INTRODUCTION

Corporate lawbreaking far outpaces street crime in this country. According to Russell Mokhiber, editor of Corporate Crime Reporter, while 16,000 Americans are murdered in street crimes every year, 56,000 Americans die of diseases or injuries caused by corporate recklessness, often rising to the level of criminal misconduct. Yet rarely are corporate crimes prosecuted, and even when they are, the victims of such crimes receive little justice. For example, although it is possible for crime victims to obtain financial compensation through state restitution or victim compensation programs, these options rarely provide adequate relief. In most situations, the civil justice system is the only avenue for redress.

In addition to compensating victims and holding corporate criminals accountable, personal injury suits, such as wrongful death, products liability and toxic tort actions, can police the dangerous practices of individual companies or entire industries. The prospect of legal liability can provide potential wrongdoers with the economic incentive to change their behavior. Often, companies that are hit with large verdicts or settlements act immediately to make their products or practices safer. Flammable children’s pajamas, backyard water slides and “Saturday Night Special” handguns are among the products taken off the market after juries awarded significant damages. Similarly, warning labels on charcoal bags and tampon packages, redesigned infant cribs and jeeps, and revised policies on emitting toxic chemicals and staffing pediatric units at hospitals – changes which have saved lives – are directly attributable to civil verdicts.
Civil cases also set the stage for government agencies or legislatures to act through stronger regulations. Moreover, by uncovering information about hidden hazards, litigation can create widespread publicity about them, allowing victims to learn about similar instances of corporate malfeasance, providing potential victims the opportunity to protect themselves from possible injuries and alerting an unsuspecting public to corporate abuses.

So-called “tort reform” legislation that seeks to immunize corporate wrongdoers by making it more difficult or impossible for victims to go to court not only hurts injured workers and consumers but also threatens the public’s welfare. At a time when corporate crime is at an all-time high and government prosecutors and agencies do little about it, eroding the last line of defense – the civil justice system – would be catastrophic to the health and safety of every American.

Below are recent examples of corporate lawbreaking, which, while egregious, did not result in criminal prosecutions. Instead, the civil justice system stepped in to provide remedies and expose the misconduct, hopefully leading to safer corporate practices in the future.
ADVANCED MEDICAL OPTICS (AMO)

The company is facing lawsuits from over 200 patients who contracted serious eye infections while using AMO’s Complete MoisturePlus contact lens solution. The infection, called Acanthamoeba keratitis, can be painful, chronic and resistant to treatment, require surgery, cause permanent vision damage, lead to blindness or even kill if it spreads to the optic nerve and brain.

Documents obtained in the course of civil litigation reveal that AMO knew consumers had suffered injuries from Complete MoisturePlus. More specifically, between February and November of 2006, AMO received complaints that its solution had caused serious eye infections that blinded several people. The company never reported those injuries to the FDA as required by law. Complaint forms weren’t discovered until June 2007, when FDA inspectors came to investigate AMO’s plant following its product recall. When asked about the documents, company officials said they had no obligation to alert the FDA because the solution’s labeling never claimed to protect against Acanthamoeba keratitis.

At the time of the investigation, the Centers for Disease Control had confirmed nearly 160 cases of the Acanthamoeba infection in patients who used Complete MoisturePlus to disinfect their contact lenses. Among the victims: Paige Reichardt, who underwent a series of surgeries to remove her cataract lens, iris and cornea and ultimately had to have her eye removed and replaced with a glass prosthetic after being infected in 2005. “I describe the pain as a feeling that someone has thrown hydrochloric acid in your eye and then stabbed it with knives,” Reichardt wrote in 2007.

Despite AMO’s violation and multiple documentation problems involving consumer complaints and quality control, the FDA never pursued fines or legal action. Instead, the agency met with company officials, had them outline how AMO would comply with regulations in the future and planned a follow-up inspection.

ASTRAZENECA

More than 15,000 patients have filed lawsuits against AstraZeneca over serious side effects from Seroquel, an atypical antipsychotic drug approved to treat bipolar disorder and schizophrenia. Victims allege that the company knew Seroquel caused major weight gain and diabetes but withheld findings from doctors and patients because it would hurt sales. Seroquel is one of the world’s top-selling drugs and AstraZeneca’s second-biggest seller, generating over $4.4 billion annually.

Internal documents unsealed through discovery during civil litigation expose company efforts to conceal overwhelming data about the dangers of Seroquel and only publish information that was profitable. Examples include:

- A February 12, 1997 memo from AstraZeneca commercial strategist Richard Lawrence discussing data from an internal study (“Study 15”) which found that patients taking Seroquel gained an average of 11 pounds in a year. “I am not
100% comfortable with this data being made publicly available at the present time….however I understand we have little choice,” Lawrence wrote. He then praised Seroquel project physician Lisa Arvanitis for a “great ‘smoke-and-mirrors’ job!” in dealing with U.S. and Canadian investigators.9

- A December 6, 1999 email from AstraZeneca publications manager John Tumas criticizing a “precedent set regarding ‘cherry picking’ of data.” He noted that the company had buried trials. He said, “The larger issue is how do we face the outside world when they begin to criticize us for suppressing data.”10

- A 2000 position paper from AstraZeneca’s global safety officer confirming a relationship between the drug and diabetes.”11

- An October 26, 2000 email from medical affairs manager Dominic Aked to colleagues, stating, “I agree we need to be able to tell a convincing story to our internal and external customers. I’m sure we can do this…A promotional claim ‘Seroquel is weight neutral during long-term treatment[ ] should help make this distinction.’”12

- A chain of emails from 2001, where marketing executives attempted to override company scientists’ recommendations about drug labeling after patients showed significant weight gain from Seroquel.”13

- A September 9, 2002 email from Seroquel global brand manager Simon Hagger alerting marketing staffers that “we are under clear instruction from the highest level within AstraZeneca at this time not to discuss details surrounding trial 41 with any external customers.” Trial 41 data showed elevated blood sugar levels in patients who took Seroquel.14

- An August 15, 2005 voicemail from AstraZeneca’s scientific alignment manager Christine Ney, who instructed sales representatives to use a “Weight and Diabetes Sell Sheet” to diffuse physician concerns about Seroquel’s side effects. “Our objective is to neutralize customer objections to Seroquel’s weight and diabetes profile,” Ney said, advising representatives to “refocus the call” to the drug’s tolerability.15

- A June 30, 2006 email from Seroquel medical science director Martin Brecher voicing concern about AstraZeneca’s position on glucose and lipids. “Regarding weight, the key fact is 3-3.5 kg wt gain” in patients taking Seroquel for 52 weeks. “I don’t know how you can spin that,” Brecher told the senior patient safety director, adding, “hope team can settle on positioning glucose metabolism that will largely de-emphasize weight gain.”16

Documents uncovered in civil litigation also revealed AstraZeneca’s aggressive push to market Seroquel for unapproved uses, including treatment of children and the elderly. The FDA approved Seroquel for treating symptoms of psychotic disorders in 1997, for schizophrenia in 2001 and for bipolar disorder beginning in 2004.17 While doctors can
prescribe FDA-approved medications as they see fit, it is illegal for drugmakers to market them for unapproved, i.e., off-label, uses.\textsuperscript{18}

Here’s what some of the internal documents say:

- “2001 communications will focus on increasing the existing off-label usage of Seroquel in [bipolar disorder], estimated to account for around 20 percent of current prescriptions and growing strongly.” “Broaden use of Seroquel beyond its current label, in a wide range of patient groups through aggressive communication of its unique profile eg bipolar disorder, Parkinson’s disease, Alzheimer’s disease, elderly, adolescents.” \textit{Seroquel PR Plan} (February 2001).\textsuperscript{19}

- “[G]rease the skids for dementia,” “turn on the DTC [Direct-To-Consumer] machine.” Handwritten notes from consumer brand director Denise Campbell after receiving marketing advice from the drug’s brand manager (2002).\textsuperscript{20}

- “Continue to encourage off-label use of Seroquel for the treatment of bipolar disorders through publications presented at major congresses.” Internal document discussing AstraZeneca paper designed to highlight Seroquel’s performance in clinical tests on bipolar patients (prepared for the 16th United States Psychiatric & Mental Health Congress held in November 2003).\textsuperscript{21}

- “[A]ll off-label slides are financed outside of commercial for obvious legal reasons….” Email from global brand manager William Hess noting the line between off-label marketing and information when discussing slides prepared in connection with a study involving off-label use of Seroquel (dated May 26, 2004).\textsuperscript{22}

\textbf{BRITISH PETROLEUM (BP)}

On March 23, 2005, an octane-boosting unit at BP’s Texas City refinery malfunctioned, causing a geyser-like release of highly flammable liquid and vapor. The vapor ignited, starting a series of explosions and fires that swept through the unit and surrounding area. Fifteen workers were killed, 180 others were injured.\textsuperscript{23}

When victims and the families of those who died went to court, they learned that BP executives and Texas City managers willfully ignored recurring major safety problems for years before the blast. Internal company memos and reports dating back to 1999 – which the company fought to keep confidential but was forced by court order to release to claimants – showed a culture of risk denial where profit trumped worker safety.\textsuperscript{24}

Eva Rowe, who lost both her parents, James, 48, and Linda, 47, in the disaster, refused BP’s settlement offers for 16 months because she wanted those documents to be made public through trial.\textsuperscript{25} “My parents were my best friends, they’re all I had,” Rowe told \textit{60 Minutes}. “To BP my parents were just another number. To them, they’re replaceable.” Rowe added, “I want everyone to know what they did, you know. If we settle and all, everything we know has to remain confidential. I don’t want that to happen.”\textsuperscript{26}
On November 9, 2006, the eve of trial, Rowe settled after BP agreed to declassify over seven million confidential documents, donate $32 million to health care, training and safety education and pay Rowe an undisclosed amount. Among the documents made public:

- An internal report sent to BP executives and site management in February 2002 stating that the Texas City refinery, among others, “has the potential for events which could result in multiple injuries, deaths” where “[p]otential upset events include fires and explosions.”

- An internal study shared with BP executives in August 2002 identifying “urgent,” “site-wide” problems that raised “serious concerns about the potential for a major site incident” at the Texas City refinery.

- An internal analysis issued in October 2002 explicitly connecting safety problems to earlier cost-cutting. The report stated that “the current integrity and reliability issues at TCR [Texas City Refinery] are clearly linked to the reduction in maintenance spending over the last decade,” concluding that “[t]he prevailing culture at the Texas City refinery was to accept cost reductions without challenge and not to raise concerns when operational integrity was compromised.”

- An October 2002 cost-benefit analysis of the price of preventing a catastrophic explosion. When explaining the company’s rationale for cutting costs, workers were compared to the Three Little Pigs:

  Frequency - the big bad wolf blows with a frequency of once per piggy lifetime.

  Consequence – If the wolf blows down the house, the piggy is gobbled.

  Maximum justifiable spend (MJS) – A piggy considers it’s worth $1000 to save its bacon.

  \[
  \frac{1.0}{\text{piggy lifetime}} \times \frac{1000}{\text{piggy life}} = \$1000. \]

- A September 2003 external BP safety audit stating that most of the Texas City site still operated with a “checkbook mentality,” committing “insufficient resources” to address identified risks, ensure a sound infrastructure and protect worker health and safety.

- Employee survey results sent to site management in April 2004 voicing frustration about indifference to worker safety. For example, when asked to rate BP’s concern for health and safety of employees, one respondent said, “I do not rate it at all. (Rock bottom)...It takes too long for a safety issue to get addressed at this site. You can bring up safety concerns, and look back 5 to 6 years back and see that the safety that has been brought up is still not addressed.” He explained that “no one here in management cares, they look at the money instead of safety, we have been very lucky so far with this...this company does bare
minimum for safety just to stay in compliance.” He added, “You do site wide surveys out here at this site, and none of the safety issues get fixed after the survey. I could type two whole pages just on this question alone.”

- A January 2005 Texas City safety culture report based on employee surveys and interviews, revealing a facility where workers faced a “culture of casual compliance” that tolerated “many unsafe conditions,” lacked resources “to address severe hazards that persist” and rewarded production and budget compliance “before anything else.” As a result, respondents felt “an exceptional degree of fear of catastrophic incidents.”

- A February 2005 email from the plant’s health and safety manager, stating “I truly believe that we are on the verge of something bigger happening” in reference to a catastrophic incident.

- A safety business plan emailed March 15, 2005 – eight days before the disaster – warning of a “key risk” that the Texas City refinery “kills someone in the next 12-18 months.”

- Employee survey results released the morning of the March 23, 2005 blast, showing continued concern for worker safety. “Still taking too many calculated risks,” one respondent said. “Safety is not practiced at the management level if the cost becomes too restrictive cost or time-wise consuming,” stated another. “We should not be able to sleep at night knowing that we are planning to spend another cent on a return project if legitimate safety and environmental projects exist,” one worker commented. “If this facility was an aircraft carrier we would be at the bottom of the ocean,” another argued.

All documents and depositions obtained through discovery were also shared with numerous authorities and investigative agencies, including the Justice Department, which ultimately brought criminal charges against BP, although many viewed the criminal actions as wholly inadequate.

“I personally believe that BP, with its corporate culture of greed over profits, murdered my parents, denying my brother Jeremy and me, along with the families of the 13 others, the joy of the love of our fathers, mothers, brothers and sisters, and the warmth of their smiles and embraces forever,” Rowe told congressional lawmakers in a March 2007 hearing.”

**ELI LILLY**

In September 1996, Eli Lilly received FDA approval to sell Zyprexa (also known by the chemical name olanzapine) for treatment of symptoms from psychotic disorders. After several years, the drug was approved for use in patients with schizophrenia and bipolar disorder. By the end of 2004, Zyprexa had global sales totaling $4.4 billion, making it Lilly’s best-selling drug.

Six months later, in June 2005, Lilly agreed to pay $690 million to settle nearly 8,000 lawsuits from patients who developed diabetes and other medical problems after taking Zyprexa. As a condition of settlement, victims had to agree “not to communicate, publish or cause to be published … the specific events, facts or circumstances giving rise to [their] claims” and return all sensitive pretrial discovery documents. With victims forced into secrecy, Lilly continued to sell Zyprexa to patients and doctors, generating $4.2 billion in worldwide sales by the end of 2005.

In December 2006 – nearly 18 months after the settlement was announced – the discovery documents became public when attorney James B. Gottstein, who was working on an unrelated case, gave them to the *New York Times*. “Patients should be told the truth about drugs like Zyprexa,” Gottstein said.

Those internal documents and emails spanning a decade show that Lilly deliberately kept information from doctors and consumers about Zyprexa’s links to severe weight gain and elevated blood sugar, both known risk factors for diabetes, because it would weaken sales. As the *Times* reported,

Lilly’s own published data, which it told its sales representatives to play down in conversations with doctors, has shown that 30 percent of patients taking Zyprexa gain 22 pounds or more after a year on the drug, and some patients have reported gaining 100 pounds or more. But Lilly was concerned that Zyprexa’s sales would be hurt if the company was more forthright about the fact that the drug might cause unmanageable weight gain or diabetes, according to the documents, which cover the period 1995 to 2004.

Among the hundreds of documents provided to the *Times*:

- A 1998 presentation where Lilly said its salespeople should be told, “Don’t introduce the issue!!!” – *i.e.*, the association between massive weight gain, diabetes and Zyprexa – when talking to doctors about the drug.
• Data from early 1999 showing that blood sugar levels had increased steadily in patients who had taken Zyprexa in a clinical trial for three years. Instead of making the information public, Lilly said the patients’ weight gain appeared to plateau after about nine months.\(^4\)

• A November 9, 1999 email from Zyprexa chief scientist Dr. Alan Breier to employees stating, “Olanzapine-associated weight gain and possible hyperglycemia is a major threat to the long-term success of this critically important molecule.”\(^5\)

• A November 17, 1999 letter from Ventura County Behavioral Health Department psychiatrist Dr. Albert Marrero to Lilly medical director John Hayes describing blood sugar problems in Zyprexa patients.\(^6\)

• A November 1999 internal report showing Lilly examined 70 clinical trials and found that 16 percent of patients on Zyprexa for a year gained over 66 pounds. Rather than publicly disclosing those figures, the company used data from a smaller group of trials to say about 30 percent of patients gained only 22 pounds.\(^7\)

• A January 30, 2002 email from Shelethea Dunning, the company’s medical liaison in Texas, alerting company managers that weight gain and hyperglycemia are “increasingly becoming an issue across Lilly divisions in the Texas marketplace.”\(^8\)

• A March 2002 market research summary reporting that psychiatrists from Lilly focus groups saw a “100 percent association” between Zyprexa and weight gain.\(^9\)

• An email from March 2002 revealing that Lilly dismissed plans to give psychiatrists information about treating diabetes because the company was concerned about linking the disease to Zyprexa. “Although M.D.’s like objective, educational materials, having our reps provide some with diabetes would further build its association to Zyprexa,” a Lilly manager wrote.\(^10\)

• A September 5, 2002 letter written to Lilly by Dr. James Turnbull, senior vice president for medical services at Frontier Health in Kingsport, Tenn., who had alerted the company in an earlier letter about problems he’d seen in patients taking Zyprexa. “This is to acknowledge the receipt of your letter of August 26, 2002 which included information about blood glucose changes with Zyprexa. It just confirms the theory that there are lies, damn lies, and statistics,” Turnbull said.\(^11\)

• A July 7, 2003 memo written before news of the link between diabetes and Zyprexa became public. “We must embrace the fact that many physicians are curtailling their use of Zyprexa (particularly in the moderately-ill patient and in the maintenance phase), solely on the basis of personal fear (of being sued).” Protecting doctors through indemnification was then raised as “the most meaningful demonstration of confidence in Zyprexa – both with our customers
and with our employees.” The memo also discussed paying millions to an industry-backed front group to diffuse concerns about Zyprexa’s link with diabetes.\textsuperscript{57}

In September 2003, Lilly changed its Zyprexa label to include a warning about the risks of hyperglycemia and diabetes but that was only because the FDA forced all makers of atypical antipsychotics to do so.\textsuperscript{58}

The leaked discovery documents also reveal that Lilly aggressively marketed Zyprexa to primary care physicians (PCPs) for off-label uses like dementia even though Zyprexa had only been approved for schizophrenia and bipolar disorder.\textsuperscript{59} Here’s a small sample of what the \textit{Times} found:

- An August 1999 document in which an unnamed Lily marketing executive wrote that PCPs “do treat dementia but do not treat bipolar disorder” and “Schizophrenia is handled by psychiatrists.” As a result, “dementia should be first message” of a campaign to PCPs,” who “might prescribe outside of label.”\textsuperscript{60}

- A 2001 Integrated Product Plan stating that “Zyprexa will remain the number one selling psychotropic in history by offering hope to the millions of people suffering from the debilitating illnesses of schizophrenia, bipolar disorder and dementia.”\textsuperscript{61}

- A June 2001 marketing document given to Lilly sales representative as part of the company’s “Viva Zyprexa” campaign, a multiyear promotional strategy in which salespeople were told to promote Zyprexa to PCPs for use in older patients with symptoms of dementia. The script included the hypothetical profile of a patient named “Martha” to illustrate one type of Zyprexa candidate. Martha’s description was consistent with someone suffering from mild dementia rather than schizophrenia or bipolar disorder.\textsuperscript{62} According to the document,

  Martha is a widow who lives independently and has been your patient for some time. She is becoming more complicated to manage, and you note increasing agitation. Her sleep is disturbed; she dozes during the day and is up most of the night. Her family has shared their concerns with you, saying, “She thinks we’re trying to take advantage of her.”

  Martha’s family doesn’t want to send her to a nursing home, but her agitation and confusion must be addressed. Your goals of treatment for Martha may include reducing her behavioral disturbances without impairing her cognitive functioning.

  **PROBE:** Do you see patients like Martha? What medication(s) do you prescribe in treating her behavioral disturbances?\textsuperscript{63}

The suggested dosage amount for “Martha” also reflects Lilly’s efforts to promote Zyprexa for off-label dementia use. Sales materials pushed a starting dose of 2.5-5 mg daily, a range commonly used in olanzapine trials for dementia. In contrast,
patients with schizophrenia typically take olanzapine in doses of at least 10-15 mg per day.  

An earlier internal document further confirms that Lilly used “Martha” as a marketing tool for dementia. A November 16, 2000 email included the following question to Zyprexa medical from company sales reps: “Since the diagnosis of our 3 patients in the Zyprexa core message piece are: Martha - dementia, David - bipolar, Christine - schizo; can you enlighten us a little more about dementia. We know that we are to describe the symptoms and stay away from diagnoses,” the sales representatives noted, “but for our own background, can you elaborate on dementia and how it is different from other things like Alzheimers, etc. We are getting a little grief from some of our docs about promoting Zyprexa for dementia, but according to the N slides in the audioconference set, there is no FDA approved drug for dementia.”

• An email received by Lilly in August 2001, in which primary care physician Joseph A. Leming shared his outrage after a Lilly sales representative promoted Zyprexa for off-label use. “I was and am so disturbed that this drug is being (in my opinion) promoted inappropriately and its use therefore potentially pose a threat to public safety that I told her that I was going to write the FDA and see if her claims of approval and legitimacy were in fact true. I also told her I would copy her on the e-mail. Hence my e-mail.”

Publishing the discovery documents had an immediate impact on victims and government officials. For example,

• Less than three weeks after the sealed documents became public, Lilly agreed to pay $500 million to settle an additional 18,000 cases from patients who alleged that Zyprexa caused their diabetes and other health problems.

• Though federal prosecutors had been investigating Lilly for its marketing of Zyprexa since 2004, and state attorneys general had been doing so since 2005, it took the December 2006 Times coverage for state and federal investigations to gain momentum.

• The Times articles prompted Rep. Henry A. Waxman (D-Cal.), chairman of the House Committee on Oversight and Government Reform, to include Lilly in a congressional probe of research and marketing related to medical devices and drugs.

The leaked documents reportedly helped the Justice Department “build a criminal case against Lilly.” In 2009, “[t]he company pleaded guilty to marketing Zyprexa illegally” and “paid a record $1.4 billion fine. Though a landmark amount, Lilly’s fine amounts to about 3.5 percent of the $39 billion in revenues Zyprexa has posted since the FDA approved it 1996.”


**HALLIBURTON/KBR**

**Burn Pits.** Current and former U.S. military personnel, private contractors and their families are suing defense contractors Halliburton and its subsidiary, KBR, in nine states, alleging dangerous and deadly waste disposal practices on U.S. bases in Iraq and Afghanistan. According to victims, since 2004 the companies have unsafely burned “[e]very type of waste imaginable…including trucks, tires, lithium batteries, hydraulic fluids, munitions boxes, petroleum-oil-lubricant (POL) products, medical waste, biohazard materials including human corpses, latrine waste, medical supplies used during small pox inoculations, paints, solvents, asbestos insulation, items containing pesticides, polyvinyl chloride pipes, animal carcasses, dangerous chemicals, and hundreds of thousands of plastic water bottles” in open-air pits that emit poisonous smoke and ash.

Among the injured: Staff Sgt. Wendy L. McBreachy, who suffers from chronic cough, respiratory symptoms, sore joints, rheumatoid arthritis, muscle spasms, chronic pain syndrome and multiple sclerosis allegedly because of toxic smoke from burn pits at Balad Air Force Base in Iraq, which “reduced visibility to only a few yards” and “filled the nearby living quarters with smoke and haze.” Also sickened, Senior Master Sgt. Glen S. Massman, who contends that his respiratory problems, frequent headaches, chest tightness, constant dry cough, increased allergic sensitivities, sleep apnea and hypertension are the result of exposure to burn pit emissions at Camp Bucca, Iraq.

“These for-profit corporations callously exposed and continue to expose soldiers and others to toxic smoke, ash and fumes,” the lawsuits state. “These exposures are causing a host of serious diseases, increased risk of serious diseases in the future, death and increased risk of death.”

**Contaminated Plant.** From April through September 2003, hundreds of Army National Guardsmen from Oregon, Indiana and West Virginia were assigned to protect KBR contractors rebuilding an Iraqi water treatment plant in Basra. The site was contaminated with sodium dichromate, a chemical compound that contains hexavalent chromium. Hexavalent chromium is linked to cancer, asthma, nosebleeds, perforated eardrums, eye, kidney and liver damage, tooth erosion and other devastating injuries. As Max Costa, chairman of New York University’s Department of Environmental Medicine, told the Associated Press, hexavalent chromium is “one of the most potent carcinogens known to man” and it can “enter every cell of the body and potentially produce widespread injury to every major organ in the body.”

Internal company documents reveal that the company knew about the contamination and dangers of exposure but remained silent as soldiers spent months in chemical dust, unprotected and unaware that they were jeopardizing their health and safety on a full-time basis. For example, a June 2003 memo shows that KBR managers were on notice that there was hexavalent chromium at the plant; the site wasn’t closed for remediation until four months later. In addition, minutes from an August 2003 KBR meeting state that there was a “serious health problem at water treatment plant,” “the problem seems worse than initially considered” and “almost 60 percent of the people exhibit the symptoms.” The minutes also say “the chemical has been on the ground since day
one,” “[w]ind is blowing the product that is lying dry on the ground” and “[p]eople are potentially exposed to something that may be very dangerous.”

Testimony confirms that KBR knowingly endangered workers and Army soldiers. In a sworn statement, KBR’s southern Iraq Health Safety Environment (HSE) manager admitted that company managers were aware of site contamination before the Guardsmen arrived. According to a December 2008 deposition from retired Lt. Col. James Gentry, soldiers belatedly learned from KBR workers that the “orange sand” at the plant was actually a carcinogen, a fact revealed to Gentry after they’d guarded the facility for four months. Six months before Gentry’s deposition, former KBR employee Danny Langford told a U.S. Senate committee that KBR managers knew American civilians exposed onsite had elevated levels of chromium in their blood, warning workers “if you want to take these blood tests back and think you’re going to file a suit on KBR, you’re just wasting your time because it’s not going to work.”

During the same congressional hearing, former KBR HSE coordinator Ed Blacke described how KBR ignored a UN report and their own industrial hygienist about the severity of the contamination along with repeated warnings from Blacke that civilian employees and Guardsmen were suffering symptoms consistent with hexavalent chromium exposure – “continuous bloody noses, spitting up of blood, coughing, irritation of the nose, eyes, throat and lungs, and shortness of breath.” Instead of taking precautions, according to Blacke, KBR superiors met with workers and soldiers, assuring them that the chemical was a “mild irritant at worst, that the plant had been thoroughly checked out, and was safe, and that they were to get back to work.” When Blacke questioned those statements, he was escorted out of the meeting and told that he was “being insubordinate, disruptive, and that my input was not appreciated.”

Blacke was later fired when he challenged KBR’s methodology for testing contamination at the plant. As he told the Senate Committee,

I understand that KBR and Halliburton take the position that the air was tested at the plant and showed low levels of chromium, however, those tests were apparently done when the air was still, not during one of the frequent dust storms in which all of the materials on the ground became airborne. Furthermore, the levels of chromium from the ground samples show that the plant was a highly dangerous and unsafe and contaminated facility, and these facts were objective facts known by KBR management, in the face of which they made the conscious decision to continue to expose the American workers, the Iraqi workers, the American military personnel, and the British military personnel at the plant to these horrifically unsafe conditions.

Blacke concluded:

In my mind, it was criminally negligent of the KBR HSE and Project management to make a decision to continue to expose personnel to Sodium Dichromate poisoning at the Qarmat Ali water treatment plant when they knew of the exposure and knew of the absence of any personal protective gear whatsoever….It is outrageous that American tax dollars are the source of the funding of the Iraqi
operation of Halliburton and KBR when those companies have demonstrated such
total and complete disregard for the health and safety of the workers for whom
they are responsible.\textsuperscript{88}

To date, nearly 50 current and former Guardsmen have filed lawsuits against KBR and
two subsidiaries, arguing they should be held accountable for the soldiers’ breathing
disorders, constant nosebleeds, rashes, stomach and chest pain, sleeping disorders and
other chronic illnesses as well as the potentially fatal consequences of hexavalent
chromium exposure.\textsuperscript{89} Unfortunately, KBR workers suffering similar injuries have been
denied their day in court: their employment contracts contained mandatory binding
arbitration clauses, which compelled them to give up their right to have their claims
resolved by a judge or jury.\textsuperscript{90}

\textbf{Electrocution.} On January 2, 2008, Staff Sergeant Ryan Maseth was killed by
electrocution while taking a shower at his Army base in the Radwaniyah Palace Complex
(RPC) in Baghdad.\textsuperscript{91} The contractor had improperly grounded an electric pump that
supplied water to the building.\textsuperscript{92} When Maseth turned on the water, the pump short-
circuited, sending electrical current through the pipes into the metal shower hose and then
through his arm to his heart. The contractor responsible for wiring the facility where
Maseth was electrocuted: KBR.

“I always lived with the fear that I may face the news that one of my sons had been killed
in the line of duty,” Maseth’s mother, Cheryl Harris, told the Senate Democratic Policy
Committee six months after her son’s death. “On January 2, 2008, that fear was realized.
What I did not expect to hear, though, was the manner of death that my son, Ryan, a
decorated Army Ranger and Green Beret, experienced,” Harris said. “While I had always
been prepared to hear that one of my sons died by way of a firefight or a roadside bomb, I
was dumbstruck to hear in the days following the news of my son’s death that he was
electrocuted while taking a shower in his living quarters on his Army base….\textsuperscript{93}

An investigation by the U.S. House Committee on Oversight and Government Reform
revealed that KBR knew about electrical dangers in Maseth’s building and throughout the
RPC but never took action.\textsuperscript{94} Among the evidence uncovered in a July 2008 hearing:

- Internal inspection records showing KBR was aware of the electrocution hazard
  on February 10, 2007, 11 months before Maseth’s death. Some of the
deficiencies KBR noted on that date – the building’s main circuit panel, the
secondary feeder panel and the water tank were not grounded.

- Work orders from Sergeant Justin Hummer, the previous occupant of Maseth’s
quarters, who repeatedly warned KBR about electrical shocks in the shower.
According to Hummer, he was shocked “four or five times in the shower”
between June and October 2007. On at least one occasion, he “had to use a
wooden handle to turn off the shower nozzle because the electrical current was so
strong.”

- A KBR assessment of electrical systems after Maseth’s death concluding that the
majority of electrical panels in the complex “are in disrepair and require
replacement’’ and that a majority of electrical systems are ‘‘in complete disarray,’’ with 45 water pumps needing to be replaced because of electrical shortage or age. In a February 25, 2008 memo, the Defense Contract Management Agency (DCMA), the Pentagon organization in charge of supervising defense contractors in Iraq, reported that the “overwhelming majority” of KBR’s findings “were identical to those findings or problems as either alleged or identified in the 10 February 2007 limited inspection. These results indicate KBR failed to correct known deficiencies….”

- A letter from KBR to the Commander of the DCMA in Iraq, written on March 20, 2008, urging that troops immediately evacuate at least six buildings at the compound where Maseth was killed because “[t]he electrical conditions in all buildings make them uninhabitable for safety and health reasons. The recommended course of action, if the buildings will continue to be used, is to disconnect the power to the buildings immediately and completely replace the electrical systems.”

Other sources confirm the House Committee’s findings. In a sworn statement prepared after Maseth’s death, DCMA official Ingrid Harrison said, “KBR has been at R.P.C. for over four years and was fully aware of the safety hazards, violations and concerns regarding the soldiers’ housing.” The contractor “chose to ignore the known unsafe conditions,” she added. And on May 20, 2009, James Childs, a master electrician hired by the Army to review KBR’s electrical work in Iraq, told a congressional investigative panel that “it was not until October 2008 that KBR finally wired [Maseth’s] building properly so that it no longer posed a threat to our soldiers. This means that for 10 months the soldiers using SSG Maseth’s building were at risk of being shocked or electrocuted, even after KBR knew that there were significant and serious problems with his building.”

Moreover, the electrocution deaths of at least three other soldiers and one contractor in 2004 and 2005 put KBR on notice that their defective work endangered lives. What were those men doing when they were killed? Like Staff Sergeant Maseth, using items exactly how they were supposed to be used. Corporal Marcos Nolasco was taking a shower, Specialist Chase Whitham was swimming in a pool, Staff Sergeant Christopher Lee Everett was power-washing a Humvee, while the air conditioner in KBR contractor Sohan Singh’s living quarters short-circuited.

Upon learning that KBR received $83.4 million in Defense Department bonuses for electrical work that resulted in five deaths – $34.4 million of which was paid three months after Sgt. Maseth was electrocuted – Senate Democratic Policy Committee chair, Senator Byron Dorgan (D-ND), said, “KBR, in good conscience, should not wait for the Pentagon to ask for the bonuses to be returned. KBR should return the money of its own accord. But given KBR’s track record, I do not expect the company to do that. And so I am going to ask the Pentagon to compel KBR to return those bonuses.”

Additional documents show that KBR knew and did nothing about potentially fatal electrical problems across Iraq. A DCMA report, which probed internal company records, “found systemic KBR failures to properly ground and bond facilities – failures
that contributed to theater personnel receiving shocks in KBR maintained facilities on average once every three days” between September 2006 and July 31, 2008. “The condition of these facilities created Life, Health, Safety (LHS) conditions for the occupants. The lack of grounding and bonding, among other electrical deficiencies” were “identified and confirmed by three separate independent inspection teams,” the report stated. “Most facilities inspected had electrical deficiencies because KBR failed to consistently follow contract standards every time it constructed or emplaced a facility, inspected a facility, responded to a service order request, or performed maintenance and/or repairs on facilities, generators and utilities,” the report said. “The systemic nature of the nonconformance continued even after the Government made KBR aware of the problem,” the report found, adding that “[t]he Government is unaware of any efforts undertaken by KBR to independently identify, assess, and implement corrective actions to its electrical support services or quality control/inspection program as a result of the extensive number of electrical shock incidents….”

Similarly, in a letter dated September 30, 2008, the Commander of DCMA warned KBR of “continuing quality deficiencies” in the electrical work it performed, adding that KBR executives were “not sufficiently in touch with the urgency or realities of what was actually occurring on the ground” and that many within the Department of Defense “have lost or are losing all remaining confidence in KBR’s capability to successfully and repeatedly perform the required electrical support services mission in Iraq.”

Congressional testimony by former KBR employees affirms a pattern of gross disregard for life-threatening risks to U.S. servicemen and women. For example,

- Jeff Bliss, a field contract electrician who worked for KBR in Afghanistan in 2005 and 2006, told the Senate Democratic Policy Committee that the “carelessness and disregard for quality work at KBR was pervasive” and that he “saw first hand how KBR’s carelessness unnecessarily put people’s lives in danger.” In his July 2008 testimony, Bliss recounted how a soldier received a 400-volt shock from wiring that had been installed by a KBR plumber and KBR security officer. He said KBR hired many inexperienced, inadequately-trained electricians and employed many Third Country Nationals (TCNs) who were unfamiliar with U.S. standards and spoke no English. “These shortcomings were made worse by the fact that KBR failed to provide adequate supervision of the work done by its electricians at almost every base I went to in Afghanistan,” Bliss explained.

- On May 20, 2009, Jim Childs, an electrical inspector hired by the Army to review U.S.-run facilities in Iraq, told the Senate Democratic Policy Committee that KBR’s electrical work in Iraq was “some of the most hazardous, worst quality work” he had ever inspected. His investigation found that “roughly 90 percent of the new construction buildings worked on by KBR were not properly wired,” meaning “over 70,000 buildings in Iraq were not up to code.” He also testified that “[r]oughly 60 percent of KBR’s electrical workers were Third Country Nationals (TCNs), many of whom had no electrical training”; that “KBR’s work created dangerous conditions in buildings that had been safe until the company began working”; and that KBR “would refuse to perform what was necessary” to
ensure the correct operation of circuit protection, “creating unsafe conditions for those inside the buildings.” Childs discovered identical code violations by KBR in Afghanistan.¹⁰²

- During the same hearing, Eric Peters, a master electrician who worked for KBR in Iraq, told the investigative panel that at least 50 percent of the KBR-managed buildings he saw were not properly wired, adding that he “worried every day that people would be seriously injured or killed by this defective work.” Like Childs, he expressed concern that TCNs – most of whom he claimed “have absolutely no knowledge of the National Electric Code or British Standards and the quality of their work reflects that” – performed the majority of KBR’s electrical work in Iraq. Peters also charged that KBR purchased unsafe breakers that had the potential to injure people and “frowned upon” any refusal to sign off on work deemed incomplete or unsafe.¹⁰³

When recently questioned by Associated Press reporters and editors about KBR’s wiring in Iraq, company Chairman, William P. Utt, had this to say: “We believe the standards that we did employ were standards that were known and thought to be acceptable in an expeditionary environment…. We don’t think the wiring that we installed was potentially dangerous.” He explained that the company should be immune from lawsuits since “[w]e are working for the government, taking a lot of instruction from the government,” adding that “there ought to be some consideration given in many of these claims to the same protections the government has from these suits that exist.”¹⁰⁴

The families of soldiers killed by KBR’s deliberate recklessness disagree. Faced with the Army’s failure to bring criminal charges against KBR after their son’s death was classified a “negligent homicide,” Sgt. Maseth’s parents have turned to the civil courts for justice.¹⁰⁵ In April 2008, Cheryl Harris and Douglas Maseth filed a wrongful death suit against KBR in federal court.¹⁰⁶ When asked about the case, KBR told the Pittsburgh Tribune-Review; “Based on our current knowledge and the information we have gathered to date, KBR has found no evidence of a link between the work the military tasked KBR to perform and the reported deaths that have resulted from electrocution.”¹⁰⁷

In March 2009, U.S. District Judge Nora Barry Fischer rejected KBR’s assertion of immunity, among others, as grounds for dismissal. “This case does not involve claims arising from active military combat operations,” Judge Fischer said in her ruling. “The issues presented by [Ms. Harris’s] claims involve the alleged negligent performance or non-performance of KBR in providing maintenance services to the United States Army.” The lawsuit, she said, “asks this court and a jury to determine whether the work that KBR actually performed at the [complex] was substandard, negligent work that resulted in Ryan Maseth’s death.”¹⁰⁸

After the ruling, Cheryl Harris said, “It is really good news. It is the absolute best news that I’ve received in the 15 months since Ryan died. I just feel like there is some justice and the right decision was made.” Harris added, “Real changes need to take place for contractors and oversight. I hate to say the word happy, because nothing is going to make me happy, but it was the right thing. And I’m so glad to see it’s happening.”¹⁰⁹ As
of June 3, 2009, the case has been delayed pending a 3rd Circuit appeal by KBR, who continues to argue that federal courts have no jurisdiction over military matters.110

Like Maseth’s family, Staff Sgt. Christopher Lee Everett’s parents are seeking accountability through the civil justice system. Patrick Everett and Larraine McGee have filed a federal lawsuit against KBR and contractor Arkel International after their son was killed by electrocution while power-washing a Humvee.111 According to their complaint, the contractors negligently installed the generator supplying electricity to the power-washer, knew the generator was not properly installed before Everett was electrocuted and received numerous complaints about the generator before Everett’s death. Despite awareness of the risks, KBR and Arkel never fixed the problem but assured troops it had been fixed, evidence of the contractors’ “conscious indifference” to the safety of servicemen and women at the base, the complaint alleges. The case is still pending.

Rape/Sexual Assaults. On July 25, 2005, 20-year-old Jamie Leigh Jones, a KBR employee, went to Iraq in support of Operation Iraqi Freedom. Three days later, she was drugged and gang-raped by male co-workers.112 Jones awoke groggy in her barrack room the next morning to find herself bleeding, bruised and in severe pain. She reported the incident and was eventually taken to the hospital by KBR security.

After her medical exam, Jones’s rape kit was turned over to the same security personnel, who then locked Jones in a shipping container for at least 24 hours without food or drink, posting two armed guards outside the doors. Jones managed to persuade one of the guards to let her contact her father by cell phone, who in turn called U.S. Rep. Ted Poe (R-Tex.), who then contacted the State Department.

Within two days, agents from the U.S. Embassy in Baghdad freed Jones.113 She was later interviewed by Halliburton/KBR supervisors, who warned her that she’d lose her job if she left Iraq. Severely injured, Jones decided to return home where she underwent reconstructive surgeries and psychiatric treatment.

When the government failed to bring criminal charges against KBR, Jones turned to the civil courts.114 Although she had signed an employment contract with KBR that contained a hidden mandatory binding arbitration provision,115 Jones recently won the right to void that clause and file her claim in court.116

“The forced arbitration clause in army contractor’s contracts, prove to protect the criminals of violent crimes, rather than enforce they be held accountable by a judge and jury,” Jones testified in Congress. “Victims of crime perpetrated by employees of taxpayer-funded government contracts in Iraq deserve the same standard of treatment and protection governed by the same laws whether they are working in the U.S. or abroad.” She argued that “Army contracting corporations harbor and ignore criminal activities in Iraq, which under the arbitration clause agreement, protects them and does not hold corporate accountability when a crime has been committed. This clause also paves the way for corporations to not be held accountable under criminal law.”117 Jones concluded, “My goal is to ensure all American civilians who become victim of violent crimes while abroad, have the right to justice before a judge and jury.”
Since Jones went public with her experience, other sexual assault victims have come forward with similar stories of KBR’s willful indifference and their inability to hold the company civilly liable. In April 9, 2008 testimony, KBR paramedic Dawn Leamon recounted KBR’s actions after she was brutally raped by a soldier and co-worker in Iraq. As she told the Senate Foreign Relations Committee:

- KBR’s first response upon learning that I had been sexually assaulted was to try to keep it quiet. KBR then performed an investigation that I feel was intended to blame me for being raped.

- KBR did little or nothing to restore my sense of safety after I reported being raped.

- I am unaware of any measures to date being taken against the KBR employee or the member of the US military who attacked me.

- I have encountered [obstacles] in pursuing justice in this matter. I don’t really understand all of the legalities of this situation, but I understand that there is an arbitration clause in the employment agreement I signed with Service Employees International that KBR claims prevents me from seeking civil justice in a court of law.\footnote{118}

KBR’s treatment of Mary Beth Kineston is consistent with the other victims’ accounts. While working for KBR in Iraq in 2004, Kineston was raped by a KBR employee, sexually assaulted by a fellow truck driver and subjected to constant sexual harassment from co-workers.\footnote{119} When Kineston told KBR management, she was ignored, disciplined and ultimately fired.\footnote{120} As she told the Senate Foreign Relations Committee in April 2008:

When I was hired I expected that KBR would protect my physical safety while working as far as it was able and I did not expect any special treatment merely because I was a female. …I was not expecting to trade my self respect or right to be free from sexual assault as a condition of continued KBR employment and I did not view myself as selling my human dignity as a female employee when I accepted KBR paychecks. I also expected that when I made a complaint about such activity, it would be thoroughly investigated in good faith, that is, with an intent to resolve the problem immediately, and that I would be protected from the perpetrator in the mean time. I also expected that if the laws were broken by KBR relative to gender discrimination or if I were a victim of a crime I would have an adequate legal remedy for the offense. I expected that given KBR had a sexual harassment policy and given KBR was obligated to abide by federal civil rights laws regarding gender discrimination it would protect me in the event I was a target of any sexual misconduct by co-workers.

I can assure this Committee that none of my expectations about KBR were fulfilled.\footnote{121}
When no criminal or disciplinary action was taken, Kineston filed a civil lawsuit against KBR, which she was forced to arbitrate. “Although I eventually won the arbitration claim with the assistance of my counsel; I was hardly made whole for my suffering and pain,” she told the Committee.\textsuperscript{122}

On October 6, 2009, the U.S. Senate passed a defense appropriations amendment to prevent contractors from forcing employees to resolve sexual assault claims through arbitration.\textsuperscript{123}

PEANUT CORPORATION OF AMERICA (PCA)

On December 21, 2008, brain tumor and lung cancer survivor Shirley Almer died after eating peanut butter tainted with salmonella typhimurium.\textsuperscript{124} “It seemed so pointless – with all the battles she overcame – to have a piece of peanut butter toast take her,” Almer’s daughter said of her 72-year-old mother.\textsuperscript{125} The contamination – which can cause vomiting, abdominal pain, diarrhea, fever, nausea, chills, headaches, muscle pains and bloody stool and kill people with weakened immune systems, such as young children and the elderly – was ultimately traced back to the Peanut Corporation of America.\textsuperscript{126}

Almer was not the only victim. As of April 20, 2009, at least eight other people died and over 700 people, half of them children, became sick in 46 states after eating PCA products infected with the same strain of salmonella.\textsuperscript{127} Twenty-four percent of victims needed to be hospitalized.\textsuperscript{128} According to the CDC, the actual number of injuries is probably much higher, since 38 cases go unreported for every case that’s reported.\textsuperscript{129} The nation-wide outbreak led to one of the largest recalls in U.S. history, with more than 2,100 product lines containing PCA ingredients taken off the shelves.\textsuperscript{130}

An FDA investigation of PCA’s Blakely, Ga. plant found that the company took no steps to clean the production line or minimize cross-contamination after PCA’s own tests showed salmonella typhimurium at the facility.\textsuperscript{131} The inspection also revealed that PCA routinely shipped peanut products it knew had tested positive for salmonella.\textsuperscript{132} This happened 12 times in 2007 and 2008. According to agency officials, PCA shipped tainted products in three instances: 1) after internal tests showed they contained salmonella; 2) before second tests contradicted the company’s initial findings of contamination; and 3) after retests showed no contamination. In all those cases, food experts say, the products should have been destroyed.\textsuperscript{133} Instead, they were sent to unsuspecting distributors (who sold them to schools, hospitals, nursing homes and other institutions) as well as some of the world’s largest food manufacturers (who put them in cookies, candy, crackers and other items) – actions that caused massive harm to innocent consumers across the nation.

Though he knew about positive test results and approved the shipping of tainted products, company President Stewart Parnell denied PCA’s role in the salmonella epidemic.\textsuperscript{134} In a January 12, 2009 email, Parnell assured employees that “PCA’s products are well-tested and safe; we were not the cause of this food-sickness outbreak.” He explained that the company had “never found any salmonella at all” in its peanut butter samples and “[n]o salmonella has been found anywhere else in our products or in our plants, or in any
unopened containers of our product.” He also blamed “news agencies” for “looking for a news story where there currently isn’t one.”

Other documents made public by the House Subcommittee on Oversight and Investigations show the extent to which PCA was “more concerned with its bottom line than the safety of its customers.” For example,

- In an October 6, 2008 email, Parnell complained to Blakely plant manager, Sammy Lightsey, that positive salmonella test results were “costing us huge $$$$$$ and causing obviously a huge lapse in time from the time we pick up peanuts until the time we can invoice.”

- In a letter to the House investigative panel, JLA official Michelle Pronto explained that PCA stopped sending her lab samples when too many test results came back positive for salmonella. “I called Mr. Lightsey to follow up on the recent discussion regarding the confirmed positive,” Pronto stated, “and he confirmed that because of the high coliform results they were going to send samples to a different lab for a while.”

- In an email written three days after the FDA identified PCA’s Blakely plant as the source of the salmonella outbreak, Parnell pleaded with an agency inspector to allow the company to keep doing business. He told the FDA official that the raw peanuts “would be cooked / further processed by us in our Texas facility and tested afterwards as all of our products are...” Within weeks of Parnell’s email, that facility was shut down because of salmonella contamination.

In prepared testimony, Charles Deibel – whose company had tested PCA’s products and alerted the Blakely plant that salmonella was in some of its peanut stock – told the House Subcommittee that PCA’s behavior deviated from food industry norms. “It is not unusual for Deibel Labs or other food testing laboratories to find that samples clients submit do test positive for salmonella and other pathogens, nor is it unusual that clients request that samples be retested,” Deibel said. “What is virtually unheard of is for an entity to disregard those results and place potentially contaminated products into the stream of commerce.”

When subpoenaed to testify before the House panel about PCA’s role in the salmonella outbreak, Parnell repeatedly invoked his 5th Amendment right not to incriminate himself. Under federal law, it is illegal to knowingly put tainted products into the food supply.

Though the FDA and the Justice Department have launched a criminal probe, no further action has been taken. As a result, victims have turned to the civil courts, filing nearly 200 personal injury claims against PCA. Among those seeking justice:

- The family of Clifford Tousignant, who died after eating tainted PCA peanut butter at his nursing home;
• The children of Shirley Almer, who died after eating salmonella-laced PCA peanut butter on toast; and

• The parents of seven-year-old Christopher Meunier, who was hospitalized for six days and continues to suffer lingering complications after eating crackers made with contaminated PCA peanut butter.\(^{146}\)

In February 2009, PCA filed for bankruptcy, and on October 1, 2009, the manufacturer’s insurance company created a trust fund of $12 million to settle claims through the bankruptcy process.\(^{147}\) However, given the number of deaths and injuries involved and the hundreds of claims that have already been filed, this fund will barely cover the damages. Lawsuits will proceed against other companies that may share responsibility. Said attorney William Marler, “[T]he $12 million will be a start in compensating the victims and their families. Please remember, at least nine people died and over 700 were sickened…. If $12 million is not sufficient to satisfy all claims, Kellogg and King Nut, the two largest re-manufacturers, will need to pay the balance.”\(^{148}\)


4 Ibid.


Email from John Tumas dated December 6, 1999, found at http://psychrights.org/research/Digest/NLPs/Seroquel/43_Exhibit42.pdf.


46 Ibid.

47 Ibid.

48 Ibid.

49 Ibid.


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109 Ibid.


121 Testimony of Mary Beth Kineston before the Senate Committee on Foreign Relations, April 9, 2008, found at http://foreign.senate.gov/testimony/2008/KinestonTestimony080409a.pdf.

122 Testimony of Mary Beth Kineston before the Senate Committee on Foreign Relations, April 9, 2008, found at http://foreign.senate.gov/testimony/2008/KinestonTestimony080409a.pdf.


128 Ibid.


