Preventing the Next Attack: 
An Examination of Policy Issues Brought to Light by 
the Rajneesh Bioterrorist Attack in Oregon in 1984

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Introduction

In September of 1984, an outbreak of *Salmonella Typhimurium* sickened at least 751 people in Wasco County, Oregon. After a lengthy investigation, members of the Rajneesh group were convicted of the poisoning. It is now commonly accepted that this event was the first bioterrorist attack in the United States. For this paper, bioterrorism is defined “…to involve the threat or use of biological agents by individuals or groups motivated by political, religious, ecological, or other ideological objectives”. ¹

This paper seeks to discuss what led to the poisoning, how the group obtained the agent, the surveillance used during the outbreak, and the response after the outbreak. Public policy at the time failed in that the group was able to obtain an agent relatively easily and in the response to the outbreak. The surveillance of the outbreak went well and is certainly a model for public health surveillance.

Background

The conflict that raged between the Antelope, Oregon community and the Rajneesh community was one that raged for four years. The Rajneesh movement began in India in the 1970s. The group revolved, theologically speaking, around one person: the charismatic Bhagwan Shree Rajneesh, the spiritual leader of the eponymous group. The Rajneesh movement featured five characteristics that some think may have lead outsiders to feel very antagonistic towards Rajneesh; they were: “…a form of radical monistic mysticism and denial of the idea of consistency”; “rejection of all defined codes of conduct and active pursuit of controversy”; and “the claim of having an enlightened master.” The movement had grand ideas of building a large city in Oregon with everyone living in a very utopian way. The group wanted to continue to grow and spread its teachings. Unfortunately for the movement, the locals in Wasco County, Oregon, did not want this growth to occur.

After much struggling with the local community in Manali, India, the Rajneeshees moved to North America. In August of 1981, the group purchased land outside of Antelope, Oregon. The conflict that arose in the US revolved primarily around land use, but was also influenced by a difference in spirituality and perceived religious values between the Rajneeshees and the locals in Oregon. (The Rajneesh claim to not be a

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5 Ibid., 258, 268.
religion, but rather a group with a spiritual leader.) The people of Antelope, Oregon wanted their serene area to remain peaceful and quiet. The Rajneesh commune’s growth in both population and building endeavors did not please the locals.

In an attempt to gain some control over the community, a number of members of the Rajneesh commune ran for local office in 1983; four won. This further incited the locals in Antelope. They saw their community being taken over by those very different from themselves. Further elections later in 1983 brought a member of the Rajneesh onto the Antelope school board. There was fear amongst locals that the Rajneeshpuram would eventually be a city of 100,000 to 200,000, making it the second largest city in Oregon. Local ranchers, environmentalists, farmers, and others in the community abhorred this idea.

The next month, a bomb exploded in a Rajneeshee-owned hotel in Portland. Rajneeshees continued to stockpile weapons in case they had to defend themselves from locals.

A year later found the area back in the midst of preparing for local elections. Tension had continued to mount over the months. The Rajneesh leaders began to think about ways they could somehow get the upper hand in the approaching elections. In August of 1984, the group decided to invite homeless people from across the country to join them. The group provided free bus fare to get to the commune. The homeless

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10 Parker, 3.
11 Ibid.
12 Latkin, 259.
were told that when they arrived at Rajneeshpuram they would have to work only if they wanted to. They would be provided with food, shelter, and freedom. In exchange, the Rajneeshees hoped to use their numbers to aid in electing Rajneeshees to local seats. The program was called “Share-A-Home”. The Rajneesh were hoping for at least 2,000 homeless people to arrive.13

Ma Anand Sheela was the highest ranking of Bhagwan’s followers. There was a close ring of leadership around her including Ma Anand Puja. Puja was a nurse practitioner and had authority over all of the medical facilities at Rajeehsapuram. She was also known as “Dr. Mengle”, a reference to the Nazi concentration camp doctor. She was identified as someone with a great interest in chemical and biological agents, and she was unafraid to use them.14 It was she who came up with the idea of sickening people.15 With a tight circle of colleagues, Puja worked for months to find an effective way of poisoning both large groups of people and single individuals. Eyeing the 1984 election, the group decided to run a test to determine how to sicken a large group of people with the intent of doing the same near election time to prevent their opponents from going to the polls. In the end, the group spread salmonella on ten salad bars in the Antelope area. 751 people became ill in two separate outbreaks between August and October of 1984.16 17 The group found that bussing in thousands of homeless people to

16 Török, Thomas J. MD; Tauxe, Robert V. MD, MPH; Wise, Robert P. MD, MPH; Livengood, John R. MD; Sokolow, Robert; Mauvais, Steven; Birkness, Kristin A.; Skeels, Michael R. PhD, MPH; Horan, John M.
later register and vote in the local election was more effective than using bacteria to sicken those who may or may not be voting.\textsuperscript{18}

\begin{thebibliography}{99}
\bibitem{Foster} Foster, Laurence R. MD, MPH. "A Large Community Outbreak of Salmonellosis Caused by Intentional Contamination of Restaurant Salad Bars." \textit{JAMA} 278, no. 5 (1997): 389.
\bibitem{Carter} Carter, Charisma and Control in Rajneeshpuram: The Role of Shared Values in the Creation of a Community, 224.
\end{thebibliography}
**Acquiring the Agent**

When it came time for Rajneesh to acquire an appropriate biological agent, Ma Anand Puja turned to VWR Scientific\(^{19}\), a distributor of scientific equipment, chemicals, and supplies, including various biological agents.\(^{20}\) As part of the process of purchasing the *Salmonella Typhimurium*, Puja disclosed the reason for acquiring the agent as being to aid in managing the group’s poultry business and to establish an independent testing facility at Rajneeshpuram.\(^{21}\) In addition to providing a benefit for the commune’s poultry operation, the acquisition of the *Salmonella Typhimurium* made sense for another reason. To be a licensed clinical laboratory, the Rajneesh Medical Corporation needed to have control organisms such as *Salmonella Typhimurium* to test for quality assurance among its technicians. Other pathogens were also maintained for the same purpose.\(^{22}\) It was therefore not unusual for a lab to acquire specimens such as those Rajneesh ordered.

Until 1996, it was still relatively easy to obtain cultures that could be used for nefarious purposes from the collections of providers such as VWR. Indeed, in 1995, an individual was able to fraudulently purchase a culture of plague from a private “germ bank”. This event spurred the inclusion in The Antiterrorism and Effective Death Penalty Act of 1996 (P. L. 104-132) a section on access to nuclear, biological, and

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This section covers the regulation of toxins and agents. The USA PATRIOT ACT led to a further update of the list of toxins and agents that are tightly controlled. Salmonella is not on the HHS and USDA Select Agents and Toxins (7 CFR Part 331, 9 CFR Part 121, and 42 CFR Part 73) list.

When visiting VWR’s website today, one can search the company’s catalogs for agents, and the general public can get so far as to see what agents are available, some traits of the organisms, and the cost, but the purchase can only be completed if the buyer is registered and pre-screened by the company. This was not the first or the last bioterrorist attack to involve the open obtaining of biological agents. Indeed, as W. Seth Carus points out in his working paper on the history of bioweapon use, “[in] 11 of the 33 cases involving acquisition, the non-state actors obtained biological agents or toxins from legitimate suppliers.”

Török, Tauxe, Wise, Livengood, Sokolow, Mauvais, Birkness, Skeels, Horan, and Foster make a good and reasonable case that

)[it] seems unlikely that any regulation of commercially available pathogens could have prevented this outbreak. It would not be necessary to purchase them because this type of culture could be easily obtained from clinical isolates or from raw foods of animal origin available in grocery stores. Production of large quantities of bacteria is inexpensive and involves simple equipment and skills. Standard practices for maintaining salad bars may be inadequate to prevent similar outbreaks in the future with salmonellae or other pathogens. As in many

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areas of our open society, current practices are inadequate to prevent deliberate contamination of food items by customers.\textsuperscript{26}

Rajneesh’s members and its leaders were very well educated, so there is a great possibility that the group may have been able to develop the salmonella agent from natural resources.

\textsuperscript{26} Török, Thomas J. MD; Tauxe, Robert V. MD, MPH; Wise, Robert P. MD, MPH; Livengood, John R. MD; Sokolow, Robert; Mauvais, Steven; Birkness, Kristin A.; Skeels, Michael R. PhD, MPH; Horan, John M. MD, MPH; Foster, Laurence R. MD, MPH, 389-395.
**Surveillance—What Went Right**

Methods used by Oregon state health officials to follow possible outbreaks were effective in the case of this outbreak. Eight days into the outbreak, the Wasco-Sherman Public Health Department in Oregon began to hear word of individuals ill with gastroenteritis. On September 25\textsuperscript{th}, the state and local health officials contacted the Centers for Disease Control (CDC) for help in evaluating and controlling the outbreak. Passive surveillance was used to locate patients with symptoms. Press releases in the local community were used to make patients and healthcare providers aware of the outbreak.\textsuperscript{27}

In addition to examining the patients, taking samples from them, and monitoring them, public health officials also went to work looking for clues as to how the outbreak was started. Employees of the various restaurants were interviewed. The restaurants were inspected. Environmental studies were conducted of the water in the area as well as the facilities in the restaurants.

\textsuperscript{27} Ibid.
Reported cases of *Salmonella Typhimurium* gastroenteritis by date of symptom onset for 674 cases (89.8%) with known date of onset, The Dalles, Ore, 1984.  

State and local health officials reach out to the CDC for help.  

Wasco-Sherman Public Health Department began to receive reports.
Response—What Went Wrong

In contrast to the work that was done in first surveilling the outbreak and conducting research into determining the source of the outbreak, the response to what information was found and the analysis of that information was inadequate. Public health officials from the local community, at the state level, and from the CDC concluded that the outbreak was not caused by any of the common mechanisms that would have caused an outbreak of *Salmonella Typhimurium* from salad bars. Instead of the possibility of the outbreak having been caused by a criminal act, let alone a bioterrorist attack, the health officials focused on the usual causes.\(^\text{29}\)

Investigators did consider the possibility that the outbreak could have been caused by an intentional act, but this was rejected early on for several reasons. Most notably, the idea was rejected because:

1. No motive was apparent.
2. No one claimed responsibility for the incident, and no demands or ultimata were issued.
3. Law enforcement officers investigated the few questionable activities reported among restaurant patrons and did not establish a recognizable pattern of unusual behavior.
4. No disgruntled employee was identified who might seek revenge on their employer. The criminal investigation confirmed that restaurant employees did not participate in the contamination efforts.
5. The epidemic exposure curves indicated that salad bars were contaminated multiple times during a several-week period, suggesting that a sustained source of *S Typhimurium* was necessary.
6. A few employees had onset of illness before the recognized patron exposures in their restaurants.
7. To our knowledge, such an event had never happened. We were aware of only 2 reports of foodborne illness caused by intentional contamination with biologic agents, and neither incident appeared to be politically motivated.\(^\text{30}\)

\(^{29}\) Ibid.

8. On the basis of our experience in other investigations, we believed that other hypotheses, although more complicated, appeared more likely, because individually each of the components had been well documented in other outbreaks.

9. Finally, even in thoroughly investigated outbreaks, the source sometimes remains occult, and, of all the reasons considered for failing to identify a source, this would be the most common.\(^{31}\)

Certainly, these reasons are legitimate. Perhaps the most significant of these reasons is that there had not been an event such as that occurred in US history.

Oregon Congressman Jim Weaver began investigating the outbreak on his own after little was definitively determined to cause the outbreak. He suspected something beyond a natural outbreak because:

There are 50,000 salad bars in the [US]; not one of them has ever been known to emanate a salmonella outbreak and yet we have 8 salad bars independently giving off salmonella in one town of 11,000 people. I said that couldn’t happen in a zillion years. So I called up the state health authorities and they said “food handlers” and I said nonsense!\(^{32}\)

Weaver contacted the FBI, state health officials, and the CDC, but nobody took action in looking at the outbreak as a criminal act.\(^{33}\)

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\(^{31}\) Török, et al., 389-395.


Epilogue

In the autumn of 1985, after Rajneesh began to fall, FBI investigators gained access to Rajneesh facilities and found *Salmonella Typhimurium* in what members of the commune called the “‘germ warfare’ laboratory.” The strain of salmonella investigators found matched that associated with the outbreak.

Further investigation and debriefs from other members of the commune revealed just how serious Ma Anand Puja and others were about poisoning others. *Salmonella* typhi, the agent that causes typhoid, was considered, but was not used. The group had tested salmonella on three county commissioners who came to visit the commune in August of 1984. Commune members put salmonella into the water provided to the commissioners. Two were sickened, and one hospitalized. The group also made attempts at getting the salmonella into the county water supply and in the Wasco County courthouse. They tried in a supermarket and a nursing home as well. Puja considered using hepatitis, and she was even interested in trying to culture AIDS.

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35 Carter, Lewis F. *Charisma and Control in Rajneeshpuram : The Role of Shared Values in the Creation of a Community*, 225.


Of the 751 people sickened by the salad bar outbreak, at least 45 were hospitalized.\(^{41}\) Of these 45, one was a newborn who was sickened after the mother became ill. The infant “…only after ‘emergency, continuous and specialized care’” survived.\(^{42}\)

In September of 1985 Ma Anand Sheela and fifteen of the twenty other Rajneesh leaders left the commune.\(^{43}\) Two months later, Bhagwan left the commune and the commune was put on the market.\(^{44}\) May of 1986 saw the indictment of Ma Anand Sheela and others for a number of crimes.\(^{45}\) In July of that year, Sheela (also known as Sheela P. Silverman), Ma Shanti Bhadra (also known as Katherine J. Elsea), and Ma Anand Puja (also known as Dianne Y. Onang, the director of medicine for Rajneesh) all plead guilty to charges such as immigration fraud, attempted poisoning, attempted murder, and arson.\(^{46}\) In December of 1998, more than two years after it was put on the market, the commune was sold for $4.3 million.\(^{47}\)

This case of bioterrorism was relatively mild. Salmonella is considered a food safety threat, a category B agent according to the CDC.\(^{48}\) As Sidel and Levy point out:


\(^{41}\) Török, et al., 389-395.


\(^{47}\) Latkin, 260.

while addressing potential biological agents and the diseases they can cause, it is critically important that health professionals maintain—and strengthen—support for other public health priorities, many of which are related to infectious diseases...such as foodborne illness.49 If monitoring and promoting prevention are continued, it may be easier to determine a case as being a criminal or terrorist act, rather than an outbreak occurring from a traditional source. This case obviously shows the need for continued surveillance, especially since an agent like *Salmonella Typhimurium* is not on the Select Agents and Toxins list. It does seem, however, that providers of agents such as *Salmonella Typhimurium* are very watchful of those to whom they are providing pathogens. The case of the Rajneesh poisoning in Wasco County in 1984 was really, all things considered, a mild case of bioterrorism; nobody was killed. The scenarios public health and law enforcement officials now see as possibilities are far more lethal than *Salmonella Typhimurium*. Other agents on the CDC’s category B list of bioterrorism agents/diseases are far more lethal. This case does demonstrate the need for further cooperation between public health agencies and law enforcement agencies to ensure that the appropriate steps are taken to properly investigate events such as this. It should not take a year after an event for law enforcement to become involved.

In the end, the poisoning did not achieve Rajneesh’s goals. The Rajneeshees bused in more than 4,000 homeless people.50 It was this bussing in of the homeless that allowed Rajneeshees to take positions in the local government. The poisoning was considered a test, and it failed. The group did not try to poison individuals again.

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Bibliography


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