

EXHIBIT 24



DEPARTMENT OF THE ARMY  
 US ARMY MEDICAL RESEARCH INSTITUTE OF INFECTIOUS DISEASES  
 1425 PORTER STREET  
 FORT DETRICK, MARYLAND 21702-5011

REPLY TO  
 ATTENTION OF:

MCMR-UIM-R

29 April 2002

## MEMORANDUM FOR RECORD

SUBJECT: Building 1425 Anthrax Contamination

1. On the afternoon of 18 April 2002, some time after 1630, I was informed by (b)(6) in private that some swipe samples performed by one of the scientists outside the B3 Laboratory were positive for *B. anthracis*. Testing throughout the night would be performed to evaluate whether those samples had virulence plasmids. The information was to be kept close-hold until it could be confirmed. I could inform my physicians if necessary. There would be a meeting at 0800 in the commander's office to decide on a course of action, should the specimens be determined to be virulent.
2. I immediately spoke with (b)(6) in private and advised him of what I had learned. We discussed potential response actions. We decided that this was an issue that would likely require both an internal and external announcement of some type. There would need to be an investigation to determine the extent of contamination and we would need to determine who might need prophylaxis. That evening, I made a list of questions that needed to be answered in the morning.
3. At 0800, a meeting was held in the commander's office which included telephonic contact with (b)(6) in Chicago, (b)(6) at the Medical Research and Materiel Command (MRMC) Headquarters, (b)(6) and others. It was determined that a press release would be written and it would be necessary to inform the employees in advance of the press release. A town hall meeting would be held at 1000 and 1030 hours, with the Bacteriology and Virology Divisions in the first group. Speakers would include (b)(6) -summary, LTC (b)(6) -sampling results, (b)(6) -safety aspects, and myself-medical assessment.
4. Immediately following the commander's meeting, I gathered my physicians and nurses in the Medical Division conference room to brief them and decide on a course of action. We felt that the risk of illness from the contamination was low, based on a couple of factors - there had been no illness amongst the workers thus far, it was possible that the contamination had existed already for some time, the hallway with the passbox contamination was remote and utilized by only a small number of individuals, most of the individuals who might be at risk were likely vaccinated, and it was unlikely there would have been much in the way of airborne contamination due to the air handling systems in the building. Based on this assessment we concluded the following:

MCMR-UIM-R

SUBJECT: Building 1425 Anthrax Contamination

a. The individuals we would invite for evaluation were those who accessed B3 or the hallway in question. Any others who had concerns, we would be happy to see them, but didn't feel they needed evaluation. We didn't feel we needed to recommend prophylaxis for the general institute population nor even for those who worked in the laboratory, but if an individual wanted it, we would provide it.

b. We needed to be sure to maintain appropriate flow through the clinic; therefore, individuals would have to come by appointment – they could start making appointments at 1100 and we would begin seeing them at 1300.

c. We needed a spreadsheet to ensure we tracked who came and what assessments were done on them.

d. We needed to develop quickly an SF600 overprint form for in-house use that could be utilized to focus on key aspects of the patient assessment, including skin and lung exam, whether or not a nasal swab was done, whether the individual worked in the area of risk, and whether prophylaxis was indicated.

5. I was one of the speakers for the town hall meeting. The main thrust of my remarks were that my interest was the safety of everyone in the institute. My medical opinion was that the risk to the population in the institute was low and for those vaccinated, even lower. The reasons included: no illness had been seen, surface contamination did not translate to airborne contamination, air handling systems were functional, without a specific documented event, it was possible the contamination had been present for some time without illness, and the levels of contamination were very low. The individuals in the potential risk groups above were invited for evaluation.

6. My medical staff saw patients all afternoon (19 April 2002) and most of the next day (Saturday, 20 April 2002). In case we had a large number of patients, we decided to cancel any scheduled physical exams in the clinic the following week, but we would try to maintain the shot and bleed schedule. On Sunday, I had phone contact with one researcher who worked in Building 1412 and deemed her illness was unrelated. She ended up seeing a civilian physician. The week of 21-26 April 2002, we saw patients every day.

7. There were some common threads to what some of the patients told us. There was confusion amongst the population about which part of the building was contaminated. When we showed individuals the building floor plan, many concerns were alleviated. Many stated that they were not worried themselves, but they had been urged by family members to get tested or evaluated. Also, many just wanted to be reassured by having a nasal swab done.

MCMR-UIM-R

SUBJECT: Building 1425 Anthrax Contamination

8. We maintained a spread sheet and kept SF600s on all the individuals evaluated. Overall, we saw 88 new individuals and did 57 nasal swabs. All swabs were negative. We continue to call back these individuals to ensure they learn of the negative test results. We placed nine individuals on 72 hours of medication (usually doxycycline), since that is what we have on hand the most. Seven of those individuals were laundry workers or their supervisors who collected laundry from the "clean" side of suite B3, where there had been a couple positive samples found. We ended up later discontinuing the medication when we decided the risk was low and the exposure that had occurred in the laboratory two weeks earlier was with a different strain. The eighth individual worked in facilities management, was very anxious asked to be treated. He decided not to continue after 72 hours. The ninth individual worked on the Center for Health Promotion and Preventive Medicine (CHPPM) environmental sampling team. He asked to start doxycycline as part of his standard protocol for unknown sampling. When I spoke with him two days later, he said he had not started the medication. I provided a daily list to the command of the number of patients we had seen and the number of nasal swabs done.

9. I was asked by the commander to call the laundry facility manager to offer to send a physician out to talk with her personnel and to answer any questions. We had seen two of the individuals from that facility over the weekend and they mentioned that their co-workers might appreciate it. I spoke with (b)(6) the manager on Monday, 22 April 2002. She said she did not want me to come out to the facility. She said she had already briefed her staff and everyone's concerns had been alleviated. She was afraid that if we were to come out now, it might cause more concern, but she thanked me for the offer. She had had many of her questions already answered by the personnel from CHPPM when they did the on-site sampling and really appreciated the work they did. In fact, she had only good things to say about the way Fort Detrick assisted with everything. I conveyed this information to the USAMRIID commander. I spoke again with Ms. (b)(6) on Thursday, 25 April 2002 to ask about the testing results done by an outside contractor - those were also negative.

(b)(6)

Chief, Medical Division