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United States Hospital Threat Assessment - Updated

Threat Assessment - May 2025

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REPORT AUTHOR

"United States Hospital Threat Assessment - Updated" research was led by Syed Khalid Muhammad, Executive Director - CommandEleven, in coordination with numerous intelligence analysts across the United States.

In addition to being the founder and Executive Director of CommandEleven, Khalid has significant field operational experience with terrorism, extremism, and insurgencies, and specific insights into the Afghan Taliban, Tehreek-e-Taliban Pakistan (TTP), Islamic State - Khorasan Province (ISKP), and other terror groups operating in Afghanistan and Pakistan. He is also considered one of the leading voices on counter intelligence in the region, referencing his own background in counter intelligence in his long list of bona fides.

ABOUT COMMANDELEVEN

CommandEleven is an intelligence and analysis firm, based in Pakistan, with assets, analysts, and researchers offering apolitical analysis on topics such as security, geopolitics, defense, and espionage. CommandEleven's intelligence includes Afghanistan, Pakistan, and Kashmir.

CommandEleven, founded in 2015 as a think tank and policy advisory, with the objective of democratizing intelligence, simplify its understanding and real-life application, while offering guidance to governments, agencies, media, and private organizations.

CommandEleven continues to inform and guide public policy and decision-makers in the government, business, and military through a rigorous program of publications, conferences, digital media, policy briefings, and recommendations.

INTRODUCTION

"GOVERNMENTS HAVE STOPPED LOOKING AT NATIONAL SECURITY AS PROTECTING THEIR CITIZENRY, AND HAVE STARTED TO ADOPT A POLITICAL SECURITY VISION FOR NATIONAL SECURITY."

The United States government has adopted a policy of negotiating and accepting intelligence from organizations who do not have the best interests of the United States at heart. As a matter of fact, the enemy states' goal is to plant as much deception within the United States as possible to make their attack easier to carry out, what is known as the path of least resistance.

For the United States government to be trusting and sharing intelligence with the Taliban's General Directorate of Intelligence (GDI) means you are ***giving them all the information that you need verified by credible sources and allowing them to deceive you into believing your intelligence is wrong, when it is actually right.*** It also gives them the opportunity to provide counter intelligence that guides you away from the real terrorists, targets and objectives.

It was once said the Taliban senior leadership would not allow a terror attack on US soil because it would mean the end of their negotiations with the US for recognition. For that argument to carry weight, the Taliban must be unified as one cohesive unit, which it does not. The Haqqani Network, Islamic State Khorasan Province (ISKP) and al Qaeda don't answer to the Taliban, rather the Taliban is dependent on the Haqqani Network and al Qaeda to continue their current regime in Afghanistan.

Secondly, the Taliban is still receiving USD 40m payments weekly, even with all the domestic pressure to stop such payments. Additionally, in the process of gaining the release of a US hostage from the Taliban, the US removed Sirajuddin Haqqani, Anas Haqqani and another member of The Haqqani Network from the FBI Most Wanted List. The US is appeasing the Taliban for their benefit, while gaining nothing in return for their appeasement.

In 2001, when President George Bush presented the Taliban with the opportunity to avoid invasion and war by handing over Osama bin Laden to the US, Mullah Omar, the leader of the Taliban since inception, replied *"the US should provide us with the evidence of bin Laden's involvement in 9/11 and we will prosecute him here in Afghanistan."*

Today, the option would be the same, the names different.

Haibatullah Akhundzada, Emir of the Taliban, would be forced to decide to hand over ***Sirajuddin Haqqani (Haqqani Network), Sanaullah Ghafari and Gulmurod Khalimov (ISKP & ISIS), Hamza bin Laden and Sayf al-Adel (al Qaeda)*** to avoid war.

We know that will not happen because it will mean the collapse of the Taliban regime.

Additionally, prior to September 11, 2001, no one in the US government or population could believe that a terror attack could be carried out on US soil.

- the CIA was quietly receiving reports of suspicious individuals and suspicious behavior, but took no action
- President Bush, at the time, had a high approval rating among the public
- domestic investigative agencies were not following up on the threat reports that the CIA was receiving or they were receiving themselves

When 9/11 happened it sent the US, along with the entire world, into war in Afghanistan and Iraq.

The same conditions exist currently in the United States.

OVERVIEW ON THE CURRENT THREAT

First, our threat assessment is based on information that has been gathered from human intelligence (HUMINT) assets based in Afghanistan and Pakistan, within Islamic State Khorasan Province (ISKP) terrorist camps.

This information was reviewed in detail, classified based on what we could prove to be credible and what we considered to be rumor/propaganda, and then sorted into understandable information that we could pass to law enforcement and security agencies in the United States.

Second, there are numerous terrorist sleeper cells already inside the United States, associated with both al Qaeda and ISKP, as well as individuals actively being radicalised that are still unknown to any analyst. We have tentatively placed the number of al Qaeda and Haqqani Network assets in the United States at approximately 11,000, which is steadily growing with every opportunity presented.

Those involved are not terrorists that will be infiltrating for these attacks, they are already in the United States on fake passports, *issued through the Haqqani run Interior Ministry of Afghanistan*, illegal crossings on both the northern and southern borders and smuggled into the country through drug and weapons smuggling routes.

We have stated, in previously analyses, that *small attacks are test runs to determine response times, which agencies respond and what the reaction of the public is to the attack in real-time.* The last point is very important because the public reaction determines the 2nd and 3rd strike opportunities for the terror groups. A map of the test runs, threats, incidents is available **HERE**.

The January 01 attack on New Orleans was a test by the Islamic State Khorasan Province (ISKP), using a method highly successful in European cities, with the addition of an explosive that had yet to be used by any country. The objective was to penetrate the first layer of security and detonate the vehicle-based improvised explosive device (VBIED), causing mass casualties, when first responders entered into the attack zone, where they could be targeted. The attack was stopped before the attacker could detonate.

While the New Orleans Police Department and the FBI Field Office in New Orleans worked very hard to disprove any links to the Islamic State, on the Apr 28, Iraqi authorities announced the arrest of an ISIS operative, who had been the “inspiration” for the New Orleans attack, was a part of ISIS External Operations, encouraged attacks with encrypted messaging apps, but had no direct command and control oversight.

Peter Neumann, a political scientist and terrorism expert, said, after the attack – *“Such threats should be taken seriously, not because IS is actually planning an attack. Rather, because IS wants to send a signal to its supporters, who are currently fully mobilized anyway due to the various attack attempts, and those they were carried out.”*

He continued – *"terrorism is about terror. And that's why it would be a success for IS if it did manage to paralyze public life with such a message."*

On March 22, 2025, a group of teenagers, two 16 and 17-year-old girls and a 16-year-old boy, were arrested considering targeting a church, synagogue, or police station. All three were radicalized individually through Islamic State online content, published by ISIS itself.

Court spokeswoman, Dr. Vera Drees said – *"Ultimately, they were determined to enter police stations or places of worship while many people were present, set them on fire with Molotov cocktails, and use firearms and stabbings to kill as many people as possible."*

This overview is to provide a clear understanding of how each ISIS or ISKP attack builds upon the previous. Either by developing additional skill sets or by gathering intelligence on response times.

This threat assessment a massive escalation from the lone wolf attacks that have become the hallmark of Islamic State attacks to VBIED attacks as a major attack and hostage situation in hospitals around the United States.

As per the chatter in the ISKP camps, these will be multi-city, coordinated attacks designed to hit America at its perceived weakest security level – hospitals.

THREAT ASSESSMENT

TOPIC:	**HOSPITAL THREAT ASSESSMENT**
DATE:	**16 MAY 2025**
TRACKING NUMBER:	**CMDELVN-THREATASSESS-2025-135A**

SUMMARY & PURPOSE

The threat assessment presented below is to advise and assist primary care centers, trauma centers and first responders in preparing for an upcoming terrorist attack to be carried out by the Islamic State (ISIS) and the Islamic State Khorasan Province (ISKP), but orchestrated by al Qaeda, as a prelude to a secondary, much larger attack, by al Qaeda.

This assessment is an updated version of a previously issued threat assessment on the same topic on 11 April, 2025.

This assessment has been reviewed and discussed by numerous individuals, who are part of our intelligence advisory network, including, but not limited to, Orange Diamond Consulting Group, Trans-Atlantic Intelligence Consortium, Sarah Adams, Wesley Harden and others.

BOTTOM LINE UP FRONT (BLUF)

Hospitals and trauma centers, specifically Tier 1, are being targeted for attack by the Islamic State (ISIS) and the Islamic State Khorasan Province (ISKP). The attack is being orchestrated by al Qaeda, Hamza bin Laden, and Sayf al-Adel, supported by Sirajuddin Haqqani, The Haqqani Network and the Afghan Taliban from terror cells and safe houses in Afghanistan.

The targeting is focused on mid-tier cities around the United States and Canada. The attacks will be multi-city and simultaneously carried out.

INTELLIGENCE CREDIBILITY CREDIBLE - HIGHLY CREDIBLE

The intelligence that has crafted this assessment was gathered by CommandEleven human intelligence (HUMINT) assets inside of Islamic State Khorasan Province training camps in both Afghanistan and Pakistan. These assets have been providing information since the end of January 2025, but intelligence became more detailed starting in mid-February and continues to flow into our intelligence classification center.

A second tier of intelligence was gathered from employees and administrators at various hospitals around the United States, who informed CommandEleven through various

communication channels, of attempts to breech their security protocols and suspicious behavior of individuals.

Our estimation, based on the chatter within the camps, is roughly 30-50 operational sleeper cells within the United States and Canada at this time, with more being created (*backups for backups*) weekly.

Therefore, it should be clear that **these attacks will be carried out by terrorists who are already in the United States and Canada**, not individuals that will infiltrate specifically for this attack.

THE THREAT AGAINST HOSPITALS

On the 18th of March, CommandEleven, after contacting various security and law enforcement agencies in the United States, issued a public awareness message via our X handle, regarding what we believe to be credible threats against hospitals around the US. The awareness message was a short, and very simply worded that advised the general public of our concern about potential attacks. This message was picked up by other X handles and expanded, based on other intelligence available to operatives in the US, which was not available to us at the time we posted the potential threat.

The threat, as we currently understand it, is:

- directed toward hospitals located in mid-tier cities, where the impact will be significant, but the security protocols will be significantly lower than major cities
- designed to be a multi-city, multi-faceted attack that will target not only the hospital, but first responders as well
- chatter in the terror camps that hostage situations could be a facet of the attacks
- attacks will be started with a vehicle based improvised explosive device (VBIED), followed by assault teams. This tactic has been used effectively in foreign countries, where terror groups have targeted military installations and civilians
- On March 02, jihadi groups circulated a graphic with US hospitals circled in red with the title – “Soft flesh awaits”

OUR OBJECTIVES

The **first objective** achieved with the message that was posted on our X handle - to create awareness and serious discussion in all quarters to deter and limit the potential of an attack, which we have seen with the numerous hospitals that have directly contacted CommandEleven, as well as the informational briefings published by the American Hospital Association and the Health Information Sharing and Analysis Center.

Neither has contacted CommandEleven directly for additional information regarding this threat.

The **second objective** - gather intelligence from individuals in the United States, both those working in hospitals, as well as general public. HUMINT is core to properly profiling attackers, understanding targets, and getting up-to-date information when there is an incident of any kind. All of these items factor into our assessment, identification of potential targets, and recommendations that we provide to hospitals, first responders and the general public.

Additional objectives with this threat assessment are multi-fold:

1. **encourage hospitals and trauma centres to complete full audits of their internal security protocols to limit the potential of a successful breach by ISKP terrorists**
    a. reviews of hospital security footage, attempting to identify any reconnaissance activities, repeat visitors, and suspicious activity.
        i. **perform a more comprehensive vetting of all newly hired employees, contractors and their staff, service teams and vendors with building access**
    b. the restriction of specific vehicular access with barriers to allow for complete search of the vehicle by explosive sniffing dogs and questioning/identification checks of individuals.
        i. **We are highly suspicious of terrorists infiltrating hospitals in uniforms or hospital dress codes to avoid detection. Hospital security must be heavily tightened to assure that modified identification credentials are not successfully used to gain entry.**
        ii. **Secure perimeter access – emergency rooms, loading docks and parking structures – where easy access can be used to infiltrate without alerting hospital security**
    c. hospital security staff must be enhanced and perform practical drills to prepare for the potential of a breach attempt. This will require coordination with local law enforcement to gain strategic advantage over the terrorists.
2. **law enforcement, intelligence and security agencies of the US and state governments actively identifying and arresting key operatives and disrupting the attack before it can be initiated**
    a. pre-emptive raids on known radicalised centres, where ISKP fighters could seek safe haven until the attacks are carried out

   b. **examination of storage facilities, locations close to, and within hospital premises, where weapons could be stored and easily accessed once the breach is achieved by terrorists.**
      i. Special attention should be paid to any tunnels that may exist under hospital structures, where a breach could be carried out without detection
3. when the attacks are carried out, hospitals and trauma centres have been made aware and prepared for the potential of an attack, thereby limiting the potential seriousness of the impact

Situation Report (SitRep)

We had a roundtable conversation with some of our analysts and researchers, including our external intelligence analysts, on the intelligence we have gathered, been provided by hospitals in the US and the "chatter" we have heard in the terror camps in Afghanistan, in relation to the threat assessment CommandEleven had released.

Thus far, we have been viewing these terror attacks from the model of the traditional terror attack, which means explosives – IED, VBIEDs and suicide bombers - and assault weapons. There is a possibility, which for some may only amount to 5%, but a very real possibility the attacks on the United States, Canada and Europe could include a ***chemical or biological weapon***.

We raised this possibility based on the following factors:

- al Qaeda has reached a point to be able to manufacture and weaponize Sarin gas
- there are 4-6 chemical weapons laboratories operational currently in Afghanistan
- the whereabouts of Sulayman Dawud al Bakkar, one of al Qaeda's chief chemical and biological weapons engineers, is unknown
- the whereabouts of Yazid Sufaat, known in counter terrorism circles as the CEO of Anthrax, is unknown
- al Qaeda has access to chemical and biological weapons both via the Islamic State in Iraq and Syria, where over 100+ chemical weapons labs were abandoned by the Assad regime

Additionally, in the very recent past, a 16-year-old was arrested after manufacturing a biological weapon which was a mixture of aconitine and ricin, which falls under the laws of control of military weapons, in a laboratory setup in his attic. When the house was searched, other toxic substances and evidence was found.

Taking that concept, we re-developed the potential attack sequence and methods.

KEY FACTORS

The following key factors have been taken into account in the re-development of the threat assessment.

- most of the "immigrants," *read support network*, that make up the terrorist population are employed in **labor intensive occupations** – plumbers, carpenters, electricians, construction workers, drivers, etc.
- *keeping this idea in mind* – this increases both the potential attack avenues and the tactics that could be employed, as well as the types of weapons that could be used
- foundation is provided by hospital administrators and staff members, who have communicated the employment status of the various nationalities that would make up the terrorist population, the known skill sets of each nationality, and the infiltration capabilities of AQ/ISIS to successfully turn them into "assets."

Target Profile

Mid-Tier Cities

For intelligence and terrorism official, mid-tier cities present the hardest targets to protect and identify potential threats.

A mid-tier city is defined as those cities whose population falls between 100,000 and 500,000 residents, making them large enough to maintain LEVEL ONE trauma centers, but lacking the security of metropolitan cities, such as New York City, Los Angeles, Chicago, Washington, DC.

The selection of a mid-tier city is made based on specific criteria:

- large enough to get media attention, but small enough to be vulnerable
- Level 1 Trauma Centers – high-value, high-casualty zones
- Slower police response time – higher death toll
- Less hardened targets – lower risk for terrorists
- all infrastructure of major cities exists without the same security presence as top-tier cities
- law enforcement will most likely not have advanced counter-terrorism training, meaning the attack can be sustained while reinforcements with advanced training are able to reach the location - slowing emergency response
- significantly lower surveillance allowing terrorists more freedom of movement without detection

Mid-Term Cities Believed to be Vulnerable

The list provided below is based on numerous criteria, as defined above:

- Birmingham, Alabama
- Phoenix, Arizona
- Tempe, Arizona
- Pasadena, California
- San Diego, California
- Bradenton/Sarasota, Florida
- Fort Myers, Florida
- St. Petersburg, Florida
- Tallahassee, Florida
- Athens, Georgia
- Atlanta, Georgia
- Chicago, Illinois
- Wichita, Kansas
- Louisville, Kentucky

- New Orleans, Louisiana
- Baltimore, Maryland
- Boston, Massasschusets
- Detroit, Michigan
- Grand Rapids, Michigan
- Omaha, Nebraska
- Raleigh, North Carolina
- Albuquerque, New Mexico
- Albany, New York
- Buffalo, New York
- Syracuse, New York
- Dayton, Ohio
- Columbus, Ohio
- Toledo, Ohio
- Tulsa, Oklahoma
- Harrisburg, Pennsylvania
- Pittsburgh, Pennsylvania
- York, Pennsylvania
- Providence, Rhode Island
- Knoxville, Tennessee
- Nashville, Tennessee
- Austin, Texas
- College Station, Texas
- Houston, Texas
- Arlington, Virginia
- Langley, Virginia
- Richmond, Virginia
- Madison, Wisconsin
- Milwaukee, Wisconsin
- Marshfield, Washington
- Spokane, Washington

We are closely reviewing areas where there is a large population of recently immigrated Muslims from **Afghanistan, Iraq, Libya, Pakistan and Syria**, who we believe could have terrorist ties and used manufactured (fake) passports to enter the United States during the Biden administration, when there was no vetting or security check. This is not a warning against all nationalities listed above, but those whose passports are questionable, meaning similar birthdates and similar locations of birth.

Attacker Profile

Terrorist (Level 1) & Supporter (Level 2) Profiles

We developed these profiles based on the inputs and chatter we heard and assessed:

- **Age:** 20-45
- **Nationalities:** Afghanistan, Egypt, Iran, Iraq, Jordan, Kuwait, Libya, Pakistan, Saudi Arabia, Somalia, Sudan, Syria, Yemen
- **Infiltration Period:** Last 5 years, higher frequency of those who will have entered in the last 3 years
- **Skill Set:**

    - *Level 1 – Sleeper Cells/Terrorists:*
        - military aged men
        - young enough to blend in, but not too young to be caught out boasting
        - handlers (age 30-35), attackers (20-32)
        - will have a level of English fluency but will be unfamiliar with common colloquial phrases. Their written English will be significantly better than their spoken English
        - will have the ability to blend within society without drawing attention to themselves, meaning they will not have strong accents from their homelands any longer
        - will converse in English as much as possible to improve their spoken English skills to avoid detection
            - this follows a guide developed by al Qaeda on how to blend into a foreign country and live without being detected, published in late 1990s, revised in approx. 2020
        - comprehensive weapons training, both small arms and heavy bore automatic weapons. Expectations of snipers on the rooftops of the hospitals/trauma centers for cover fire and surveillance during the siege
        - cells will not know of each other or the members of their own cells until roughly 1 week before the attack, when all will be gathered into one location and sequestered until the attack
            - When this happens, it should be considered a clear signal of an imminent attack indicator
        - handlers will be building counter cells, in case members are caught or uncompromised
        - all members will be long-term ISKP or ISIS members, assuring their commitment to achieving the objectives
        - only the handler will have contact with the core operational team in Afghanistan. This will be via a non-traditional method such as chats within games

- there are 5-7 bomb makers within the group of attackers, who will prepare both the IEDs, VBIEDs and the suicide vests

- *Level 2 – Support/Extended Cells:*
  - aged 25-45
  - drivers, trained medical staff/nursing background, electricians, carpenters, air conditioner repairmen, construction workers, clerks and traditional support staff, which blend in easily and unnoticed
    - **hospitals/first responders/tier 1 trauma centers should profile and strictly vet individuals of the nationalities listed in Appendix A posted on these roles**
  - some with EMT/law enforcement/military backgrounds to operate as first responders
  - they are labor intensive staff; their conversational English will not be at the same level as the handlers or attackers
  - role will be to prepare entry points, attach electronic devices to disable security where needed, modify ventilation systems for the potential delivery of a chemical or biological weapon
    - **all recent work done in these areas MUST be counter-checked to verify nothing has been added or installed that could be used in a terror attack.**
    - **this should be done by individuals that have been previously properly vetted**
  - the triggers to all electronic systems will be manual with timers because cell networks will be downed, meaning they will be taken offline so they won't work, to avoid any armed explosives. Each device will be built based on specifications provided by the handlers so they are able to activate them during the siege/standoff
  - these individuals will not know each other nor have any communication with each other
  - these are going to be the hardest to trace because they will not have any part of the actual attack, other than the drivers and trained medical/nursing staff backgrounds. *Clean skins*, meaning they know no one within the attack structure, so even if caught, they can provide no information.

Tactical Understanding

Most Dangerous Scenario

ISKP & al Qaeda Coordinate

- Overload first responders, DHS, FBI, local LEA in days and weeks before the attack with numerous false flags (non-credible threats) to make the real attack seem less possible
- ISIS and ISKP carry out the multi-city hospital siege
- al Qaeda carries out a multiple airplane, multiple target attack on Washington, DC and other symbolic cities, like Detroit, MI, Chicago, Il, Los Angeles, CA, San Francisco, CA, Miami, FL, Boston, MA, Las Vegas, NV

Attack Models

We are seeing this attack in 2 potential formats.

First, a coordinated attack on a series of hospitals, prior to a major multi-city attack. These attacks will include VBIED detonations for mass casualties, and the armed assault by heavily armed terrorists, attempting to create hostage situations similar to the 2008 Mumbai, India attacks.

For those unfamiliar with the Mumbai attack, 10 terrorists, divided into multiple groups, were dispatched to different locations in Mumbai, while a larger contingent attacked the Taj Mahal Hotel, taking hostages and forcing a standoff for over 4 days, killing over 175 and injuring more than 300. 9 of the 10 terrorists were killed by Indian security forces.

We have included a link to the United States Senate Committee on Homeland Security and Governmental Affairs entitled - "Lessons from the Mumbai Terrorist Attacks - Parts I and II" from January 8 and 28, 2009 - of which very few points have been implemented.

We see this as the most likely first attempt, targeting a selection of hospitals, where ISKP reconnaissance teams have determined security to be more easily penetrable. This model also provides the attackers the fluidity to change targets based on ground realities.

The second, and significantly more dangerous, option is a simultaneous, multi-city attack on hospitals, first responders and mission critical infrastructure (law enforcement, emergency services, transportation hubs). This would require a massive mobilisation of resources from ISKP, which would be difficult to keep hidden from US law enforcement and intelligence agencies, which is why we are putting this as a secondary possibility, dependant on the success of the first option.

DO NOT RULE OUT A TWO STAGE ATTACK.

- Attack 1 – Mumbai Model
- Attack 2 – Controlled Target Rich Environment (Hospital, Secure Areas, etc.)

We believe the tactical/kinetic methodology will follow this model, broken down into steps:

1. Attack on general public (**trigger event**) – ***Mumbai style***
    a. This attack will be directed towards restaurants, shopping malls, transport hubs (bus/train/subway stations). It could target a cultural or social event where the public turn out will be high enough to justify the attack
2. First Responders Entry
    a. The first responders will bring their own attackers mixed within the actual first responders.
    b. There will be decoy ambulances and police cars that will be wired with explosives. These decoys will be detonated on site to increase the casualty levels, but after some vehicles depart for the targeted hospitals/trauma centers
3. Victims transferred to hospitals/trauma centers
    a. As victims are transferred to hospitals, the decoy ambulances will be used at VBIEDs to take control of the hospital/trauma center itself. They could be used to block roads to establish a perimeter of their choosing
4. Armed assault on the hospital/trauma center
    a. Once the VBIEDs are detonated, the hospital/trauma center will be stormed by armed assault teams to establish control
    b. Assault teams will be directed to arm and detonate the chemical/bioweapon before electricity is shut down to the hospital, making disbursement through the ventilation impossible
5. Suicide bomber detonates device in hospital/trauma center premises
    a. The detonation will be designed to delivery mass casualties and structural damage making evacuation/hostage retrieval more difficult for tactical teams
    b. The potential for explosives to be deployed within the hospital on structural support is possible. These would be devices operating on a frequency with a detonation device that is not linked to the cell towers, as the towers will be shutdown
6. Siege ended, all terrorists killed, hostages retrieved
    a. Once the siege is ended, tactical assault teams will move in with medical response teams to evacuate the hostages from the hospital/trauma center
    b. The hostages return to their homes, offices, and interact with family members/co-workers, spreading the biological weapon, which would bring the final stage of the attack to a close
7. Hostages, family members, co-workers begin to show symptoms of infection with a biological/chemical weapon
    a. Once the symptoms of the biological/chemical weapon begin to appear, the body count of interactions will be undeterminable.

NOTE FOR FIRST RESPONDERS

When a mass casualty event is planned, the actual target area is less important than understanding the routes and secure staging areas first responders will use.

These routes and staging areas present additional target rich environments for the terrorists.

Information Distribution

This information is being shared openly to inform the public of the threat and provide guidelines to the public, hospitals and law enforcement on how to prepare for and counter the threat.

APPENDIX A: MUSLIM-MAJORITY IMMIGRATION SETTLEMENT PATTERNS (2021-2024)

COUNTRY OF ORIGIN	TOP US RESETTLEMENT CITIES/AREAS
AFGHANISTAN	Sacramento, CA – Houston, TX – Dallas, TX – Nova, VA – Oklahoma City, OK – Phoenix, AZ
SYRIA	Buffalo, NY – Rochester, NY – Houston, TX – Chicago, IL – San Diego, CA
SOMALIA	Minneapolis, MN – Columbus, OH – Seattle, WA – San Diego, CA
IRAQ	Detroit/Dearborn, MI – Dallas, TX – Nashville, TN – San Diego, CA – Phoenix, AZ
YEMEN	Dearborn, MI – New York City (NY) – Buffalo, NY – Chicago, IL
IRAN	Los Angeles, CA, Orange County, CA – Houston, TX – Northern VA
PAKISTAN	Brooklyn/Queens, NY – Houston, TX – Chicago, IL – Dallas, TX – Atlanta, GA
SUDAN	Omaha, NE – Columbus, OH – Des Moines, IA – Nashville, TN

Appendix B: Summary of Settlement Clusters (2021-2024)

Country of Origin	Top US Resettlement Cities/Areas
Atlanta, GA	Somali – Sudanese – mixed Muslim nations
Buffalo, NY	Syrian – Somali – Yemeni
Chicago, IL	Iraqi – Pakistani – Syrian
Columbus, OH	Somali – Sudanese
Dallas/Fort Worth, TX	Afghan – Iraqi – Pakistani
Detroit/Dearborn, MI	Iraqi – Lebanese – Syrian – Yemeni
Houston, TX	Afghan – Iranian – Iraqi – Syrian
Minneapolis, MN	Oromo (Ethiopia) - Somali – Sudanese
Northern Virginia	Afghan – Iranian – Iraqi
Phoenix, AZ	Afghan – Iraqi – Syrian
Rochester, NY	Afghan – Syrian
Sacramento, CA	Afghan
San Diego, CA	Afghan – Iraqi – Somali – Syrian
Seattle, WA	Afghan – Iraqi – Somali

ABOUT THE AUTHOR

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