, Clinical and Forensic Perspectives*. London, UK: Jones and Bartlett.
- <sup>11</sup>Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future. *Journal of Mental Health*, 11(6), 585 – 594. doi: 10.1080/09638230020023930.
- <sup>12</sup>Strayer, A. & Marzani, G. (2010). Suicide by Cop: Averting the Crisis. *University of Virginia, Critical Incident Analysis Group*.
- <sup>12a</sup>Willman, D. (2008). Apparent suicide in anthrax case. *Los Angeles Times*. Retrieved from <http://articles.latimes.com/2008/aug/01/nation/na-anthrax1>.

## Appendix I - Diagnostic Considerations

### INTRODUCTION

At the time of his death, Dr. Ivins was the subject of a pending indictment as the principal suspect in the anthrax letter mailings that terrorized the nation in the fall of 2001. Had he survived and faced criminal prosecution on federal charges, several aspects of the case would have suggested a comprehensive psychiatric assessment within the forensic context. Among them: the unusual and highly publicized nature of the crime; the potential of a death penalty; the presence of a significant psychiatric treatment history; Dr. Ivins' ongoing use of psychotropic medications; and his hospitalization for mental health and substance abuse problems just prior to the planned indictment.

It is likely that Dr. Ivins' competency to stand trial would have been assessed at the request of the defense, the prosecution, or the judge. In order to be competent to stand trial, a person must have a rational as well as factual understanding of the proceedings against him, and have sufficient ability to consult with his attorney with a reasonable degree of rational understanding. The threshold for being competent to stand trial is low, and it is likely that Dr. Ivins would have been found competent to proceed.

It is also likely that Dr. Ivins' mental state at the time of the alleged offenses would have been assessed. The issue would have been whether he met the criteria under federal law for a finding of not guilty by reason of insanity. Specifically, he would have been assessed to determine whether at the time of the anthrax mailings, he was suffering from a severe mental disease or defect that resulted in him being unable to appreciate the nature, quality, or wrongfulness of his conduct.

Whether or not Dr. Ivins would have pursued an insanity defense can never be known. Nevertheless, had there been a conviction, information from his psychiatric assessments related to the charges would have been considered in the sentencing phase — no matter what legal defenses had been employed.

**Appendix I - Diagnostic Considerations**

One approach to developing an understanding of Dr. Ivins after his death would be to conduct a psychological autopsy. This process is often undertaken to ascertain whether a death was indeed a suicide, and identify the rationale for and possible contributing factors to the suicidal behavior. The process also serves a quality assurance function. It provides a review of the clinical assessment and intervention services that were or were not employed, and it can contribute to a better understanding not only of the particular suicide but also of suicidal behaviors in general.

For several reasons, however, the Panel's assessment of Dr. Ivins is not being presented as a psychological autopsy per se. First, as detailed in the Toxicology section of this report, the evidence is clear that Dr. Ivins died from an intentional overdose of acetaminophen and possibly other medications; the Panel has concluded that Dr. Ivins' death was indeed a suicide. In addition, the Panel was not authorized to attempt direct interviews of Dr. Ivins' care providers, co-workers, family members, or acquaintances, who routinely would be interviewed in a psychological autopsy. Finally, Dr. Ivins' suicide was only one aspect of the case that was of concern to the Panel. The primary task for the Panel was to determine how an event like the anthrax attacks can be prevented from recurring — and toward that end, to develop a better understanding of the interface, or relationship, between Dr. Ivins' psychiatric problems and the alleged criminal behavior. The Panel's investigation, therefore, was not limited to Dr. Ivins' mental state at the time of his death, but was focused as much if not more on the period prior to and at the time of the attacks.

As a result, the Panel utilized a more traditional forensic psychiatric approach. Following the biopsychosocial<sup>13</sup> model, the Panel members applied their knowledge of the forensic mental health evaluation process to understand the biological, psychological, and social influences on Dr. Ivins' behavior prior to and after the alleged offense.

## Appendix I - Diagnostic Considerations

If a traditional forensic psychiatric evaluation like this one were documented with a written report, a typical format would be:

- Introductory information about the subject of review;
- Identification of the questions of concern;
- A description of the process of the evaluation, including what information was considered pertinent to review, what tests or procedures might provide useful information, and a listing of all information reviewed;
- A detailed review of the subject's history (often subsumed under the heading Background Information);
- A description of any pertinent medical issues;
- A detailed description of the current mental status of the subject, and a discussion of how it may have fluctuated or changed over time and what it was at specific times in the past;
- A description of any tests or procedures used in the evaluation together with the results; impressions or conclusions formed as a result of the evaluation, including a detailed diagnostic formulation and how these were arrived at from available data;
- The answers to any specific questions posed by the attorneys or the court; and
- Any recommendations that resulted from the forensic review.

Aspects of this forensic evaluation process are outlined in detail in the other sections of this report. The reader is referred specifically to the sections entitled Statement of Purpose, Methods, Types of Materials Examined, and Summary of Psychiatric Treatment. Detailed background history is provided in the Narrative Sections of the report as well as the other background topic sections. However, no physical

**Appendix I - Diagnostic Considerations**

examination or additional medical or neurological tests could be conducted in this case, and there is no evidence that Dr. Ivins ever completed formal psychological or neuropsychological testing.

What follows are the Panel's impressions given the available information, which, as is often the case in retrospective assessments, has its limits. The Panel could not interview the subject of interest, conduct any additional testing, or attempt to directly clarify any clinical questions. To the Panel's knowledge, no clinical interviews of Dr. Ivins were conducted to explore his potential competency to stand trial or his mental state at the time of the alleged offenses. As noted, the Panel was not authorized to attempt direct interviews of Dr. Ivins' care providers, co-workers, family members, or acquaintances.

Although psychiatric records are available throughout the period in question (2000-2008) and from an earlier period (1978-1980), there are gaps in that documentation. The ability of the various clinicians to fill those gaps in interviews was limited by the constraints of recall — years, even decades, had passed since many of the psychiatric or counseling sessions. Given Dr. Ivins' status as a key suspect in this extraordinarily prominent case, as well as his suicide, the therapists also might have exercised caution — a concern for possible legal or professional repercussions would not be surprising. It should also be noted that the interviews of involved clinicians were not conducted by mental health professionals, but by FBI and USPS investigators. Although these investigators made a thorough effort to obtain information, their questions were not specifically directed at clarification of diagnoses. Thus some information that was available and relevant to diagnosis might have been missed.

Nonetheless, much information was available for review — from the outpatient clinical records, from work-related evaluations, from emergency room evaluations, [REDACTED]

[REDACTED]  
Providers were interviewed more than once and the information

## Appendix I - Diagnostic Considerations

obtained was carefully documented. Many people who knew Dr. Ivins at different times of his life, including family, friends, co-workers, and acquaintances, were interviewed by investigators. The Panel was able to review clinical information and social and background history in the context of the detailed investigative records associated with this case. These investigative records contained written documents and audio recordings of Dr. Ivins' conversations, his thoughts and his ideas, providing a window into his behavior, his relationships, his interests and activities, and his own assessments of his mental states.

Because of our inability to interview Dr. Ivins or other individuals with pertinent knowledge, the Panel does not offer diagnostic conclusions. Nevertheless, our review has allowed us to develop a significant understanding of the psychiatric issues in Dr. Ivins' life and their possible impact in this case. Considering how Dr. Ivins' symptom presentations and his behavior fit into our current understanding of and classification of mental illnesses, we have offered our "differential diagnosis," or set of diagnostic possibilities, in an effort to clarify our understanding of his behavior, both before and after the anthrax mailings. The diagnostic classification system we used is that outlined in the Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition, Text Revision, (DSM-IVTR)<sup>14</sup>. The Panel's diagnostic impressions of Dr. Ivins, presented through this system, are described near the end of this section.

### **THE PSYCHIATRIC RECORD**

A logical place to begin the review of diagnoses is to consider how the various clinicians who saw and treated Dr. Ivins diagnosed and described him during their treatment, as well as Dr. Ivins' own statements to his therapists about his behaviors and symptoms. Evidence for and against the validity of these diagnoses and statements can also be gleaned from other sources.

## Appendix I - Diagnostic Considerations

Little information is available about Dr. Ivins' mental health during childhood and adolescence. There is no evidence that he was ever formally diagnosed with a mental illness or even that he was formally assessed in regard to behavior problems. In therapy as an adult, he

Dr. Ivins described only negative feelings toward both parents. He

shared them with the few individuals with whom he either wanted to form a relationship (e.g., KKG Sister #2) or with whom he actually did form a relationship (e.g., Technician #2). In his mother and brothers he described paranoia and rage. He described his oldest brother as a psychopath and his mother as "schizophrenic." No information indicates she was ever diagnosed as such, however,

**Appendix I - Diagnostic Considerations**

and she had no known psychiatric hospitalizations. When interviewed by investigators, neither sibling validated the extremely dysfunctional family picture Dr. Ivins presented.



There is, however, evidence of disturbance during this college period. According to his own later account, his self-described obsession with the sorority Kappa Kappa Gamma (KKG) began in 1966, when a KKG member turned him down for a date. There is also documentation that he threatened to poison his college roommates if they tried to eat his food.

Dr. Ivins stayed at University of Cincinnati following his undergraduate education and completed his master and doctorate degrees within the expected time period, receiving those degrees in 1970 and 1976 respectively. He married a woman he met while she was a student at the University of South Carolina on August 22, 1975, just after she turned 21.

During his post-doctoral work (1976-1978) at the University of North Carolina at Chapel Hill, Dr. Ivins reportedly had two sessions with a therapist. Records from those sessions are not available, but we know that during this period, despite his recent marriage, he became obsessively focused on a graduate student, known in this document as KKG Sister #2.

## Appendix I - Diagnostic Considerations

He attempted to share intimate details of his life with her, but perceived her response as a rebuff. As described in the Narrative section of this report, he responded with a series of threatening and criminal behaviors towards her, which he described later to therapists.



## Appendix I - Diagnostic Considerations



Dr. #2 had used the DSM classification system to record his diagnostic impressions. The system is built on five axes. Axis I includes all mental disorders except personality disorders or developmental disorders.

## Appendix I - Diagnostic Considerations

Axis II is reserved for personality disorders and developmental disorders. Axis III represents pertinent medical diagnoses, and IV lists known stressors within the last year. Axis V records the Global Assessment of Functioning (GAF) score, which measures the overall degree of impairment present at the time of assessment.

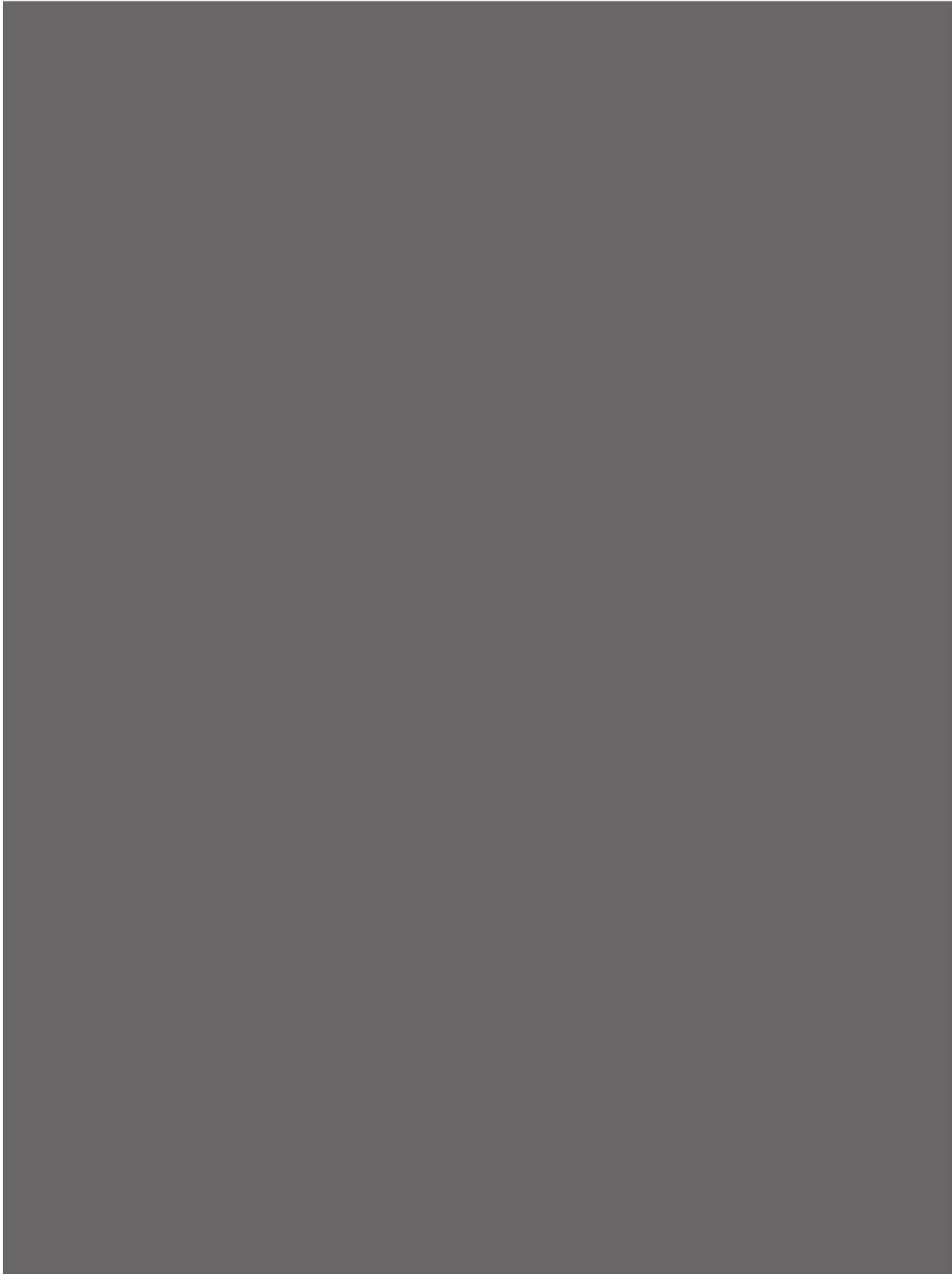
In 2000, Dr. #2 noted these diagnostic impressions:



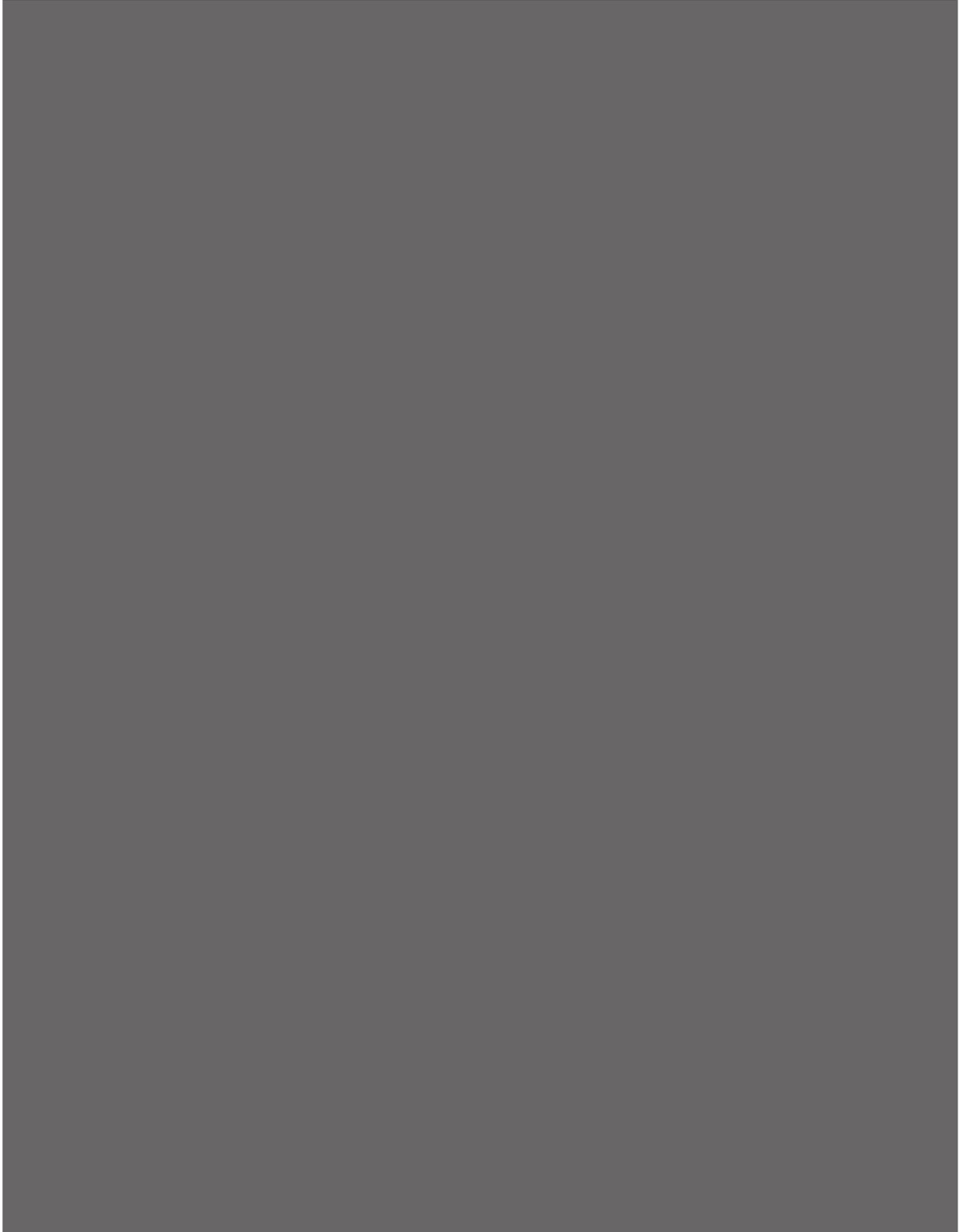
(The notation "NOS" — "not otherwise specified" — means the diagnosis fits the general category, but does not fit all of the features of any particular sub-category. "R/O" means the diagnosis requires further exploration to determine whether it should be ruled out.)



**Appendix I - Diagnostic Considerations**



## Appendix I - Diagnostic Considerations



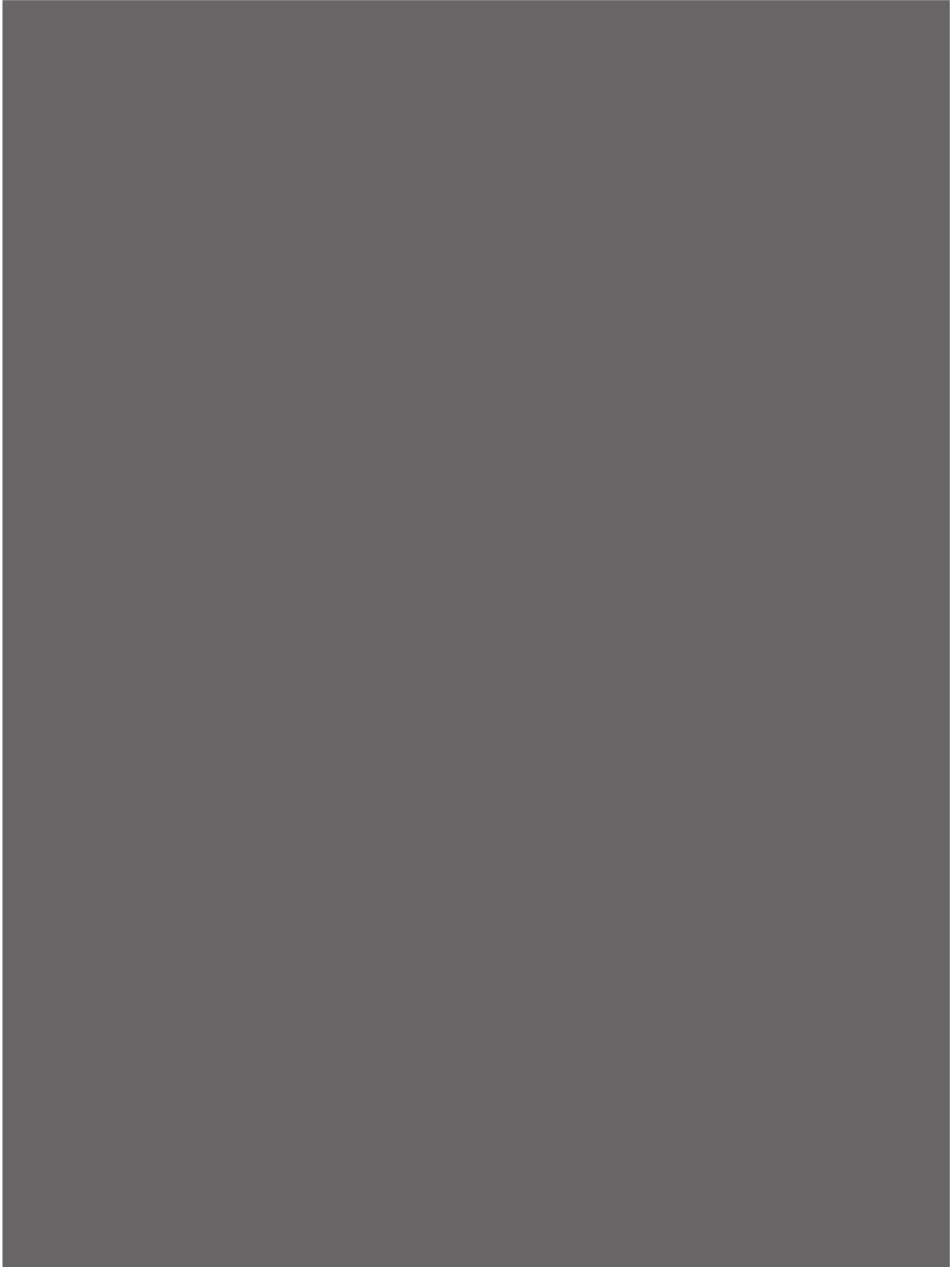
## Appendix I - Diagnostic Considerations



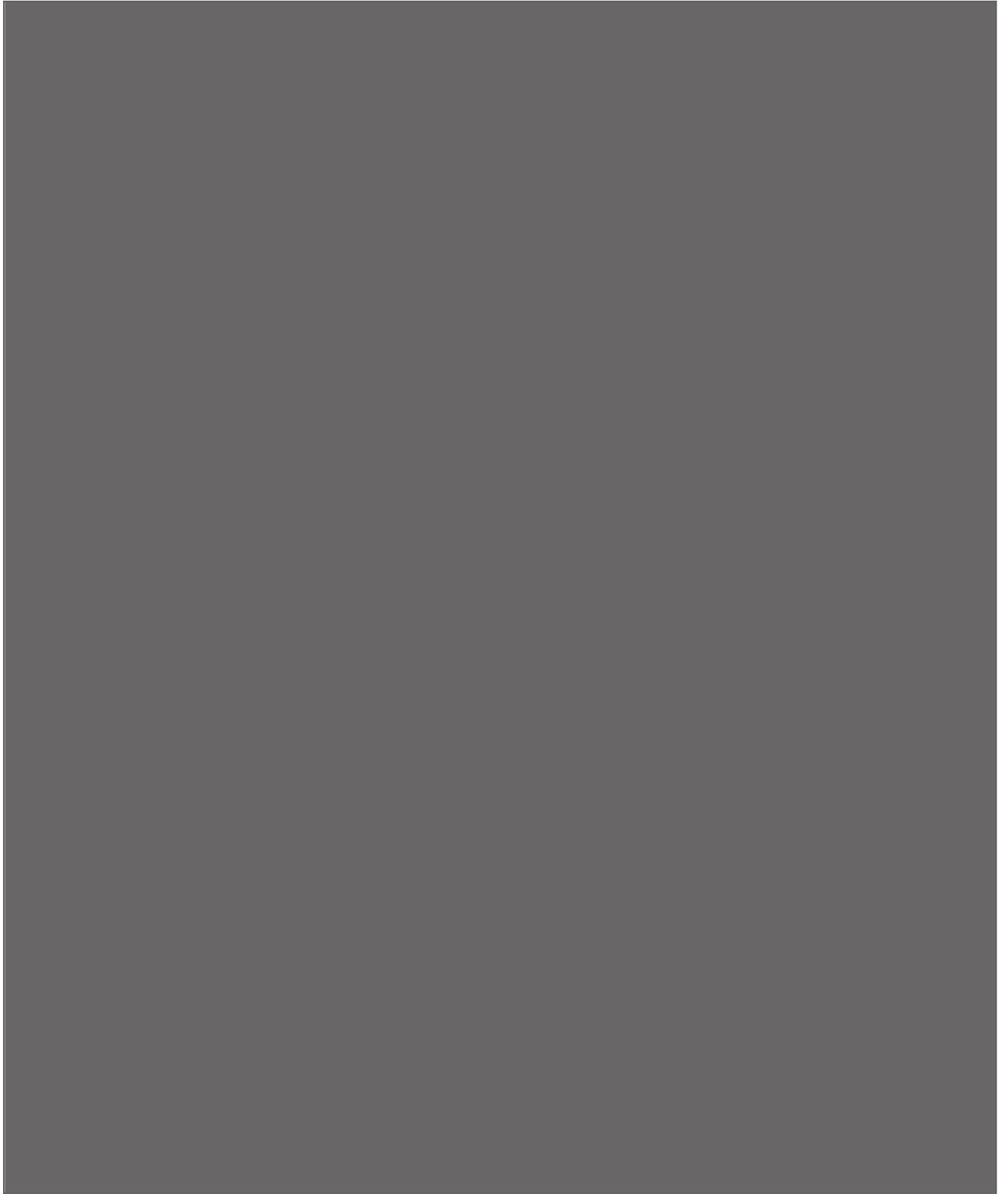
Dr. Ivins' own emails support abuse of alcohol as early as 1999 or 2000, following the departure of Technician #2 from his lab. Later, however, Dr. Ivins dated his increased drinking and abuse of prescription and over-the-counter medications to November 2007, when his residence was searched and family members interviewed. After the events of November 2007, there is documentation of slurred speech, slouching in his chair at work and falls secondary to intoxication and/or sedation.



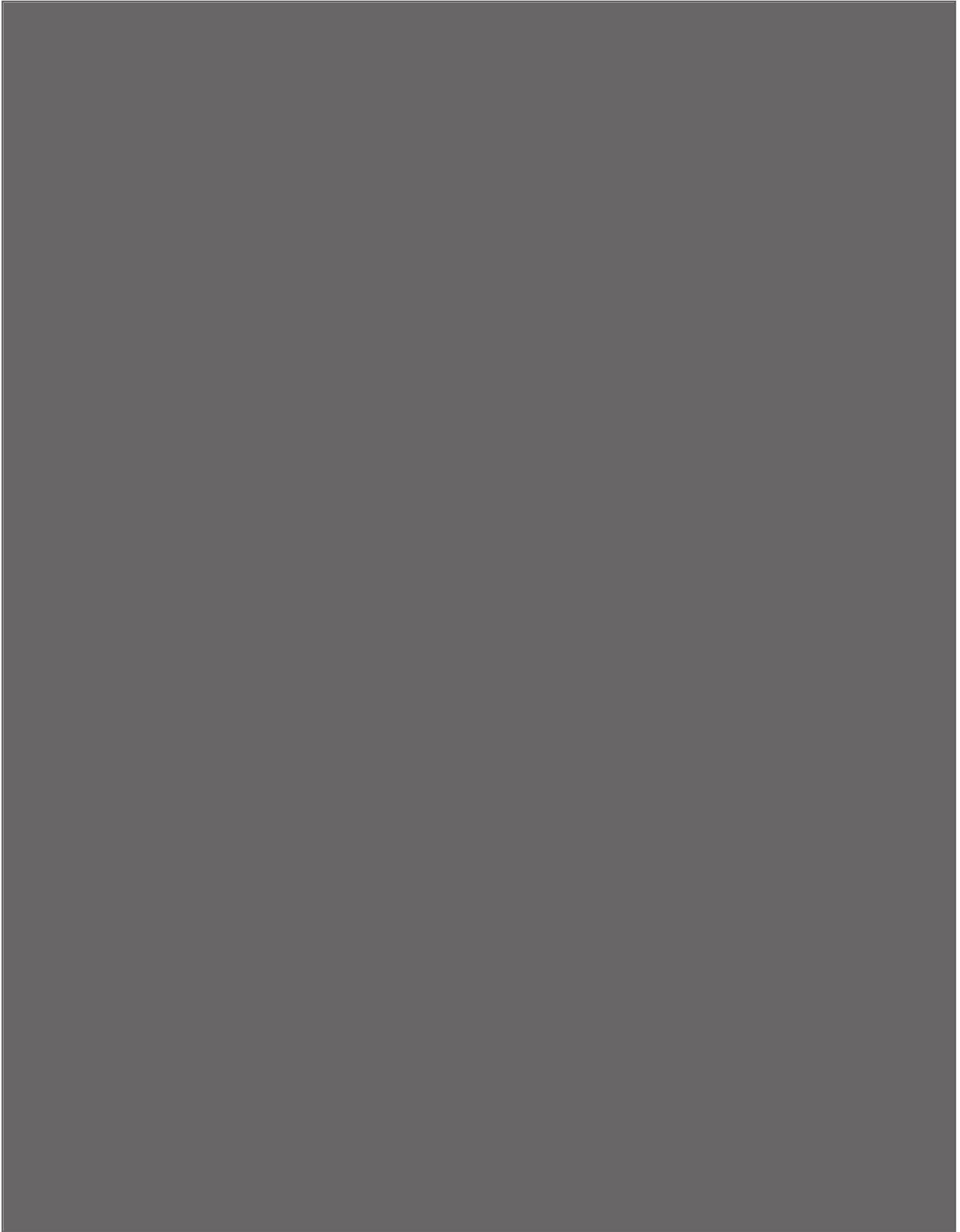
## Appendix I - Diagnostic Considerations



**Appendix I - Diagnostic Considerations**



## Appendix I - Diagnostic Considerations



## Appendix I - Diagnostic Considerations



Shortly after discharge he purchased enough acetaminophen to take a lethal overdose, and at some point in the next two days he did so.

**Appendix I - Diagnostic Considerations**

He was discovered collapsed in the bathroom of his home by a family member. Emergency services were called.

On admission to Frederick Memorial Hospital, Dr. Ivins' diagnosis was [REDACTED] He died July 29, after life support measures were discontinued in compliance with the family's decision.

**DR. IVINS' SELF-ASSESSMENTS**

Dr. Ivins' own writings offer many self-assessments and descriptions of symptoms. He referred, at times explicitly, to depression, paranoia, and delusional thoughts; described a sense of observing himself from the outside (depersonalization); talked and wrote about there being two Bruces (dissociation); described being harmed by the rejection of KKG members; and worried about becoming, and being, schizophrenic.

He spoke of feeling no remorse. He expressed homicidal and suicidal ideation [REDACTED] and at times identified specific plans to harm others and himself. He admitted to a preoccupation with blindfolds and bondage and a [REDACTED] [REDACTED] He expressed extreme dislike of New York City, New Yorkers, and all things related to New York.

In addition, Dr. Ivins admitted to an obsession with the sorority Kappa Kappa Gamma. He admitted to secretive and at times criminal behaviors, such as breaking into sorority houses, stealing, vandalism, driving long distances at night, lying, and misrepresenting himself as someone else in situations that cast that other person in a negative light.

In a self-help effort associated with his [REDACTED] treatment,  
[REDACTED]

**Appendix I - Diagnostic Considerations**

Some who interacted regularly with Dr. Ivins described times when he seemed to be “under a black cloud,” and odd behaviors and preoccupations, such as the episodes described in the Narrative concerning Technician #2 that involved schemes to decorate her apartment and to take her, blindfolded, to an adult bookstore. His stalking behavior frightened KKG Sister #2, and there is extensive evidence that he also stalked Technician #2, although she was not always aware of it. There also is evidence of a focus on Kathryn Price, as previously discussed. As noted, he described his perceived rejection by KKG Sister #1 as the trigger for a 40-plus-year obsession with Kappa Kappa Gamma.

There is also significant documentation that Dr. Ivins perceived stress in his home situation, both in his marriage and with his children. In the period leading up to the mailings, he also perceived stress at work — because of the negative attention being given to the anthrax vaccination program and because of the potential that his research program would be phased out. He also described depression and paranoid delusional ideas, especially after two female co-workers left his laboratory. He had become obsessively focused on the first woman who left; when the second left, he saw her departure as the removal of his only remaining major support.

## Appendix I - Diagnostic Considerations

### **SUMMARY DESCRIPTIVE MENTAL STATUS**

Based on the psychiatric record and on Dr. Ivins' self-assessments, the Panel was able to develop a summary descriptive mental status — a description that serves as a precursor to the development of a differential diagnosis:



## Appendix I - Diagnostic Considerations

He stalked at least two different women. [REDACTED]

[REDACTED]

[REDACTED] As discussed, he ultimately committed suicide by taking an intentional overdose of acetaminophen.



**Appendix I - Diagnostic Considerations**

[REDACTED]

The major impact that substance use and abuse likely had on his behavior and symptom picture was only addressed within the last year of his life. And it was also not until that last year that Dr. Ivins was hospitalized for psychiatric reasons — [REDACTED] [REDACTED] as well as a history of bizarre and aggressive behaviors.

[REDACTED]

[REDACTED] This suggests that after having used alcohol and medications to decrease his overt anxiety for years, their reduction or cessation might, ironically, have increased his risk of self-destruction. His suicide took place when the reality of his pending indictment was causing increased stress and anxiety.

It does not appear that Dr. Ivins' treatment ever resulted in full resolution of his symptoms. The picture evident at the time of his first documented mental health contact is [REDACTED] [REDACTED] In all likelihood, the therapy contacts and the medication treatments he was given did provide some symptom relief and supported him in his day-to-day functioning. [REDACTED]

[REDACTED]

## Appendix I - Diagnostic Considerations



### THE PANEL'S DIAGNOSTIC IMPRESSIONS

DSM-IV-TR, the Diagnostic and Statistical Manual referred to earlier, itself cautions about the potential limitations of using its classification system in a forensic context. Given the information available for this review, however, the Panel believes that a differential diagnosis emerges.

These differential diagnoses will be restricted to Axis I and Axis II. Although Dr. Ivins voiced a number of somatic complaints over time, his medical conditions, which would be listed on Axis III, were not viewed as significant in understanding his psychiatric picture. Stressors on Axis IV would include legal, family, financial, interpersonal, and work-related issues, including pending retirement, all of which varied over time.



This listing is viewed as a cumulative description — covering the entire available, 30-plus year history of Dr. Ivins' psychiatric record. For uniformity, the Code references are citations in the DSM-IV-TR.

Axis I:



## Appendix I - Diagnostic Considerations



Axis II:



[REDACTED] document Dr. Ivins' maladaptive patterns of abuse of alcohol and prescribed anti-anxiety and sleep medications as well as over-the-counter sleep aids, leading to clinically significant impairments and distress. The impact of this abuse and dependence can be considered significant, because there is evidence he worked with highly dangerous select agents while in an impaired state. It appears that Dr. Ivins developed tolerance to alcohol and sedatives, hypnotics and anxiolytics, because he needed increased amounts to achieve the desired effects. He admitted to taking larger amounts than intended and continued use despite knowledge of the problems likely to result. In 1979, a year before he was hired by USAMRIID, Dr. #1 noted [REDACTED]

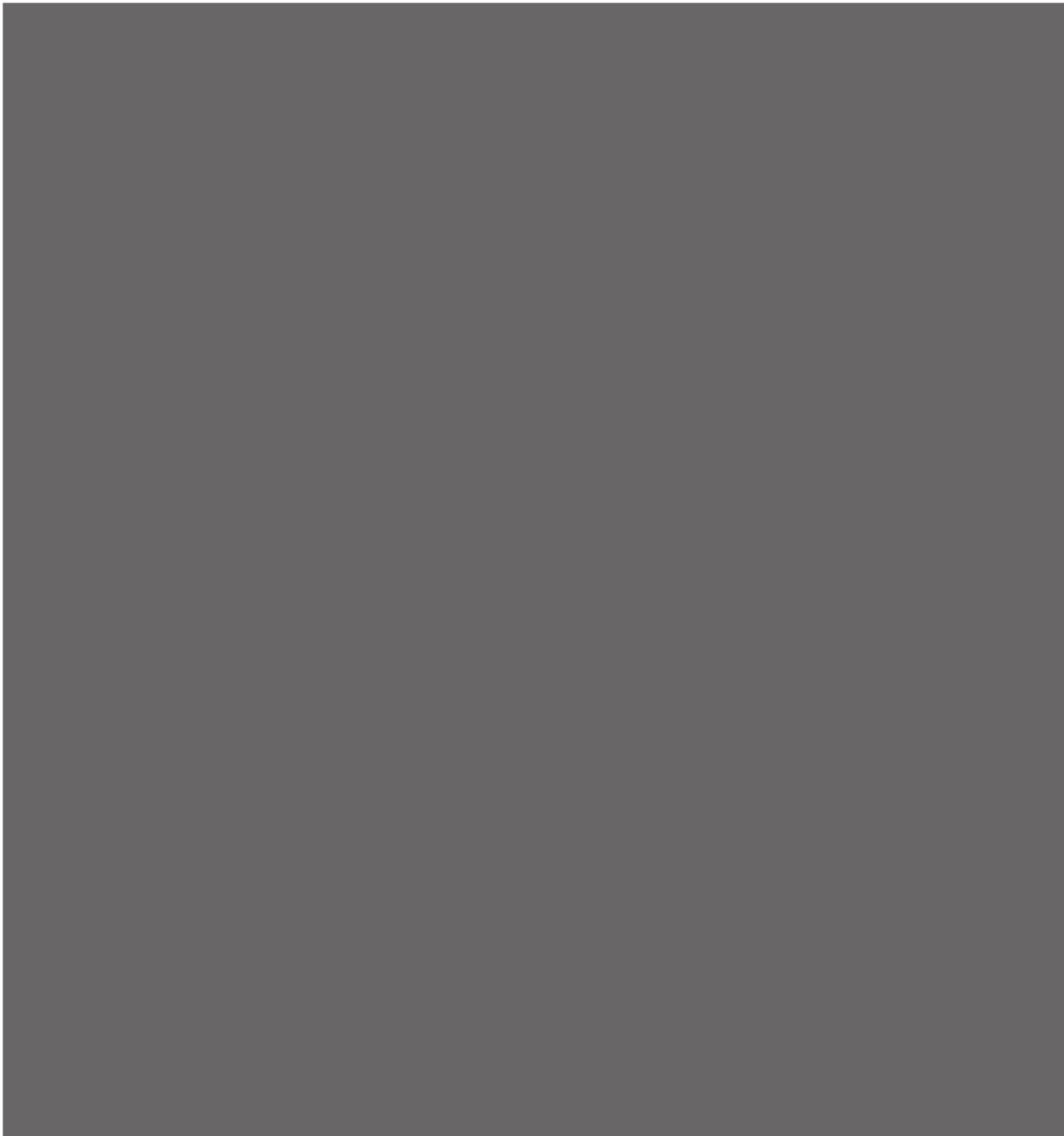
[REDACTED] As noted above, it appears Dr. Ivins attempted to self-medicate his anxiety and, in all likelihood,

## Appendix I - Diagnostic Considerations

his depression, through increasing use of alcohol and over-use of prescription and over-the-counter anti-anxiety and sleep medications.



## Appendix I - Diagnostic Considerations



Dr. Ivins was interested in bondage and blindfolds, and female undergarments; he set up a mailbox specifically for receipt of bondage-related materials and correspondence regarding it; he placed large numbers of blindfold-related images on his computer. All of this behavior supports the diagnosis of Paraphilia Not Otherwise Specified,

**Appendix I - Diagnostic Considerations**

likely involving fetishism, sexual masochism or sexual sadism. Paraphilia involves recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of non-living objects (fetishism); the act of being humiliated, beaten, bound, or otherwise made to suffer (masochism); or acts in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person (sadism).

As noted, Dr. Ivins described an obsession with Kappa Kappa Gamma that spanned more than 30 years. This obsession is not consistent with those seen in Obsessive Compulsive Disorder (OCD). Individuals suffering from OCD find their obsessions intrusive and inappropriate and experience significant anxiety or distress as a result. They also try to suppress or ignore such thoughts and impulses or to neutralize them through some other action. There is no evidence to support that any of this was true of Dr. Ivins. It appears that this symptom is better understood as part of a possible Delusional Disorder as outlined above or more likely as part of the personality-disordered pathology as described below.

As part of his obsession with KKG and KKG Sister #2, Dr. Ivins' displayed a long history of stalking behavior. As Meloy<sup>17</sup> notes, most definitions of stalking involve three elements: 1) a pattern of behavioral intrusion upon another person that is unwanted; 2) an implicit threat that is evidenced in the patterns of behavioral intrusion; and 3) an experience of fear on the part of the person threatened or made the object of this behavior, if the person is aware of the behaviors. Mullen et al<sup>18</sup> have developed a useful typology that looks at the stalker's primary motivation and the developmental context for starting the stalking behavior, the nature of the stalker's original relationship with the victim, and psychiatric diagnoses. Dr. Ivins could be viewed as falling into the "Rejected" group. Individuals involved in stalking may suffer from a Delusional Disorder. It is also common to find that the stalker meets the criteria for a personality disorder diagnosis.

**Appendix I - Diagnostic Considerations**

Dr. Ivins appears to meet the criteria for diagnoses on Axis II; much of his behavior can be viewed as the product of severe personality-disordered pathology. A personality disorder is defined in the DSM-IV-TR as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in the way the person perceives and interprets himself, other people and events; in the range, intensity, lability and appropriateness of the person's emotional responses; in interpersonal functioning; and in impulse control. The pattern is inflexible and pervasive across a broad range of personal and social situations, and leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning. Arising in adolescence or early adulthood if not earlier, the pattern is stable and long-lasting.

It appears that Dr. Ivins meets the criteria for the diagnosis of Borderline Personality Disorder. DSM-TR-IV defines this disorder as "a pervasive pattern of instability of interpersonal relationships, self-image and affects (perceived moods), and marked impulsivity beginning by early adulthood and present in a variety of contexts" and requires that five or more specific criteria be met. Retrospective review suggests that Dr. Ivins exhibited a pattern of unstable and intense interpersonal relationships characterized by alternate extremes of idealization and devaluation; identity disturbance with markedly and persistently unstable self-image and sense of self; recurrent suicidal behavior; affective instability due to marked reactivity of mood; inappropriate, intense anger or difficulty controlling anger; and [REDACTED]

He also meets the criteria for the diagnosis of Paranoid Personality Disorder. Dr. Ivins demonstrated a distrust and suspicion of others, often interpreting their motives as malevolent. This pattern is evident all the way back to late adolescence. He showed evidence of suspecting that others were exploiting, harming or deceiving him,

**Appendix I - Diagnostic Considerations**

without adequate basis. He frequently questioned his friends' loyalty and reacted as if he could not count on them. He had difficulty confiding in others, fearing the information would be used maliciously against him. He read hidden, demeaning, or threatening meanings into benign remarks and, rather than forgiving insults, injuries or slights, persistently bore grudges. He perceived inquiries into his work as attacks on his character and reputation and was quick to react angrily and to counterattack.

However, the diagnoses of Borderline Personality Disorder and Paranoid Personality Disorder fall short of providing a complete picture of Dr. Ivins' personality-disordered pathology. Also evident are characteristics supporting a diagnosis of Personality Disorder Not Otherwise Specified, with Narcissistic and Antisocial Features. Narcissistic characteristics include interpersonal exploitiveness and lack of empathy. Antisocial features include evidence of deceitfulness — repeated lying and use of aliases — and lack of remorse — indifference or rationalizations concerning [REDACTED] or stealing from others. The Panel therefore believes the diagnosis of Personality Disorder Not Otherwise Specified, with Narcissistic and Antisocial Features is appropriate. Dr. Ivins does not, however, meet the full criteria for the additional, independent diagnosis of Antisocial Personality Disorder. He did not, by history, demonstrate the necessary criteria before the age of 15, required for this diagnosis.

In summary, for years before the anthrax mailings and until the time of his death, Dr. Ivins met the diagnostic criteria for a number of psychiatric disorders.

His family, friends, employers or coworkers occasionally described him as odd, eccentric, intense or moody, but they did not view him as overtly mentally ill until the last year of his life. Retrospective review reveals a man who virtually lived two lives. On the surface he was a respected, law-abiding scientist and devoted father with his share of day-to-day problems and challenges at work and at home.

**Appendix I - Diagnostic Considerations**

Closer examination revealed him to be a secretive, paranoid, resentful and rage-filled man who actively voiced and planned [REDACTED]

[REDACTED] It was the Panel's opinion that Dr. Ivins suffered from serious psychiatric problems both prior to and after the anthrax mailings, although it is unlikely that they would have been viewed as sufficiently incapacitating to support a finding of not guilty by reason of insanity had he raised that defense at trial.

Although Dr. Ivins remained under psychiatric care for most of the period pertinent to this review, [REDACTED]

[REDACTED] Even after Dr. Ivins disclosed this information — and even after he became a primary suspect in the attacks — little attention was apparently paid to the unusual nature of his work and the severe stressors he faced, the Panel's review of the records indicates. This is perhaps due to the fact that Dr. #3 had not read Therapist #1's notes, which were in his possession. He was therefore unaware of their importance. Therapist #3 was not provided access to those records from 2000, and therefore was also unprepared for the July 9, 2008 group therapy meeting at which Dr. Ivins revealed his list of people he planned to shoot and kill.

His involuntary commitment to a psychiatric hospital after his July 9, 2008 outburst, however, marked a change in his management and likely prevented significant additional harm to others, although again the unusual nature of his pending legal situation did not appear to factor much in his treatment planning. Because Dr. Ivins refused to continue

**Appendix I - Diagnostic Considerations**

outpatient treatment by Dr. #3 and Therapist #3, he was scheduled to follow up with a psychiatrist he had never met. This appointment would not have occurred until two weeks after his July 24, 2008 discharge from the hospital. At the time of his release he was assessed as no longer imminently suicidal, but the risk factors identified above remained. It appears that Dr. Ivins chose to end his own life rather than face prosecution for the anthrax mailings.

**End Notes for Diagnostic Considerations**

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- <sup>13</sup>Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future. *Journal of Mental Health*, 11(6), 585 – 594. doi: 10.1080/09638230020023930.
- <sup>14</sup>American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.
- <sup>15</sup>Palmer, H. (1988). *The Enneagram: Understanding Yourself and the Others in Your Life*. San Francisco, CA: Harper Collins.
- <sup>16</sup>Menzies, R.P., Fedoroff, J.P., Green, C.M., & Isaacson, K. (1995). Prediction of Dangerous Behavior in Male Erotomania. *Br J Psychiatry*, 166, 529-536.
- <sup>17</sup>Meloy, J.R. (1998). *The Psychology of Stalking: Clinical and Forensic Perspectives*. San Diego, CA: Academic Press.
- <sup>18</sup>Mullen, P.E., Pathe, M., & Purcell, R. (2000). *Stalkers and Their Victims*. Cambridge, UK: Cambridge University Press.

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

Early on investigators suspected the source of the anthrax in the letters was a domestic laboratory, which by 2005 they believed was USAMRIID at Fort Detrick, Md. That conclusion in itself gave rise to a number of questions: How could the anthrax attacks have been launched from a government facility? What, if anything, went wrong with security measures that existed at the time? What system of safeguards, if any, can diminish the likelihood of such an event's reoccurrence?

Prevention of security breaches like this one — an insider intentionally misusing dangerous biological agents — as well as other adverse events — is a function of biosurety programs. Biosurety consists of four basic elements:<sup>18a</sup>

- Physical security (often referred to as “guns, gates, and guards”)
- Biosafety (appropriate handling of biological agents and good laboratory practice)
- Agent accountability (keeping track of agents), and
- Personnel reliability

The Panel identified concerns in all four of these areas, but the primary focus of this section will be the last element — the functioning of personnel reliability measures during Dr. Ivins' tenure at USAMRIID. A more limited commentary on safety, security and accountability aspects in this case will follow that discussion.

\* \* \*

A personnel reliability program (PRP) is an organization's system of procedures and policies to ensure that only safe and trustworthy persons are allowed access to classified or potentially dangerous materials. The U.S. Department of Defense (DoD) initially developed its PRP program during the Cold War to ensure that personnel who

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

controlled, handled, had access to, or controlled access to nuclear weapons were mentally and medically fit and reliable, and did not pose a counterintelligence threat. The goals of the DoD program are described in the DoD Instruction 5210.42:

1. The Department of Defense shall support the national security of the United States by maintaining an effective nuclear deterrent while protecting the public health, safety, and environment. For that reason, nuclear weapons require special consideration because of their policy implications and military importance, their destructive power, and the political consequences of an accident or an unauthorized act. The safety, security, control, and effectiveness of nuclear weapons are of paramount importance to the security of the United States.
2. Nuclear weapons shall not be subject to loss, theft, sabotage, unauthorized use, unauthorized destruction, unauthorized disablement, jettison, or accidental damage.
3. Only those personnel who have demonstrated the highest degree of individual reliability for allegiance, trustworthiness, conduct, behavior, and responsibility shall be allowed to perform duties associated with nuclear weapons, and they shall be continuously evaluated for adherence to PRP standards.

Biosafety measures were initially focused primarily on health and safety, and were aimed at ensuring that laboratory personnel and the community outside the laboratory did not become accidentally infected. In 1984 the Centers for Disease Control (CDC) published "Biosafety in Microbiological and Biomedical Laboratories," an advisory set of laboratory safety guidelines that were adopted by DoD, civilian, and government laboratories. The 4th edition, published in 1999, continued the theme of health and safety from previous editions, and

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

contains the following recommendations regarding work with *B. anthracis* and other dangerous organisms:

Any work with *B. anthracis* requires special security considerations due to its potential use for purposes of biological terrorism....

*Recommended Precautions:* Biosafety Level 2 practices, containment equipment, and facilities are recommended for activities using clinical materials and diagnostic quantities of infectious cultures. Animal Biosafety Level 2 practices, containment equipment, and facilities are recommended for studies utilizing experimentally infected laboratory rodents. Biosafety Level 3 practices, containment equipment, and facilities are recommended for work involving production quantities or concentrations of cultures, and for activities with a high potential for aerosol production.

In addition to general biosafety precautions, individuals like Dr. Ivins, who worked with biological agents that were part of biodefense research for the DoD, were covered by general Army security policies regarding classified information. As a result, from the beginning of his employment at USAMRIID, Dr. Ivins was subject to personnel security measures — i.e., he had to receive a U.S. Army security clearance to do his work. The record shows that he received his first clearance, granting him access to classified information, on September 25, 1978. Prior to that clearance, he had received a National Agency Check (NAC), which disclosed no criminal record. He received an additional clearance on December 29, 1980. Throughout his tenure at USAMRIID, he periodically underwent additional security investigations and obtained additional clearances.

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

### Glossary of Acronyms used in Appendix II

**BSAT** — Biological Select Agents and Toxins

**BPRP** — The Army's Biological Personnel Reliability Program

**CMA** — Competent Medical Authority

**Form 4700** — Replaced SF93 in 2000.

**NAC** — National Agency Check

**PDI** — Potentially Disqualifying Information

**PRP** — Personnel Reliability Program

**PSI** — Personnel Security Investigations

**SAR** — Select Agent Rule

**SIP** — Special Immunization Program — A program to provide vaccines to personnel at Fort Detrick to select individuals. Operated since 1970.

**SRA** — Security Risk Assessment

**SF 93 – Standard Form 93** — required form for USAMRIID personnel to fill out before 1999

**SSBI** — Single Scope Background Investigation

### FROM 1978 TO 1988: AR 604-5

After leaving his post-doctoral position at the University of North Carolina, Dr. Ivins was hired first, in 1978, by the Uniformed Services University of the Health Science in Bethesda, Md., and then, in 1980, by USAMRIID. In both cases, Dr. Ivins would have been subject to Army Regulation (AR) 604-5: "Personnel Security Clearance: Clearance of Personnel for Access to Classified Defense Information and Material," effective March 1, 1970. That document lists a number of possible bases for denial or revocation of security clearance. Many, including

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

the following, would have been relevant to Dr. Ivins had the full range of his behaviors been known:

### Chapter 3-1

(16) Any deliberate misrepresentation, falsification, or omission of material fact.

(17) Any criminal, infamous, dishonest, immoral, or notoriously disgraceful conduct, habitual use of intoxicants to excess, drug addiction, or sexual perversion.

(18) Acts of a reckless, irresponsible, or wanton nature which indicate such poor judgment and instability as to suggest that the individual might disclose security information to unauthorized persons or otherwise assist such persons, whether deliberately or inadvertently, in activities inimical to the security of the United States.

(19) All other behavior, activities, or associations which tend to show that the person is not reliable or trustworthy.

(20) Any illness, including any mental illness, of a nature which in the opinion of competent medical authority may cause significant defect in judgment or reliability if the individual, with due regard to the transient or continuing effect of the illness and the medical findings in such case.

Although our information is incomplete, it appears that Dr. Ivins had a Secret level clearance for the majority of his time at USAMRIID. Under AR 604-5, a Secret level clearance required "A National Agency Check plus written inquiries to appropriate local law enforcement agencies, former employers and supervisors, and schools attended..." In Chapter 4, AR 604-5 also calls for review of medical records as part of the security clearance process for civilian employees if the records "are available." Chapter 4 also provides that no interim clearance is

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

to be provided if the “medical record or other source indicates the existence, current or past, of any mental or nervous disorder, or emotional instability unless competent medical authority certifies the disorder or instability has been overcome or is of such a nature that it does not impair the individual’s judgment or reliability.”

### **FROM 1988 TO 2001: AR 380-67**

Army Regulation (AR) 380-67, dated September 1988, updated AR 604-5 and the Army’s Personnel Security Program. This new regulation, which applied to all Army personnel and civilian employees and contractors, remained in place at USAMRIID prior to late 2001 — and after the attacks as well. In Chapter 1 Section III 1-302, It provided for “A personnel security investigation consisting of both record reviews and interviews with sources of information ... covering the most recent 5 years of an individual’s life or since the 18th birthday, whichever is shorter, provided that at least the last 2 years are covered...” Periodic reinvestigations were required every five years but would “normally not exceed the previous 5 year period.”

AR 380-67 lists a number of criteria for application of the security standard. These criteria apply specifically to those working with nuclear and chemical weapons but extend to those in other Army facilities and laboratories as well. Most or all of the following were relevant to Dr. Ivins and might therefore, had underlying facts and behaviors been discovered, have led to his disqualification early in his USAMRIID career:

- Criminal or dishonest conduct
- Acts of omission or commission that indicate poor judgment, unreliability or untrustworthiness
- Any behavior or illness, including any mental condition, which, in the opinion of competent medical authority, may cause a defect

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

in judgment or reliability with due regard to the transient or continuing effect of the illness and the medical findings in such case

- Vulnerability to coercion, influence, or pressure that may cause conduct contrary to the national interest. Possible sources of vulnerability are: (1) the presence of immediate family members or other persons to whom the applicant is bonded by affection or obligation in a nation (or areas under its domination) whose interests may be inimical to those of the United States, or (2) any other circumstances that could cause the applicant to be vulnerable...
- Any knowing and willful falsification, cover-up, concealment, misrepresentation, or omission of a material fact from any written or oral statement, document, form or other representation or device used by the Department of Defense or any other Federal agency
- Refusing or intentionally failing to provide a current personal security questionnaire (PSQ) or omitting material facts in a PSQ or other security form. Refusing to submit to a medical or psychological evaluation when information indicates the individual may have a mental or nervous disorder or be addicted to alcohol or any controlled substance
- Acts of sexual misconduct or perversion indicative of moral turpitude, poor judgment, or lack of regard for the laws of society

In at least two places, AR 380-67 gives background investigators the right to review medical records in certain situations. One set of situations is outlined in Appendix A, B-4. The other is contained in Chapter 5-106.

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

Appendix A, B-4, contains the following language:

p. Medical records. Medical records shall not be reviewed unless:

(1) The requester indicates that subject's medical records were unavailable for review prior to submitting the request for investigation, or

2) The requester indicates that unfavorable information is contained in subject's medical records, or

(3) The subject lists one or more of the following on the Statement of Personal History or Personnel Security Questionnaire:

(a) A history of mental or nervous disorders.

(b) That subject is now or has been addicted to the use of habit-forming drugs such as narcotics or barbiturates or is now or has been a chronic user to excess of alcoholic beverages.

The Panel believes that Item 3 (a) above suggests that Dr. Ivins' records would have been appropriate for review. Dr. Ivins did disclose in his Personnel Security Questionnaires that he had been treated in the past for what he variously indicated was "job-related stress" and "passive-aggressive behavior."

Likewise, his disclosures would seem to make the following language from Chapter 5-106 germane. This language from the 1988 regulation allowed background investigators to request additional information or clarification under specific circumstances:

Requests for additional information or clarification:

d. Information from medical records that indicates mental disorder or emotional instability or results of any psychiatric or mental health evaluation or treatment for a mental condition.

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

When any information indicates a history of mental or nervous disorder or reported behavior appears to be abnormal, indicating impaired judgment, reliability, or maturity, CCF [Central Clearance Facility, a unit of the U.S. Army Military Personnel Center] will request a mental health evaluation to determine whether or not any defect in judgment or reliability or any serious behavior disorder exists. A board-certified or board-eligible psychiatrist or licensed or certified clinical psychologist who is employed by or under contract to the U.S. military or U.S. Government will conduct mental health evaluations for security clearance purposes. The evaluation report should outline the methods used in the evaluation (for example, psychological testing and clinical interviews), include a narrative case history, assess the results of any psychological tests, and include a diagnosis under DSM III [Diagnostic and Statistical Manual, 3rd Edition] (see note) or state that no diagnosis exists. The report should include a prognosis and indicate what effect the diagnosed condition has on judgment, reliability, and stability, and describe any characteristics in a normal or stressful situation. If the individual's condition is under control through treatment or medication, the report should indicate what could happen if the individual did not comply with treatment and what likelihood exists of failure to comply. If appropriate, the report should indicate an estimated time or condition that could cause a favorable change.

AR 380-67 also describes the grounds for denial of a clearance. The following language is contained in Chapter 5 Paragraph 5-107.

Grounds for denial:

If information developed by the command indicates the existence, current or past, of any mental or nervous disorder or emotional instability, a request for a PSI (Personnel Security Investigation) will not be submitted and interim clearance will

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

not be granted. Clearance can be granted only if competent medical authority...certifies that the disorder or instability has been overcome or will not cause a defect in the person's judgment or reliability.

Additional grounds for denial, related to criminal conduct, are found in Appendix I of AR 380-67, Paragraphs I-5 and I-6. Paragraph I-5 relates to criminal conduct, and is relevant in view of Dr. Ivins' history of illegally entering sorority houses, of vandalizing the home and car of KKG Sister #2, of use of firearms, and other activities. Paragraph I-6 relates to mental or emotional disorders.

### **Criminal Conduct (Appendix I of AR 380-67)**

a. Basis: Criminal or dishonest conduct. When it is determined that an applicant for a security clearance, or a person holding a clearance, has engaged in conduct which would constitute a felony under the laws of the United States, the clearance of such person shall be denied or revoked unless it is determined that there are compelling reasons to grant or continue such clearance. Compelling reasons can only be shown by clear and convincing evidence of the following:

- (1) The felonious conduct
  - (a) did not involve an exceptionally grave offense;
  - (b) was an isolated episode; and
  - (c) the individual has demonstrated trustworthiness and respect for the law over an extended period since the offense occurred; or
- (2) The felonious conduct
  - (a) did not involve an exceptionally grave offense;
  - (b) was an isolated episode;
  - (c) was due to the immaturity of the individual at the time it occurred; and

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

### **Criminal Conduct (Appendix I of AR 380-67) *continued***

- (d) the individual has demonstrated maturity, trustworthiness, and respect for the law since that time; or
  - (3) In cases where the individual has committed felonious conduct but was not convicted of a felony, there are extenuating circumstances which mitigate the seriousness of the conduct such that it does not reflect a lack of trustworthiness or respect for the law.

Involvement in criminal activities which does not constitute a felony under the laws of the United States shall be evaluated in accordance with the criteria set forth below. (For purposes of this paragraph, the term "felony" means any crime punishable by imprisonment for more than a year. The term "exceptionally grave offense" includes crimes against the Federal Government, its instrumentalities, officers, employees, or agents; or involves dishonesty, fraud, bribery, or false statement; or involves breach of trust or fiduciary duty; or involves serious threat to life or public safety.)

b. Disqualifying factors (behavior falls within one or more of the following categories):

- (1) Criminal conduct involving:
  - (a) Commission of a State felony.
  - (b) Force, coercion, or intimidation.
  - (c) Firearms, explosives, or other weapons.
  - (d) Dishonesty or false statements, e.g., fraud, theft, embezzlement, falsification of documents or statements.
  - (e) Obstruction or corruption of Government functions.
  - (f) Deprivation of civil rights.
  - (g) Violence against persons.

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

### **Criminal Conduct (Appendix I of AR 380-67) *continued***

- (2) Criminal conduct punishable by confinement for one year or more.
- (3) An established pattern of criminal conduct, whether the individual was convicted or not...
- (4) Criminal conduct that is so recent in time as to preclude a determination that recurrence is unlikely...
- (5) Criminal conduct indicative of a serious mental aberration, lack of remorse, or insufficient probability of rehabilitative success (e.g., spouse or child abuse)....

### **Disqualifying Mental or Emotional Disorders (Appendix I of AR 380-67)**

#### Adjudication Policy

#### I-6. Mental or emotional disorders

- a. Basis: Any behavior or illness, including any mental condition, which, in the opinion of competent medical authority, may cause a defect in judgment or reliability with due regard to the transient or continuing effect of the illness and the medical findings in such case.
- b. Disqualifying factors (behavior or condition falls within one or more of the following categories):
  - (1) Diagnosis by competent medical authority (board-certified psychiatrist or clinical psychologist) that the individual has an illness or mental condition which may result in a significant defect in judgment or reliability.
  - (2) Conduct or personality traits that are bizarre or reflect abnormal behavior or instability even though there has been no history of mental illness or treatment, but which nevertheless, in the opinion of competent medical authority, may cause a defect in judgment or reliability.

**Appendix II - Biosafety and Biosecurity  
(Personnel Reliability Programs)****Disqualifying Mental or Emotional Disorders  
(Appendix I of AR 380-67) *continued***

- (3) A diagnosis by competent medical authority that the individual suffers from mental or intellectual incompetence or mental retardation to a degree significant enough to establish or suggest that the individual could not recognize, understand, or comprehend the necessity of security regulations, or procedures, or that judgment or reliability are significantly impaired, or that the individual could be influenced or swayed to act contrary to the national security.
  - (5) Diagnosis by competent medical authority that an illness or condition that had affected judgment or reliability may recur even though the individual currently manifests no symptoms, or symptoms currently are reduced or in remission.
  - (6) Failure to take prescribed medication or participate in treatment (including follow-up treatment or aftercare), or otherwise failing to follow medical advice relating to treatment of the illness or mental condition.
- c. Mitigating factors (circumstances which may mitigate disqualifying information):
- (1) Diagnosis by competent medical authority that an individual's previous mental or emotional illness or condition that did cause significant defect in judgment or reliability is cured and has no probability of recurrence, or such a minimal probability of recurrence as to reasonably estimate there will be none.
  - (2) The contributing factors or circumstances which caused the bizarre conduct or traits, abnormal behavior, or defect in judgment and reliability have been eliminated or rectified, there is a corresponding alleviation of the individual's condition and the contributing factors or circumstances are not expected to recur.

**Appendix II - Biosafety and Biosecurity  
(Personnel Reliability Programs)****Disqualifying Mental or Emotional Disorders  
(Appendix I of AR 380-67) *continued***

- (3) Evidence of the individual's continued reliable use of prescribed medication for a period of at least 2 years without recurrence and testimony by competent medical authority that continued maintenance of prescribed medication is medically practical and likely to preclude recurrence of the illness or condition affecting judgment or reliability.
- (4) There has been no evidence of a psychotic condition, a serious or disabling neurotic disorder, or a serious character or personality disorder for the past 10 years.

\* \* \*

**A SECOND SOURCE OF INFORMATION: SPECIAL IMMUNIZATION  
PROGRAM CONSENT FORMS**

AR 380-67 was not the only mechanism that could have led Dr. Ivins' employers to a deeper understanding of his past.

Beginning in 1970 and continuing through 2002, personnel at Fort Detrick who received vaccines were enrolled in the Special Immunization Program (SIP), which included an annual medical evaluation to detect possible side effects of the vaccines. Until 1999, USAMRIID personnel enrolled in the SIP were required to fill out Standard Form 93 (SF93) medical history forms annually. In 1999, the SIP phased out the use of SF93 and adopted Form 4700. Both of these forms were reviewed by medical personnel in conjunction with medical evaluations in making decisions about possible restrictions from hot-suite work.

As part of this SIP process, Dr. Ivins signed at least 10 Report of Medical History consent forms between August 13, 1990 and May 7, 1998. These forms authorized "any of the doctors, hospitals, or clinics

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service." He signed similar forms in the years that followed, as detailed in the section of this report entitled "HIPAA and the Confidentiality of Medical Records." However, Form 4700, which USAMRIID adopted in 1999, did not include Question 16 from SF 93, which asks "Have you ever been treated for a mental condition? (If yes specify when, where, and give details.)" Nevertheless, until March 2006 when he withdrew consent for release of his records and instead indicated that his treating psychiatrist would provide a summary of his treatment, the forms Dr. Ivins signed all allowed for release of all of his medical records as part of these annual assessments. It is unclear whether those involved in the Special Immunization Program were authorized to share information they gathered with those responsible for personnel security, but it appears, regardless, that the information was not shared.

### **FROM ARMY PERSONNEL SECURITY TO BIOLOGICAL SURETY AND PERSONNEL RELIABILITY PROGRAMS**

As we have seen, from the time Dr. Ivins joined USAMRIID in 1980, the Personnel Security Programs applied to him and other workers with biological agents were general Army security clearance programs devised originally for use in connection with the Cold War and the nuclear, chemical, and espionage threats of that period.

#### *The Anti-Terrorism Act of 1996*

In the aftermath of the Oklahoma City bombing of 1995, however, Congress passed the Anti-Terrorism Act of 1996, and included consideration of biological agents. As part of the Act, Congress assigned responsibility for developing regulations for controlling access to and possession of biological warfare agents to the U.S. Department of Health and Human Services (DHHS) and the CDC. The regulations went into effect in April 1997 (42 CFR 72.6). Until this time, certain

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

biological agents had been commonly regarded as high risk, but no formal list of Biological Select Agents and Toxins (BSAT) had been developed let alone any formal program for managing their use. The new regulations established this list and program, which included procedures for the transfer or shipment of these agents.

### *The Select Agent Rule and Personnel Reliability Programs*

Those regulations were modified and strengthened in 2002 with passage of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188). Also referred to as the Bioterrorism Act, this legislation granted the U.S. Department of Agriculture comparable authority to regulate select agents and toxins that present a severe threat to animals or plants, or animal and plant products. DHHS and USDA published a series of Interim Final Rules (42 CFR 73, 9 CFR 121, and 7 CFR 331) in 2003 and 2005, implementing provisions of the Act through the Select Agent Rule (SAR).

These regulations contain measures to ensure that those who work with BSAT are safe and do not pose a security risk, and that BSAT are accounted for and handled properly. The measures are broadly referred to as personnel reliability programs (PRPs).

In accordance with these regulations, individuals who work with BSAT must have a security risk assessment (SRA) conducted by the Department of Justice to ensure that restricted persons, as defined by 18 USC 175b, are not given access to any select agent or toxin. The SRA, it should be noted, is not the same as a security clearance conducted in accordance with National Security Directive 63, which calls for Single Scope Background Investigations (SSBI), or in accordance with AR 380-67. For example, the SRA does not involve interviews of "collateral sources" such as neighbors, employers, and colleagues.

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

The SRA is limited to a multi-agency check for restricted-person characteristics. Nevertheless, the SRA examines some databases that are not covered by the SSBI, and, although narrower in scope, covers the individual's whole life, not a five-to-10 year window. In addition, the applicant must sign a form indicating that he or she does not fall within one of the categories of restricted persons.

A Restricted Person is one who:

- (a) is under indictment for a crime punishable by imprisonment for a term exceeding 1 year;
- (b) has been convicted in any court of a crime punishable by imprisonment for a term exceeding one year;
- (c) is a fugitive from justice;
- (d) is an unlawful user of any controlled substance (as defined in Section 102 of the Controlled Substances Act (21 U.S.C. Section 802));
- (e) is an alien illegally or unlawfully in the United States;
- (f) has been adjudicated as a mental defective or has been committed to any mental institution;
- (g) is an alien (other than an alien lawfully admitted for permanent residence) who is a national of a country as to which the Secretary of State pursuant to section 6(j) of the Export Administration Act of 1979 (50 U.S.C. App. 2405(j)), Section 620A of Chapter 1 of Part M of the Foreign Assistance Act of 1961 (22 U.S.C. Section 2371) or Section 40(d) of Chapter 3 of the Arms Export Control Act (22 U.S.C. Section 2780(d)) has made a determination (that remains in effect) that such country has repeatedly provided support for act of international terrorism;

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

(h) has been discharged from the Armed Services of the United States under dishonorable conditions.

### *The DoD's Biological Personnel Reliability Program*

In 2005, the DoD supplemented its own measures and those of the SAR with adoption of the Biological Personnel Reliability Program (BPRP). This program was finalized in a Department of Defense Instruction dated April 18, 2006. This Instruction adopted, among other things, the definition of "restricted persons" just described. It also imposed the requirement that all individuals working with BSAT in DoD facilities undergo an SSBI and be cleared at the Secret level.

Just as the emergence of these new regulations and systems for ensuring personnel safety and security took several years, their adoption at USAMRIID was also a gradual process; the current system at Fort Detrick did not become fully operative until 2007. Aspects of the program established by the Select Agent Rule, however, were implemented as early as 2001 pursuant to Interim Guidance Messages issued December 21, 2001 and February 7, 2002.

Interim Guidance Message 1 and Interim Guidance Message 2 addressed "The Army Biological Surety Program" and "Establishing the Army Biological Personnel Reliability Program," respectively.

Guidance Message 1, dated December 21, 2001 indicated that the Vice Chief of Staff of the U.S. Army (VCSA) had directed that an Army Biological Surety Program be established, and that "[a]ppropriate biological surety (AR 50-X) and Security (AR 190-X) will be developed, coordinated, and published with a target publication date of 1QFY03." In an effort to tighten inventory controls, Guidance Message 1 charged commanders at each facility with establishing a system "to track working stocks and references stocks of the specified agents, into and out of storage, with a record as to whether the agent container was placed back into storage or the agent was consumed in the experimentation."

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

Message 1 also outlined steps to tighten facility controls. It ordered commanders to institute random searches of personal belongings as personnel exited the facility, as well as measures to govern the transport of agents and toxins. And it provided: "Commanders will implement the two-person rule, video monitoring, or roving observers, either singularly or in combination, according to safety and operational conditions." (The two-person rule requires that work with select agents always involve at least one person acting as an observer.) The Message also specified physical security measures, entry and access controls, room and laboratory standards, and establishment of a security response force, as well as safety measures.

Interim Guidance Message 2 — "Establishing the Army Biological Personnel Reliability Program" — was published February 7, 2002, but not fully implemented until January 7, 2005. It specified the Army's intent to establish a Biological Personnel Reliability Program (BPRP) at Army Research, Development, Testing and Evaluation (RDTE) laboratories and facilities that work with *Bacillus anthracis* (Anthrax)<sup>19</sup>, *Clostridium botulinum* or its toxins (Botulism), *Yersinia pestis* (plague), and several other virulent agents.

Guidance Message 2 included specific provisions for the BPRP, which were later adopted. These program-related provisions related to:

- Designation of those positions that require BPRP involvement
- Identification of those individuals to be enrolled in the program
- Selection, screening, and evaluation of BPRP candidates on the basis of valid Personnel Security Investigations (PSI) that are less than five years old, "screening of local personnel records and medical evaluations, and a favorably completed urinalysis drug test per AR 600-85"

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

- Personal interviews and briefings of BPRP enrollees by a certifying official
- Limitation of BPRP positions to BPRP certified personnel only
- Continuing evaluation of BPRP-involved personnel “by supervisors, fellow workers, certifying officials and support agency personnel”
- Periodic random urinalysis drug testing
- Periodic reinvestigation on a five-year basis
- Medical restrictions from performance of biological duties when applicable
- Temporary or permanent disqualification of unreliable personnel, when warranted
- Administrative termination of BPRP status when a person is no longer assigned to a BPRP position

The requirements for BPRP certification also called for the selection, screening and evaluation of BPRP candidates, according to these criteria:

- Urinalysis, drug testing
- Physical competence, mental alertness and technical proficiency commensurate with duty requirements
- Evidence of dependability in accepting responsibilities and effectively performing in an approved manner; flexibility in adjusting to changes in the working environment
- Positive attitudes towards working with biological agents

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

- A personal interview conducted by the certifying official for each BPRP candidate “looking for evidence of the person’s perception of responsibility, exercise of sound judgment, effective performance, and ability to adjust to changes in the working environment”
- A favorable personnel records review
- An evaluation by a Competent Medical Authority (CMA) of the person’s physical and mental capability and mental reliability to perform BPRP duties. “All potentially disqualifying information must be documented in the person’s health record. The CMA will provide the certifying official with sufficient medical information to make a sound judgment on a person’s suitability for the BPRP.”

Disqualifying Factors included various conditions and behaviors, some calling for automatic disqualification and others for the certifying official’s evaluation of the circumstances and the degree to which the person’s reliability was affected. Examples of these conditions and behaviors included:

- Alcohol dependence or abuse
- Alcohol-related incidents
- Drug abuse and other inappropriate drug use
- Negligence or delinquency in the performance of duty
- Conviction of, or involvement in, a serious incident. “These include incidents that indicate a contemptuous attitude toward the law, regulations, or other duly constituted authority. Serious incidents include, but are not limited to, assault, sexual misconduct, financial irresponsibility, inordinate number of traffic tickets, and child or spouse abuse.”

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

- Medical conditions, including “any significant mental or physical condition substantiated by CMA, or aberrant behavior considered by the certifying official to be prejudicial to reliable performance of BPRP duties.”
- Hypnosis
- Serious progressive illnesses
- Poor attitude or lack of motivation
- Suicide attempt
- Inability to wear protective equipment

Both Guidance Messages were ultimately consolidated in a memorandum dated February 4, 2003: “Deputy Secretary of Defense Memorandum, Subject: Safeguarding Biological Select Agents.”

This Memorandum specified:

Individuals whose duties afford access to, or involve security of, biological select agents or toxins listed in reference (a) shall be screened initially for suitability and reliability. This means that they shall be emotionally and mentally stable, trustworthy, and adequately trained to perform the assigned duties and shall be the subject of a current and favorably adjudicated National Agency Check with Local Agency Checks and Credit Checks (NACLIC), with reinvestigation every five years. Additionally, individuals with access to high priority agents and toxins (Centers for Disease Control “Category A”) shall be the subject of a current and favorably adjudicated Single Scope Background Investigation (SSBI) with a reinvestigation every five years, and they shall be evaluated on a continuing basis using the criteria issued by ASD (C31) [Assistant Secretary of Defense for Command, Control, Communications, and Intelligence].

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

### POST-ATTACK: 2002 — 2006

As the BPRP and Biological Surety programs were gradually adopted at USAMRIID, Dr. Ivins continued to give his consent to inspection of his medical records. And on occasion, authorities did engage in some kind of follow-up concerning them. Beginning in 2005, after his temporary request to be out of the hot suite, his mental health was monitored on a regular basis.

As part of his Security Risk Assessments, Dr. Ivins, signed release forms authorizing the DOJ:

to obtain any information relevant to assessing my suitability to access, possess, use, receive or transfer select biological agents and toxins from any relevant source...[and] ...release of records, results or information relating to, or obtained in connection with my security risk assessment to any law enforcement or intelligence authority or other federal, state or local entity with relevant jurisdiction where such information reveals a risk to human, animal and/or plant health or national security.

Dr. Ivins signed these forms on March 25, 2003 and again on May 15, 2007.

In addition, under AR 380-67, individuals who presented with Potentially Disqualifying Information (PDI) could be disqualified from working with select agents, depending upon the information obtained during follow-up investigation and monitoring. In this context, a Personnel Security Questionnaire completed by the U.S. Office of Personnel Management Investigations Service in 2004 addressed the issue of Dr. Ivins potentially having a disqualifying condition. The name of Dr. Ivins' psychiatrist is redacted on the form. In the DoD formal review of the anthrax mailings, the redacted name is identified as that of Dr. #3.

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

Subject was recontacted on 6/19/2003 and advised the medical condition for which he sought treatment by Dr. xxxx did not and does not affect his judgment or reliability. Dr. xxxx did not advise Ivins of any diagnosis or prognosis, however. Xxxx [Office of Personnel Management] researched the medication prescribed by Dr. xxxx and determined that the medication is prescribed for anxiety and depression.

The dates of treatment correspond to the time period that Dr. Ivins was treated by Dr. #3. The investigator completing the questionnaire indicated the following with regard to Dr. #3's report to the investigator:

The person under investigation does not have a condition or treatment that could impair his/her judgment or reliability, particularly in the context of safeguarding classified national security information or special nuclear information or material. Span of contact listed as 5/20/2000 to present.

On March 24, 2006, Dr. Ivins modified his medical questionnaire to exclude access to his actual mental health records. He wrote that Dr. #3 would provide a summary of his treatment. The change apparently went unnoticed and unchallenged by the medical authorities.

Dr. Ivins underwent an SSBI, as he had in 2002. Like the first, it found no history of criminal convictions or allegations. Indeed, after the second review, USAMRIID provided him with a Top Secret security clearance, which was higher than his previous Secret clearance. In addition, he was found eligible for the next higher level: Top Secret with access to Sensitive Compartmented Intelligence (TS-SCI). Adjudication at this next level, however, would have required a polygraph examination, which was never pursued.

In addition to the criminal background check, USAMRIID researchers underwent an annual occupational mental and physical health

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

screening that was part of a couple of programs, including the Special Immunization Program. These reviews were conducted through the Occupational Medicine Clinic at Barquist Army Community Hospital, which is close by USAMRIID. It does not appear, however, that information collected by Barquist clinicians was shared with those responsible for security assessments.

The end result was that on November 19, 2007, Dr. Ivins was "read in" to the BPRP at USAMRIID and cleared to work in the hot suite. Ironically, however, USAMRIID Security was on a separate track. The FBI had informed USAMRIID Security of its November 1 search of Dr. Ivins' home and office. As a result, USAMRIID Security files show, "for mental status reasons ... his division had his access removed from the BSL-3 containment suites with badge and PIN number turned off. This decision was based on the Division Director's authority although this access removal was not noted in his biosurety file."

On July 8, 2008, Dr. Ivins, who in April had announced his impending retirement, was officially removed from the BPRP. By that time, his supervisors had also learned from him about the extent of his problems with alcohol and his medication abuse and treatment for them.

### **SAFETY, SECURITY AND ACCOUNTABILITY**

As we discussed at the beginning of this chapter, biosurety is a matter not only of personnel reliability, but also of safety, security and accountability. A few observations on these latter topics are also in order.

USAMRIID clearly took certain steps to provide biosurety. Effective January 31, 1993, for example, the Institute adopted USAMRIID Regulation 380-1, which provided for facility security measures. Specifically, the Regulation was designed "to provide a safe secure environment for employees and visitors, to provide safe operations

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

with the Frederick Community, and prevent the loss and or theft of personal and Government property.” The Regulation provided: “Access to the Institute, and specific areas within the Institute, will be controlled through a sense of awareness and dedication of employees, the use of a security force, key control, and use of supplemental electronic devices.”

After the events of September 11, 2001, the intensity and enforcement of Biosurety measures changed in many settings. The transition at USAMRIID was prolonged; as noted previously the new regulations were not fully operative until 2007. In the Panel’s view, the gradual nature of this process was justified: It was consistent with the need to balance the importance of the mission with the need to take a careful approach to building an improved and workable BPRP.

Still, it was also clear to this Panel that there were gaps in the design and implementation of the Biosurety program prior to and in the years immediately after the anthrax mailings. The Panel noted these issues of concern:

- “Tailgating” through security points
- Contamination of the cold suite without resolution of the cause
- Dysfunctional personal behavior being observed and recorded without appropriate action being taken
- Suspicious behavioral patterns (hot suite visit irregularity) not being investigated
- Established procedures not being followed nor rectified, and
- Inventory of hot suite materials not being rigorously maintained and reviewed

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

A few specific examples:

- After the attacks, Dr. Ivins' behavior, in particular his medical condition, mental state and interaction with fellow employees, appeared to become more erratic and dysfunctional. Yet he remained in a position of substantial authority, still controlling the agent of the original attacks. Additional supervision and oversight for security reasons was not apparent — his badge deactivation from the BSL-3 suites occurred due to his expressions of mental distress following the November 1, 2007 FBI searches of his home and office.
- As uncovered during this investigation, Dr. Ivins was involved in at least three incidents involving inattention to biosafety issues: two spills and swabbings that were not reported promptly or handled according to accepted procedures, and one episode where he took exposed clothing home to launder. Not only did these episodes take place — they escaped notice until Dr. Ivins himself disclosed them.
- Finally, a lack of internal accountability regarding quantities of select agents allowed 100 mls of Ames strain anthrax from the RMR-1029 flask to be "lost" — and allowed the loss to escape internal identification. It was only upon close review during the criminal investigation of the anthrax mailings that this discrepancy was uncovered. (The circumstances surrounding this disappearance — and in particular, the role the disappearance may have played in the mailings — are unclear.) In any case, this kind of lapse precluded prevention of the very security breach — i.e. an insider negligently or intentionally misusing dangerous biological agents — that any biosurety program is designed to prevent.

### **SUMMARY**

Over the course of more than 25 years — from the beginning of his employment with USAMRIID in 1980 until 2006 — Dr. Ivins gave authorities permission to obtain his medical records more than a dozen

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

times. Had these records been obtained, they would have shown a longstanding pattern of disturbed thinking in response to stress —

Had they been obtained before 2001, they would have identified him as a risk under AR 380-67. They would therefore have denied him the opportunity to conduct the attacks.

Had they been obtained after 2001, they would have identified him as a risk under the new personnel security measures and ultimately the Biological Personnel Reliability Program (BPRP). They therefore would have denied him the opportunity he actually had for years to repeat the attacks.

But they were not obtained. And when Dr. Ivins did finally lose his access to the hot suite, it was not because of screening under the Select Agent Rule (SAR) of the DHHS and USDA or the BPRP of the DoD. It was because of his reported mental state after the FBI searched his home, a search that resulted in the confiscation of materials that included Glock pistols, stun guns and a Taser.

Why did the systems that were supposed to offer protection both before and after the attacks fail? The Panel's review suggests these factors:

- **Dr. Ivins' self-disclosures featured key omissions:**

Dr. Ivins did not fully disclose his past and current psychiatric treatment on screening forms and he did not report the use of prescription antipsychotic medications, which were prescribed by his

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

treating psychiatrist in 2000, 2003, 2005, and 2008. He also failed to report to the doctors treating him in 2000 and beyond that he had been prescribed antipsychotics in the late 1970s. Nor did he report his increasing substance abuse.

These failures to disclose, had they been discovered, might have disqualified him in and of themselves.

- **Investigatory follow-through was lacking:** Despite Dr. Ivins' acknowledgments on screening forms of symptoms of mental illness, background investigators did not follow through either at all or sufficiently to discover critical information. Not only his confirmation of symptoms, but the inconsistencies in his self-reports and his eventual refusal to provide records all warranted investigation. But those investigations did not take place.

For example, on February 18, 1987, Dr. Ivins completed a SF 93 medical history report in which he placed question marks next to the following items regarding his psychiatric history: Memory Change, Trouble with Decisions, Hallucinations, Improbable Beliefs, Anxiety. He also noted that he "Had professional mental health consultation in graduate school." This form was signed off by a registered nurse. There is no evidence that these issues were investigated.

Dr. Ivins listed Dr. #1 as his initial treating psychiatrist. It appears that Dr. #1 was never contacted nor her records ever requested. Either of these steps would have resulted in authorities learning that

Nor was there any follow-up to the numerous discrepancies in the information Dr. Ivins provided about his mental health history on SF 93 forms dating back to the 1980s. For example Dr. Ivins initially reported a history of receiving counseling for "passive aggressive"

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

behavior; he subsequently reported it was for "job-related stress." On some forms he indicated that he was treated from 1976-78, at other times 1978 through 1980, either in Washington, D.C. or Bethesda, Md. On his SF 93 in 1987, Dr. Ivins indicated that he had also been treated while in graduate school; there are no other records of this. The inconsistencies in these forms were either deemed insignificant or were never detected; in any event, again, they were not pursued.

From the beginning of his employment at USAMRIID, authorities also could have accessed pharmacy billing records, which were available to USAMRIID occupational health clinics as part of the SIP had they asked Dr. Ivins to sign a release for them. These records detailed Dr. Ivins' considerable use of prescription antidepressants, benzodiazepines, and other sleep agents as well as occasional antipsychotic use. It appears that no request for a release was ever issued.

Finally, as noted, on March 24, 2006, Dr. Ivins modified his medical questionnaire to exclude access to his actual mental health records. He instructed instead that Dr. #3 would provide a summary of his treatment. This change produced no consequences.

- **Information requested was not always provided:** When complete records were requested, only a limited portion was provided. In the summer of 2005, for example, USAMRIID requested Dr. Ivins' complete records from Dr. #3's office, where Dr. Ivins had been a patient for five years. The records the office actually provided went back only three months. Yet the July 2005 evaluation report at Barquist does not indicate that the limited record release was the subject of further inquiry. It indicates only that Dr. Ivins' medical records had been reviewed.

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

Had the full record been obtained, it would have contained Dr. #3's notes from his initial evaluation of Dr. Ivins, documenting his patient's



- **Dr. Ivins' treating psychiatrist lacked both an awareness of the medical record and an appreciation of the stakes involved in assessment:** In July of 2005, Dr. Ivins' access to the hot suite, which had been temporarily restricted a few months earlier, was reinstated. The decision to reinstate was based at least in part, on the approval of his treating psychiatrist, Dr. #3. This psychiatrist told investigators that his decisions in all such situations were based on a negotiation with his patient. He deferred to Dr. Ivins' judgment, he explained, because Dr. Ivins knew more about the requirements of the position. We note that this is a common approach on the part of treating clinicians who are asked for an opinion regarding their patient's excuse from or return to work.

Later, in January 2008, Dr. #3 was asked to certify Dr. Ivins as fit to work again, albeit part-time, in the hot suite. Dr. #3 performed an examination limited to a brief cognitive screen and cleared him to work in that setting.

Dr. #3's handling of both of these situations suggests that Dr. #3 did not fully appreciate the seriousness of the work in which Dr. Ivins was engaged.

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

In an interview with investigators on July 7, 2009, Dr. #3 acknowledged that at the time he was certifying Dr. Ivins as fit to work in 2005, he had not reviewed Therapist #1's notes in the clinic record or spoken with her about Dr. Ivins' [REDACTED]

[REDACTED]

Even after Dr. Ivins' significant deterioration, Dr. #3 continued to maintain that he was fit to work in a secure setting. In an interview July 23, 2008 — during the last week of Dr. Ivins' life and while he was still psychiatrically hospitalized after threatening to kill co-workers — Dr. #3 continued to maintain that he had no personal knowledge to question Dr. Ivins' capability to work with select agents. Dr. #3 said on that date that his assessment for fitness would be the same as he had provided in 2003.

It should be noted: There *were* instances where the system worked as intended. For example, on a Supplemental Medical Data form dated April 27, 2005, Dr. Ivins self-reported a history of anxiety, depression and insomnia as well as a history of back injury that caused intermittent discomfort. On that form Dr. Ivins also reported that he was now drinking a glass of wine five times per week and taking diazepam, citalopram, zolpidem, and cyclobenzaprine. He expressed discomfort and agreed to be temporarily barred from the hot suite. He was, and authorities also placed him under increased health surveillance. As of May 2005, Dr. Ivins was seen every two to three months for reevaluation at Barquist. He underwent a fitness for duty evaluation there in July 2005.

But for the most part the process did not work. It allowed an individual with a past history of vandalism and other [REDACTED] and impaired [REDACTED]

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

judgment due to mental illness and eventually substance abuse, to work in a secure facility with agents of mass destruction — and to keep working there for years after he had committed an act of mass murder.

The Panel believes that part of the explanation may lie in the shifting security landscape. Beginning in 2001, the rules governing security at USAMRIID began to change, with PRP procedures slowly replacing those defined under AR 380-67. The evolutionary nature of this shift may have delayed discovery of problematic information.

But familiarity, the Panel believes, played a much greater role in the failure of the systems to operate. Over the decades, Dr. Ivins' tenure at USAMRIID, mingled with respect for him as a scientist, appears to have led to a degree of complacency toward him. His co-workers and supervisors had long since become accustomed to him, eccentricities and all. Their complacency was such that in the final months of his career at USAMRIID, many of them observed his deteriorating emotional and physical condition — including a black eye from a fall due to intoxication — but did not report their observations or take other action. Familiarity may also explain why those involved in the medical surveillance system did not follow through when information they requested: 1) either was not provided at all; or 2) was provided and suggested the need for additional inquiry.

### **RECOMMENDATIONS**

With one exception, detailed below, the Panel has no recommendations for alteration of the biosecurity and biosafety measures established by the Select Agent Rule and the DoD BPRP (Biological Personnel Reliability Program). The Panel is aware that the utility of the BSAT list is the subject of an ongoing discussion that is beyond the scope of this analysis and the Panel's expertise. Although the Panel believes that existing measures should be adequate to protect biosafety and biosecurity in these laboratories, our review of the medical records and other investigative materials does lead us to recommendations

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

regarding how those procedures are executed, as well as warnings related to pitfalls seen in this and other occupational health settings.

In addition, the Panel's analysis of this case leads to observations regarding the application of the SAR in private and academic laboratories.

In making these recommendations, the Panel emphasizes the need to respect the privacy of the medical information belonging to all individuals, including those working with BSAT. Individuals who consent to having their medical and psychiatric information reviewed as a prerequisite to working with these agents must be confident that the information is managed with utmost discretion and shared with a limited number of others on a strict "need to know" basis.

We support a careful review of individuals who are diagnosed with major mental illness and/or who are prescribed psychotropic medications. We are opposed to automatic and permanent disqualification from BSAT work on the basis of psychiatric diagnosis alone or the use of a particular category of medication, without careful further review. Indeed, we have no proof that the anthrax attacks perpetrated by Dr. Ivins were the result of a major mental disorder as opposed to misguided motivations ranging potentially from attempts to bolster national security to purely selfish. Rather than being based on psychiatric diagnosis, disqualification should be based upon function and actions that indicate criminal behavior, safety risk, or a lack of reliability; regard for the law, trustworthiness, and safety; or that leave the individual vulnerable to coercion.

As noted above, the SAR currently excludes from BSAT access those deemed "restricted persons" by virtue of having been "adjudicated as a mental defective" or having been "committed to any mental institution." "Adjudicated as a mental defective" means that "a court, board, commission or other lawful authority has determined that he or she, as a result of marked subnormal intelligence, or mental illness,

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

incompetency, condition, or disease: 1) is a danger to himself, herself, or others; or 2) lacks the mental capacity to contract or manage his or her own affairs." The term "adjudicated as a mental defective" also explicitly includes a finding of not guilty by reason of insanity or incompetence to stand trial. Dangerousness to self or others is the sole basis for involuntary civil commitment.

These criteria are both overly broad and unduly narrow. High-functioning, trustworthy individuals may experience an acute onset of mental illness or medical illness, including reactions to prescribed medication, which results in involuntary hospitalization, receive effective treatment, and then return to full function. Automatic and permanent disqualification of a scientist from his or her work on this basis without further inquiry is unnecessary. Moreover, as in Dr. Ivins' case, there are serious behavioral abnormalities that can adversely affect an individual's safety, stability, and security that fall far short of resulting in a "mental defective" adjudication or involuntary hospitalization. Security Risk Assessments conducted pursuant to the SAR do not capture aberrant behavior that has not resulted in an indictment or conviction, as in Dr. Ivins' case. In addition, the accuracy of SRA application of the "mental defective" and "civil commitment" criteria is dependent on the states reporting adjudications regarding mental health issues in a timely and accurate fashion. This has been problematic to date.

Thus, this standard runs the risk of false positives — excluding as a risk those who are not true risks — and false negatives — failing to detect those who are at risk by virtue of using an inadequate measure. In addition we note that the antiquated language used in these criteria insults the millions of Americans with mental illness and reinforces the stigma associated with those illnesses.

The Panel also recognizes that perpetration of the anthrax mailings by a senior scientist at a federal laboratory may be regarded by many as

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

a “Black Swan”: a rare event of high impact that is predictable only in hindsight. In the Panel’s view, this was a rare event, but it is one that could have been anticipated — and prevented. Indeed, had existing protocols been executed in a rigorous fashion, the attacks might have been avoided. While the risk of such an event is small, the consequences are high, and careful execution of existing PRP measures can decrease the risk of an occurrence of this or similar events in the future.

The major personnel reliability factors that gave Dr. Ivins the opportunity to carry out the anthrax mailings and then maintain his access to the facilities and resources at USAMRIID — even while his condition deteriorated — relate to failures in the following areas:

- (1) Recognition of the significance of the information and misinformation Dr. Ivins provided and resulting failure to follow up on that information
- (2) Reliance upon the treating clinician to provide objective and accurate input regarding fitness for duty
- (3) Reliance upon the treating clinician to provide a complete set of medical records and failure to respond when an incomplete set was provided
- (4) Lack of objectivity due to familiarity between Dr. Ivins and those who performed his medical assessments
- (5) Failure of coworkers and supervisors to recognize and take action regarding Dr. Ivins’ deteriorating condition and behaviors
- (6) Failure of Dr. Ivins’ treating psychiatrist to be aware of [REDACTED] behaviors as documented in his own files by his own personnel

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

In light of these observations, we suggest the following:

1. Background investigators should be trained thoroughly to recognize red flags related to both counterintelligence and mental health issues and to respond to those indicators with thorough investigation.
2. Information from treating clinicians should be regarded as important but not dispositive. All fitness-for-duty evaluations and medical reviews should be conducted by clinicians who have had no treatment or other relationship with the subject of the investigation and who receive specific training in conducting fitness-for-duty evaluations in high-security settings.
3. Requests for information from treating clinicians should include a detailed written and verbal description of the significance of the information requested and the potential consequences to national security of inaccurate and incomplete information. The clinician providing the information should be asked to sign a form acknowledging this discussion and certifying the accuracy and completeness of the information provided. The treating clinician should be given the option of recusing himself or herself from making the assessment, deferring to an independent evaluator. Release of information forms signed by the employee should contain a waiver indemnifying the clinician from legal liability related to sharing appropriate concerns in good faith with investigators.
4. PRP measures that allow for requisition of medical records should be utilized and consent to release of the records made a condition of continued access and security clearance.
5. All possible measures should be taken to ensure the privacy of medical information, with information disclosed only on a "need to know" basis and with strict penalties for inappropriate disclosure.

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

6. The BPRP process should include a longitudinal review of all medical questionnaires to detect discrepancies and inconsistencies, and follow up of any that are detected.
  
7. Personnel Reliability Programs, though a crucial element of Biosurety, must operate in an environment that ensures adequate physical security, promotes safe handling practices for select agents and other materials, and maintains full and accurate accountability of those agents. Accomplishing this depends on the establishment of adequate rules and regulations, such as those called for by 42 C.F.R. § 73, laboratory leadership that professes and models commitment to the necessary standards and practices, a work force educated in these standards and practices, ongoing monitoring and auditing practices, and consistent objective application of security measures to all personnel at all times. As this case demonstrates, inadequate attention to these issues can have disastrous results. Close attention to these aspects of a Biosurety program, on the other hand, can assure that research scientists and the general public both experience a safe environment in which to work and live, while knowledge about these agents progresses.

Many of the issues discussed in this chapter were the subject of a detailed review by the DoD in a formal internal AR 15-6 Investigation conducted by Colonel [REDACTED]. That review identified a number of biosurety problems, but ultimately concluded that the "goals of the Biosurety program and BPRP, as well as BSAT safeguards based upon DoD and Army Regulations and Guidance preceding the implementation of AR-50X, were met in regards to Dr. Bruce Ivins during the period of 2000-2008. There was no specific evidence available to any of the Biosurety elements that there were issues with Dr. Ivins' reliability until July 2008...."

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

The Panel was able to access information that may not have been provided to Colonel [REDACTED] and recognizes that he was provided a short time frame in which to make his report. The Panel respectfully disagrees with his conclusion. Based on our review of the investigatory materials, while there was compliance with and fulfillment of some of the procedures extant at the time, the execution of those procedures was not successful in detecting Dr. Ivins' lack of fitness and lack of qualification for his security clearance due to a combination of factors noted above. As such, we cannot concur that the goals of the biological surety program were met.

Specifically, we note that Dr. Ivins, a career employee, was able to access the hot suites in his lab during off hours for three consecutive days between September 14 and September 16, 2001, and again for 10 consecutive days between September 28 and October 7, 2001. This pattern of behavior was unusual for him, but was never questioned. That unchecked access allowed him uninterrupted time to process and prepare for dissemination a significant quantity of anthrax, which was ultimately used in the attacks. Other investigatory materials indicate a variety of problems with physical security measures at USAMRIID prior to the attacks, including unmonitored access to the hot suites for those specific individuals who have automated badge access and easy ability to remove materials from the laboratory.

Likewise, as already noted, Dr. Ivins was involved in at least three incidents involving inattention to biosafety issues, and 100 ml of Ames strain anthrax was "lost" — without its absence even being noted.

Also as noted, Dr. Ivins' behavior after the attacks, in particular his medical condition, mental state and interaction with fellow employees, appeared to become more erratic and dysfunctional. Yet he remained in a position of substantial authority, with ongoing access to potential agents of mass destruction — without any apparent additional supervision and oversight.

## **Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)**

On July 7, 2008, while working at USAMRIID, Dr. Ivins demonstrated outwardly threatening behavior toward a female colleague. Alarmed, she approached Dr. Ivins' direct supervisor for advice. She told her supervisor that Dr. Ivins was acting in a threatening manner, implying that he would take revenge against coworkers who were "diming" him out. Dr. Ivins was talking to himself as if "to a ghost," she said, and she was afraid he would "go postal." The Panel could find no evidence that Dr. Ivins' supervisor documented the event or requested assessment for Dr. Ivins or intervention by USAMRIID security. Almost inexplicably, the supervisor instead suggested the employee "hide in the hot suites" because Dr. Ivins was restricted from access there and would be retiring at the end of the summer.

Disturbed by the failure of this supervisor to take action, and still extremely concerned about Dr. Ivins' level of dangerousness, a witness at USAMRIID then contacted the FBI investigators and described his bizarre and threatening behaviors, documents reviewed by the Panel revealed. In response to the witness's call, the prosecution team grew more concerned about Dr. Ivins' stability. They promptly relayed her account of Dr. Ivins' threatening behavior to his attorney and it is unknown what action, if any, was taken by the attorney.

Two days later, Dr. Ivins arrived at his group therapy meeting in an agitated state, revealing that he was procuring a gun in order to shoot and kill a list of co-workers before going out "in a blaze of glory" at the hands of police. These plans to kill others prompted his therapists to involuntarily hospitalize Dr. Ivins, whose petition authorized the Frederick police to arrive at USAMRIID on July 10, 2008. Clinicians who independently assessed him at the hospital authorized his involuntary hospitalization. Based on a number of factors, the Panel believes that the intervention of the therapist to petition for Dr. Ivins' involuntary hospitalization almost certainly saved the lives of those whom he had targeted for a mass killing. These risk factors included the nature of the threats, the explicit homicidal plan in place, the

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

listing of individual victims, the arsenal seized at his home, the independent assessments at the hospital corroborating his extreme level of dangerousness, and even his own telephone statements to Therapist #2 that he required hospitalization because there was no less restrictive alternative and he was a danger to himself and others.

The Panel reviewed the subsequent USAMRIID AR 15-6 internal review that occurred in the month following Dr. Ivins' death, and the statements made at that time by the supervisor. In that internal review, Dr. Ivins' supervisor failed to relate either the threatening behavior that was reported at USAMRIID on July 7, or the advice provided to the employee to "hide in the hot suites." The Panel could find no USAMRIID documentation that this event had ever taken place, but the July 7 call and its contents were documented by the FBI. Because of this supervisor's failure to reveal this incident to Colonel [REDACTED] the internal USAMRIID review was incomplete, the Panel believes.

Dr. Ivins' removal from USAMRIID took place not because of the intervention of the USAMRIID supervisor, but rather as a result of his similarly alarming behavior and statements at the July 9 group therapy meeting, where his therapists were caught completely by surprise. The resulting Emergency Petition filed by Therapist #3 at the request of Dr. #3 set in motion the events that led to Dr. Ivins' involuntary hospitalization and the July 12 seizure of his ammunition, body armor and a bulletproof vest by the FBI. In a voicemail to Therapist #3, Dr. Ivins admitted that he was both suicidal and homicidal at the time and therefore required psychiatric hospitalization.

We note that Colonel [REDACTED] attributed the failure to provide additional surveillance of Dr. Ivins to:

(1) the FBI's previous erroneous identification of Steven Hatfill as a suspect and what Col. [REDACTED] characterized as an "innocent until proven guilty" approach on the part of the FBI,

**Appendix II - Biosafety and Biosecurity  
(Personnel Reliability Programs)**

(2) the fact that "the FBI had recently cleared Dr. Ivins to continue his BSAT work, as evidenced by the approval by the CDC, effective October 2, 2007, under the Select Agents Program," and

(3) the FBI's failure "to communicate to the USAMRIID chain of command a clear message that Dr. Ivins was a 'suspect' or to provide evidence to incriminate him meant that Dr. Ivins maintained his status as a trustworthy person."

With regard to the first point, the Security Risk Assessment conducted by the FBI was consistent with the requirements of the Select Agent Rule that the person being cleared is determined not to be a "restricted person" as defined under the rule. Regarding the last point, the Panel received information that USAMRIID command was indeed notified that Dr. Ivins was a suspect, but it is not clear what leeway USAMRIID command was given to act on that information, given that an active investigation was still under way.

The Panel endorses the enhanced security measures that have been adopted in the years since the anthrax attacks. We do so recognizing that these Biosurety measures can be viewed as imposing both practical and psychological burdens on employees, especially those who have traditionally worked in a scientific research environment in which they have been accorded high levels of responsibility and independence. Resistance or inadequate attention to such measures may stem from the belief that they constitute either an abridgement of individual rights, or unnecessary constraints on a productive scientific research environment. Overcoming this resistance may require a shift in workplace culture that includes weighing the risks and benefits of such measures, and instituting policies and procedures that maximize safety and security, as well as privacy and respect for individual employees.

## Appendix II - Biosafety and Biosecurity (Personnel Reliability Programs)

### End Notes for Biosafety and Biosecurity

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<sup>18a</sup>Carr, K., Henschel, E.A., Wilhelmsen, C., Carr, B. (2004). Implementation of biosurety systems in a large Department of Defense medical research laboratory. *Journal of Biosecurity and Bioterrorism*, 2:7-16.

<sup>19</sup>"Bacillus" refers to the shape of the organism; "anthracis" denotes the coal-black color of the lesions caused by cutaneous anthrax infections.

**Appendix III - Violence and Risk Assessment****INTRODUCTION**

As acts of bioterrorism by a government-employed scientist, the anthrax mailings of 2001 were unprecedented attacks that call for a consideration of issues of violence-risk assessment and prevention. To this end, the Panel reviewed two major areas: [REDACTED]

The second includes his possible unsuccessful suicide attempt, the ongoing assessment of his risk of harm to self, and his ultimate suicide. These issues span much of his lifetime, both predating and postdating the anthrax mailings of 2001.

As noted, the Panel's review of Dr. Ivins' psychiatric records and other criminal investigative materials strongly supports the DOJ's determination that he conducted the anthrax mailings of 2001. The Panel also determined that, beginning as early as graduate school, but continuing throughout his life, [REDACTED]

[REDACTED] Finally, the review supports the conclusion that he committed suicide by intentional overdose shortly before he was to be indicted for the anthrax mailings.

**RISK ASSESSMENT OF VIOLENCE — BACKGROUND**

A growing literature describes risk assessment of violence towards others. Guidelines have also been developed concerning assessment of risk for violence toward self and suicide. Despite public perceptions to the contrary, episodes of violence are statistically infrequent, and their prediction is therefore difficult. There is no way to predict with certainty that a given individual will commit an actual episode of violence toward himself or others. It is likely, however, that specific incidents of violent behavior or suicide are often prevented by careful assessment and implementation of risk management interventions.

**Appendix III - Violence and Risk Assessment**

Possible interventions to prevent violence to self or others, however, also come with a cost. They may include restriction of liberty, either through civil commitment or involuntary treatment with psychotropic medications. Treatment interventions themselves can carry a risk of harm to the individual. Treatment, including prescription of medication, can cause uncomfortable and potentially permanent side effects. Identification as seriously mentally ill can lead to stigmatization and even legal repercussions, such as loss of rights resulting from civil commitment. There is a constant tension between, on the one hand, public safety concerns or the need to care for those the state deems incapable of caring for themselves, and, on the other hand, personal liberties.

Violent behavior is the product of the interaction of multiple personal, environmental, and situational factors. As a result, there is no simple approach to risk prediction for violence to others. One approach, based on review of data collected from individuals who have been violent, involves examination of static and dynamic risk factors. Static factors, usually historical, cannot be changed; they include past history of violence, past antisocial behaviors, age and gender. Their consideration can improve our ability to determine who is more likely to be violent within a given population. Dynamic factors are those that may change through some type of intervention or on their own over time. Examples are impulsivity (acting without much thought about the consequences), negative affect (unhappy moods such as depression or anger), psychosis (severe mental illness that causes a person to have trouble accurately understanding their situation), antisocial attitudes, substance abuse, problems in interpersonal relationships, and treatment non-compliance (not taking medication that is prescribed for a mental illness).

During Dr. Ivins' lifetime, continuing research led to improvements in threat and risk assessment and to consideration of different "domains" or categories of risk factors. Steadman et al<sup>20</sup> identified four different

**Appendix III - Violence and Risk Assessment**

categories that have proved useful to study: dispositional, historical, clinical, and contextual (dependent on situations and circumstances). In addition, recognition grew that risk can be considered always present to some degree but varies over time. The concept of targeted violence<sup>21</sup> further expanded understanding of risk assessment in certain situations. Increasingly, attention is now also being focused on consideration of protective factors that may reduce risk in individual cases.

**DR. IVINS' RISK FACTORS**

Dr. Ivins possessed several known risk factors for violence toward others: male gender; a past history [REDACTED] mental illness combined with substance abuse; exposure to violence during childhood; and antisocial traits. In addition, prior to the anthrax mailings he experienced a number of situational triggers associated with acts of violence: negative work-related events, threats to his professional identity, and perceived rejection and abandonment.

He also presented with multiple known risk factors for suicide: male gender; white race; access to firearms; unstable therapeutic relationship; suicidal ideas, plan and intent, and at least one possible suicide attempt. His diagnostic picture included elements of a number of diagnoses known to be associated with an increased risk of suicide:

[REDACTED]

Retrospective analysis of his records and investigative materials indicates that Dr. Ivins exhibited a number of additional features that have been linked to an increased risk of suicide. They include co-morbidity (combined presence) of psychiatric problems, (i.e.,

**Appendix III - Violence and Risk Assessment**

depression or personality disorder and alcohol abuse); recent lack of social support; poor relationships within the family; recent stressful life event(s); family history of mental disorders; hopelessness; anxiety; shame; psychological turmoil; narcissistic vulnerability; and history of [REDACTED] Situational risk factors, such as the dissolution of his previously expressed religious beliefs, pending retirement, diminished psychosocial support system, pending criminal prosecution, and difficulty identifying reasons for living, also likely contributed to his increased risk of self-harm prior to the time of his death.

From a more practical standpoint, individuals who are hospitalized for suicidal ideation, as Dr. Ivins was on July 10, 2008, are at increased risk for suicide post-discharge.

In summary, Dr. Ivins possessed many serious risk factors for violence toward himself and others over an extended period of time.

**CONCEPTUALIZING DR. IVINS' BEHAVIOR**

In order to understand the anthrax mailings, it is necessary to consider Dr. Ivins' behavior in some broader contexts. Although it has been determined that the mailings occurred during two separate episodes, they nonetheless took place within a relatively confined time period, were likely fueled by the same motivations, and may even have been part of the same original plan. They can therefore be considered one continuous episode of behavior. In addition, no matter what his motivation, Dr. Ivins knew, given his training and experience in handling this pathogen, how lethal an anthrax release would be. The number of deaths and illness that resulted from the mailings, the potential they held for even more extensive morbidity and mortality, and Dr. Ivins' presumed knowledge of that damage all suggest that the mailings could be considered as an attempt at mass murder. The question arises: What do we know about Dr. Ivins that fits with what is known about other individuals who have been involved in these types of criminal behaviors?

**Appendix III - Violence and Risk Assessment**

Meloy et al<sup>22</sup> studied a group of individuals (30 adults and 34 adolescents) who committed mass murders in the last half of the 20th century. Much of what is known about Dr. Ivins' behaviors prior to the mailings is similar to what the authors reported in their review.

Dr. Ivins shared a number of characteristics reported by Meloy and associates: white male; interest in weapons and possession of multiple weapons (including bullet-proof vests); a "warrior mentality," characterized by an identification with aggression, authority, and feelings of grandiosity and omnipotence; a history of mental illness; paranoid, narcissistic, and antisocial personality traits; and use of fantasy to manage rejection and humiliation. Additionally, Dr. Ivins, like the members of Meloy and associates' study group, experienced a precipitating or triggering event, such as actual or perceived abandonment, jealousy, erotomania, or job stressors. Other similarities

[REDACTED]

[REDACTED] Meloy's perpetrators also showed an absence of emotion. Most committed suicide or were killed by the police.

It is also important to note Dr. Ivins' behavior prior to the mailings, and in particular, his stalking behaviors, and his openness with his therapist about them. Fein and Vossekuil<sup>23</sup> describe how the psychiatric interview can give the stalker the opportunity to tell his story, be heard, and possibly reassess his behavior. Dr. Ivins appeared to use his therapy contacts for these purposes on more than one occasion. Mullen et al<sup>24</sup> also describe how the initial psychiatric interview lets the stalker both express resentment and provide an account of events, and encourages the examiner to make a detailed inquiry about the behavior.

[REDACTED]

[REDACTED]

**Appendix III - Violence and Risk Assessment**

[REDACTED]

[REDACTED] Nonetheless, regardless of specific diagnoses, Dr. Ivins' treating clinicians believed his symptoms required intervention. The available documentation does not specify why particular treatment interventions were made and why others were not.

Guidelines for assessment include detailed questioning about the threat, and an evaluation of the risk of violence not only to the person being stalked but in general. Evidence indicates that the more specific the threat, the more likely it is to be carried out. Other risk factors include a prior intimate relationship between the stalker and victim, criminal history, substance abuse, prior history of threats, absence of psychosis, depression and suicidality. It is worth noting that the risk is higher if the stalker leaves threatening messages on the victim's car.

Several of these factors were evident in Dr. Ivins' case: substance abuse, [REDACTED] depression, suicidality, and vandalizing the victim's car by spray painting messages on it.

Although he had no documented criminal record prior to the anthrax attacks, Dr. Ivins did have a significant history of criminal behavior targeted to KKG and KKG Sister #2. This behavior included theft, breaking and entering, fraud, libel, harassment and vandalism. At the time he committed suicide, he was on the verge of being indicted on charges of Use of a Weapon of Mass Destruction.

**Appendix III - Violence and Risk Assessment**

The question arises: To what degree, if any, were these criminal behaviors the result of a mental disorder?

The relationship between mental illness and criminal behavior is complex. Criminal behavior most commonly occurs in the absence of mental illness, and it can occur in the presence of mental illness but be unrelated to that illness. It can also occur in the presence of mental illness and be related to that illness, or illnesses, to varying degrees — representing anything from a contributing to an excusing condition. As discussed in the Diagnostic Section of this report, Dr. Ivins' death precluded the completion of a comprehensive forensic psychiatric assessment that would have shed light on this question. Had he lived and been indicted, however, Dr. Ivins almost certainly would have received such a psychiatric assessment.

**MANAGEMENT OF DR. IVINS' VIOLENCE RISK**

When a clinician learns that a patient has been thinking of violence — toward self or others — the burden falls on the clinician to explore the threat or intent carefully. The clinician assesses the likelihood that violence will actually occur, based on the information available to him or her. Specifically, he or she evaluates the feasibility of the individuals carrying out the act, the lethality of the threatened action, the degree of intention to act, and the patient's access to the means to carry it out. This evaluation in turn drives informed decision making about what interventions may be needed and when. This evaluation requires balancing the risks and benefits of aggressive intervention, such as involuntary hospitalization, against alternative interventions, aimed at decreasing the likelihood that the patient will act on their aggressive thoughts or impulses. In hindsight, of course, decisions in these situations, if the outcome is negative, can easily be criticized by those who were not actively involved. We offer the following as observations rather than as a critique of the care provided.

### Appendix III - Violence and Risk Assessment

Dr. Ivins had a long history of verbalizing rage and of describing prior

[REDACTED]

[REDACTED] He received diagnoses of mental illness during treatment with at least four different therapists between 1978-1980 and 2000-2001. It is important to note that there also were also two decades during this period, the 1980s and '90s, when he was not symptomatic enough to request or be referred for psychiatric treatment. During this period, however, he did engage in criminal behavior related to his KKG obsession — he stalked, libeled, vandalized, and committed acts of breaking and entering and burglary. Until 2008, none of these

[REDACTED]

Each clinician who treated him appears to have initiated some type of intervention in response to his clinical presentation, [REDACTED]

**Appendix III - Violence and Risk Assessment**



As noted elsewhere, however, Dr. Ivins never indicated on any of his employment-related health questionnaires that he was being treated with antipsychotic medication, although he did report use of antidepressant and anti-anxiety medication.

Review of Dr. Ivins' outpatient records reveals little formal documentation of assessment of violence-risk to others or a rationale for his treatment plan. Dr. Ivins remained at USAMRIID, in a senior role as an anthrax researcher. In 2000, he reported to Dr. #2 that



But during the 2000-2001 timeframe, it is not clear to what extent, if any, his clinicians considered Dr. Ivins' unique work situation and access to lethal pathogens in evaluating risk. Dr. Ivins had failed to provide Dr. #2's name on yearly medical and mental health assessment questionnaires from USAMRIID. Had he been listed by Dr. Ivins, and had he been contacted by USAMRIID, Dr. #2 would not have recommended a security clearance, he later said. But he never was contacted.



**Appendix III - Violence and Risk Assessment**

[REDACTED]

Documents show that in 2005 Dr. #3 supported Dr. Ivins' self-initiated request to be removed temporarily from the hot suite. And three years later, Dr. #3 concurred in effecting an emergency hospitalization of Dr. Ivins after he verbalized homicidal ideations towards coworkers during a group therapy session. As with the assessment of his possible risk to others, Dr. Ivins' outpatient treatment records contain no documentation of a detailed, formal assessment of his risk for harm to himself, even though he was treated for [REDACTED] periodically over a 30 year period. Dr. Ivins was in treatment for various psychiatric problems from at least his time in graduate school, returned to treatment more than a year before the mailings, and continued in treatment until shortly before his death. Among the questions that arise are: Would different or more aggressive treatment interventions have modified Dr. Ivins' risk of carrying out the anthrax mailings and his eventual suicide? What factors might have interfered with more thorough assessment of risk and possibly better management of that risk?

As described in detail elsewhere in this report, considerable information indicates that Dr. Ivins' mental status had deteriorated at the time he re-engaged in treatment in the year 2000. [REDACTED]

[REDACTED]

**Appendix III - Violence and Risk Assessment**

[REDACTED] There is also limited documentation in his own emails about Dr. Ivins' increasing use of medication and alcohol to self-medicate his growing anxiety. In addition, it is unclear what, if any, attempts were made to engage Dr. Ivins' family or workplace in ongoing monitoring of his potential risk.

[REDACTED]

In retrospect, Dr. Ivins may have appeared much improved because he had resolved to commit suicide upon his release. With the benefit of knowing his ultimate end, Dr. Ivins' reassuring statements were suspect, and his discharge premature, especially given his substance abuse and his decision to sever his existing treatment relationships. As noted above, the dangers of hindsight bias are great, and the Panel will not second-guess the decisions made and not made by hospital staff. It may be beneficial to note that intelligent, highly educated patients with good verbal skills pose special challenges with regard to suicide risk assessment. In addition, those who are under severe legal and career stress may be at particular risk of suicide, given the threat to their identity and their capacity to pursue discharge once they have decided to take their own lives.

**Appendix III - Violence and Risk Assessment****End Notes for Violence and Risk Assessment**

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- <sup>20</sup>Steadman H., Monahan J., Robbins P., Appelbaum P., Grisso T., Klassen D., Mulvey E., Roth L. (1993). From dangerousness to risk assessment: implications for appropriate research strategies. In: Hodgins S., ed. *Mental Disorder and Crime*. Thousand Oaks, CA: Sage Publications Inc: 39-62.
- <sup>21</sup>Borum R., Fein R., Vossekuil B., Berglund J. (1999). Threat assessment: Defining an approach for evaluating risk of targeted violence. *Behavioral Sciences & the Law*, Vol 17(3): 323-337
- <sup>22</sup>Meloy J.R., Hempel A.G., Gray B.T., Mohandie K., Shiva A., Richards T.C. (2004). A comparative analysis of North American adolescent and adult mass murderers. *Behavioral Sciences & the Law*, Vol 22(3). Special issue: Serial and mass homicide, 291-309.
- <sup>23</sup>Fein, R., Vossekuil. B. (1998). Preventing attacks on public officials and public figures: A Secret Service perspective. In J.R. Meloy (Ed.), *The Psychology of Stalking: Clinical and Forensic Perspectives* (pp.175-191). San Diego Press.
- <sup>24</sup>Mullen, P.E., Pathe M., Purcell R. (2000). *Stalkers and Their Victims*. Cambridge University Press, Cambridge, UK.

**Appendix IV - Commitment Law in Maryland****INTRODUCTION**

Dr. Ivins committed suicide within days after his discharge from inpatient psychiatric treatment in Maryland. One of the questions this Panel examined was: Had Dr. Ivins been hospitalized longer under Maryland civil commitment law, could the suicide have been prevented and would the outcome of the case have been different?

Civil commitment is the legal process through which individuals may be involuntarily hospitalized. The process weighs the liberty interests of the individual against the risk of danger to the self, others, or, in some jurisdictions, property. In the United States, it is generally the state government that has the authority to define the specific conditions under which an individual may be confined to a mental hospital against his or her will.

In general, two conditions must be met to use the civil commitment process. The individual must: 1) be suffering from some form of mental disease or defect, and 2) represent some degree of dangerousness — to themselves or others or, in some jurisdictions, property — that is related to the mental condition. More specific operational definitions of the types of mental conditions that must be present, the sources of clinical information that must be provided by medical professionals and the duration of confinement are defined in state or federal statutes and regulations. Civil Commitment is also referred to as Involuntary Commitment or Involuntary Admission.

**SUMMARY OF CIVIL COMMITMENT PROCEEDINGS INVOLVING DR. IVINS**

Proceedings to civilly commit Dr. Ivins under Maryland law were initiated July 10, 2008. On this date his treating therapist, in consultation with his treating psychiatrist, initiated an Emergency Petition, also known as a Petition for Emergency Evaluation (Maryland Code, Health General Article § 10-620 et.seq.), which compelled the Frederick Police Department to detain Dr. Ivins and transport him for psychiatric evaluation. The Emergency Petition text, written by a

**Appendix IV - Commitment Law in Maryland**

Frederick Peace Officer, reported that "he [Dr. Ivins] described a detailed plan of how he was going to take out co-workers and people who wronged him." The Emergency Petition also stated that "he had access to a .22 cal rifle, a Glock handgun and body armor," and that he had a "plan about getting even with the government and system." Frederick Police officers, together with officers from Fort Detrick, took Dr. Ivins into custody at about 2 p.m. and transported him to the Frederick Memorial Hospital (FMH), Emergency Department. The FMH mental health crisis staff, including a licensed clinical social worker (LCSW) and two physicians, certified Dr. Ivins as meeting criteria under Maryland Code for Civil Commitment. The next day, he was transferred to and admitted involuntarily at Sheppard Pratt Hospital in Towson, Md.

Under Maryland commitment code, an individual has a right to a hearing within 10 calendar days of the date of confinement to the facility. The commitment hearing with an administrative law judge was originally scheduled for July 16, but social work progress notes on July 15, 2008 indicate that the hearing was postponed; no reason was cited. Inpatient physician progress notes from July 21, 2008 indicate that Dr. Ivins and his attending physician signed a voluntary admission form that day. Dr. Ivins' status became voluntary when he signed this form.

Dr. Ivins was discharged from the hospital July 24, 2008. He was not discharged Against Medical Advice (AMA), and the hospital progress notes do not indicate that he submitted a written request to be discharged. In Maryland individuals who are on a voluntary status, as Dr. Ivins now was, must give three days' written notice to leave the hospital on their own initiative. The record does not reflect that any such notice was given. Nor do the hospital's progress notes indicate overt pressure on staff by Dr. Ivins for discharge; rather they indicate cooperative participation in discharge planning. [REDACTED]

[REDACTED]

**Appendix IV - Commitment Law in Maryland****NATIONAL ADVOCACY PERSPECTIVES ON CIVIL COMMITMENT**

National advocacy organizations have a range of positions on civil commitment.

At one end of the spectrum is the position espoused by the Judge David L. Bazelon Center for Mental Health Law, a Washington, D.C.-based advocacy group for people with mental disabilities. "The Bazelon Center opposes involuntary inpatient civil commitment except in response to an emergency, and then only when based on a standard of imminent danger of significant physical harm to self or others and when there is no less restrictive alternative. Civil commitment requires a meaningful judicial process to protect the individuals' rights."

In further support of this position, the Bazelon Center cites opinion from the U.S. Supreme Court that: "Civil commitment to a psychiatric hospital is a 'massive deprivation of liberty' (Humphrey v. Cady, 405 U.S. 504, 509 (1972)). which the state cannot accomplish without due process of law."<sup>25</sup> Moreover, the court has found "no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."<sup>26</sup>

The Arlington, Va.-based National Alliance on Mental Illness (NAMI), which represents the concerns of individuals with mental illness as well as their families, has a broad and inclusive position on civil commitment for psychiatric treatment. This position has been criticized as being weak and supporting forced treatment early in the course of the emergence of a psychiatric episode. The NAMI position supports family involvement in the commitment process, but does not assert that family members have a right to oversee the commitment process. Specifically, NAMI holds that access to effective treatment in community settings and enhanced communication between clinicians reduces the

**Appendix IV - Commitment Law in Maryland**

need for involuntary commitment. NAMI does not, however, support commitment processes that require imminent dangerousness as a requirement for civil commitment. These national positions provide well-deliberated positions on civil commitment for the millions of Americans with a stake in these issues — psychiatric patients, professionals, family members and others.

**NATIONAL DEVELOPMENT IN CIVIL COMMITMENT LAW**

In tandem with the civil rights era in the 1960s and 1970s in the United States, many states revised and clarified laws governing the process of civil commitment for the purpose of treating mental illness. More recently several states have attempted to broaden commitment criteria so that the threshold for commitment is less strict, especially in one additional area: provisions for outpatient commitment.

Recent developments in civil commitment law have reflected attempts to expand the conditions under which civil commitment can be used to detain mentally ill individuals for psychiatric treatment. To date, each attempt has been met with firm opposition grounded in the Supreme Court sentiment that “civil commitment to a psychiatric hospital is a ‘massive deprivation of liberty.’” (Humphrey v. Cady, 405 U.S. 504, 509 (1972) American culture places a strong emphasis on the rights of individuals to function autonomously in community settings. Any proposed change in law or regulation that appears to impinge on the capacity of individuals to move about freely in society is resisted. Nonetheless, recent widespread public support for extended commitment legislation such as Kendra’s Law speaks to a potential opportunity for reconsideration of civil commitment standards.

Finally, we note this: No civil commitment provisions currently enable the use of dangerousness to national security or threat of terrorism as grounds for involuntary commitment to treatment at a psychiatric facility. If a clinician believes that a patient is going to commit an act

## Appendix IV - Commitment Law in Maryland

of terrorism because of mental illness, then that person is subject to commitment under standard commitment provisions.

### **STATE CIVIL COMMITMENT CODES**

The legal authority to create and implement civil commitment laws lies, in the vast majority of cases, with state government. In most states, civil commitment laws for inpatient psychiatric treatment share these criteria:

- The individual must have a mental condition.
- The individual must represent some degree of dangerousness or risk to harm self or others.
- The treatment cannot be effectively offered in a less restrictive setting.
- The clinical evaluation must be by a mental health professional.
- The decision to commit must be made by a legal authority after due deliberation, and must be subject to periodic legal review.

The details of these core elements vary. It is common for commitment laws to include a two- step process, in which broad provisions and a lower level of evidence are required for a brief confinement on an emergency basis that buys time for a more thorough evaluation. The second legal step in a commitment process generally occurs after a formal mental health evaluation has been completed. Evidence of mental illness and potential risks are presented by a mental health professional to a judge, and may result in an individual being held for a much longer period of time, ranging from 30 to 180 days, before an additional commitment review is required.

### **CIVIL COMMITMENT CODE IN MARYLAND**

The process for Civil Commitment in Maryland is provided in Title 10, Department of Health and Mental Hygiene, Subtitle 21; Mental Health

**Appendix IV - Commitment Law in Maryland**

Regulations, Chapter 01; Involuntary Admission to Inpatient Mental Health Facilities.<sup>27</sup>

According to this process, individuals in community settings can be brought for a certification evaluation by an Emergency Petition. An Emergency Petition may be filed by anyone who is concerned with the welfare of the individual. For persons already in a hospital, two physicians must certify that involuntary criteria are met.

In the preceding section, "State Civil Commitment Codes," five core elements of commitment were discussed. The Maryland code addresses all five. The first is the presence of a mental illness. Under Maryland code a petition for emergency evaluation enables law enforcement to bring an individual to an emergency site for evaluation. At that site, which must be certified by the Department of Health and Mental Hygiene, an initial evaluation is made and an Application for Involuntary Admission completed. The application is a request to a facility for admission and must be accompanied by the certification of two physicians or a physician and a psychologist. These professionals must be licensed to practice in Maryland. The process requires the physician to certify that the individual has a mental disorder, needs inpatient treatment and is either unable or unwilling to consent to voluntary treatment. The physician must specify the exact diagnosis.

The second element is a requirement that there be a risk of harm to self or others. In Maryland, the individual must be found to represent a danger to life or safety of self or others. The danger must be documented on the certification form. There is not a specific written requirement for the immediacy of the danger.

The third component is directly addressed on the Maryland certification form. It specifically states that the physician or psychologist must determine that there is "no available less restrictive form of intervention that is consistent with the welfare and safety of the

**Appendix IV - Commitment Law in Maryland**

individual.” Given the variation among communities in resources, inclusion of the word “available” allows for local distinctions.

The fourth core component is the evaluation by a mental health professional. In Maryland, the initial certification process requires two physicians or a physician and psychologist to certify the individual as needing involuntary admission. A psychiatrist or individual with specific skills in the diagnosis and treatment of mental illness does not have to be part of the process at this point.

The fifth component is that the commitment decision is made by a legal entity and not the physician, family member or other interested party. Persons certified must have an administrative hearing within 10 days of admission. At this hearing the psychiatric hospital presents testimony in favor of ongoing admission and treatment of an individual and the individual presents his or her defense. Both parties may call various witnesses. A psychiatrist usually testifies for the hospital. The patient has the right to be represented by an attorney, who may be a public defender provided by Maryland or the individual’s own attorney at the patient’s expense. The patient may also have a psychiatrist or any other witnesses he or she wishes to have present, also at the patient’s personal expense.

**DISCUSSION OF CIVIL COMMITMENT IN RELATION TO THE CASE OF DR. IVINS**

As previously noted, Dr. Ivins was involuntarily committed to Sheppard Pratt Hospital on July 11, 2008, after making threats during a group therapy session. The Frederick Memorial Hospital physician who wrote out the Report as to Certification of Commitment form stated: [REDACTED]

[REDACTED] He was admitted involuntarily under civil commitment proceedings and was changed to voluntary status 10 days into the admission. He participated in discharge planning and was discharged from the hospital as a routine discharge. Five days later he died from suicide.

**Appendix IV - Commitment Law in Maryland**

At least three key questions arise:

- Would it have been possible under Maryland civil commitment codes to keep Dr. Ivins in the hospital longer?
- If Dr. Ivins had been hospitalized longer, would the outcome have been any different? and
- Would greater information exchange between investigators, attorneys and treating professionals have made a difference in the outcome?

Dr. Ivins was clearly experiencing many stressors. He was the prime suspect in a murder investigation that was likely to lead to a death penalty prosecution. He was facing a loss of career status and social support in connection with an unwelcomed retirement. His family relationships were strained and his social supports limited. He had recently suffered a disruption in his relationship with a trusted therapist. He had a recent history of alcohol abuse and prescription drug abuse (in remission only for several months). [REDACTED]

[REDACTED] He also had some risk for homicide based on the enduring personality traits described above as well as more immediate threats he had made that precipitated the admission. At the time of this hospitalization, however, he no longer had access to the hot suites at USAMRIID where the select biologic agent, anthrax, was housed. [REDACTED]

Psychiatrists on the Panel contend that it would have been unlikely that Dr. Ivins could have been committed or forced to stay longer in the hospital given how well he appeared near the end of his

**Appendix IV - Commitment Law in Maryland**

hospitalization and what the hospital clinicians knew. Therapist #3 thought that Dr. Ivins posed a threat to her and sought a restraining order to prevent Dr. Ivins from having contact with her. Therapist #3 called Dr. #4 to express her concerns about Dr. Ivins' dangerousness.

Therapist #3's concerns, however, may have been outweighed by statements made by Dr. #3 to Dr. #4. The two doctors talked on July 23. We have no record of what Dr. #3 said. We do know, however, what Dr. #3 told the FBI that day. He said he did not have a reason to change his opinion from 2003 that Dr. Ivins "does not have a condition or treatment that could impair his/her judgment or reliability, particularly in the context of safeguarding classified National Security information or special nuclear information or material." Dr. #3 also told the FBI on July 23 that he had no personal knowledge to preclude Dr. Ivins from performing his job or working with weapons of mass destruction.

Based on these statements to the FBI, the Panel believes it likely that Dr. #3 supported Dr. #4's plan to discharge Dr. Ivins on the following day. The Panel also notes that Dr. #4 would have been aware that Dr. #3 had worked with Dr. Ivins for more than eight years, whereas Therapist #3 had only worked with Dr. Ivins for approximately six months.

From review of the hospital record and discussion with investigators, there is no clear indication that clinicians at the treating hospital knew specific details about the investigation, the weight of evidence against him, or the imminence of the charges that faced Dr. Ivins. The final page of the discharge summary does record a prognosis of



**Appendix IV - Commitment Law in Maryland**

[REDACTED]

[REDACTED] In retrospect this may have been a “flight into health” — i.e., the behavior sometimes seen after individuals with suicidal intent have made specific plans and thus feel a sense of relief. But the hospital-based clinicians did not have the advantage of hindsight, and psychiatrists on the Panel believe that Dr. #4 lacked sufficient information to warrant involuntary commitment proceedings, especially given the stance Dr. #3 expressed to the FBI the same date that he spoke with Dr. #4.

Another issue deliberated by the panel concerns the “VIP patient.” Patients with VIP status sometimes paradoxically receive lower quality care, in part because the normal level of objective discernment by medical personnel gets compromised.<sup>28,29</sup>

The Panel reviewed previous and early psychiatric treatment and multiple e-mail interactions as well as the testimony of coworkers. This review demonstrated a longstanding pattern: Dr. Ivins was skilled at appearing to function at one level while simultaneously, at another level, conducting covert activities and harboring intense rage and revengeful thoughts at specific persons. This ability to appear functional while operating at another level may be somewhat similar to the glib social skills often described as a component of sociopathic personalities or “engaging cons.” In the discharge summary from the final psychiatric hospitalization, it is noted that [REDACTED]

[REDACTED]

[REDACTED] This information indicates that the hospital and attending physician had formulated

[REDACTED]

**Appendix IV - Commitment Law in Maryland**

In summary, the Panel is in agreement that based on the limited information accessible to Dr. #4 and Dr. Ivins' outward stability in the final three days of hospitalization, Maryland civil commitment laws could likely not have been used to force Dr. Ivins to remain longer in the hospital.

A new question then arises: Had Dr. Ivins been hospitalized longer, would the outcome have been any different?

In the Panel's view, it is certainly possible that a longer hospitalization would have decreased the risk of Dr. Ivins committing suicide prior to being arraigned for the anthrax deaths. But in the Panel's view, it is far from clear that a longer hospitalization would have prevented his suicide altogether, given the circumstances and pressures he was facing.

Longer hospitalization would not necessarily have further resolved features of depression or given Dr. Ivins a clear sense of hope and optimism about his immediate future. For his entire adult life, Dr. Ivins had relied on his intelligence to outsmart the authorities, and for decades it had worked, enabling him to escape the consequences of his many illegal and covert behaviors. His appearance of cooperation with investigators at the beginning of the anthrax investigation was consistent with this pattern, in that it enabled him to monitor the investigation and potentially "outsmart" the authorities again. But eventually the government mounted a very thorough and scientifically sophisticated investigation. As a result, Dr. Ivins faced the threat of being unmasked, which would likely lead to capital charges and possible pre-trial incarceration. After a lifetime of outsmarting the authorities, he had himself been outsmarted. Based on his own statements made in a July 9 group meeting, these realizations would have led to a choice: He could face death by execution following a prolonged trial and incarceration in stressful conditions or he could die by calculated and controlled suicide.

**Appendix IV - Commitment Law in Maryland**

Would greater information exchange between investigators, attorneys and treating professionals have made a difference in the outcome?

The Panel agrees: Had the prosecuting and/or investigative team been able to provide information regarding the potential immediacy of arraignment for the anthrax deaths, the inpatient psychiatrist might have developed a different risk analysis that would have resulted in a delay of discharge, either electively or through civil commitment. FBI investigators did seek to speak with Dr. #4, but were unsuccessful. Hospital officials, in fact, citing HIPAA regulations (see next section) declined even to confirm that Dr. Ivins was a patient in the facility. It should be noted that Dr. Ivins had not signed a waiver for Dr. #4 to speak with FBI investigators. It should also be noted that the treating psychiatrist's duty is to act in the best interest of the patient, not to assist in the criminal investigation. Had FBI investigators been able to speak with Dr. #4, however, he might have deemed a longer hospitalization to be in his patient's interest.

But once again, the only real difference in the outcome might have been in the timing.

**SUMMARY**

On July 10, 2008, Dr. Ivins was involuntarily committed to a psychiatric hospitalization under Maryland Civil Commitment laws. He was admitted on July 11 and cooperated with the admission. He was changed to voluntary status on July 21 and discharged on July 24, 2008. He committed suicide within days. Under Maryland civil commitment laws, he might have been able to have been committed to the hospital for a longer period of time, but this is debatable. Regardless, he might well have committed suicide prior to his trial.

Civil commitment and involuntary hospitalization were not an option at the time of the crime in 2001. Unlike his direct homicidal and suicidal statements of July 2008, Dr. Ivins did not make specific

**Appendix IV - Commitment Law in Maryland**

statements in 2001 that would have triggered commitment proceedings based on imminent threat towards himself or others.

**End Notes for Commitment Law in Maryland**

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- <sup>25</sup>Specht V. Patterson. 386 U.S. 605, 608. (1967).  
Retrieved from <http://supreme.justia.com/us/386/605/case.html>.
- <sup>26</sup>O'Connor V. Donaldson. 422 U.S. 563, 574. (1975).  
Retrieved from <http://supreme.justia.com/us/386/605/case.html>.
- <sup>27</sup>Code of Maryland Regulations. (2010). Title 10, Subtitle 21, Chapter 01.  
Retrieved from [http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.21.01.\\*](http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.21.01.*)
- <sup>28</sup>Groves J.E., Dunderdale B.A., Stern T.A. (2002). Celebrity Patients, VIPs, and Potentates. *The Primary Care Companion to the Journal of Clinical Psychiatry*, 4(6), 215-223.
- <sup>29</sup>Post J., Robins R. (1995). *When Illness Strikes the Leader: The Dilemma of the Captive King*. London: Yale University Press.

## Appendix V - Confidentiality of Medical Records

Given the significance of the information contained in Dr. Ivins' medical records, the fact that it remained confidential is an important issue in this case. The Panel assessed how this information was managed by his care providers, employers and investigators, and whether the necessary flow of information was impeded by existing privacy laws. This section examines how the confidentiality of health care information is protected by federal and state law, as well as real and perceived limitations on disclosure of such information.

### **HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT**

The federal Health Insurance Portability Accountability Act of 1996 (HIPAA) provides standards that protect the privacy of health care information. HIPAA standards officially went into effect in the state of Maryland and other states on April 14, 2003. HIPAA specifically addresses the use and disclosure of individuals' health care information, called "protected health information," by health care providers. According to HIPAA standards, protected health care information may not be disclosed by a health care provider to an outside agency unless authorized in writing by the subject of that information. HIPAA does permit the use and disclosure of protected health care information without an individual's written permission in certain circumstances that relate to national priorities, including law enforcement. According to the Office of Civil Rights (OCR) Privacy Brief<sup>30</sup>, health care providers may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances:

1. As required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests
2. To identify or locate a suspect, fugitive, material witness, or missing person
3. In response to a law enforcement official's request for information about a victim or suspected victim of a crime

**Appendix V - Confidentiality of Medical Records**

4. To alert law enforcement of a person's death, if the provider suspects that criminal activity caused the death
5. When a provider believes that protected health information is evidence of a crime that occurred on its premises
6. By a health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime

As noted in the OCR Privacy Brief, HIPAA standards also permit disclosure of protected health information in the event of a serious threat to health or safety:

Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

In addition, HIPAA standards permit disclosure of protected health information for essential government functions:

Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

**Appendix V - Confidentiality of Medical Records****MARYLAND CONFIDENTIALITY OF MEDICAL RECORDS ACT**

It is important to note that HIPAA provides a foundational standard for protection of health care information and is preempted by state law that provides greater protection of the privacy of protected health information. Maryland state laws governing protection of such information must therefore be considered in this case.<sup>31</sup>

Maryland's Confidentiality of Medical Records Act (MCMRA), codified at Health-General § 4-301 et seq., has been operative since 1991. Federal law and Maryland state law both allow disclosures to law enforcement officials who are conducting an investigation. Comparing MCMRA and HIPAA statutes regarding law enforcement investigations, the Maryland Health Care Commission states that "State law compels, while Federal law allows disclosure for compulsory law enforcement investigation."

Also, Federal law and Maryland state law both allow disclosure of health information to employers, with Federal law allowing employer access for work-related illness issues and State law allowing disclosure by consent. In comparing the MCMRA and HIPAA statutes regarding employer access to health information, the Commission states that "State law appears to give broader protection to employees regarding their medical records." However, an individual's consent to release medical information to any person or entity is dispositive under either statute.

**MEDICAL RECORDS OF DR. BRUCE EDWARDS IVINS**

Medical records pertaining to this discussion are Dr. Ivins' outpatient, inpatient, and emergency room records. Records available for review by this panel consisted of the following:

1. Outpatient health records. These consist of therapy notes of Dr. Ivins' outpatient psychiatric treatment under Dr. #1 between September 12, 1978 and August 9, 1979; under Dr. #2 from February 1, 2000 to July 24, 2000; and additional outpatient health records from 2000 through 2008. The outpatient health

**Appendix V - Confidentiality of Medical Records**

records include treatment information concerning Dr. Ivins' mental health, substance use, and physical health. In addition, Blue Cross/Blue Shield billing records containing subscriber claim information were available for the period 1998 through 2007.

2. Inpatient health records. These records provide information about the following hospitalizations:

- Suburban Hospital, 4/17/08 — 4/22/08
- Joseph S. Massie Unit, 5/2/08 — 5/28/08
- Sheppard-Pratt Hospital, 7/11/08 — 7/24/08
- Frederick Memorial Hospital, 7/28/08 — 7/29/08

3. Emergency room records. These records provide information about the following emergency room visits:

- Frederick Memorial Hospital, 3/19/08
- Frederick Memorial Hospital, 7/10/08
- Frederick Memorial Hospital, 7/27/08

**DOCUMENTS RELATED TO SHARING OF DR. IVINS' MEDICAL RECORDS**

Multiple signed releases of information and related events are documented in the case files. A summary follows:

- Between August 13, 1990 and May 7, 1998, Dr. Ivins signed at least 10 Report of Medical History consents from USAMRIID authorizing "any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service."
- Between July 18, 2000 and July 4, 2008, Dr. Ivins signed at least 20 authorizations for disclosure of his health care information.

**Appendix V - Confidentiality of Medical Records**

These documents authorized sharing of selected portions of his health care information among his health care providers, employers, and legal defense team.

- In response to the 9/11 attacks and 2001 anthrax letters, Congress passed the Bioterrorism Preparedness and Response Act of 2002. This statute was designed to institute appropriate safeguards and security requirements for persons having access to deadly biological agents and toxins. Among the controls implemented for individuals with access to pathogens such as anthrax was a thorough background check.

As part of that process, on December 16, 2002, Dr. Ivins signed a security background investigation release of information authorizing access to his mental health information for the preceding seven years. (Standard Form 86, issued by the U.S. Office of Personnel Management, is administered to individuals seeking national security positions.) On March 25, 2003 and again on May 15, 2007, Dr. Ivins signed five-year consents authorizing the U.S. Department of Justice "to obtain any information relevant to assessing my suitability to access, possess, use, receive or transfer select biological agents and toxins from any relevant source."

The consents authorized "release of records, results or information relating to, or obtained in connection with my security risk assessment to any law enforcement or intelligence authority or other federal, state or local entity with relevant jurisdiction where such information reveals a risk to human, animal and/or plant health or national security." The consents also authorized "release of records, results or other information relating to, or obtained in connection with my security risk assessment to laboratories, universities, or other entities, both public and private, responsible for making security assessments, employment and/or licensing determinations and suitability or security decisions when the information is relevant

**Appendix V - Confidentiality of Medical Records**

to an assessment of my suitability to access, possess, receive, use or transfer biological agents or toxins.”

**PRIVACY LAW IMPLICATIONS REGARDING THE CASE**

At several points in the history of this case, Dr. Ivins’ protected health information was provided to appropriate authorities. At other points, the information could have been shared but was not. What follows is a discussion of how information flowed between and among the various parties and how privacy law affected the progress and outcome of this case:

- Sharing of information among Dr. Ivins’ civilian health care providers — inpatient, emergency room and outpatient as well as psychiatric, substance abuse and medical care personnel.

The flow of information was authorized by Dr. Ivins, and it generally proceeded as needed to support the delivery of a range of necessary health care services. Instances are documented, however, in which Dr. Ivins’ reluctance to provide authorization interfered with appropriate flow of clinical information. For example, Dr. Ivins did not sign a waiver for Therapist #3 to be contacted by Sheppard Pratt Hospital. Also, gaps in communication sometimes occurred, including a lack of information sharing between Dr. #3 and both Suburban Hospital and the Massie Unit. Both of these instances may have affected the assessment of Dr. Ivins’ level of risk of harm to himself and to others. As Dr. #3 later admitted to the FBI, he had not read some of the most concerning documents in the medical record, and therefore may not have realized the importance of the records that he maintained in his practice.

- Sharing of health care information between Dr. Ivins’ health care providers and his employers at USAMRIID.

**Appendix V - Confidentiality of Medical Records**

USAMRIID apparently did not obtain Dr. Ivins' mental health treatment records prior to the start of his employment, even though he had self-disclosed his treatment with Dr. #1 on his Standard Form (SF) 93, a report of medical history. Dr. #1's records from September 12, 1978 to August 9, 1979 documented [REDACTED]

[REDACTED] *Had medical personnel at USAMRIID reviewed these records and followed procedure, Dr. Ivins' [REDACTED] sabotage of KKG Sister #2's research would have disqualified him for employment. Dr. Ivins therefore would not have been able to work with biowarfare agents at USAMRIID.*

After Dr. Ivins was hired, case files subsequently documented several instances where treatment summaries and statements about Dr. Ivins' overall progress were shared with his employer. [REDACTED]

[REDACTED] that pertinent details about his illnesses were not communicated to his employers.

Several factors contributed to the inadequate sharing of information. These included:

- Medical personnel failing to request medical records
- A lack of detail in the reports Dr. #3 provided to employers
- Dr. Ivins' selective provision and release of information. For example, on March 24, 2006, Dr. Ivins signed a Medical Records Authorization for Disclosure of Information for his employer. The period of treatment was marked "as indicated" and Restrictions on Information was marked "no psychiatric records." USAMRIID medical staff made no further inquiry regarding this refusal.
- Dr. Ivins' practice of providing false or misleading information on health-related forms. For example, on the December 16, 2002 release of information form, Dr. Ivins answered "yes" to the

**Appendix V - Confidentiality of Medical Records**

following question: "Did the mental health care related consultation(s) [to which he admitted in the previous question] involve only marital, family, or grief counseling not related to violence by you?" Dr. Ivins continued to reference "work" and "family" stress on other health-related forms at USAMRIID.

Given the documentation of [REDACTED] that existed in these medical records, truthful answers to these questions might well have barred him from working with *Bacillus anthracis*. Contrary to USAMRIID policy, Dr. Ivins also failed to document in his April 2002 annual medical review his two clinician visits to acquire two different antibiotics for the treatment of a skin infection (cellulitis) of the hand that he acquired at the time of the mailings. The second of these antibiotics, doxycycline, is the preferred antibiotic for the treatment of cutaneous anthrax.

- Use of different systems for managing protected health care information. The USAMRIID clinic where Dr. Ivins received health care services used the Armed Forces Health Longitudinal Technology Application (AHLTA) as a medical record data base. However, Dr. Ivins' civilian health care providers were not part of this extensive electronic system. These differences posed additional barriers to the sharing of health information between Dr. Ivins' mental health care providers in the community and the medical staff at USAMRIID.
- Gathering of health care information by federal investigators as part of their criminal investigation

Prior to July, 2008, Department of Justice attorneys had believed that federal and state privacy laws would prevent access to Dr. Ivins' medical records without a court authorization. In addition, investigators were focused on gathering information that could lead to Dr. Ivins' indictment and conviction. Federal agents would have been required to show probable cause that protected health care information would link Dr. Ivins to the crime in order to gain access

**Appendix V - Confidentiality of Medical Records**

to the information. But agents had no idea whether the records contained such evidence. Federal investigators requested access to the records but Assistant U.S. Attorneys and the Department of Justice viewed privacy law as a significant legal barrier to accessing the records.

Following Dr. Ivins' homicidal threats during a July 2008 group therapy session, investigators, concerned about imminent danger to witnesses and others, obtained permission from the U.S. Attorney's Office for the sole purpose of interviewing Therapists #1, #2, #3 and Dr. #3. Investigators did not receive permission to access medical records or conduct any further interviews until a federal court order was signed by Judge Royce C. Lamberth.

Federal investigators subsequently conducted a series of interviews to obtain information about Dr. Ivins' psychiatric diagnoses and his health care treatment. These interviews involved Dr. Ivins' health care providers at USAMRIID, Suburban Hospital, Sheppard-Pratt Hospital, and Frederick Memorial Hospital, as well as Dr. Ivins' outpatient psychiatrists and other mental health and substance abuse treatment providers in the community — almost all of the mental health professionals he had met with over three decades.

**SUMMARY**

In summary, timely access to pertinent details about Dr. Ivins' medical and psychiatric illnesses did not occur. Several factors — many unrelated to privacy law — explain why. They included:

- A failure by Dr. Ivins' employer to request records
- Inadequate sharing of information by at least one therapist (Dr. #3) with Dr. Ivins' employer when records were requested
- Dr. Ivins' falsehoods, and

**Appendix V - Confidentiality of Medical Records**

- The separate electronic data-base systems used by Dr. Ivins' employer and his mental health care providers in the community

Because Dr. Ivins had signed multiple waivers of his right to health information privacy, privacy law did not generally prevent the flow of health care information. However, privacy law did present a significant legal barrier to federal investigators, who were not able to obtain crucial information until after his death. The possibility also remains that privacy law was perceived as a barrier by health care providers involved in the case.

**End Notes for Confidentiality of Medical Records**

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<sup>30</sup>US Department of Health and Human Services. (2003). OCR Privacy Brief: *Summary of the HIPAA Privacy Rule*. Washington, DC: U.S. Government Printing Office.

<sup>31</sup>Maryland Health Care Commission, Office of the Attorney General, Department of Health and Mental Hygiene, the State Advisory Council on Medical Privacy and Confidentiality, with assistance from the Maryland State Bar Association Health Law Section HIPAA Subcommittee.

## Appendix VI - Toxicology

### INTRODUCTION

Throughout his life Dr. Ivins told mental health professionals of his plans [REDACTED] Although he never consummated any of these plans, [REDACTED]

### SECTION I — [REDACTED]

## Appendix VI - Toxicology



And as late as July of 2008, Dr. Ivins told the therapy group of his plans of “how to murder someone and not make a mess.”

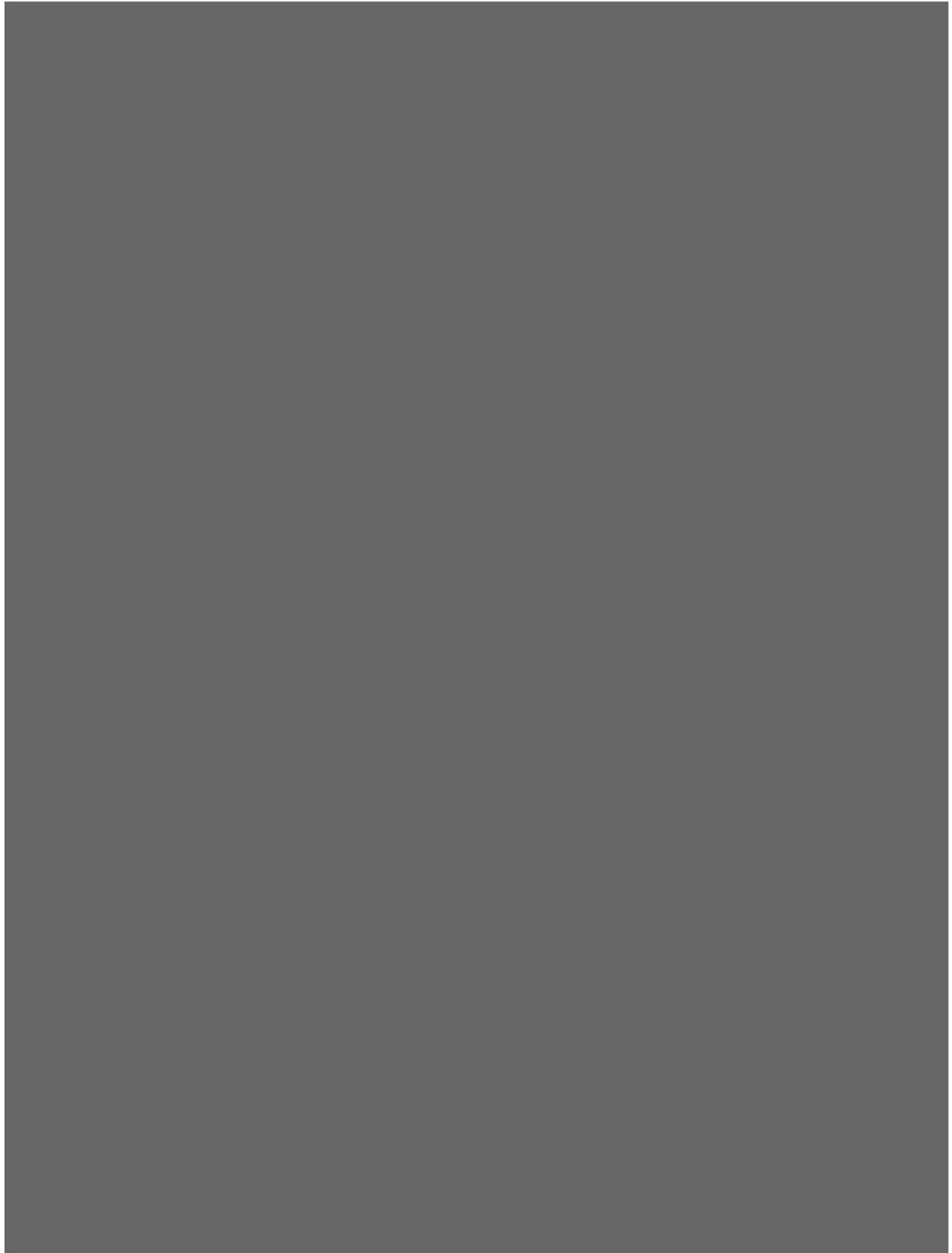
### **SECTION II —**



That same month, Dr. Ivins overdosed in what may have been a suicide attempt — if it was, he never acknowledged it. At 2:42 p.m. March 19, 2008, he was brought to the Frederick Memorial Emergency



**Appendix VI - Toxicology**



## Appendix VI - Toxicology



### **SECTION III – Dr. Ivins’ Suicide**

Immediately after his discharge from Sheppard Pratt on July 24, 2008, Dr. Ivins bought a bottle of Tylenol PM at the Giant Eagle at 1305 West

**Appendix VI - Toxicology**

7th Street in Frederick, along with a few grocery items. A receipt from that purchase is time-stamped 12:31 p.m. At 1:44 p.m., he filled three prescriptions at the same store. An FBI report notes a search of Dr. Ivins' trash on July 31 revealed two empty boxes of Tylenol PM along with the July 24 Giant Eagle receipt for Tylenol PM.

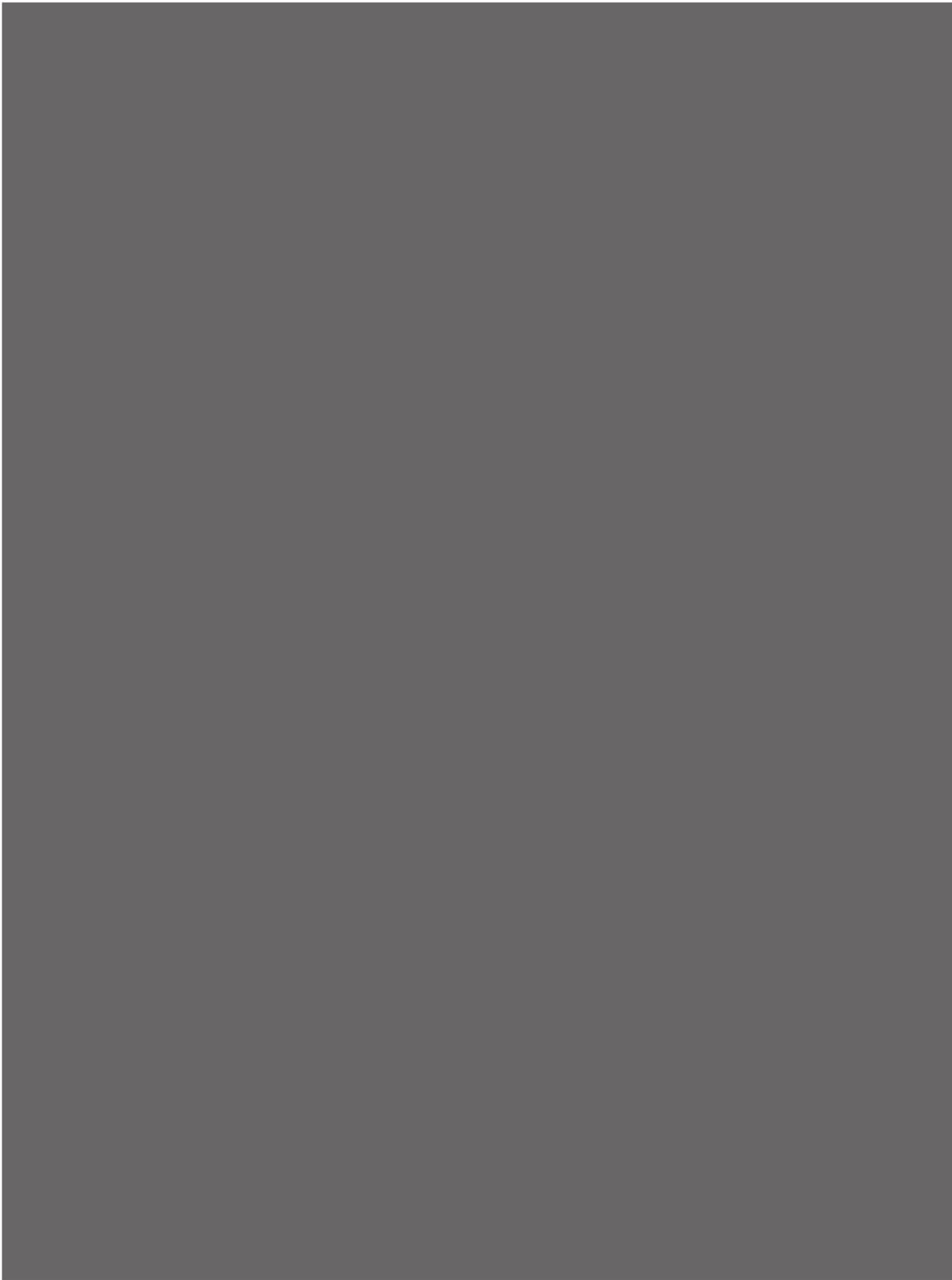
At 1:08 a.m. July 27, EMS received a call concerning Dr. Ivins. Paramedics arrived at his home at 1:14 a.m. and found him unresponsive, with labored respiratory effort. He was lying on a bathroom floor in a pool of what "appeared to be urine." Although minimally responsive to pain, he had no other appropriate response. He was "cold to touch" and had "blister type wounds" that the family could not account for. Dr. Ivins was "breathing rapidly" and his airway "did not appear patent."

EMS personnel initially controlled the airway with a bag-valve mask and nasopharyngeal airway; later he was nasally intubated. His initial blood glucose at the scene was elevated at 288 mg/dL and his electrocardiogram (ECG) demonstrated sinus tachycardia (rapid heartbeat) with a rate of 140 beats per minute without any ectopy (abnormal beats). EMS noted that his family had last checked on Dr. Ivins at 7:00 p.m. and that he had been "asleep in bed." At 1:00 a.m., however, family found "BI on the floor of the bathroom unresponsive" prompting the emergency call.

He arrived at Frederick Memorial at 1:47 a.m. [REDACTED]

[REDACTED]

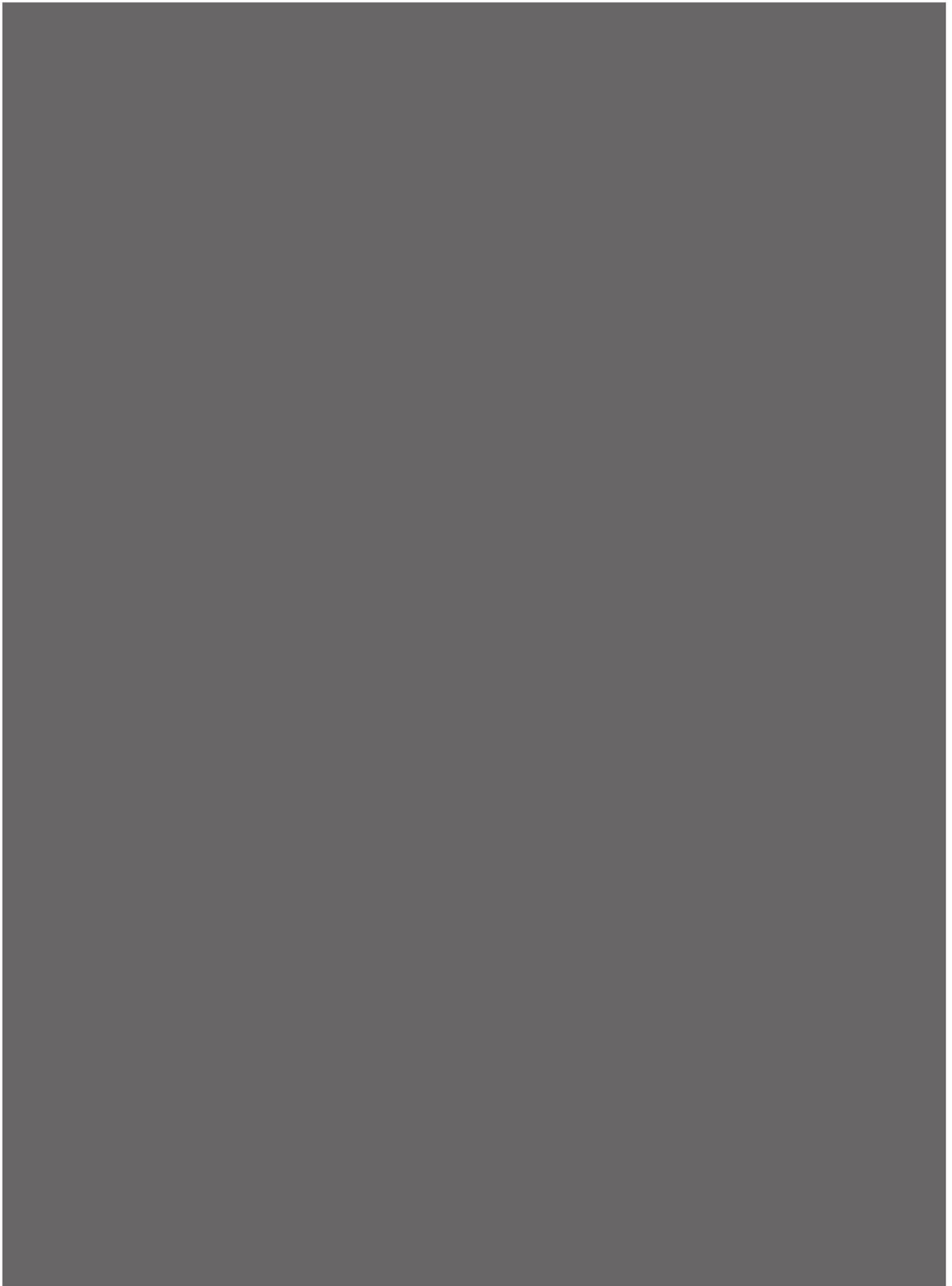
**Appendix VI - Toxicology**



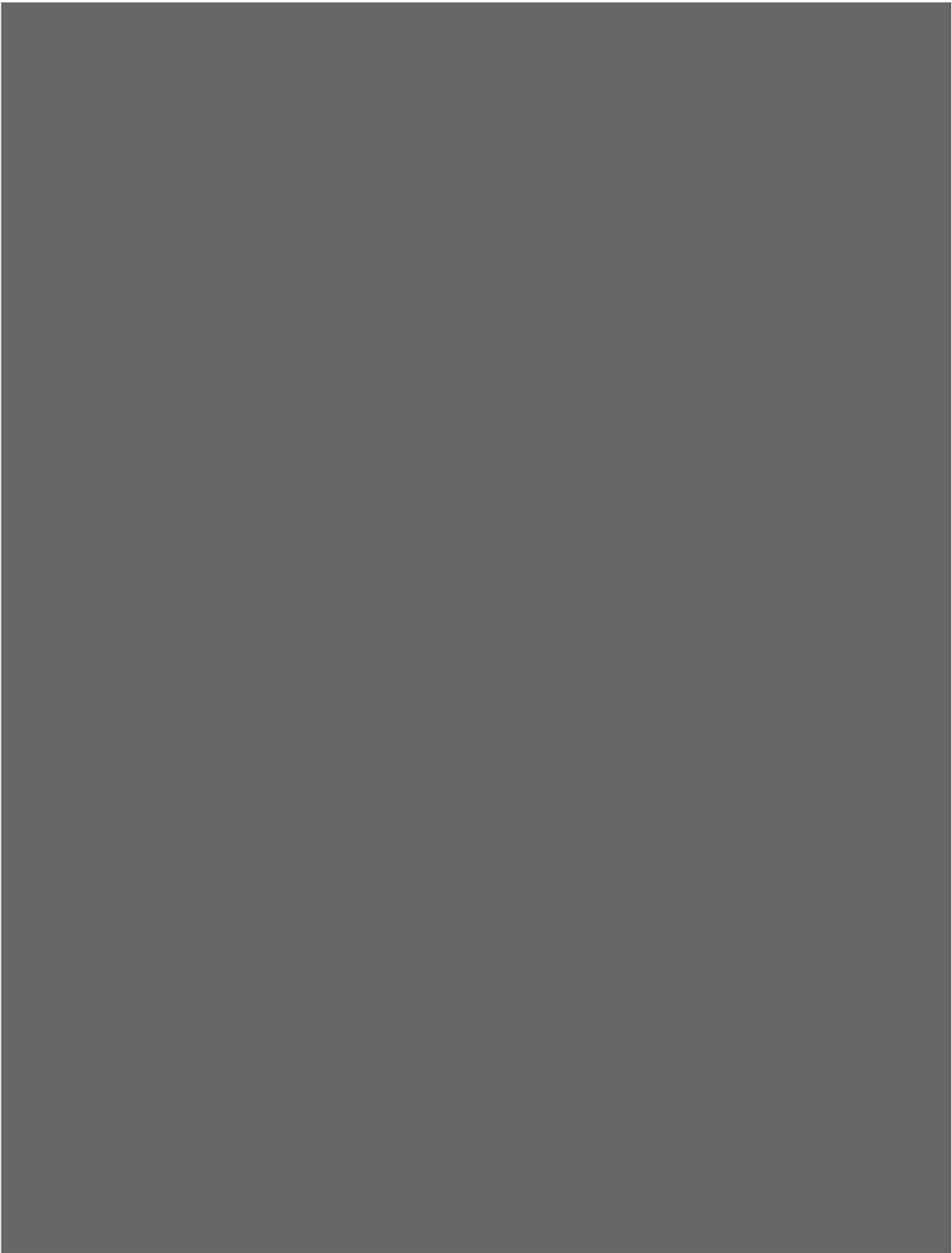
## Appendix VI - Toxicology



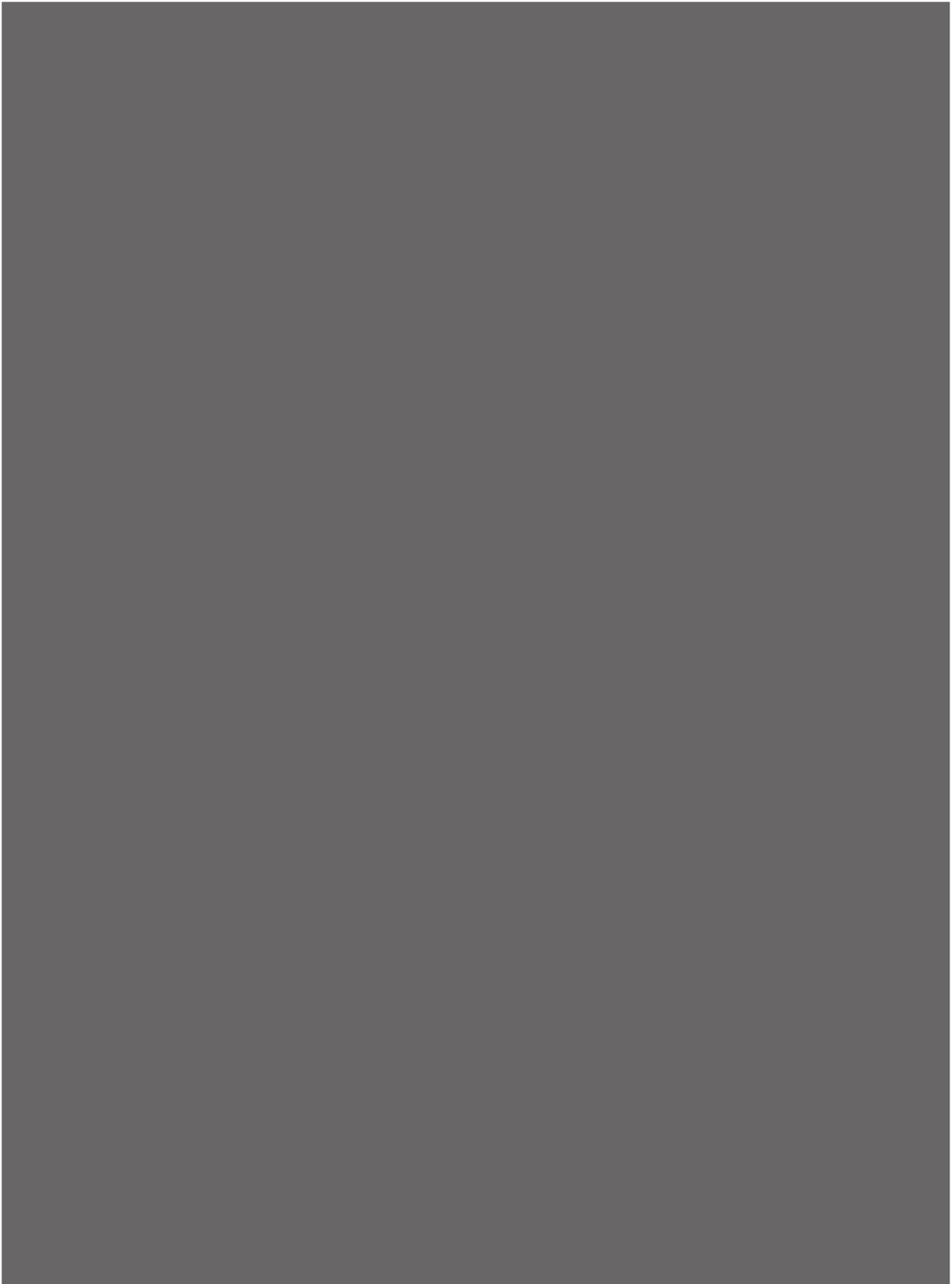
**Appendix VI - Toxicology**



**Appendix VI - Toxicology**



**Appendix VI - Toxicology**



**Appendix VI - Toxicology**

To fully comprehend Dr. Ivins' initial clinical presentation on July 27 and his subsequent hospital course, it is important to have a basic understanding of each of the medications he was reported to have access to before he entered the hospital.

*Acetaminophen*

Acetaminophen (Acetyl-Para-Amino-Phenol or APAP), an antipyretic (fever-reducer) and analgesic, is a common component in hundreds of over-the-counter and prescription medications. APAP toxicity is a major cause of fulminant hepatic failure (FHF) (complete liver failure), and is implicated in a significant percentage of liver failure cases seen at major hospitals.

The first phase of APAP poisoning is the first 24 hours. It is characterized by nonspecific findings such as nausea, vomiting, and decreased appetite. In this phase the patient may appear normal if no other medications have been taken in the overdose. In the second phase of APAP poisoning the patient begins to develop clinical and laboratory evidence of liver injury. In the third phase, the patient progresses to fulminant liver failure, with potential associated complications such as metabolic acidosis, coagulopathy, and

**Appendix VI - Toxicology**

encephalopathy. In phase four, usually 72-96 hours after ingestion, the patient's liver function may return and the patient may recover. However, in marked toxicity, recovery cannot occur before the onset of other complications, such as renal failure, brain herniation, and septic shock, which may result in death.

With therapeutic dosing, more than 90 percent of APAP is metabolized to form nontoxic metabolites. Approximately 5 percent is metabolized by the liver's cytochrome P450 mixed-function oxidase enzymes to a toxic metabolite called N-acetyl-p-benzoquinoneimine (NAPQI). In normal dosing, NAPQI is rapidly detoxified by glutathione to nontoxic metabolites. Acetaminophen overdoses overwhelm the non-toxic metabolic pathways, resulting in increased use of the cytochrome P450 pathway and increased formation of NAPQI, subsequent depletion of glutathione, and ultimately liver injury.

The antidote for acetaminophen toxicity is N-acetyl-cysteine (NAC). NAC is extremely effective when started within eight hours of ingestion of a potentially toxic dose of APAP. In patients already manifesting laboratory and clinical evidence of APAP-induced hepatic injury (i.e., in patients who present more than eight hours after overdose), NAC has secondary mechanisms that improve overall patient outcomes, but far less so than when the antidote is administered promptly.

Based on his laboratory tests, it appears that Dr. Ivins presented to the hospital more than eight hours after his overdose of acetaminophen. However, his initial abnormal laboratory findings were not due solely to his APAP overdose; there were also complications associated with the other medications he ingested. Dr. Ivins not only took an overdose of acetaminophen, he also took an overdose of other medications that caused profound sedation, as well as subsequent "pressure sores," rhabdomyolysis, metabolic acidosis, electrolyte abnormalities, dehydration, and renal failure. Even though his clinicians recognized from the start that, based on his laboratory values, his prognosis was poor, not all those early abnormalities can be attributed to APAP

## Appendix VI - Toxicology

toxicity alone and therefore could not and cannot properly be used to determine his outcome.

### *Diphenhydramine*

Diphenhydramine (the sleep agent in Tylenol PM) is a reversible, competitive inhibitor of histamine and muscarinic nerve cell receptors. Following acute overdose, diphenhydramine causes an anticholinergic syndrome consisting of rapid heart rate, dry skin, dry mucous membranes, large dilated pupils, urinary retention, and delirium. Diphenhydramine's H1-receptor blocking activity disrupts brain cortical neurotransmission, thereby exacerbating sedation and causing seizures. In a review of 136 patients with diphenhydramine overdose, the most common findings were somnolence, lethargy, and coma, occurring in approximately 55 percent of reported overdoses. The sedation associated with diphenhydramine can result in "pressure sores" as described in Dr. Ivins' case and underlying muscle breakdown, or rhabdomyolysis. This rhabdomyolysis can subsequently lead to damage to the kidney and subsequent acute renal failure, as also noted in Dr. Ivins' case.

### *Valproate*

Valproate (Depakote) is a prescription medication with multiple pharmacological actions, including increasing the levels of gamma-aminobutyric acid, an inhibitory neurotransmitter, and inhibiting neuronal sodium channels. In acute overdose, valproic acid is readily absorbed from the gastrointestinal tract. Delayed absorption may occur following massive overdose with divalproex sodium (Depakote), due to its sustained release formulation. Symptoms of acute overdose may consist of gastrointestinal distress, hypotension, respiratory failure, and altered mentation varying from confusion to coma. Cardiorespiratory arrest, profound metabolic acidosis, and cerebral edema have been associated with massive ingestions and levels greater than 1000 mg/L. Peak levels may be delayed up to 24 hours

## Appendix VI - Toxicology

following massive overdose. Metabolic acidosis, liver failure, and hyperammonemia may occur. Hemodialysis may be efficacious in removing valproic acid in massive ingestions where levels exceed 1000 mg/L. Dr. Ivins had received a prescription for valproate days prior to his death, but it is unknown whether he had ingested the medication, because, for reasons that are not clear, no level was obtained.

### *Citalopram*

Citalopram (Celexa), an anti-depressant, inhibits the presynaptic reuptake of serotonin (5-HT) and thereby improves a patient's mood. After overdose, patients may initially develop nausea, vomiting, rapid heart rate, lethargy, and ataxia (difficulty walking). If citalopram levels are high enough, serotonin syndrome may develop, causing confusion, elevated body temperature, increased neurologic reflex activity, sweating, skin flushing, muscle rigidity, and seizures. Citalopram can also induce heart arrhythmias. Laboratory abnormalities reported with marked citalopram poisoning include metabolic acidosis, rhabdomyolysis, coagulopathy, acute renal failure and hepatic dysfunction.

### *Quetiapine*

Quetiapine (Seroquel) is an anti-psychotic medication whose primary effect is as an antagonist of central dopaminergic (D-2 receptor) neurotransmission, resulting in sedation. Acute overdoses can manifest as coma with respiratory depression. Quetiapine is also an alpha-adrenergic blocker that can result in dilation of the blood vessels and subsequent hypotension.

### *Trazodone*

Trazodone is an atypical antidepressant that possesses both antidepressant and sedative activities. An antagonist of the serotonin 5HT<sub>2A</sub> receptor, it has some selective inhibition of reuptake of serotonin. The most common manifestation of overdose is central

## Appendix VI - Toxicology

nervous system depression that may progress to coma. Hypotension may also be seen following overdose.

### *Duloxetine*

Duloxetine (Cymbalta) is a serotonin and norepinephrine reuptake inhibitor. There are few published reports of overdose with duloxetine. Clinical effects may include confusion, agitation, and rapid heart rate.

## **SECTION IV – Synopsis of Toxicology**

### **Summary**

A review of the EMS and Hospital records from July 27 to July 29 clearly shows that Dr. Ivins took an intentional overdose of multiple medications. In so doing, we believe he followed a careful, two-step plan, entirely consistent with [REDACTED]

[REDACTED] He took an extreme amount of sedatives in order to lose consciousness. But knowing that he might be found unconscious before he died and resuscitated, he also took a fatal overdose of acetaminophen to assure that healthcare teams could not save him.

His initial clinical presentation was consistent with a diphenhydramine overdose potentially combined with an overdose of a sedative (e.g., diazepam) and/or citalopram and/or quetiapine and/or trazodone and/or valproate. [REDACTED]

[REDACTED] The exact time(s) of the ingestion of these substances is unknown, but by his wife's reports and his laboratory values his overdose most likely occurred on July 26.

## Appendix VI - Toxicology

To obtain an acetaminophen level of [REDACTED], Dr. Ivins would have had to ingest a large number of pills. Acetaminophen is only available in an oral form. [REDACTED]

[REDACTED]

We fully concur with the health care team at Frederick Memorial: Dr. Ivins took an intentional overdose of multiple medications, including acetaminophen, which ultimately resulted in his death.

**Appendix VII - Dr. Ivins and The American Red Cross**

In the days and months after the 9/11 attack there was a dramatic increase in volunteers of all types at the Red Cross, particularly Emergency Service/Disaster Response. One of those who offered their services was Dr. Ivins, who on September 22, 2001, registered with the American Red Cross's Frederick (Maryland) County Chapter in Walkersville, Md.

Dr. Ivins' offer to help and his subsequent relationship with the Red Cross can be viewed as the products of simple patriotism. A careful look at the record, however, provides more circumstantial evidence that relates to issues uncovered in other parts of this report. It also indicates a variety of deep personal motivations, as well as some of the same extraordinary behavior seen in other chapters of his life. Finally, it shows that the Red Cross protocols for screening volunteers disclosed many of the same issues found in Dr. Ivins' medical and employment records, and led to his disqualification for disaster deployment.

\* \* \*

Dr. Ivins' September 22 application was complete and detailed. Among the standard forms he completed were the Volunteer Application and the Volunteer Consent for Release of Background Information. The former asks for such basic information as address and contact information, job history, previous experience, and availability.

What especially stands out as unusual is the way Dr. Ivins completed this form in the job description: He wrote that he worked as a microbiologist at Ft. Detrick, at USAMRIID and was doing "anthrax research." As previously noted, he wrote these words after the first set of anthrax letters had been mailed but before the attacks had become known publicly. As also noted, this was the first and last time that he referred explicitly to anthrax in any of his Red Cross or any other of the dozens if not hundreds of forms that he filled out over the years. The timing of the reference is at least suggestive.

**Appendix VII - Dr. Ivins and The American Red Cross**

Dr. Ivins also on September 22 filled out a Volunteer Consent for Release of Background Information. This form gives consent for the Red Cross to "inquire into my educational background, references, driving record, employment history, volunteer history or police records." The Red Cross uses a third party agency to check applicants for any criminal records. Dr. Ivins, of course, had none, and the initial background check revealed nothing of concern.

The context for Dr. Ivins' September 22 application is also noteworthy.

On the preceding Saturday, September 15, a few days after the 9/11 attacks, Dr. Ivins had sent Technician #2 a message: "incredibly sad and angry at what's happened, now that it has sunk in...angry at those who did this, who support them, who coddle them, and who excuse them."

The first set of anthrax letters were postmarked September 18. On September 20, the *Washington Post* published a story regarding Senator Leahy's and civil liberties groups' reservations about the Administration's proposals for anti-terrorism legislation; the following day, Dr. Ivins sent an email to KKG Sister #2 in which he complained that his work had gone from "basic researcher" to "product-oriented."

Dr. Ivins was still upset on September 22, the day he applied to the Red Cross as a volunteer. He wrote Technician #2 an email expressing confusion and regret and wonder at why people did not like him. But he also sent her another message in which he said he had taken a Disaster Response course with the Red Cross/Frederick Chapter — records indicate that he did indeed complete "Introduction to Disaster Services" that day. He found the work "fascinating; really interested in it," he wrote, and "something [I] can get into with real passion" when he retired. He was looking forward to the next meeting, in mid-October.

The pattern here is one that was repeated many times over during the next several months. Dr. Ivins would express anger, frustration, anxiety

**Appendix VII - Dr. Ivins and The American Red Cross**

and other negative emotions, and then describe the Red Cross and his possible relationship with it in positive terms. Again and again it appears that the Red Cross was the one bright spot on his mental horizon.

On September 26, Dr. Ivins wrote Technician #2 again. He had heard that Osama bin Laden and the terrorists have anthrax; he was upset at the ACLU and Congress for opposing anti-terrorist proposals; he felt guilty about NOT feeling guilty; he was tiring of his Sunday morning Mass music. But again, he reported, he was looking forward to his Red Cross "possibilities."

Between September 28 and October 5, Dr. Ivins again spent an extraordinary amount of time in the hot suite, and the second set of letters was postmarked October 9. On December 15, he swabbed down his office space for anthrax without seeking the proper approvals or making the required reporting.

But interspersed with these events were more Red Cross-related thoughts and activities. On October 2 he wrote Technician #2 an email in which he expressed his anticipation of making "new friends" at the Red Cross. He also wrote her about the "possibility that after you get your degree you might be interested in being 'on-call' physician for any suspected BW attacks in the country. ... With your experience (and immunizations) and people in high places talking about BW terrorism being likely, your knowledge, skills and abilities could be a real asset." (As noted previously, it was not until October 4 that the media and the Florida Department of Health reported the first diagnosis of inhalational anthrax; Robert Stevens died the following day.)

Five weeks later, on November 17, he took a course in "mass care" (feeding and sheltering in the event of a mass disaster) at the local Chapter, and on December 17, two days after swabbing his office, he filled out a Red Cross "Disaster Services Volunteer Information" form.

**Appendix VII - Dr. Ivins and The American Red Cross**

Dr. Ivins checked the box on this form indicating his interest in becoming a member of the DAT, or Disaster Action Team. This kind of service requires being on call one week a month and possible deployment to major disasters outside the local area. Such out-of-town deployment represents a more intensive kind of volunteer service and, it is worth noting, would have elevated the significance and prestige of Dr. Ivins' status within the Red Cross and with his colleagues in the workplace.

Under the "Other Skills or Knowledge ... that you feel may benefit Frederick County Chapter Disaster Services," Dr. Ivins wrote: "I work at USAMRIID. Perhaps I could help in case of a disaster related to biological agents."

Although he did not mention anthrax or the fact that a disaster involving biological agents had already occurred, Dr. Ivins was, with this statement, calling warranted attention to his special skills. Awareness of the disaster was of course already extremely high.

After submitting his application and clearing the background check, Dr. Ivins was, like most volunteers, encouraged to take a series of on-line and classroom training courses. As volunteers build their competency through these courses, they can become eligible for national deployment to high-profile disasters.

Red Cross records show that Dr. Ivins completed 10 courses over the next four years, from Introduction to Disaster Services in September 2001 to Adult First Aid and CPR in August 2005. Some courses are one-hour classes; some require several classes: The level of activity he showed is reasonably high, and records indicate that by January 2005, Dr. Ivins had been accepted for deployment to national disasters.

In December, 2002, however, an incident took place that had a profound effect on Dr. Ivins, in ways that are reminiscent of his reactions to many other perceived slights. The Frederick County Chapter of the American

**Appendix VII - Dr. Ivins and The American Red Cross**

Red Cross distributed a request for volunteers to assist with "canteening" during an FBI search for evidence. Canteening is a Red Cross term for providing beverages, snacks and other services to emergency response personnel deployed at a disaster or public event. In this case, investigators, acting on a tip, were going to search a pond in the Frederick area for physical evidence in the anthrax case.

The Chapter sent the email to Dr. Ivins without knowing what the search involved. At USAMRIID, however, word circulated, and some of Dr. Ivins' co-workers cautioned him not to go; after all, as an employee at USAMRIID who worked with anthrax, he was automatically a "person of interest" to the FBI and his presence might seem improper. But Dr. Ivins went anyway, which is intriguing in and of itself. He left his car at the Chapter and was driven to the site with other volunteers.

During the course of the canteening, however, he was recognized by an FBI agent who knew him from previous investigative work at USAMRIID. The agent contacted the lead volunteer and asked that Dr. Ivins be escorted from the site. Dr. Ivins was told that, because he worked at USAMRIID, it was inappropriate for him to be there. The lead volunteer then called the Chapter, whose Emergency Services Director (ESD) drove to the site and picked him up outside the command post. She drove Dr. Ivins back to the Chapter to retrieve his car.

According to the ESD, there was no indication that Dr. Ivins' removal from the site had been handled in a harsh or embarrassing way. And, as we have already noted, Dr. Ivins went to the pond voluntarily and actually against the advice of his co-workers. But 17 months later, Dr. Ivins was still clearly upset about what had happened, and was now suggesting that he had been victimized after being "sent" to the pond. In an email to the ESD on May 4, 2004, he wrote:

OK! Don't ever feel bad about the pond incident, (ESD). If I had refused to go after being asked [to canteen], it would have probably looked as suspicious as saying "yes" to the request.

**Appendix VII - Dr. Ivins and The American Red Cross**

They probably would have said something like: 'don't want to return to the scene, huh, Mr. Ivins?!!!! Afraid you'll be recognized by the neighbors, huh, Mr. Ivins?!!!!!! So...either way, they'd ask me about it.' As I said last night, my being sent to "the pond" has been a source of lots of jokes here."

A couple weeks later, on May 19, he was still dwelling on the matter. He wrote another email to a chapter staff person: "OK. (Staff person)! If I need to take stuff down and return it to Chapter Headquarters, please let me know? Maybe I should wear a special shirt that says, 'I am not at The Pond!'"

Through this emotional reaction 17 months after the fact, it is clear that, although Dr. Ivins had not expressed his resentment about the incident to anyone at the time, the incident had been festering within him. This pattern is essentially the same as the one he showed in his behavior toward KKG Sister #2 and in many other episodes during his life. It's also clear that he viewed it as a situation in which an outside force or group ("they," in the May 4 email) were somehow persecuting him unfairly.

Almost three years later — more than four years after the actual incident — the events at the pond still rankled. On February 26, 2007, the FBI tape recorded a conversation between Dr. Ivins and a witness. Dr. Ivins' part of the conversation began: "How are things?...We had a Red Cross Drill near the pond where the FBI escorted me out when I was asked by our chapter to help provide soup, coffee, donuts, etc".

\* \* \*

There is no record of Dr. Ivins reporting any physical or health issues when he first applied to serve as a Red Cross volunteer, but as time went on and he filled out his annual Red Cross medical reviews, he disclosed about a dozen.

**Appendix VII - Dr. Ivins and The American Red Cross**

For example, a Red Cross Health review form completed in January 2005 indicated he had been seen by a physician or other health care provider during the past year. He reported that he had arthritis and a herniated disc in his back, and was restricted from heavy lifting. He was taking an anti-inflammatory for his arthritis. He also reported that he had been treated once every month for anxiety and depression, and was taking diazepam (an anxiety medication) and zolpidem (a sleep aid).

When asked to give permission to the Red Cross staff physician consultant or designee to contact his health care provider, he stated: "I do NOT give my permission for my medical records to be released. You may speak to my health care providers."

At the bottom of the page he added (printed): "My medical records are private & personal and will not be released to you. You may contact my health care providers as to my ability to be a Red Cross volunteer."

On March 20, 2006, Dr. Ivins again listed a variety of health problems. He had allergies to "pollen and molds," he said. He was unable to lift 50 pounds or stand or walk or be on uneven terrain for two hours. And he checked the appropriate boxes for problems with stomach/intestine; hernia; hearing; anxiety; post-traumatic stress disorder; bipolar disorder; and sleep apnea/sleep disorders. He said he was taking multiple medications — citalopram; diazepam; gabapentin; lidocaine patch; and naproxen.

The Red Cross responded to these disclosures by removing Dr. Ivins from consideration for any future national deployment with the Disaster Action Team, and informing him that his profile in the Red Cross data base for managing disaster services personnel would be updated accordingly. On April 30, 2006, ARC leadership sent Dr. Ivins an email explaining that his "Disaster Services Human Resources (DSHR) profile will reflect chapter only for deployments" and that "review of your medical profile" had played a part in this decision. A month later, on May 31, 2006, the Red Cross followed up by placing

**Appendix VII - Dr. Ivins and The American Red Cross**

in Dr. Ivins' file a form assigning him a "hardship code," based on his medical review. The code meant he could work in the chapter only; he could not be deployed.

This was likely a serious blow. It not only meant Dr. Ivins would not be permitted to participate in the larger and more public high profile disasters across the country, but also that much of the training he had taken would not be utilized.

On April 9, 2007, Dr. Ivins updated his medical status review. Again, he noted multiple restrictions similar to the previous review. He also noted additional allergies — besides mold and pollen, he added dust and shrimp; and medications similar to what he had taken previously, but now including esomeprazole, an acid reflux medication.

Later that same year, on November 3, Dr. Ivins emailed a request for a medical leave of absence from Red Cross activities, coinciding with the medical leave he was taking from his job. He asked, however, to stay on mailing list, and wrote that he hoped to continue working "in a few months."

By the next spring, Dr. Ivins wanted to return. On April 14, 2008, he completed a "Personal Statement of Understanding" form, seeking reinstatement in DSHR. This form is completed by anyone seeking to become a disaster volunteer, or, as in this case, re-instatement as a disaster volunteer. It outlines the conditions an individual must accept as a member of the DSHR System, such as availability, work performance standards, and status in the system.

A Red Cross Health Status form accompanied this form. Dr. Ivins again acknowledged several limitations (inability to lift or carry 50 pounds; allergies to mold and mildew; inability to "work productively during change/stress.") He again listed several medications he was taking.

On July 7, 2008 the DSHR summary sheet listed "Extreme emotional stress" and "air quality" as restrictions on Dr. Ivins' application. Dr. Ivins

**Appendix VII - Dr. Ivins and The American Red Cross**

died before any further steps could be taken, but the inclusion of these restrictions strongly suggests that he would not have been reinstated.

**Summary**

As we have seen elsewhere in this report, Dr. Ivins often felt alienated from and rejected by others. The offer to help with “biological agents” could have been a sincere offer to use his skills. But it also could have stemmed from other motivations. It may have reflected a desire to monitor the response to the attacks, for his own benefit. This notion receives at least some support from the fact that he went to the pond when others at USAMRIID suggested he not go. Or it may have reflected Dr. Ivins’ desire to be seen as important and valuable at a time when he perceived that others did not regard his work as important. The latter notion is supported by the email he sent Technician #2 in which he described how her — and implicitly his — expertise would be more important in the event of a bioterrorism attack. Or it may have reflected some combination of these various motivations.

In any case, it appears that the Red Cross served, for at least a while, as a kind of safety valve for Dr. Ivins, a cause that he sincerely felt good about serving. There is no contradiction between the notion that he might have personally benefited from the relationship in some manner and the notion that it also inspired idealistic or altruistic feelings.

Ultimately, though, the Red Cross connection, like so many others in his life, withered. The organization’s protocols elicited information from him that led to the placement of serious restrictions on his role. Once a safety valve, the Red Cross became, instead, the source of another disappointment, the instrument of another blow.

**Attachment #1: Victims of Anthrax: The Five Fatalities**

Amerithrax represented the largest bioterrorism investigation in American history. The investigation spanned nearly a decade, required the development of new scientific methods, and involved the efforts of countless local, state and federal investigators. Although the financial impact of the anthrax attack is difficult to estimate, the human costs are clear: At least 17 people became seriously ill but survived; another 31 people tested positive for anthrax exposure. The pain this tragic event brought to all those affected, including their families, is incalculable. This attachment honors the five individuals who paid the ultimate price. Their lives serve as a reminder that we must learn from this event to prevent similar events in the future.

**Mr. Robert L. Stevens**

(6/20/1938 — 10/5/2001)

Robert L. Stevens, 63, was photo editor for *The Sun* newspaper, owned by AMI in Boca Raton, Fla. Mr. Stevens met his future wife while working as a freelance photographer in England. Married for nearly 30 years, he was a loving husband, father and grandfather. He was also an avid outdoorsman, who enjoyed gardening, hiking, fishing and woodworking. With retirement approaching, Mr. Stevens and his wife had planned to visit Paris together.

**Attachment #1: Victims of Anthrax: The Five Fatalities****Mr. Thomas Lee Morris, Jr.**

(3/2/1946 — 10/21/2001)

Thomas Lee Morris, Jr., 55, was a postal worker in Washington, D.C.

Mr. Morris had worked for the U.S. Postal Service since 1973. He was described by a representative of the American Postal Workers Union as "a model employee." Before joining the postal service, Mr. Morris served at Kincheloe Air Force Base in Michigan. An avid bowler, he was president of a bowling league at Parkland Bowl in Silver Hill, Md., where he was widely admired for his good nature and ability to get along well with everybody.

**Mr. Joseph P. Curseen, Jr.**

(9/6/1954 — 10/22/2001)

Joseph P. Curseen, Jr., 47, was a postal worker in Washington, D.C. A graduate of Marquette University, he was described by the American Postal Workers Union as a highly dedicated worker who did not use sick leave once in the 15 years he worked for the Postal Service. As president of his neighborhood community association, Mr. Curseen worked to establish a playground for the neighborhood children. He was a longstanding member of Our Lady of Perpetual Help, where he served as a Eucharistic minister.

**Attachment #1: Victims of Anthrax: The Five Fatalities****Ms. Kathy Thi Nguyen**

(4/26/1940 — 10/31/2001)

Kathy Thi Nguyen, 61, was a hospital stockroom worker at the Manhattan Eye, Ear and Throat Hospital in New York City. Ms. Nguyen was a Vietnamese immigrant who lived in the Crotona Park East section of the Bronx. As one of the few Asians living in a predominantly Hispanic neighborhood, she often cooked Vietnamese dishes for her neighbors. Popular with co-workers and neighbors, Ms. Nguyen was a devout Catholic who worshiped at St. John Chrysostum Church.

**Ms. Otilie P. Lundgren**

(7/10/1907 — 11/21/2001)

Otilie P. Lundgren, 94, lived in Oxford, Conn. As a young woman in the in the 1930s and '40s, Ms. Lundgren was a legal secretary and office manager. During World War II she volunteered in church and civic efforts, sending care packages to servicemen overseas. In her early 50s she married Carl Lundgren, an attorney, and cared for him until his death. Mrs. Lundgren was an active member of Immanuel Lutheran Church, and she regularly socialized with friends. A voracious reader even at 94, she enjoyed everything from art history books to mystery novels.

# Attachment #2: Frederick News-Post Letter Submitted Fraudulently by Dr. Ivins as That of KKG Sister #2

## Defends hazing

It seems that every time I read an article in the *News-Post* about college fraternities or sororities, the tone of the article is decidedly negative. "Frat member floats kitten in punch" (April 15, 1983) continues that unfortunate tradition.

As a member of Kappa Kappa Gamma, one of our nation's oldest and most prestigious college sororities, I am continually dismayed by attempts of the media and other outsiders to disparage the Greek System. I am especially incensed at vitriolic attacks on our practices of "hazing," which non-Greeks fail to realize serve numerous valuable functions that I would like to briefly enumerate.

For of all, hazing strengthens the mettle of pledges by preparing them for the many trials they will surely face in later life. Secondly, hazing builds loyalty to the pledge class and to the overall organization. Last but not least, hazing is the final stage of the all-important weeding-out process.

Charges that actives are to blame for accidental injuries which sometimes occur during pledge hazing are totally without foundation. No active ever forces any pledge or initiate to do anything in a sorority or fraternity — an individual is free to depledge at any time.

Charges that hazing and other related activities are detrimental to the academic performance of pledges obviously come from individuals who don't realize that the primary education in a college or university environment doesn't come from reading a book or sitting in a classroom, but rather from dynamically interacting with one's peers.

No one ever hears non-Greeks laud the accomplishments of those within their ranks, yet the proud Halls of American History are lined with men and women who were members of college fraternities and sororities. No matter what the press may say about us, I'm still proud to be in a sorority, proud to be counted among our country's very best.

Here Dr. Ivins fraudulently signed the name and address of KKG Sister #2.

Other recent scams under investigation by Frederick City police include an elderly man being ripped off by a woman, a woman being ripped off by a man, and a woman being ripped off by a man.



It is obvious — I need a bigger horse!

## Letters to the editor

time to share with our residents. We are determined to have these individuals remain in the community and churches who come and brighten the lives of our residents.

This type of caring, sharing and help is the core to which President Reagan has alluded to many times as the American Spirit. We honor you publicly during this month as a show of our appreciation for the great work and many hours devoted to our residents.

EUGENE JACKSON  
Administrator

### Literacy Council

I just wanted to thank you for the fine treatment you gave our series about education in jails. You might be interested to know that while I was preparing the series, I corresponded with Mrs. Bush who is quite a supporter of Literacy Councils around the country, and she told me to send a copy of the series to the Literacy Council after it appeared in the *News-Post*.

## Yesterday

Items from Files of the News-Post  
50 years ago

MAY 9, 1933

**SPONSORED BY THE EMBITSBURG** assembl club of the Frederick County. It was the original musical comedy, "No Hits, No Runs, No Errors," will be presented. The show has been arranged by Wayde Chrimer, secretary of the club and contains all local talent. The Elder Orchestra will also appear in the show.

**RIDING A HANDMADE** bicycle, reputed to be at least 75 years old, J. Paul Delphoy, a local business man, accompanied approximately 125 other Frederick cyclists on the trade age of 55 years old on his annual ride of its kind to be held in the spring, began from Mr. Delphoy's motorcycle and bicycle establishment on West Patrick Street. After cycling for awhile, lunch was served by Delphoy and his assistants, including 110 pounds of winners, 1,000 fingerrolls and about 75 gallons of lemonade.

**ONE OF THE LARGEST** indoor jigsaw puzzles ever made, 9 feet high and 18 feet long, will be 800 number and about 1,000 pieces. The puzzle was made by Charles Endicovers of Maryland, to be held during the annual convention of the Maryland Union at Hood College. The immense puzzle was designed and copies are being made by Spencer E. Sisco, Baltimore.

**THE NEW STATE LICENSE** Appeal Board, of which W. Clifton McSherry, Frederick, is a member, will hold a session at the Frederick County courthouse at which applications for licenses to sell beer in this county, to which objection was raised, will be heard and passed upon. The decision of the appeal body is final.

20 years ago

MAY 9, 1963

**THE ANNUAL MEETING** of the Frederick Orchestra was held at the office of Charles J. Warner, musical director. It was reported that the National Budget, which had passed the day before, would have a detrimental effect on the Society of Frederick County was pleased with the accompanying performance by the Frederick Orchestra. The Ballet may perform again here next season.

**A SCHEDULE** of art films to be shown in the area this summer was announced

OUT IN A MAJORITY PARKING LOT... "Wid", The catch was, he couldn't get his big winnings until he put an equal amount of cash on the barrel head. He rushed to the bank, withdrew the cash, and that's the last he ever saw of the "good ol' boys" who ripped him off.

Journal du jour... Bob Reid's latest from Annapolis

Tom McMillen, the former All-America basketball star from Maryland and Rhodes scholar, wants to be a Congressman representing Maryland's 4th District comprised mostly of Anne Arundel County.

This comes as no surprise, since the Atlanta Hawks star in the National Basketball Association has been used mostly as a reserve the past two years, and at 31, is not sure another year in the NBA is his smartest move.

Millionaire Ted Turner, who owns not only the Hawks but all those cable television interests is throwing a \$50,000 ring-ding fund-raiser to help Tom get his start in politics.

McMillan, whose digs are in Crofton, has been, pardon the expression, highly visible in Democratic politics the past year as a fundraiser and party supporter.

Getting involved in senior citizen programs is one way to keep abreast of some of the dangers lurking out there — such as these hellacious car games. It's also a way to meet new friends and find lost horizons.

I have just finished reading the novel "Lusitania" by David Butler, an incredible, beautiful, moving and eloquent book, especially as one reads it there is the constant subconscious knowledge of the moral abyss that on the world politicians have poised us on in their unappreciable search for the ultimate world control.

This book should be required reading for EVERYBODY — the heads of state with impromptu these elected officials determination to continue to build and explore for even more efficient methods of destruction, all those persons responsible for having handed them the power to do so. Also for corporate executives whose major purpose is a healthy profit margin and the even larger group — those of us determined to close their eyes and ears as they open their mouths to tell God is on their side, regardless of their personal responsibility in promoting the amphibian-ization of others while refusing to acknowledge the love and compassion that is the basis of most religions.

This book is based on the true story of the sinking of the Lusitania in World War I. It is one in which only one or two of the authors' reasoning behind ideologies, the errand blindness and unforgivable desire to win whatever ends necessary, are a terrifying reminder as we sit on the edge of committing worse atrocities, not out of a desire for free thought but out of the ignoble one of control.

When the president of one of the most powerful countries says "first strike capabilities" he is using a euphemism for genocide. It is no longer a question of win or lose, it is a fact of annihilation. I have no particular wish to die and I have no particular desire to be prevented from speaking out, but I am not prepared to be responsible for persons with beliefs, both political and religious, different from mine, being obliterated. No one anywhere has the right to put my name behind the finger on the proverbial button. Does any one have yours?

A.J. HARTUNG P.O. Box 427, Burkittsville

Salute to volunteers

Volunteer recognition month is an appropriate time for the administration of Pleasant View Nursing Home of Mt. Airy Inc. to recognize the many upper Midwesterners who tirelessly give of their volunteers who tirelessly give of their

It seems that every time I read an article in the News-Post about college fraternities or sororities, the tone of the article is decidedly negative. "Frat member floots kitten in punch" (April 15, 1983) continues that unfortunate tradition.

Defends hazing

As a member of Kappa Kappa Gamma, one of our nation's oldest and most



JACK ANDERSON The Washington Merry-go-round

Post office seeks to replace home delivery with 'clusterboxes'

WASHINGTON — The U.S. Postal Service has mounted a sneak attack on your feet right to have mail delivered without consulting Congress.

Without consulting Congress, the Postal Rate Commission or — least of all — the public, the post office pookbahs in Washington have been quietly probing and installing "clusterboxes" — eight or more individual mailboxes grouped together at convenient neighborhood locations.

The convenience, of course, is all on the Postal Service's side. Customers, including me, can no longer pick up their mail at the front door or the curb, but must trudge out in the snow, rain, heat or gloom of night to the communal clusterbox. Obviously, the clusterbox caper is saving the Postal Service money. But the way the authorities are going about it can be best described as high-handed — or underhanded. Here's how the Post Office Finance works:

By the way, Finance works: Under postal regulations, new housing developments aren't eligible for mail service until at least half the lots are "improved" — an ambiguous term that can mean anything from ground being plied to actual occupancy of the completed house.

reasure that the primary education in a course of university environment... second program will feature short comedies starring Charlie Chaplin.

PLANS FOR THE second annual anti-one auction at the Frederick Academy... Mrs. J. Tyson Lee and her committees... There will be a preview of items for sale to be in a sorority, proud to be counted among our country's very best.

Here Dr. Ivins fraudulently signed the name and address of KKG Sister #2.

Post office seeks to replace home delivery with 'clusterboxes'

WATCH ON WASTE: A regional office of the Interior Department spent 4,000 man hours at a cost of \$50,000 preparing price estimates for one auction of coal leases. But the experts' painstaking work was all for naught. A regional official told House Appropriations Committee members that the staff's efforts "went down the drain" when the educationally assistant secretary admitted that he had only "casually" glanced at the staff's detailed calculations before the sale was conducted.

By the way, Finance works: Under postal regulations, new housing developments aren't eligible for mail service until at least half the lots are "improved" — an ambiguous term that can mean anything from ground being plied to actual occupancy of the completed house.

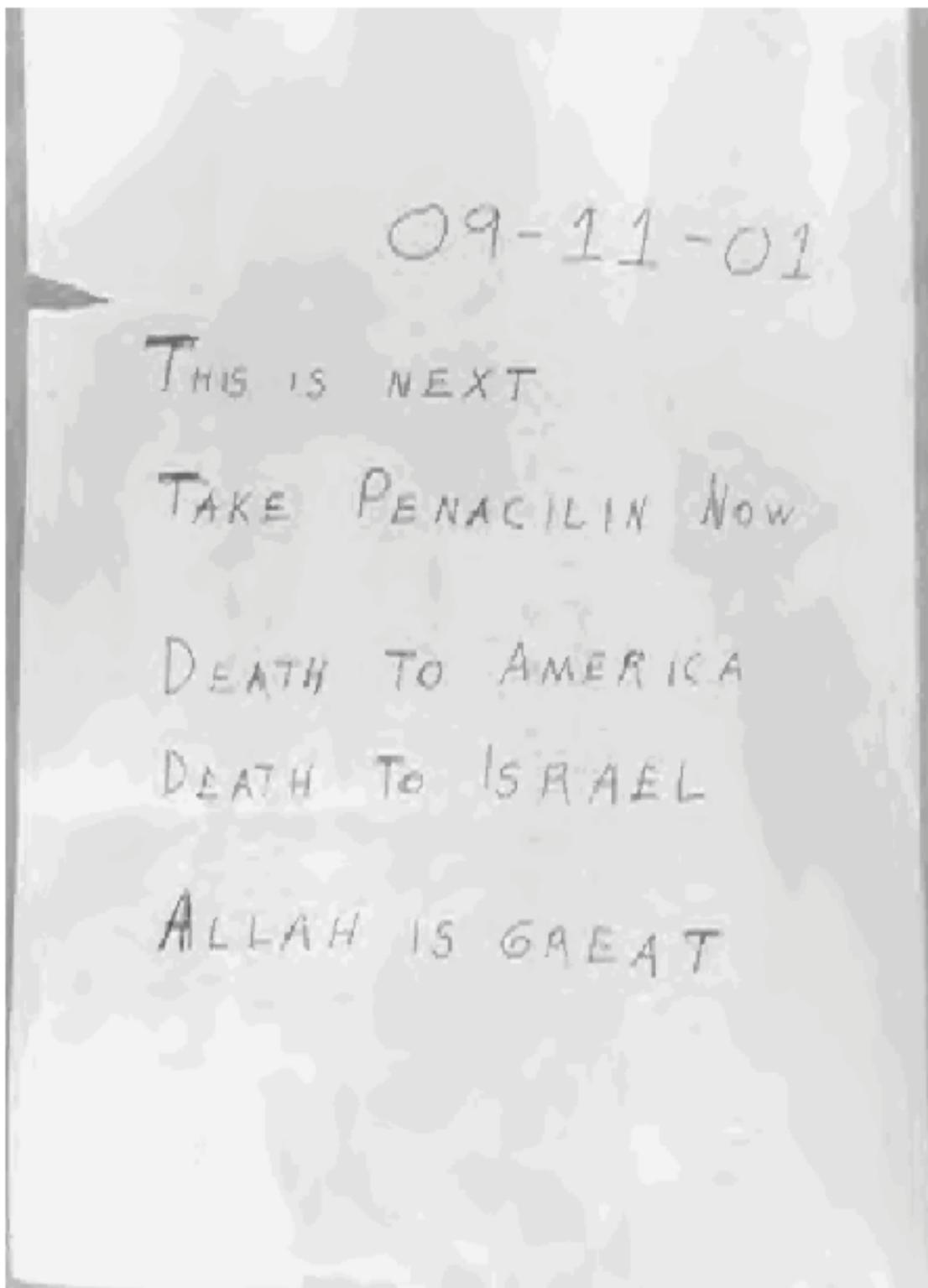
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United Feature Syndicate Inc.

Attachment #3: A September 18 Anthrax Letter



**Attachment #4: Biographies of Panel Members**

*Chair*

**Gregory Saathoff**

Gregory Saathoff, M.D., is the Executive Director of the Critical Incident Analysis Group, and holds a joint appointment as Associate Professor of Research in the Departments of Psychiatry and Neurobehavioral Science and the Department of Emergency Medicine at the University of Virginia School of Medicine.

Educated at the University of Notre Dame, University of Missouri and University of Virginia, Dr. Saathoff has served in the Army Reserve Medical Corps and was deployed during the first Gulf War, earning the Army Commendation Medal in 1991. Since 1996 he has served as Conflict Resolution Specialist for the FBI's Critical Incident Response Group and its Research Advisory Board. In that role, he consults with their Behavioral Analysis Unit and the Crisis Negotiation Unit. He has testified before the U.S. Senate Homeland Security Committee, the U.S. Commission on Civil Rights and has provided expert testimony in Federal court involving treason and terrorism. His research interests include public response to WMDs. Books include the Crisis Guide to Psychotropic Drugs and Poisons, and co-editorship of Criminal Poisoning: Clinical and Forensic Perspectives.

**Attachment #4: Biographies of Panel Members***Vice-Chair***Gerald DeFrancisco**

Gerald M. (Jerry) DeFrancisco is President of Humanitarian Services for the American National Red Cross. Mr. DeFrancisco provides executive-level leadership and management oversight of operations for 2000 local Red Cross locations across the country; Services to Armed Forces; International Services; Preparedness, Health & Safety Services; and the Hurricane Recovery Program. He has over 35 years experience in the telecommunications and management consulting industries, attaining senior leadership positions in a wide variety of assignments in all phases of general management, including corporate strategy, operations, customer service delivery, and sales and marketing.

Prior to joining the Red Cross, he was President of Beacon Professional Group and Ultrapro International, global consulting firms specializing in strategy, operations sustainability, and performance improvement. Prior to this, he was a senior executive at AT&T, serving as Executive VP Broadband and Internet Services; VP Business Innovation; and President and CEO of AT&T Alascom, a \$350 million AT&T affiliate. A U.S. Army veteran, Mr. DeFrancisco has served on various non-profit boards and has been a speaker and panelist in numerous industry conferences and forums.

**Attachment #4: Biographies of Panel Members****David Benedek**

David M. Benedek, M.D., COL, MC, USA is Professor and Deputy Chair, Department of Psychiatry and Associate Director, Center for the Study of Traumatic Stress at the Uniformed Services University of the Health Sciences. He has authored or co-authored over 80 scientific publications, and has presented on numerous aspects of military, disaster, and forensic psychiatry at regional, national, and international professional conferences. Dr. Benedek is a past President of the Society of Uniformed Service Psychiatrists—the Military District Branch of the American Psychiatric Association and is a Distinguished Fellow of the American Psychiatric Association. Prior to his assignment to the Uniformed Services University he directed the National Capital Consortium Forensic Psychiatry Fellowship at Walter Reed Army Medical Center. He also served as Consultant to the U.S. Army Surgeon General for Forensic Psychiatry from 2004 until July of 2008. He now directs the National Capital Area Integrated Clinical Study Site for Psychological Health and Traumatic Brain Injury.

**Attachment #4: Biographies of Panel Members****Anita Everett**

Anita Everett, M.D., is Section Chief Johns Hopkins Bayview Community and General Psychiatry, Baltimore, Maryland. She is on the faculty of the Johns Hopkins School of Medicine and the Bloomberg School of Public Health, Department of Mental Health. Her current area of research is the health behavior of individuals with long-term mental illnesses. Prior to joining the Johns Hopkins staff, Dr. Everett served as the Chief Medical Advisor to the Substance Abuse and Mental Health Services Administration. There she worked on various projects that centered on promoting access to quality services and appropriate medications for individuals with mental disabilities. From 1999 to 2003 she served as the Inspector General to the Office of the Governor in the Department of Mental Health in Virginia. Dr. Everett is active in the American Psychiatric Association, the Maryland Psychiatric Society, and the American Association of Community Psychiatrists, and has published widely. She is currently engaged in international projects with the Ministries of Health, Department of Mental Health in Iraq and Afghanistan on the implementation of mental health services in these countries.

**Attachment #4: Biographies of Panel Members****Christopher Holstege**

Christopher P. Holstege, M.D., is an Associate Professor at the University of Virginia's School of Medicine and Chief of the University of Virginia's Division of Medical Toxicology. He has published extensively in medical literature and is lead editor of the book entitled *Criminal Poisoning: Clinical and Forensic Perspectives*. Dr. Holstege lectures on various topics in the field of medical toxicology, with a focus on such areas as criminal poisoners and chemical weapons of mass destruction. He has been integrally involved in the diagnosis, criminal investigation, and management of a number of high profile criminal poisonings. In appreciation of his work in both education and clinical service, Dr. Holstege received the Dean's Award for Clinical Excellence from the University of Virginia School of Medicine and the National Faculty Teaching Award from the American College of Emergency Physicians. Dr. Holstege obtained his Bachelor of Science degree in Chemistry from Calvin College and his Doctor of Medicine from Wayne State University School of Medicine. He is a diplomate of the American Board of Medical Toxicology.

**Attachment #4: Biographies of Panel Members****Sally Johnson**

Sally C. Johnson, M.D., is a Forensic Psychiatrist and Professor in the Department of Psychiatry at The University of North Carolina at Chapel Hill in the UNC Forensic Psychiatry Program and Clinic. She maintains appointments at both Duke and UNC Law Schools, teaching in the area of psychiatry and law. She conducts criminal and civil forensic evaluations, research, and provides consultation to attorneys, state and federal agencies and the courts regarding issues at the interface of psychiatry and the law.

Dr. Johnson received her undergraduate degree from Pennsylvania State University, her medical degree from Jefferson Medical College, and her Psychiatry training at Duke University Medical Center. She completed career service as a physician with the United States Public Health Services (USPHS), assigned to the Federal Bureau of Prisons, retiring as Captain. She has extensive clinical and administrative experience in correctional psychiatry and medicine and served frequently as an expert witness and consultant to the Federal Courts. She is the recipient of the Attorney General's, the Federal Bureau of Prisons and the USPHS distinguished service awards.

**Attachment #4: Biographies of Panel Members****Steven Lamberti**

J. Steven Lamberti, M.D., is a Professor in the Department of Psychiatry and Director of the Severe Mental Disorders Program at the University of Rochester Medical Center. There, he oversees research, teaching, and clinical care pertaining to persons with schizophrenia and related disorders. Dr. Lamberti is also Chair of the Research Subject Review Board for Behavioral and Social Sciences at the University of Rochester. His career is dedicated to developing new treatment approaches for adults with severe mental disorders, especially those at risk for repeated hospitalization, arrest, and incarceration. Dr. Lamberti was founding director of Project Link, a prototype forensic assertive community treatment (FACT) program designed to prevent jail recidivism through mental health and criminal justice collaboration. For their work with Project Link, Dr. Lamberti and his colleagues received the 1999 American Psychiatric Association (APA) Gold Award. Dr. Lamberti is also a recipient of the 2004 APA Van Ameringen Award for Psychiatric Rehabilitation. A Distinguished Fellow of the APA, Dr. Lamberti is currently principal investigator in a National Institute of Mental Health study to develop the FACT model of intervention.

**Attachment #4: Biographies of Panel Members****Ronald Schouten**

Ronald Schouten, M.D., J.D., is an Associate Professor of Psychiatry at Harvard Medical School and Director of the Law & Psychiatry Service of the Massachusetts General Hospital. He is boarded in psychiatry and forensic psychiatry, and is a member of the Bar of Illinois. Dr. Schouten has expertise as a teacher and consultant in the areas of impaired professionals, sexual harassment, violence in the workplace, the Americans with Disabilities Act, and organizational consultation. He served as a subject matter expert for the Biological Threat Classification Program of the Department of Homeland Security and has testified before the Congressional Subcommittee on Prevention of Nuclear and Biological Attack. He was the mental health liaison for the Association of Trial Lawyers of America to the September 11 Victims' Fund, and served on consensus panels drafting guidelines on workplace violence for the FBI and the American Society of Industrial Security. He participated in the ODNI's Summer Hard Problem Program (SHARP) in 2008 and 2009 and is a member of NCPC's Biological Sciences Experts Group.

**Attachment #4: Biographies of Panel Members****Joseph White**

Joseph C. White is the Senior Vice President of Chapter Operations for the American National Red Cross. Mr. White provides support for 700 chapters across the country, overseeing and coordinating national initiatives including Preparedness and Health and Safety Services, Best Practices, and Technology Resources. On June 7, 2007, Mr. White was appointed a member of the Emergency Response Senior Advisory Council to the Department of Homeland Security by Secretary Michael Chertoff.

Prior to his Red Cross leadership role and after serving in the U.S. Army, Mr. White was a 27-year career banker serving in numerous senior level positions, including President of the City Region of Boatmen's Bank in St. Louis from 1988-1993, CEO of Boatmen's Bancshares of Iowa from 1993-1996, and CEO of Boatmen's Investment Services from 1996-1997. From 1997-1999, Mr. White was Midwest Regional President for Boatmen's Bancshares' successor bank, Bank of America. He then worked for Fleishman-Hillard, a national public relations firm, prior to moving to the American Red Cross.

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