Civilian Registry for Diagnosed Havana Syndrome Patients and Anomalous Health Incidents (AHI) among Civilians Occurring on US Soil: January 2026 Update.

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January 2026

LIST OF ABBREVIATIONS

AHI	Anomalous Health Incidents
AHI1	Clinically Validated Cases of Havana Syndrome
AHI2	Unvalidated Cases of Havana Syndrome
CDC	Center for Disease Control
CNS	Central Nervous System
CRHS	Civilian Registry for diagnosed Havana Syndrome and its AHI
DHA	Defense Health Agency
DOD	Department of Defense
EM Energy	Electromagnetic Energy
GAO	Government Accountability Office
HAVANA Act	Helping American Victims Afflicted by Neurological Attacks Act of 2021
HS	Havana Syndrome
IC	Intelligence Community
MHS	Military Health System
TBI	Traumatic Brain Injury
NASEM	National Academy of Sciences, Engineering and Medicine
NIH	National Institute of Health
NKBI	Non-Kinetic Brain Injury
US	United States

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Summary

Diagnosed civilian Havana Syndrome and Anomalous Health Incident cases on US soil are increasing, yet the United States still lacks a civilian case definition, reporting pathway, and clinician guidance from CDC or NIH. This January 2026 update reports findings from the Civilian Registry for diagnosed Havana Syndrome victims (CRHS), established in August 2024 to document and analyze physician diagnosed civilian cases in the absence of federal civilian surveillance. The first report in January 2025 documented seven verified diagnoses and 30 additional self-reported physician diagnoses without documentation. As of January 2026, CRHS includes 14 verified civilian diagnoses supported by medical information and 39 additional civilians who report a physician diagnosis. This report treats Havana Syndrome as a distinct neurological syndrome with an AHI1 phenotype that is clinically validated and separable from attribution debates, with the leading mechanism converging on directed, pulsed radiofrequency exposure. The growth in verified diagnosed cases indicates an emerging neurologic health threat in the general population and underscores the continuing absence of a coordinated US public health response.

1. Why a Civilian Registry Is Necessary

Havana Syndrome (HS) is a distinct neurologic syndrome characterized by abrupt onset Anomalous Health Incidents (AHI) and persistent neurocognitive sequelae. As reported in the 2024 NIH studies, AHI cases are stratified into AHI1 and AHI2 groups.[1,2] The AHI1 group denotes the clinically validated acute onset phenotype, with characteristic clinical, vestibular, and neuroimaging patterns described in the medical literature.[3] Mechanism is increasingly converging on directed energy exposure, particularly directed, pulsed radiofrequency energy, as the most plausible cause for the core AHI1 presentation. Giordano (2025) states, "It is now widely accepted that directed energy exposure is the most probable cause".[4] The AHI2 group includes self-reported cases not validated by the above criteria.

Attribution is separate from mechanism and remains largely classified. The inability of the Intelligence Community to assign responsibility does not negate the medical reality of a diagnosable syndrome. The US government has acknowledged HS through the HAVANA Act of 2021 and Department of Labor guidance for federal claimants.[5] Civilian cases on US soil remain outside those investigatory and validation pathways.

Surveillance of US Civilian cases occurring on US Soil is absent despite the scale of reported incidents in government cohorts. GAO describes a federal AHI care and registry framework limited to US government employees and eligible family members, yet no parallel public health reporting mechanism exists for civilians.[6] A CDC FOIA response dated March 3, 2025 released heavily redacted materials and did not produce any civilian facing diagnostic guidance.

CRHS is a volunteer registry maintained by a physician. It records two categories of US Civilian cases that occurred on US Soil. Verified Diagnosed Cases include patients who provide medical documentation showing a diagnosis of Havana Syndrome or an equivalent diagnosis. Self Reported Diagnosed Cases include patients who report a physician diagnosis but do not share documentation for verification. Verified cases are analyzed for demographics, geography, and

other factors. The January 2025 CHRS report summarized cases collected from August 2024 through January 2025.[7]

The registry is therefore necessary as interim national infrastructure. It preserves denominators, supports clustering analyses, and creates an administrative record for policy makers while CDC and NIH remain inactive.

2. Registry Composition and Verification Status as of January 2026

As of January 2026, CRHS includes 14 verified civilians with medical documentation and up to 39 additional civilians who report receiving a physician diagnosis of Havana Syndrome or an equivalent diagnosis. This represents growth from January 2025, when seven verified cases and approximately 30 self-reported diagnoses were documented. The number of verified diagnosed patients doubled since January 2025 Report. Chart 1 summarizes this change.

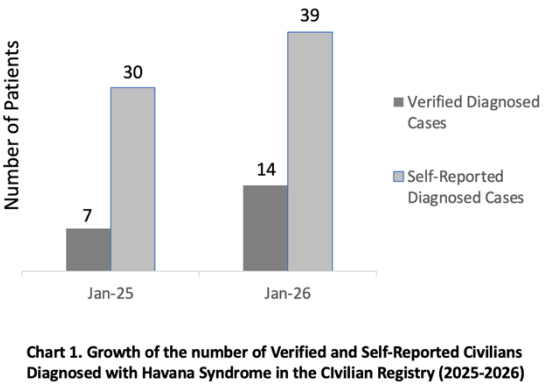

Chart 1. Growth of the number of Verified and Self-Reported Civilians Diagnosed with Havana Syndrome in the Civilian Registry (2025-2026)

Male/Female distribution of verified patients was roughly 50% in the 2025 report, while the number of female patients shifted to 70% since.

The median age of verified patients increased from 50 in the 2025 report to 53 in this update. The registry continues to include one verified teenage patient.

Distribution of verified patients by state is presented in Chart 2. States which had new verified patients since the January 2025 Report are identified in the Chart 2, and the total number of

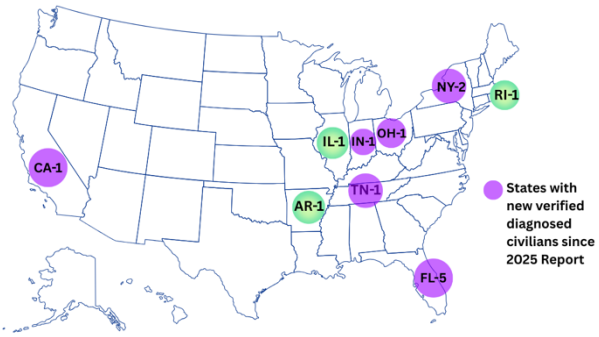

Chart 2. Distribution of Verified Cases of Civilians Diagnosed with Havana Syndrome in the Civilian Registry (2025 – 2026)

verified diagnosed patients follows the state abbreviation (FL-5, NY-2), etc. Florida had the highest number of verified patients, followed by NY.

The number of verified diagnosed civilians varied from year to year, with the average of 3.2 cases between years of 2022-2025.

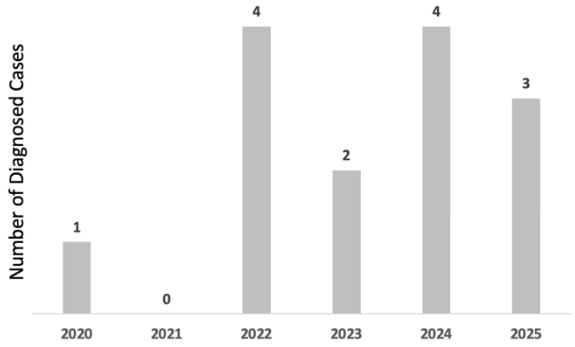

Chart 3. Number of verified diagnoses patients per year 2020-2025

Additional notes from verified cases:

1. One patient is on permanent disability attributed to Havana Syndrome.
2. One patient was referred to the Department of Defense by Professor James Giordano of Georgetown University on two occasions. No investigation followed.
3. Physicians for four verified patients notified their state epidemiologists of civilian Havana Syndrome cases and requested CDC guidance. No responses have been received.
4. All verified patients report recurrent or ongoing AHIs.

3. Civilian Registry (CRHS) Engagement with US Health Agencies

CDC and NIH hold the core public health responsibilities for novel neurologic threats, yet neither has established a civilian facing program for HS or AHI. This section summarizes CRHS interactions with CDC and NIH.

3.1 Centers for Disease Control and Prevention (CDC)

The CDC, as the nation's leading public health agency, is responsible for tracking emerging health threats, issuing guidance, and coordinating responses to novel syndromes. However, FOIA responses reveal a lack of civilian-focused efforts on AHI/HS.

A FOIA request submitted November 6, 2024 sought documents on tracking, investigating, and analyzing AHI/HS among U.S. residents with domestic incidents on U.S. soil from January 1, 2018, to November 1, 2024. The CDC's final response, dated March 3, 2025, from the Office of Safety, Security, and Asset Management (OSSAM), released nine pages of records including fully redacted "CDC Anomalous Health Incidents (AHI) Guidance". Upon analysis, this redacted document matched the publicly available 2022 DOL Bulletin which advises filing worker compensation claims for AHIs under an ICD-10 code corresponding to Acute Traumatic Brain Injury.[5] This guidance is restricted to federal employees and dependents, with no equivalent for civilians.

On September 29, 2025, Targeted Justice submitted a formal petition urging CDC to recognize civilian AHI/HS, establish surveillance, and provide physician guidance.[8] The agency replied:

> *Here is the information you requested on petition Havana Syndrome. Unfortunately, this question is out of scope for CDC-INFO.*

This dismissal underscores a profound absurdity in the federal response to a novel health threat: the nation's premier public health agency, tasked with protecting all Americans from emerging hazards, and effectively abdicates responsibility for civilians exposed to the same syndrome that has prompted extensive government action for federal personnel. This position is illogical, both in the ethical and the practical sense: public health threats do not respect employment status or dependency classifications, and ignoring civilian cases risks underestimating prevalence, delaying interventions, and perpetuating misdiagnoses.

For instance, consider a hypothetical scenario where a family is attacked in a hotel room during an AHI: a government employee, their dependent children, and a non-dependent relative (e.g., an adult sibling) all experience AHI. Under current policy, the government would investigate the employee and dependent, but the relative would be ignored, despite identical exposure. This

selective approach not only fragments epidemiological data but also raises discrimination concerns, potentially violating principles of equal protection under public health laws like the Public Health Service Act. As mentioned in the *Registry Composition* section of this Report, diagnosed civilian victims are not being tracked or investigated by the DOD that currently leads HS and AHI investigative efforts.

Moreover, the dismissal of civilian victims of Havana Syndrome is not merely passive neglect but involves active suppression, as evidenced by restrictions placed on leading medical experts who previously diagnosed civilian cases. For instance, Dr. Michael E. Hoffer, an otolaryngologist at the University of Miami, disclosed the following re. his ability to diagnosed civilian cases:

> *I hope you didn't come all this way and be disappointed, but I am not allowed to diagnose Havana Syndrome victims any longer. The government won't let me.*

This statement, provided under penalty of perjury, reflects a policy shift around 2023 where Dr. Hoffer began denying appointments to non-government employees, despite having previously diagnosed civilians using the same criteria. Formal petition text is available here: https://open.substack.com/pub/lenbermd/p/formal-petition-to-the-cdc

3.2 National Institutes of Health (NIH)

The NIH, focused on biomedical research, has sponsored key AHI studies which excluded civilians. The 2024 neuroimaging study by *Pierpaoli et al.* and clinical findings by *Chan et al.* published in in JAMA analyzed 81 AHI patients and 48 controls.[1,2] The NIH press release announcing the publication of these studies narrated: NIH studies find no evidence of MRI-detectable brain injury.[9] This categorical conclusion was based on lumping all AHI cases together, while NIH's own reporting stratified AHI cases into AHI1 (cases validated by neuro-vestibular Hoffer 2018 criteria[3]) and AHI2 (those not validated). This conclusion prompted widespread criticism, particularly the failure to report findings in the stratified clinical phenotype AHI1. Formal re-analysis of 2024 NIH study is now available.[10]

Re-analysis, focusing on 43 AHI1 patients using Supplemental Tables in the NIH study, revealed subtle but persistent changes, such as reduced salience network connectivity (adjusted p ~0.02), paralleling previous 2019 *Verma et al.* findings converging on the same anatomical regions in the brain, and consistent with diffuse TBI.[10,11] This re-analysis essentially overwrites the previous "no MRI brain injury" conclusion.

The stratification of Anomalous Health Incidents into AHI1 and AHI2 categories is crucial for advancing accurate diagnosis, research, and policy on Havana Syndrome, as it distinguishes validated cases with objective neuro-vestibular evidence from those with subjective symptoms alone. The existence of AHI1 effectively rule out purely psychogenic origins. This differentiation ensures that investigations focus on genuine pathophysiological changes, like reduced salience network connectivity, preventing dilution of data by including AHI2 cases that may stem from stress or unrelated conditions.

Moreover, the false narrative of "no brain injury" became the basis for the 2024 IC Updated Assessment on AHI (released by ODNI in January 2025) which resulted in false conclusions.[12] Specifically:

> ***Medical Research:*** *The IC continues to assess that medical research indicates that US personnel and dependents reporting possible AHIs do not have a consistent set of physical injuries, based on research published in 2024 from the National Institutes of Health (NIH) that reaffirms prior medical analysis.*

The NIH studies were halted in September 2024 after an internal review found participant coercion violating informed consent.[13] No new NIH AHI research has resumed as of December 2025. In October 2025, a congressional committee issued criminal referrals to the DOJ alleging illegal activities in Havana Syndrome probes aimed at the response by the U.S. intelligence community (IC) and the National Institutes of Health (NIH), which is still ongoing.[14]

Importantly, this was not the first time the IC meddled with scientific inquiry into Havana Syndrome. The Senate Select Committee on Intelligence's 2024 Report sheds light on earlier

interferences.[15] The 2019 Verma et al. neuroimaging study conducted at UPenn indicated diffuse brain injury.[11] The follow-up UPenn's research found that all of the group-level differences were driven by a subset of the AHI population (now recognized as AHI1). However, the study was shelved. The university officials stated they did not attempt to publish the study because “they believed a U.S. government (USG) researcher tried to publicly undermine their findings”.[15]

This incident essentially triggered the NIH studies that have now been criticized, re-analyzed, and investigated for coercion of patients, deliberate methodological choices and interpretations that were politically motivated rather than scientifically justified.

A formal petition to NIH on September 29, 2025, called for recognition, research inclusion, and clinical protocols for civilians, citing ethical lapses in prior work and the need for independent validation.[16] No response from the agency has been received. The text of the NIH petition is available: https://open.substack.com/pub/lenbermd/p/formal-petition-to-the-nih

3.3 Consequences of CDC/NIH inaction in Civilian Havana Syndrome Cases

CDC and NIH inaction and lack of response to the 2025 CHRS Report and respective Formal Petitions have produced concrete negative consequences:

1. Civilian incidence is systematically undercounted. CDC has issued no Health Advisory, civilian case definition, or reporting mechanism for HS and AHI on U.S. soil.

2. Clinical misdiagnosis is structurally enabled. Front line physicians have no CDC criteria or protocols, leading to misattribution and missed documentation, even when clinicians alert state epidemiologists.

3. Preventable disability accumulates in civilians. Victims, including children, experience painful incapacitating AHIs and persistent neurocognitive deficits, but lack access to specialized evaluation and multidisciplinary care.

4. Critical clinical and exposure data is lost. NIH exclusion of civilians from studies, clinics, and registries prevents capture of exposure histories and long-term outcomes, delaying diagnostic, mitigation, and treatment advances.

5. A discriminatory system is entrenched. Federal employees and dependents receive structured pathways and benefits, while civilians are treated as second class, including restricted access to expert diagnosis.

6. Science and policy are distorted, and trust erodes. Biased datasets and diluted conclusions feed misleading narratives about injury consistency and mechanism, reinforce institutional skepticism, and undermine confidence in CDC and NIH transparency.

3.4 Public Support of the Formal Petitions to the CDC and NIH

Public support for CDC and NIH action on diagnosed civilian Havana Syndrome and Anomalous Health Incident cases is measurable, documented, and publicly visible. As of the time of publishing this report, the Change.org petition titled *"CDC & NIH: Recognize, Track, and Investigate Diagnosed Civilian Havana Syndrome/AHI Cases"* reports 1,049 verified signatures indicating sustained civic engagement beyond the smaller circle of directly affected families and clinicians. (https://www.change.org/p/cdc-nih-recognize-track-and-investigate-diagnosed-civilian-havana-syndrome-ahi-cases)

4. Diagnosis, Mechanism, and Attribution in AHI1 Cases of Havana Syndrome

The CRHS operates in a landscape where much of the information on AHI and HS remains classified, particularly within the Intelligence Community (IC) and Department of Defense (DOD). The controversy surrounding this unique neurological syndrome has been intentionally

obfuscated by mixing diagnosis, mechanism, and attribution. This section is dedicated to bringing clarity to this much contested topic.

Unique and novel Havana Syndrome can be diagnosed without knowing who caused it. To draw the analogy, medical profession can identify asbestos injury without naming the companies that put it in the walls. Yet, when it comes to AHI, policy debates often treat the lack of attribution as evidence against the syndrome.

The AHI1 framework discussed above clarifies the clinical entity. Based on criteria described in early case series, AHI1 captures cases with acute onset sensory phenomena, rapid neurologic symptoms, objective neuro-vestibular findings, and now a distinct MRI pattern. This phenotype is clinically distinct from less specific presentations such as AHI2 and is central to reliable diagnosis and research.

By emphasizing AHI1, policy makers can advance public health recognition without relying on classified attribution. A civilian facing response can focus on case definition, reporting, clinical guidance, and prevention while attribution remains contested.

Mechanism behind validated AHI has converged around directed, pulsed radiofrequency energy as the most plausible explanation for the core AHI1 symptom complex, as reflected in major expert assessments. This includes the 2020 NASEM report, FOIA-obtained 2022 IC Scientific Panel Assessment and subsequent expert commentary, including Giordano's 2025 statement: "It is now widely accepted that directed energy exposure is the most probable cause".[4,17,18]

Attribution ("who is doing it") remains an Intelligence Community question. It is framed around foreign actors only, and does not include important AHI1/AHI2 stratification. The scope of the 2024 ODNI Assessment on AHI is deliberately limited.[12] For example, it doesn't account for the US's own capabilities to perpetrate Havana Syndrome. Congressional Act of The Directed Energy Weapon Systems Acquisition of 2016[19] defines directed energy weapon systems as follows:

> *"Directed energy weapon system" means military action using highly focused sound, electromagnetic, or particle-beam energy to incapacitate, damage, or destroy enemy equipment, facilities, or* ***personnel****.*

The 2024 ODNI medical research line of reasoning relies on NIH 2024 false narrative based on pooled findings which does not assess the clinically validated AHI1 subgroup separately. This is consequential because AHI1 specific findings can be diluted when mixed with heterogeneous presentations.

This clear separation of diagnosis/mechanism from attribution is crucial for civilians diagnosed with Havana Syndrome and suffering from AHI on US soil. The US needs a civilian case definition, reporting mechanism, and clinician guidance, coupled with investigation and prevention measures that need, but don't depend on attribution. The public health response is too important, and cannot wait for the politically sensitive topic of attribution.

5. Conclusion

Diagnosed civilian HS and AHI cases on US soil are increasing and are being documented in CRHS. As of January 2026, the registry contains 14 verified diagnoses and up to 39 additional self-reported diagnoses, up from seven and 30 in January 2025. These cases present as a distinct neurologic syndrome with potentially severe and lasting neurocognitive consequences. The number of civilian cases is severely underreported due to the voluntary nature of the registry, absence of the official guidance, IC meddling in the scientific inquiry, reliance on politically motivated narratives, and deliberate conflation of diagnostic capabilities, mechanism and attribution. Despite FOIA disclosures and formal petitions, CDC and NIH have not created a civilian facing case definition, reporting mechanism, or clinical guidance. The registry therefore remains an essential interim public health instrument and a basis for specific federal action.

6. Recommendations

The 2026 update identifies four immediate actions. CDC should create a civilian surveillance and clinical guidance pathway. NIH should restart ethically sound research with civilian inclusion and AHI1 stratification. Law enforcement and the Intelligence Community should investigate validated cases on US soil while keeping medical diagnosis distinct from attribution. Congress should mandate accountability and timelines across agencies.

1. For CDC: Establish a national civilian reporting and surveillance mechanism for HS and AHI. Publish a case definition and clinician guidance, including AHI1 based diagnostic pathways and recommended referrals. Coordinate with state and local health departments.

2. For NIH: Implement civilian inclusive protocols and fund independent replication focused on the AHI1 phenotype, using advanced neuroimaging and neurophysiology where appropriate. Ensure informed consent protections and independent oversight.

3. For law enforcement and the Intelligence Community: Open investigative pathways for medically validated AHI1 cases occurring on US soil. Create a multidisciplinary task force that can accept civilian referrals and can share unclassified prevention and detection guidance.

4. For Congress: Require CDC and NIH to respond formally to petitions and to report progress on civilian surveillance, research, and protective measures. Mandate regular public reporting on validated civilian cases and on prevention programs.

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