0038-04-CID789-83988

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-4
SSAN: NA
Date of Birth: Unkown
Date of Death: BTB 19 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 1 June 2004

Autopsy No.: ME04-387
AFIP No.: Pending
Rank: Civ
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody at Abu Ghraib prison. There is a verbal report only of pain.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis of undetermined etiology

MANNER OF DEATH: Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

(b)(6)-4

PRELIMINARY AUTOPSY DIAGNOSES:

I. Peritonitis
   A. 3 liters of cloudy brown liquid with feculent material and fibrinous adhesions
   B. Dense peri-splenic adhesions
   C. No perforations or injuries of the stomach, small bowel, or colon identified at autopsy

II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)

III. Healing 3/8 inch abrasion of the right shin

IV. Tooth number 8 absent due to decay (used by family members as identification)

V. No significant trauma

VI. Toxicology and histology pending

(b)(6)-2

(b)(6)-2, MD
MAJ, MC, USA
Deputy Medical Examiner

238-04-7f4-83988

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4

SSAN: NA
Date of Birth: Unknown
Date of Death: BTB 19 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 8 Jul 2004

Autopsy No.: ME04-387
AFIP No.: 292645
Rank: Civ
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody at Abu Ghraib prison.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis

MANNER OF DEATH: Natural

42

Ey 8

FINAL AUTOPSY DIAGNOSES:

I. Peritonitis
   A. 3 liters of cloudy brown liquid with feculent material and fibrinous adhesions in the peritoneal cavity
   B. Dense peri-splenic adhesions
   C. No perforations or injuries of the stomach, small bowel, or colon identified at autopsy
   D. Neutrophilic and histiocytic inflammation of the serosa (microscopic)

II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)
   A. Moderate anthracosis (microscopic)

III. Chronic thyroiditis (microscopic)

IV. Healing 3/8 inch abrasion of the right shin

V. Tooth number 8 absent due to decay (used by family members as identification)

VI. No significant trauma

VII. Toxicology (blood clot)
   A. Meperidine 0.46 mg/L
   B. Promethazine 0.23 mg/L
   C. Diphenhydramine 0.37 mg/L
   D. No ethanol (bile) or illicit substances

EXTERNAL EXAMINATION

The body is that of a thin, 74 inches in length, 160 pounds (estimated), Caucasian male with an estimated age of 40 years.

Lividity is posterior, purple, and fixed. Rigor is absent.

The scalp is covered with black hair in a normal distribution. There is a beard and mustache. The irides are brown and the pupils are round and equal in diameter. The external auditory canals are unremarkable. The ears are unremarkable. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural and in poor repair. Tooth # 8 is missing.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema.

There is early decomposition consisting of vascular marbling and skin slippage.

CLOTHING AND PERSONAL EFFECTS

The body is received nude at the time of autopsy.

MEDICAL INTERVENTION

There are no attached medical devices at the time of autopsy.

RADIOGRAPHS

No radiopaque foreign objects or displaced fractures are identified.

EVIDENCE OF INJURY

On the anterior right shin is a 3/8 inch red abrasion.

INTERNAL EXAMINATION

HEAD:

The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. Clear cerebrospinal fluid surrounds the 1350 gm brain, which has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

The cervical spine is intact and there is no paraspinous muscular hemorrhage.

BODY CAVITIES:
The peritoneal cavity contains approximately 3 liters of cloudy brown liquid and feculent material. The left pleural cavity contains approximately 400 ml of cloudy brown liquid and has dense fibrous adhesions. The ribs, sternum, and vertebral bodies are visibly and palpably intact. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1000 and 750 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 300 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show no significant atherosclerosis. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4-cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1450 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains a minute amount of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has dense adhesions of the capsule.

PANCREAS:
The pancreas is autolyzed. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 150 and 175 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 30 ml of red urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach is empty. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present and unremarkable.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by PH3 (b)(6)-2
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous, blood, urine, spleen, lung, kidney, liver, brain, bile, and psoas
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION

Heart: Sections show no significant pathologic abnormality.
Lungs: Sections show moderate anthracosis, atelectasis, and decomposition.
Thyroid: Sections show chronic inflammation.
Gastrointestinal tract: Sections show mucosal autolysis. Sections of appendix show a mixed, predominantly histiocytic, infiltrate of the attached soft tissue. The muscularis of the appendix has no significant inflammation.
Spleen: Sections show no significant pathologic abnormality.
Liver: Section shows no significant pathologic abnormality.
Pancreas: Section is unremarkable.
Kidney: Section is unremarkable.

TOXICOLOGY

Toxicologic analysis of bile was negative for ethanol and the blood clot was negative for illicit substances. The blood clot was positive for meperidine (0.46 mg/L), promethazine (0.23 mg/L), and diphenhydramine (0.37 mg/L).

Ex 8

(b)(6)-4

OPINION

This Iraqi male died of peritonitis. Significant findings of the autopsy include a large amount of pus within the abdominal cavity. An anatomic source of the infection was not identified. Although trauma cannot be completely excluded as a potential source for peritonitis this is unlikely given the absence of visible injury to the organs of the abdominal cavity. Toxicology was positive for medications used for pain (meperidine), nausea (promethazine), and an antihistamine (diphenhydramine).

The manner of death is natural.

(b)(6)-2

(b)(6)-2, MD 8/24/04

MAJ, MC, USA
Deputy Medical Examiner

47

Ex. 6

UO58-04-789-85988

DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

REPLY TO
ATTENTION OF

AFIP-CME-T

PATIENT IDENTIFICATION

AFIP Accessions Number	Sequence
2929645	01

Name (b)(6)-4

TO:

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

SSAN: **Autopsy:** ME04-387
Toxicology Accession #: 042888
Date Report Generated: June 28, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 5/19/2004 **Date Received:** 6/17/2004

VOLATILES: The **BILE** was examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

DRUGS: The **BLOOD CLOT** was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

Positive Narcotic Analgesic: Meperidine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.46 mg/L of meperidine as quantitated by gas chromatography.

Positive Phenothiazine: Promethazine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.23 mg/L of promethazine as quantitated by gas chromatography.

Positive Antihistamine: Diphenhydramine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.37 mg/L of diphenhydramine as quantitated by gas chromatography.

(b)(6)-2

(b)(6)-2, PhD
Certifying Scientist, (b)(3)-1
Office of the Armed Forces Medical Examiner

(b)(6)-2, PhD, DABFT
Director, (b)(3)-1
Office of the Armed Forces Medical Examiner

48

Ex 8

(b)(6)-4

inprocessed on	21 OCT 03
height	5'7"
weight	169
condition	good
c/o	Hx of seizures
meds	medication?

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-4
SSAN: N/A
Date of Birth: BTB 1943
Date of Death: 8 FEB 2004
Date of Autopsy: 28 FEB 2004
Date of Report: 28 FEB 2004

Autopsy No.: ME 04-100
AFIP No.: Pending
Rank: Iraqi Civilian
Place of Death: Tikrit, Iraq
Place of Autopsy: BIAP Mortuary
Baghdad Airport, Iraq

Circumstances of Death: This believed to be 61 year old male Iraqi civilian was a detainee of the U.S. Armed Forces at the Detention Central Collection Facility, Tikrit, Iraq when he was discovered deceased in his bed when he failed to report to the morning head count procedure. The decedent reported a medical history of diabetes and renal disease at the time of his capture.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Identification is established by visual examination by CID agents.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

PRELIMINARY AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease
   1. Moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branches of the left coronary artery (50-75% stenosis).
   2. Moderate aortic atherosclerosis with bilateral renal artery take-off stenosis.
   3. Bilateral renal atrophy with intraparenchymal arteriole atherosclerosis and marked arterionephrosclerosis and cortical cysts.
   4. Cranial artery atherosclerosis of the vertebral, basilar, posterior communicating and middle cerebral arteries.

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

II. Mild to moderate decomposition.

III. Toxicology pending.

(b)(6)-2 MAJ, MC

(b)(6)-2 D.O.
MAJ MC USA
Deputy Medical Examiner

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

FINAL AUTOPSY EXAMINATION REPORT

Name: (b)(6)-2
SSAN: N/A
Date of Birth: BTB 1943
Date of Death: 8 FEB 2004
Date of Autopsy: 28 FEB 2004
Date of Report: 29 JUN 2004

Autopsy No.: ME 04-100
AFIP No.: 2917546
Rank: Iraqi Civilian
Place of Death: Tikrit, Iraq
Place of Autopsy: BIAP Mortuary
Baghdad Airport, Iraq

Circumstances of Death: This believed to be 61 year old male Iraqi civilian was a detainee of the U.S. Armed Forces at the Detention Central Collection Facility, Tikrit, Iraq when he was discovered deceased in his bed when he failed to report to the morning head count procedure. The decedent reported a medical history of diabetes and renal disease at the time of his capture.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Identification is established by visual examination by CID agents. DNA testing was performed and is on file for comparison should exemplars become available.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease

1. Moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branches of the left coronary artery (50-75% stenosis).
2. Moderate aortic atherosclerosis with bilateral renal artery take-off stenosis.
3. Bilateral renal atrophy with intraparenchymal arteriole atherosclerosis and marked arterionephrosclerosis and cortical cysts.
4. Cranial artery atherosclerosis of the vertebral, basilar, posterior communicating and middle cerebral arteries.

II. Mild to moderate decomposition.

III. Toxicology is positive for ethanol, acetone, 1-propanol and acetaldehyde (urine only) in the blood and urine. Drugs of abuse were not detected.

EXTERNAL EXAMINATION

The body is that of a cachetic male Iraqi national. The body weighs approximately 130 pounds, is 69 ½ inches in length and appears the reported age of 61 years. The body temperature is ambient. Rigor is present to an equal degree in all extremities. Lividity is difficult to assess because of dark skin pigmentation but is present and fixed on the posterior surface of the body, except in areas exposed to pressure. There is mild to moderate decomposition of the body with areas of skin slippage on the posterior scalp, the right wrist and anterior right lower leg and marbling of the skin of the back, buttocks, posterior surface of the arms and legs, palms of the hands and the abdomen.

The scalp hair is black and gray and the decedent has frontal baldness. Facial hair consists of a full gray and black beard and mustache. The irides are brown. The corneae are slightly cloudy. The conjunctivae are free of injuries and hemorrhages. The sclerae are free of hemorrhages. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal septum and skeleton is palpably intact. The lips are without evident injury. The teeth are natural and poor condition with multiple unrepaired caries. Examination of the neck reveals no evidence of injury. The hyoid bone and thyroid cartilage are intact.

The chest is free of injuries and deformities. A 3.3 x 1.2 cm oval scar is on the anterior left costal margin and a 3.2 x 2.3 cm oval scar is in the left upper quadrant of the abdomen. No injury of the ribs or sternum is evident externally. The abdomen is flat and free of palpable masses. The external genitalia are those of a normal circumcised adult male with bilateral descended testes. The testes are free of palpable masses. The buttocks and anus are unremarkable.

The extremities show injuries that will be described below. The fingernails are intact. An 11.5 x 4.5 cm area and an area of 7.0 x 3.0 cm of non-descript black ink writing is on the medial surface and lateral surface of the left knee, respectively. There is a paper identification tag affixed to the right wrist and right second toe.

The back has a 2.5 x 2.0 cm scar immediately right of midline in the thoracic region and a 2.5 x 2.0 cm oval scar immediately below the scar just described.

CLOTHING AND PERSONAL EFFECTS

The following clothing items and personal effects are present on the body at the time of autopsy:
A blue shirt, a green sweater, a white linen undergarment, and two white socks.

MEDICAL INTERVENTION

There is no medical intervention.

RADIOGRAPHS

Full body postmortem radiographs are obtained and demonstrates the following:
1. No long bone fractures
2. No foreign bodies

0025-04-CID469-79635

EVIDENCE OF INJURY

The ordering of the following injuries is for descriptive purposes only, and is not intended to imply order of infliction or relative severity. All wound pathways are given relative to standard anatomic position.

A 2.4 x 1.4 cm crusted abrasion and a 1.5 x 1.4 cm crusted abrasion are on the forehead. A 1.0 x 0.5 cm abrasion is on the nose.

On the volar surface of the right forearm are multiple oval purple contusions that average 1.0 cm in diameter. A 1.5 x 0.4 cm crusted abrasion and a 1.2 x 1.2 cm crusted abrasion are on the medial and the lateral surface of the left forearm, respectively.
On the posterior surface of the left hand are a 2.5 x 1.5 cm purple contusion and a 1.5 x 1.0 cm purple contusion. There is a 1.8 x 1.7 cm crusted abrasion with surrounding contusion on the lateral surface of the left knee and a 1.5 x 1.0 cm crusted abrasion immediately below the left patella.

Over the spinous processes of the lumbar spine is a 1.8 x 1.1 cm contusion.

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. There is congestion and pooling of blood over the posterior aspect of the brain from livor mortis. Clear cerebrospinal fluid surrounds the 1325 gm brain, which has unremarkable gyri and sulci. The brain parenchyma is soft and pink/red from refrigeration. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable. There is atherosclerosis of the vertebral, basilar and middle cerebral arteries.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact gray/white mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. 50 ml of serosanguineous fluid are in each hemithorax. No excess fluid is in the pericardial or peritoneal cavities. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 750 and 725 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

EXHIBIT 9 33

AUTOPSY REPORT ME04-100
(b)(6)-4

CARDIOVASCULAR SYSTEM:
The 390 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branch of the left coronary artery (50-75% stenosis). The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal arteries have moderate stenosis of their origins at the aorta from aortic atherosclerosis. The mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1125 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains about 4 ml of green-black bile and no stones. The gallbladder mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 80 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is soft and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 55 and 60 gm, respectively. The external surfaces are coarsely granular with multiple renal cortical cysts, ranging from 0.3 –1.0 cm in diameter. The cut surfaces are dark red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. There is marked intra-renal atherosclerosis of the arterioles of the renal parenchyma. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 100 ml of cloudy yellow urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach contains approximately 500 ml of brown fluid and rare food particles. The gastric wall is intact.

AUTOPSY REPORT ME04-100 (b)(6)-4 0025-04-CID469-79635

The greater curve of the stomach is densely adherent to the duodenum. The duodenum, loops of small bowel, and colon are otherwise unremarkable. The appendix is present.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by OAFME photographer.
- Specimens retained for toxicologic testing and/or DNA identification are: blood, urine, spleen, liver, lung, kidney, brain, bile, gastric contents, and psoas muscle.
- The dissected organs are forwarded with body.
- Personal effects are released to the appropriate mortuary operations representatives.

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides.

0025-04-CID469-79635

AUTOPSY REPORT ME04-100
(b)(6)-4

OPINION

This believed to be 61 year old Iraqi male died from atherosclerotic cardiovascular disease. The mechanism of death is often cardiac arrhythmia secondary to the diseased myocardium and conduction system. The presence of systemic atherosclerosis and the marked renal changes, including renal atrophy, is suggestive of the decedent having diabetes mellitus. The manner of death is natural.

(b)(6)-2
(b)(6)-2 D.O.
MAJ MC USA
Deputy Medical Examiner

EXHIBIT 9 35

DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

REPLY TO
ATTENTION OF

AFIP-CME-T

TO:

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

PATIENT IDENTIFICATION

AFIP Accessions Number 2917546 **Sequence** 00

Name (b)(6)-4

SSAN: **Autopsy:** ME04-100

Toxicology Accession #: 041072

Report Date: MARCH 15, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: **Date Received:** 3/3/2004

CYANIDE: There was no cyanide detected in the chest blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

VOLATILES: The **BLOOD AND URINE** were examined for the presence of ethanol (cutoff of 20 mg/dL), acetaldehyde, acetone, 2-propanol, 1-propanol, t-butanol, 2-butanol, iso-butanol and 1-butanol by headspace gas chromatography. The following volatiles were detected: (concentration(s) in mg/dL)

	Acetaldehyde	Ethanol	Acetone	1-Propanol
BLOOD		69	Trace	Trace
URINE	Trace	31	Trace	6

Trace = value greater than or equal to 1mg/dL, but less than 5 mg/dL

DRUGS: The **BLOOD** was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

(b)(6)-2, PhD
Certifying Scientist (b)(3)-1
Office of the Armed Forces Medical Examiner

(b)(6)-2
(b)(6)-2 PhD, DABFT
Director, Forensic (b)(3)-1
Office of the Armed Forces Medical Examiner

EXHIBIT 9

0025-04 CID469-79635

CERTIFICATE OF DEATH (OVERSEAS)
Acte de décès (D'Outre-Mer)

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms): (b)(6)-4

GRADE Grade:

BRANCH OF SERVICE Arme: Iraqi Civilian

SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale:

ORGANIZATION Organisation: Detainee in Iraq

NATION (e.g., United States) Pays: Iraq

DATE OF BIRTH Date de naissance:

SEX Sexe: [X] MALE Masculin [ ] FEMALE Femmin

RACE Race: [X] CAUCASOID Caucasique [ ] NEGROID Negroide [ ] OTHER (Specify) Autre (Spécifier)

MARITAL STATUS État Civil: [ ] SINGLE Célibataire [ ] MARRIED Marié [ ] WIDOWED Veuf [ ] DIVORCED Divorcé [ ] SEPARATED Séparé

RELIGION Culte: [ ] PROTESTANT Protestant [ ] CATHOLIC Catholique [ ] JEWISH Juif [ ] OTHER (Specify) Autre (Spécifier)

NAME OF NEXT OF KIN Nom du plus proche parent:

RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit:

STREET ADDRESS Domicile à (Rue):

CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal compris):

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH (Enter only once cause per line) Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort[1]	Atherosclerotic Cardiovascular Disease	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès: [X] NATURAL Mort naturelle [ ] ACCIDENT Mort accidentelle [ ] SUICIDE Suicide [ ] HOMICIDE Homicide

AUTOPSY PERFORMED Autopsie effectuée: [X] YES Oui [ ] NO Non

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie:

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures:

NAME OF PATHOLOGIST Nom du pathologiste: (b)(6)-2 MAJ MC USA

(b)(6)-2 [signature] MAJ, MC

DATE Date: 28 Feb 2004

AVIATION ACCIDENT Accident à Avion: [ ] YES Oui [X] NO Non

DATE OF DEATH (Hour, ...) Date de décès (l'heure, le jour, le mois, l'année): 08 Feb 2004

PLACE OF DEATH Lieu de décès: Tikrit, Iraq

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE
J'ai examiné les restes mortels du défuntet je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire: (b)(6)-2

TITLE OR DEGREE Titre ou diplôme: Deputy Medical Examiner

GRADE Grade: MAJ

INSTALLATION OR ADDRESS Installation ou adresse: Dover AFB, DE 19902

DATE Date: 13 MAY 04

(b)(6)-2 [signature] MAJ, MC

[1] State disease, injury or complication which c... heart failure, etc.
[2] State conditions contributing to the death, but not related to the disease or condition causing death.
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu 'un arrêt du coeur, etc
[2] Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

DD FORM 1 APR 77 2064 REPLACES DA FORM 3565, 1 JAN 72 AND DA FORM 3565-R(PAS), 26 SEP 75, WHICH ARE OBSOLETE.

EXHIBIT 9

0181-04-CID259-80228
0074-04-C10789

G-1

PRISONER IN-PROCESSING MEDICAL SCREEN

NAME (b)(6)-4 COMPOUND ISN (b)(6)-4
DATE 12JUN04 DOB 1956 AGE 48
HISTORY BY TRANSLATOR (YES) NO
NAME OF TRANSLATOR [redacted] B6-2

DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?

Ø

HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN AND HOW WERE YOU TREATED?

Ø

A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES (NO)
B) HAVE YOU BEEN COUGHING UP BLOOD? YES (NO)
C) HAVE YOU BEEN LOSING A LOT OF WEIGHT? UNK (YES) NO

CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE)

HTN, IRREG H.R.

MEDICATIONS
(b)(6)-2 CAPATIN

ARE YOU ABLE TO WALK UNASSISTED? (YES) NO
ARE YOU ABLE TO FEED YOURSELF? (YES) NO
ALLERGIES TO MEDICATIONS? NKA

PULSE 92 BLOOD PRESSURE 130/80 RESPIRATORY RATE 16

WEIGHT 245 HEIGHT 5'8

SIGNATURE HM2 [redacted] B6-2

ABUSE PT CLAIMS HE WAS PUNCHED IN STOMACH YESTERDAY BY SOLDIER

YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO MD OR PA UNLESS MINOR PROBLEM FOR QUESTION 1. A NO TO QUESTION 5 OR 6 ALSO REQUIRES MD/PA EVALUATION

MD/PA FOLLOW UP NOTE DATE

ASSESSMENT

Refer to SF 600

Dated 16 JUN 04

[redacted] B6-2

#E000

MEDICATIONS

SIGNATURE

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 3

018-04-CID259-80228

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

0074-04-CID789

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 June 04	S) 48 y/o ♂ detainee referred by medic for evaluation.
P 92	Pt has multiple complaints.
BP 110/80	#1 - Pt reports he was punched in the stomach ~~after~~ while
R 19	being transported in helicopter. He reports this was done by coalition forces.
	#2 HTN well controlled with propranolol and captopril. He was
	started on HCTZ and prinivil when seen by JIDC provider.
	His BP was nl today.
⊕ HTN PMH	O) WNWD ♂ NAD VS stable GAIT - NL
PSH - trauma wound - [illegible]	NEURO: CN II - XII, C4 - T1 motor + L1 - S2 motor
9 children FH - married [illegible] - d [illegible]	GROSSLY INTACT (B) DTRs - 2+ (B)
SH - ⊘ tobacco	HEENT - NL NECK - supple
MED	LUNGS - CTA (B) HEART - RRR
Allergies: NKDA	ABD - OBESE with large surgical scar otherwise benign
	Genitals - nl ♂ ↓ [illegible]
	EXT MOVES - WELL
	INTEGUMENTARY - NEG FOR ecchymosis or scars
	A) 1. Pt alleges abuse by coalition forces
	2. HTN
	P) 1. Refer to CID
	2. continue c̄ HCTZ and prinivil as directed
	3. case and plan discussed @ length c̄ pt through interpreter

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

ISN: (b)(6)-4

COMPOUND: B4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 3

MEDCOM - 608

0138-04-CID259-80202

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
31 May 04	S - 42 y/o ♂ Detainee referred by CID for complete
CUFF 198/110, MANUAL 174/114	physical + history. Otherwise this BP was elevated
BP -	today in clinic. He denies any current chest pain
P - 107	headaches or visual changes
T - 99.1	
R - 18	O) WDWN ♂ NAD VS ↑ BP AFEBRILE GAIT - NL
	NEURO CN II - CN XII, C4 - T1 MOTOR + L1 - S2 MOTOR GROSSLY INTACT B
PMH -	DTRs 2+ B
	HEENT - NL NECK - supple, no adenopathy or thyromegaly
FH - [illegible]	LUNGS - CTA B HEART - RRR s̄ MURMURS
SH - 6 cig [illegible] x 15 [illegible]	ABD - BENIGN Genital - 1cm MASS on (L) TESTICLE "PAINLESS" x 10 yrs
MED - NO CURRENT	Rectal - NL sphincter tone, stool brown, Hemo neg, no masses or hemorrhoids
Allergies - NKDA	Prostate - smooth, symmetrical, neg for nodules
	EXT - MOVES ALL EXT, pulse equal B
150/86 [illegible]	integumentary - neg for acute scabs, ecchymosis or lacerations
	A) 1. ↑ BP 2. Painless testicular mass x 10 yrs - probable [illegible]
	3. Otherwise nl PE
	P) 1. F/u on sick call for [illegible] BP checks
	2. Case and plan discussed with pt through (b)(6)-2 interpreter
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME: (b)(6)-4

RANK:

SSN:

DOB:

UNIT: V C

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

MEDCOM - 609

FOR OFFICIAL USE ONLY

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

REPORT OF DETAINEE MEDICAL SCREENING:

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid Dz

N/A

Medication Allergies: (NO) (YES) List -

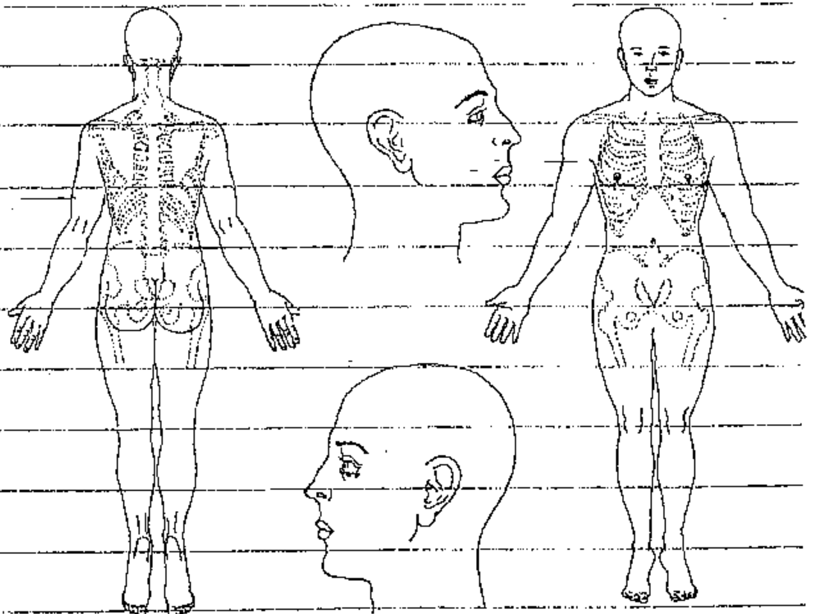
Current Medications: (Name/Dose/Frequency/Last Taken) (NONE)

N/A

Recent Injuries: (NO) (YES) Describe -

Exam Findings: BP: 134 / 80 Pulse: 96 Resp: 18

Utilize Diagram and Space Below to Indicate Examination Findings.
If additional space required, continue on reverse



(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

Name/Rank/Unit of Screener

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

Detainee Information:

Name: (b)(6)-4

Control Number: (b)(6)-4

Date/Time of Detention:

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

MEDCOM - 610

FOR OFFICIAL USE ONLY

MEDICAL RECORD		PROGRESS NOTES 050-04-01259-80155

DATE	NOTES
	"Brief note"
2 May 2003	55 yo HVDC[?] c h/o myocardial infarction x 2, hyperlipidemia [illegible] and hypertension presents for [illegible] exam.
NKDA	PMHX
	① MI ? [illegible] (1996) — He denies EST, Cath or stent
	MI (1999) — [illegible]
	② Hypercholesterolemia ? of last # — on Zocor 20 mg [illegible]
	③ Hypertension
	PSHX Hemorrhoid Surg, 1973 — Meds ① Atenolol 25 mg po qd
	FMHX Mother died of MI @ 45 yo — ② ASA 81 mg po qd
	Social Smoker 1/4-1/2 PPD Now — ③ SL NTG 0.4 PRN
	Exam — ④ Zocor 20 mg po qd
	Appears well, NAD — ROS ∅ C/P/SOB/Edema/PND/Orthopnea
	171/92 93 20 97% — ∅ [illegible] BS/Melena/hematochezia
	Skin warm, dry, ∅ infestation — ⊕ hemorrhoids
	ENT PERRLA EOMI
	Dry membranes — ABD obese ⊕ BS soft NTTP
	Canals clear TMS [illegible] — Ext ⊖ Edema ⊖ Homans
	Neck ⊖ JVD — DP, PT 2/4
	Chest Thorax NTTP CTA B/L — (b)(6)-2
	Heart S1+S2, NLSZ ∅ m/r/g — CPT

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

39 DP

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10

FOR OFFICIAL USE ONLY

EXHIBIT 3

0050-04-C1025P-00195

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Sept 03	Occult Blood Stool Test negative [illegible]
[illegible]	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible] chol 213
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	Plan [illegible] (b)(6)-2
	[illegible]

FOR OFFICIAL USE ONLY

EXHIBIT 3

STANDARD FORM 600 (REV 6 97) BACK

0050-04-C10259-80155

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 MAR 04	1130pm (2330) Called to # 39 Rm for c/o Mid Sternal Chest Pain (Being) onset 1 hr PTA. Pt Assessed At bedside and found an Ambulatory to AID TMC. Once At TMC NIBP, SaO2 and 5 Lead ECG Initiated. on Monitor Appeared to be SR c ST Elevation in Lead II @ 2340 Pt Became unresponsive and Monitor Δ'd to Pulseless V-TACH. I Precordial Thump Administered s Success, IV Initiated #18 (R) AC c LR 1000cc ? [illegible]. 100mg Lidocaine Administered As Ø Defib Immediately Available. OPA Airway Placed and Breathing Mask Utilized / CPR Started. @ 1145 1mg Epi Administered IV, and CPR Continued. Ø Pulse s CPR. 1mg Atropine Administered Via IV @ 1148. CPR Continued. Monitor Showed V-Fib s Pulses (+) Pulses c CPR @ 1152 Defib Arrived Pt Shocked @ 200, 300, 360. s Return of Rythm or Pulses. 2nd Epi 1mg given Per IV. CPR Continued. Attempt At Digital Intubation c 7.5 ET Tube s Success. Mouth to Mouth Continued. 2nd 1mg Atropine Administered via IV. CPR Continued. @ 1205 E-Med Medic Arrived. Attempted BVM Ventilation s Success, Head repositioned and BVM Continued c CPR. Care of Patient Transferred to E-Med Medics c Full Report and Code Summary Documentation. Pt left AID Facility Full Cardiac Arrest in Care of E-Med Medics.

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

(b)(6)-2

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V1.00

EXHIBIT 3

FOR OFFICIAL USE ONLY

0006 [illegible]

(b)(6)-4 M/55

BLOOD/SERUM Req Loc: [illegible] BIAB
Collected: 23 Sep 200391000 Received: 02 Oct [illegible]
Accession: 031002 LSP 573357 HCP: MTF.OTHER

Test	Result	
CHOLESTEROL	[illegible]	<certified>
TRIGLYCERIDE	[illegible]	<certified>
[illegible]	[illegible]	<certified>
[illegible]	[illegible]	<certified>
CHOLESTEROL [illegible]	5.1	<certified>
PROSTATE SPECIFIC AG	1.20	<certified>

*** End of Report ***

C9H28 HVD39 (b)(6)-4 M/55 ph#

FOR OFFICIAL USE ONLY

EXHIBIT 3

0050-04-C0259-80155

EXHIBIT 3

MEDICATION ADMINISTRATION RECORD

Name: (b)(6)-4 Unit: HUD Month: MAR. 04

Medication/Dose/Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ASA 325mg QAM	X	X	X	X	X	X	X																								
Atenolol 25mg QAM	X	X	X	X	X	X	X																								
Zocor 40mg QAM	X	X	X	X	X	X	X																								
Benadryl 25mg QAM	X	X	X	X	X	X	X																								

MEDCOM - 615

FOR OFFICIAL USE ONLY

DETAINEE #: (b)(6)-4

AGE: 55

ALLERGIES: NKDA

MEDICATIONS:

Atenolol 25 qd
Aspirin qd
Zocar ~~20~~ 40 mg qd
Colace 100 mg BID prn
Benadryl 25 mg qhs prn
SL NTG 0.4 mg prn x3 (chest pain)

PROBLEM LIST:

DIAGNOSTIC TESTS:

GUIAC STOOL- Sept. 2003, negative

PEAK FLOW-

EKG- June 2003

PSA-

OTHER-

PMHX:

MI x2
hypercholesterolemia
hypertension
Hemmoriod surgery (1995)
smoker
hemmoriods

LABS:

142 | 106 | [illegible]
[illegible] | [illegible] | 1.5

[illegible]

ALB 4.5
ALT 12
AST 19
TBIL 0.7

HOSPITALIZATION SUMMARIES:

FOR OFFICIAL USE ONLY

EXHIBIT 3

000[illegible]7

0050-04-C10259-80155

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3/8/04	Code Note
0845	Pt presents in cardiac arrest since 5 minutes
	ō midnight. Initial evaluation in the field
	reported by EMS to show that pt presented
PMHx	to jail medic c̄ CP and quickly deteriorated
	[illegible]
	Upon presentation to EMEDS full ACLS
	protocol was followed. CRNA placed a
	7.5 ETT at 21cm, placement was confirmed
	c̄ Ⓑ bs. Telemetry confirmed asystole.
	Epinephrine in the usual dosage was
	given x 2 rounds while performing
	concurrent CPR. Despite all these
	efforts, pt remained in asystole
	s̄ any signs of life. Code was
	stopped at 0832. Pt's pupils
	were fixed & dilated, He had no response
	to any stimuli. He had no respiratory
	effort and no pulse. Time of death is
	0832.
	(b)(6)-2 , MD
	Staff Emergency Physician EMED

RECORDS MAINTAINED AT (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

Security Detainee # (b)(6)-4

112th MP Battalion

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

FOR OFFICIAL USE ONLY

EXHIBIT 3

MEDCOM - 617

CCSO 04-CID259-80155

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4			

ORGANIZATION Organisation	NATION (e.g. United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe
	IRAQI		[X] MALE Masculin / [ ] FEMALE Féminin

RACE Race	MARITAL STATUS Etat Civil		RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER (Specify) Autre (Spécifier)
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	
OTHER (Specify) Autre (Spécifier)	WIDOWED Veuf	SEPARATED Séparé	JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicilié à (Rue)	CITY OR TOWN AND STATE (Include ZIP Code) Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH (Enter only one cause per line) Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort[1]		Acute Myocardial infarction	
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Coronary artery Disease	
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]			

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée [ ] YES Oui [ ] NO Non		CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
X NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie		Cardio pulmonary arrest
ACCIDENT Mort accidentelle			
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste		
HOMICIDE Homicide	SIGNATURE Signature	DATE Date	AVIATION ACCIDENT Accident d'Avion [ ] YES Oui [ ] NO Non

DATE OF DEATH (Hour, day, month, year) Date de décès (l'heure, le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.

(b)(6)-2 ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplôme
	LtCol D.O

GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse	
LtCol	(b)(3)-1 BIAP	(b)(6)-2
DATE Date	(b)(6)-2	LtCol, USAF, MC, SFS
08 Mar 2004		(b)(6)-2 SHAW AFB, SC

[1]State disease, injury or complication ... etc.
[2]State conditions contributing to the d...
[1]Préciser la nature de la maladie, de la blessure ou ... non la manière de mourir, telle qu'un arrêt du coeur, etc.
[2]Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

EXHIBIT 4

FOR OFFICIAL USE ONLY

DD FORM 1 APR 77 2064 REPLACES AF FORM ... WHICH IS OBSOLETE.

000029

CO50-04-C10250-80155

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

PRELIMINARY AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
SSAN:
Date of Birth: 6 DEC 1948
Date of Incident: 8 MAR 2004
Date of Autopsy: 10 MAR 2004
Date of Report: 11 MAR 2004

Autopsy No.: ME04-110
AFIP No.: Pending
Rank: EPOW
Place of Death: Baghdad, Iraq
Place of Autopsy: Baghdad International Airport

Circumstances of Death: Circumstances of Death: This 55-year-old male Enemy Prisoner of War had a history of ischemic heart disease. His past medical history includes hypertension, hypercholesterolemia, and possibly two previous myocardial infarctions. His medications included atenolol, Zocar, and aspirin, as well as sublingual nitroglycerin as needed. On the evening of 7 MAR 2004 he complained of chest pain and shortness of breath. He was brought to the medical clinic for evaluation where he became unresponsive. Resuscitation efforts, including Advanced Cardiac Life Support at a medical treatment facility, were unsuccessful.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: Identification is obtained by paperwork accompanying the body, including a photograph with a matching prisoner number.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

FOR OFFICIAL USE ONLY

EXHIBIT 15

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

(b)(6)-4
ME04-110

PRELIMINARY AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease

A. History of ischemic heart disease
B. Cardiomegaly, marked (heart weight 620 grams)
C. Coronary atherosclerosis, focally severe
D. Diffuse myocardial scarring
E. Arterionephrosclerosis, mild

II. Marked Pulmonary Edema

III. Remote penetrating ballistic injury of the left buttock
A. Entrance: Inferior-medial aspect of left buttock (scar)
B. Wound Path: Skin, subcutaneous tissue, and muscle of left buttock, muscle of proximal left thigh
C. Recovered: Metallic foreign body encapsulated in fibrous tissue within muscle of proximal left thigh
D. Wound Direction: Left to right, back to front, and downward

IV. Fractures of the 5th and 6th ribs on the right, associated with hemorrhage into chest wall musculature and abrasions/thermal injury of the chest (resuscitation efforts)

V. Laceration of the nose and abrasion of the right index finger

VI. Toxicology Pending

(b)(6)-2 MD, FS, DMO
CDR, MC, USN
Chief Deputy Medical Examiner

FOR OFFICIAL USE ONLY

EXHIBIT 15

0186-04-CID259-80231

0071-04-CID789

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 JUN 04	S) 19 y/o ♂ Detainee presents c̄ multiple complaints
BP 136/78	#1 - (L) Flank pain c̄ dysuria. He denies any nausea or vomiting.
P 90	He denies any gross hematuria. He gives h/o kidney stones in 2000
Temp 98.8	He reports that flank pain c̄ dysuria have been x 4 days. He denies
R 18	any abd pain.
	#2 - Continued back pain since being beaten by apparent
PMH	Coalition forces. He reports he was beaten at a house near
PSH	Al-Adamea palace, he states he was beaten for eight days
FH - Single Vendor	during the eight days he reports that he was forced to
SH - (-) ETOH (-) Tobacco	sit on a water bottle, he was sodomized with a dildo, and
Meds - (-) current	#3 his head was submerged under water. In addition he states
Allergies - NKDA	he was electrified with electricity. #4 He denies having any
	bruising, scabs or scars currently. Otherwise this history was
UA SG 1.020	taken through interpreter.
Bld 1+	O) WNWD ♂ NAD VS STABLE/AFEBRILE GAIT - SLOW
All other Chem WNL	Neuro: CN II - XII, C4-T1 MOTOR AND L1-S2 MOTOR GROSSLY INTACT (B)
	DTRs 2+ (B) SLR - NEG
	HENT - NL NECK - supple s̄ adenopathy or thyromegaly
	SPINE - TTP C, T, + L-Spine NO Bony step offs
	LUNGS - CTA (B) HEART - RRR ABD - BENIGN NEG CVA TENDERNESS
	EXT - MOVES SLOWLY + WITH APPARENT PAIN
	INTEGUMENTARY - NEG FOR ecchymosis or scabs (OVER)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION. *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO

ISN: (b)(6)-4

COMPOUND: GANCI #2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

FOR OFFICIAL USE ONLY

EXHIBIT 25

LAW ENFORCEMENT SENSITIVE
MEDCOM - 621

A) 1 (L) Flank Pain Dysuria Prostatic Urolithiasis
2. Alleged abuse c̄ continued Back Pain

P) 1 Toradol injection in clinic today thru Motrin prn
2. will refer to General surgeon for anoscope evaluation due to Alleged Sodomy
3. Refer to CID for investigation.
4 case and Plan discussed @ length c̄ patient through interpretor

(b)(6)-2 PA-C
LT, SP USA

EXHIBIT 2

6

0186-04-CID259-80231

0085-04-CID519-

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5/16/04	Was at Abu Ghraib
	Injured this past May -
	Now c/o pain in area of kidney.
	Has blood in the urine
	Also pain referred to upper back & bladder
	He was beaten for 5 days
	States he recalls the names - (b)(6)-2
	Interpreter from Egypt -
	Two black soldiers -
	An Iraqi " (b)(6)-4
	Started beating him c̄ sticks - on the back - -
	Placed in a small room underground -
	Placed in handcuffs - very tight - injuries to both wrists
	Had his head kept under water - did it several times to point of passing out
	Then he was placed in water & wires placed on him as if to shock him - said he was shocked 2-3 times
	Vomited up blood c̄ last underwater

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
CAMP BUCCA	Civilian Internee	INTERMENT FACILITY	(b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.

(b)(6)-4

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 6

MEDCOM - 623

0186-04-C10259-8023.

0025-04-CID519-

Then he was punched by a big black soldier - on the cheek. A second black man c̄ a tattoo that looked like a scorpion on his Ⓒ arm - he was also beating him. He passed out c̄ the beating. He was placed in an isolated room.

He says he was raped by a girl with the assistance of the Iraqi & [(b)(6)-2] c̄ an "industrial penis" placed in his rectum. He started yelling and they stopped injuring him but he had been bleeding by this. Then they kicked him. The Iraqi interpr. [(b)(6)-4] came then brought & made him drink urine - ? his own. His eyes were blindfolded.

Then next day he was moved to a prison North of Baghdad - Al [illegible]

He has not been injured since.

Now c/o pain Ⓒ CVA.

Blood in urine (bladder pain

Placed on Cipro today -

Hx of kidney stone -

D) Eye - uncomfortable looking leaving slit to left. [illegible] ⊕ ptosis and [illegible]. Gaze on Ⓛ. Neck ⊕ pain on Ⓛ. Pain spinal [illegible]. Cor - RRR. Lungs - CTA. Abd - [illegible]. Ski - ⊕ old scars on wrists bilat.

A) Injuries to skin [illegible] musculoskeletal injury

D) Refer to S-3 for [illegible]

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

[(b)(6)-4] [(b)(6)-2]

0093-04-CID519

EPW/CI Medical Report					
Last Name (b)(6)-4		First Name, MI (b)(6)-4		Internment Serial Num. (b)(6)-4	
EPW/CI Location C-IN CAMP		BirthDate 1986/01/01	Sex M	Height 66	Weight 163
Physical Condition G-GOOD	Education B-ELEMENTARY SCHOOL	Religion 33-SUNNI-ISLAM		Marital Status S-SINGLE	
Distinguishing Marks:					
Remarks					
Hair Color	Eye Color	Race X-OTHER	Blood Type	Diet	

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
160551-01	2004/06/11	1:02:23 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/12	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0093-04-CID519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S

BACK PAIN, HX OF KIDNEY STONES, UNABLE TO URINATE X 1D

O

T- 98.0, BP- 157/84, P- 109

A

POSS KIDNET STONE

P

REHYDRATE, TEST URINE

I

0102- INITIATED IV (L) ARM 1000CC NS

0111 BP- 164/95, P- 111

0130 1000CC 9% NS IV

0141: T- 97.7

0151

1000CC NS 9% IV

0153

BP 145/60, P-111

0154: 30MG IVP KETROLAC

0207: INITIATED FOLEY CATHETER, URINE OS LIGHT YELLOW

0220

SPG- 1.005, MOD BLOOD (NON-HEMOLYZED)

0222

CIPRO IV 40MG OVER 1 HR

0242

EMPTIED 1400CC CLEAR YELLOW URINE FROM FOLEY BAG

0320

250CC NS IV

0321

FOLEY REMOVED

IV DCD, RT COMP

F

UTI, CIPRO 500MG BID X 5D, IB 800MG TID X 5D

0043-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1986/01/01	M	66	163

Physical Condition	Education	Religion	Marital Status
G-GOOD	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	S-SINGLE

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
160551-02	2004/06/12	1:18:32 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/12	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT

0093-04-CID519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S

KIDNEY PAIN UNRESPONSIVE TO CIPRO

O

PT ARRIVED 10 JUNE, TREATED W/ CIPRO, HAS NOT COMPLETED TREATMENT DIAGNOSED W/ UTI

A

UTI

P

CIPRO IV 400MG IN 200ML 5% DEXTROSE (R) ARM 18G.

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0043-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT

0068-04-CID259-80231

0093-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1986/01/01	M	66	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	S-SINGLE

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
16055104	2004/06/16	2:58:08 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/17	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0043-04-CID514

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: injuries at abu gharib in May 04, injuries to neck, back, chest c clubs, injuries to wrists c hand cuffs, injuries to rectum c gigalo

O: lungs NAD, ms - walking bent over, positive tenderness over back and L neck, COR-RRR, Lungs CDA,

A: injuries c hematuria

P: report case

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT

0093-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

0093-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1986/01/01	M	66	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	S-SINGLE

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
16055103	2004/06/16	6:56:39 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/17	12:00:00 AM

Immunizations

Medical Officer Performing Exam

33

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 1

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: "kidney pain" x 1 d, able to urinate, says cipro no effect

O: t 97.7, bp 140/68

A: Possible UTI

P: Transport and test

I: 0636: u/a SpG 1.030, blood non-hemolyzed, pH 5.0

E: UTI, Bactrum 960 bid x 7d

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT

0093-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0093-04-CID259-80231
0093-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.		
(b)(6)-4	(b)(6)-4	(b)(6)-4		

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1986/01/01	M	66	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	S-SINGLE

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
16055117	2004/07/08	10:44:15 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/07/08	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0093-04-CID 519

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: with back pain, f/u for uti med allergy to pcn. Pt has taked cipro bactrin with no relief back pain still strong vomitted upon arrival to aid station.

O: bp 148/69 p107 spo2 98 t 98.3

A: Kidney pain

P: IV 1000cc n.s. phenergan i.v. 25 mg.1cc n.s. im lu quad of buttoks 1000cc lr iv d/c 1415

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0093-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

0093-04-CID 519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1986/01/01	M	66	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	S-SINGLE

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
160551-06	2004/07/11	10:50:59 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/07/11	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: UTI f/u, pt c/o LUQ pn radiating to shoulder

O: t-98.78, 169/79, p-96 no RQ pn, urine test- moderate blood

A: possible bladder infection

P: NKDA

currently taking Cirpo 500mg

Levaquin 500mg QIDx7d

0186-04-CID259-80231

0093-04-CID519

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT

DOD 044630-00231

0093-04-CID519

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
C-IN CAMP	1986/01/01	M	66	163

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	S-SINGLE

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
16551-06	2004/07/11	11:30:01 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/07/12	12:00:00 AM

Immunizations

Medical Officer Performing Exam

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: pt states he had an artificial penis put into his anus up North while incarcirated, he had bleeding following this

O: Anus exterior hemorroid, oval fistula akso present by (b)(6)-2 exam.

A: anal fistula

P: refer for further eval.

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

0043 04-010514

Comments (From Page 1)	Internment Serial Num. (b)(6)-4

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9

B-099

ORIG-04 (DD257-80237)

Sick Call

EPW Medical Screen Form

39th Brigade Surgeons Office

Date: 15 May 04

Time: 1015°

Name: (b)(6)-4

Interpreter Present ☒ Yes ☐ No

Understands English? ☒ No ☐ Yes ☐ Fluent ☐ Basic

Married ☐ Yes ☐ No

Estimated Height: ______ Weight: ______ Age: 18

Any visible wounds/injuries/deformities: ______

Any visible scars/tattoos/identifying marks: ______

General Appearance: ☐ Healthy ☐ Malnourished ☒ Ill ☐ Other ______

Past Medical History: (L) Kidney Stone - x 4yr

Allergies: NKDA

Medications: Past: Voltaren Inj / Motrin /

VS: Pulse: 80 B/P: 136/74 Temp 97.8

HEENT: WNL

Chest: WNL

CV: WNL

Abdomen: S/NT / % ↑ (L) flank pain / Ø NV

UE/LE/Spine: WNL

Neurological: WNL

General assessment: ______

Follow up needed: ☐ No ☒ Yes: Rx: ① IM toradol 30mg now ② Continue Motrin ③ ↑ po fluid intake

Signed: SSG (b)(6)-2 Date: 15 May 04

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

MEDCOM - 646

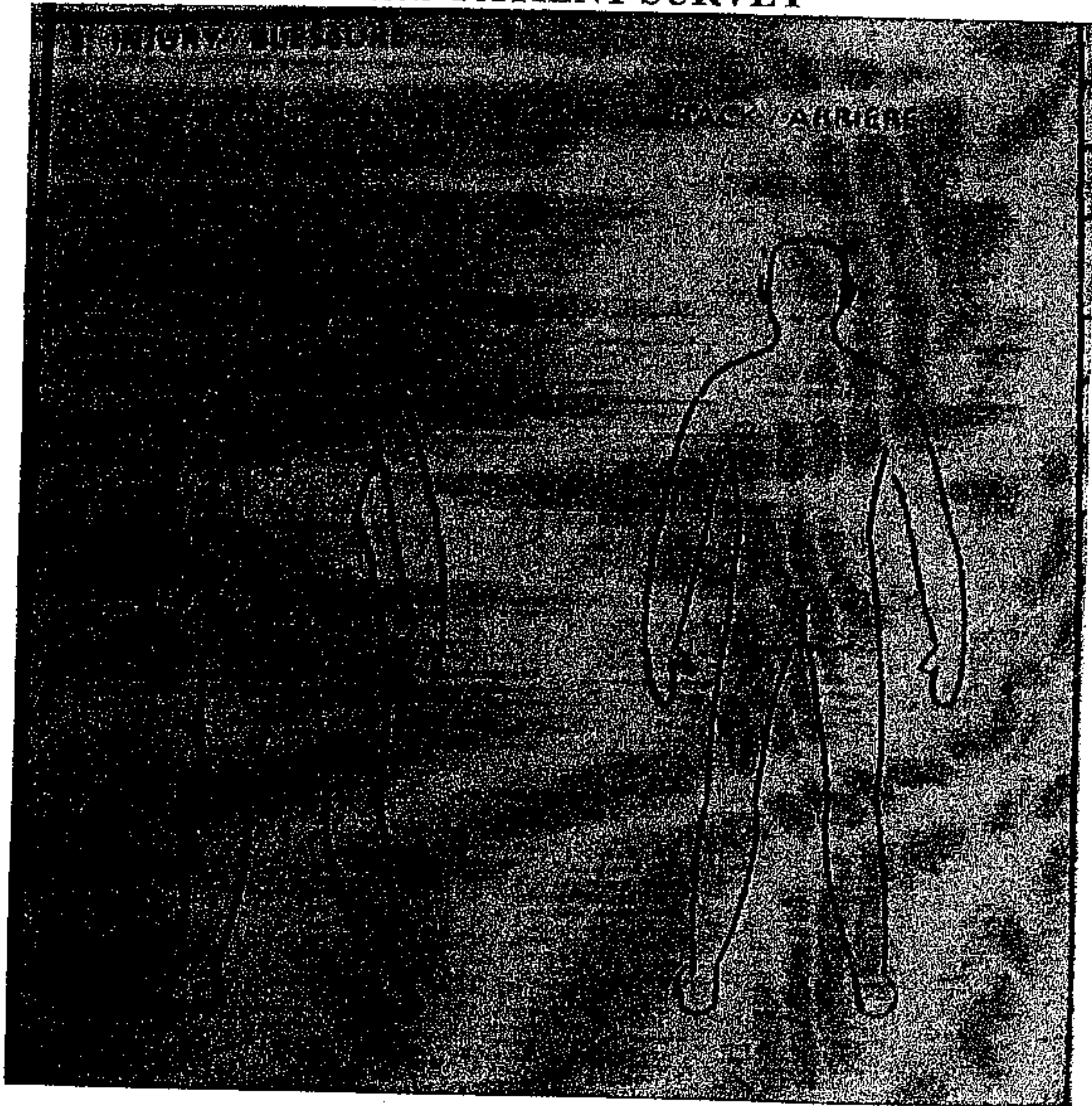
EXHIBIT

17

0186-04-CID259-80231

(b)(6)-4

C-MED PATIENT SURVEY



Description:
Small scar (L) knee

124/80

(b)(6)-2

Medic (b)(6)-2

MD/PA

DATE 15 April 04

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

MEDCOM - 647

EXHIBIT 17

(b)(6)-4

0186-04-CID259-80231

Brigade Surgeon
39th Brigade Combat Team
1st Cavalry Division

DETAINEE MEDICAL SCREENING FORM

DATE: 8 May 04

(b)(6)-4

NAME: (b)(6)-4 AGE: 18 HEIGHT: ______ WEIGHT: ______

ALLERGIES: ☒ NO ☐ YES: ______

MEDICATIONS: Voltarin Inj

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS DISEASES: hx: multiple Kidney Stones, ☐ OPIUM USE

SMOKER: ☐ YES ☐ NO (L) Kidney - onset 2000

EXAM: T - 98°

P: 112 BP: 118/80 APPEARANCE: ☐ HEALTHY, ☐ MALNOURISHED, ☒ ILL

HEENT: PERRLA CHEST: CTA - Reports pN c Deep Inhalation

CV: RRR ABDOMEN: S/NT

MS: MAE c pN SKIN: W/D

DENTAL: ______

GENERAL ASSESSMENT: Painful micturition - Sympathy (L) Flank (b)(6)-2

SIGNED (b)(6)-2 SGW/MG MEDICAL OFFICER: (b)(6)-2 COL MC
(CLS, 91 W) (MC, DC, MS)

SICK CALL: 8 May 04

DATE COMPLAINT DX/TX Kidney Stone.

1/0 - (L) Kidney pn x 5 d. Currently under MD care in Baghdad for Stones. Reports 3x Stones (L) Kidney - has had multiple Stones from (L) Kidney since 2000 -
PLAN (1) 30mg Toradol IM now (2) Po. Fluids (3) F/U on sick call in AM

9 MAY 04 - Renal Pain Much improved no problem c urination (b)(6)-2 (b)(6)-2
No c/o R Knee Pain - Knee Scuffs - Rx DTR - Rx Ibuprofen 600 - Tylenol (b)(6)-2 (b)(6)-2 LPC SP

12 May 04 - No obvious MS changes (b)(6)-2

DISCHARGE NOTE: ☒ NO CHANGE IN HEALTH STATUS DATE: 11 May 04

↓ Renal pn. Currently taking Motrin as directed.

12 MAY 04 - No new medical/dental problems
Sm amt (L) Kidney pn.

SIGNED: SSG (b)(6)-2 SGW/MG MEDICAL OFFICER: (b)(6)-2 MAJ MC
(CLS, 91W) (MC, DC, MS)

14 May 04
c/o (L) flank pN today - Given Ref. c Motrin (b)(6)-2 (b)(6)-2
(b)(6)-2 SSG (b)(6)-2

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

MEDCOM - 648

50

EXHIBIT

BHA MEDICAL SCREENING FORM
1-82 FA, 1 BDE, 1 CAV
CAMP CUERVO, BAGHDAD
Last Revised: 11 JUL 04

Name: (b)(6)-4 D259-80271
Age: 29
Date/Time of Exam: 18 July 2004 1902
Type: Initial / (Transfer) / Release

HISTORY Bb-2

Current illness: pt states No illnesses.

PMHX/Hospitalizations/Surgeries/TB: ∅

Allergies: ∅

Medicines currently taken: Lorazepam 2mg q 12 hrs.

ETOH/Tobacco/Drug use: ⊕ tob, ∅ ETOH, ∅ Drugs

EXAM T: 98.2 P: 70 R: 16 B/P: 108/68

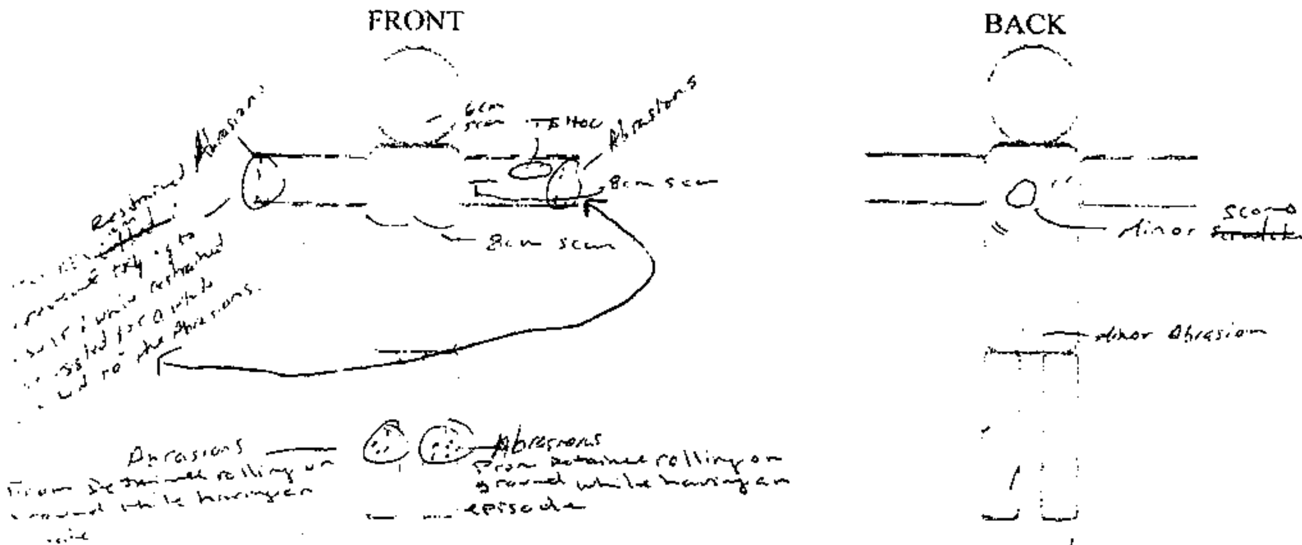
General:

HEENT:

CX:

ABD:

EXT:



Is this detainee fit for interrogation / (transfer) / release? (YES) / NO

Notes:

Signature: (b)(6)-2 (b)(6)-2

EXHIBIT 2

HISTORY

Current illness: Ø

PMHX/Hospitalizations/Surgeries/TB: Ø.

Allergies: Ø.

Medicines currently taken: Ø

ETOH/Tobacco/Drug use: (+) TOB, Ø ETOH, Ø DRUGS.

EXAM T: 98.4°F P: 70 R: 18 B/P: 120/68

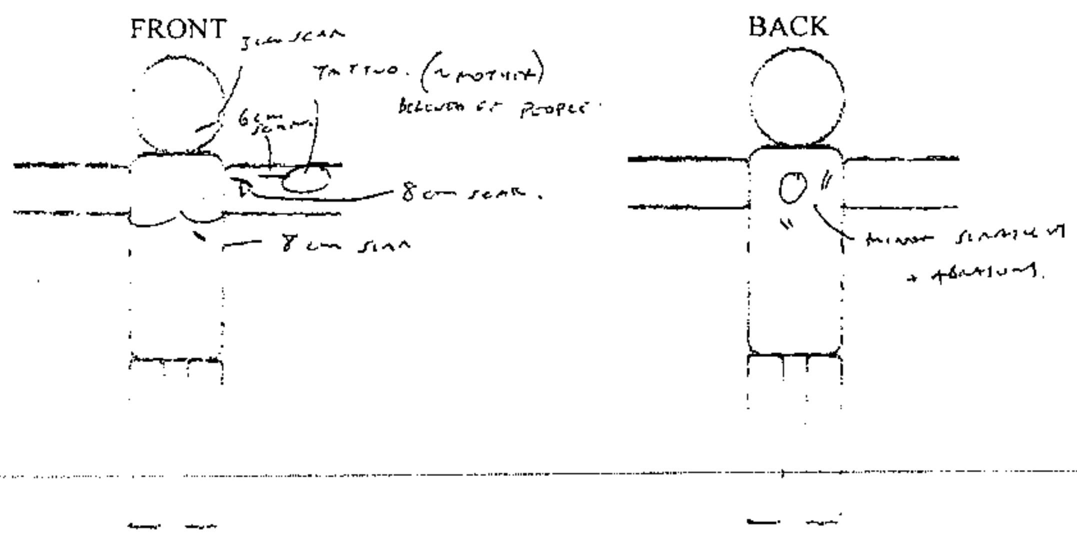
General: PT NAD [illegible]

HEENT: NCAT, [illegible]

CX: [illegible]

ABD: [illegible]

EXT: WNL



Is this detainee fit for interrogation? (YES) / NO

Signature: (b)(6)-2 Date: 04 1850 JUL 04.

CAMP CUERVO MEDICATION ISSUE TRACKING SHEET

MEDICATION Lorazepam 1mg po ½ tab	NAME (b)(6)-4	DATE 6 Jun 04
DOSAGE [illegible] ½ tab	ISSUED BY (b)(6)-2	EXPIRATION
ROUTE P.O	(b)(6)-2 [illegible]	

DATE	TIME	NAME	ISSUED	ISSUED BY	INITIALS
[illegible] 04	0930	(b)(6)-4	Lorazepam 1mg po ½tab	(b)(6)-2	
[illegible] 04	2115		Lorazepam 1mg po ½tab		
[illegible] 04	0930		Lorazepam 1mg po ½tab		
[illegible]	2105		Lorazepam 1mg po ½tab		
[illegible] 04	0600		Lorazepam 1mg po ½tab		
[illegible] 04	2120		Lorazepam 1mg po ½tab		
[illegible] Jul 04	1455		Lorazepam 1mg po ½tab		
[illegible] 04	2300		Lorazepam 1mg po ½tab		
[illegible] 04	0800		Lorazepam 1mg po ½tab		
[illegible] 04	1420		Lorazepam 1mg po ½tab		
[illegible] July 04	0100		Lorazepam 2mg 1tab		
[illegible] July 04	1832		Lorazepam 2mg 1tab		
[illegible] July 04	2200		Lorazepam 2mg 1tab		
[illegible] July 04	0955		Lorazepam 2mg 1tab		
[illegible]	2100		Lorazepam 2mg 1tab		
[illegible] July 04	0950		Lorazepam 2mg 1tab		
[illegible] July 04	2150		Lorazepam 2mg 1tab		
[illegible] July 04	0520		Lorazepam 2mg 1tab		
[illegible] July 04	2015		Lorazepam 2mg 1tab		
[illegible] July 04	0850		Lorazepam 2mg 1tab		
[illegible] July 04	2110		Lorazepam 2mg 1tab		
[illegible] July 04	0945		Lorazepam 2mg 1tab		
[illegible] July 04	2100		Lorazepam 2mg 1tab		
[illegible] July 04	0400		Lorazepam 2mg 1tab		
[illegible] July 04	2115		Lorazepam 2mg 1tab		
[illegible] July 04	0915		Lorazepam 2mg 1tab		
5 July 04	2130		Lorazepam 2mg 1tab		

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

For Official Use Only / Law Enforcement Sensitive

0114-04-CID789

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

0234-04-CID259-80271

3 JUL 04. S/ 23 y/o ♂ detainee c seizure-like episode x 20 min
1305 ago. Guard heard pt fall and bang his cell door.
Guards went to his cell and saw pt on floor
rolling to left and right. Pt then stood up with his
[illegible] back against the cell wall and started shaking his entire
[illegible] body. He then laid on the ground and kicked his
[illegible] feet up in the air and [illegible] on his shoulder.
[illegible] Pt's last episode was 6 months ago. He was taken
to see a doctor who prescribed meds (unk) to take
for sleep. Pt did not take meds. Pt doesn't like
confined space or being alone. Was not able to
sleep last night. Pt he feels fine now. Pt he
has the wrong guy and would like to be released.
O/ Pt had no/ur w/o[illegible].
Gen pt laying on floor when I arrived. Some
vomit on shirt. Pt conversing normally & [illegible]
[illegible]. Pt able to stand.
HEENT: NCAT, OS - [illegible] OD - [illegible], [illegible]
[illegible] w/[illegible], Teeth intact.
[illegible] [illegible] on back/wrist, no blood, (b)(6)-2
[illegible] c 2-12 (-) [illegible] intact.
Gross [illegible] [illegible], [illegible] [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
			[illegible]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)	REGISTER NO.	WARD NO.
(b)(6)-4		

Detainee
[illegible] BHA

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

0234-04-CID259-80271

3 Jun 04 cont
1325

A/ - Seizure-like episode vs anxiety disorder

P/ 1 Cont c̄ [illegible]
2. Lorazepam 2mg . 1/2 T [illegible] 600 × 10.
1 Call guard for s/s Return.

(b)(6)-2 , PA-C

9 Jun 04
1600 hrs
T [illegible]
P 78
R 20
[illegible]

S/ 23 y/o ♂ detainee c̄ seizure-like episode 20 min ago.
PT the episode he started breathing heavily before it started. PT no aura. PT he felt depressed before it started. Also c/o H/A prior to episode. Depression → H/A → hyperventilation → seizure. Guard stated that he heard a yell. When he looked inside the cell the PT was squatting on the floor. PT then threw himself back against the wall, fell to the floor and started rolling around as he did the last time. His cellmate held his legs, the guards entered the cell and kept him on his side. PT stopped trying to move. PT his episodes started after his father died in '92. PT he misses his family and he wants to go home.

O/ PT A&O x3
PT lying on floor when I arrived. PT able to communicate c̄ interpreter. PT able to walk to exam room. PT [illegible] c̄ norm tone + thought content.
HEENT: Neat, OD - ∅ vision/[illegible] OS - [illegible], TM's clear. Septum [illegible], Throat clear, dentition intact.
Skin: minor abrasion on back, [illegible], minor blood from abrasion of [illegible].
Neuro: CN II-XII grossly intact (- OD)
Gross [illegible] gait

EXHIBIT - 3

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

For Official Use Only / Law Enforcement Sensitive 0114-04-CID789

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

0234-04-CID259-80271

9 Jul 04 (cont)

1720 hrs [illegible] 1/2 tab [illegible] BID

[illegible] Dr. [illegible] agrees this is not [illegible] activity. [illegible] [illegible] for further [illegible]

(b)(6)-2

10 Jul 04 (S) Detainee had another episode which consisted of him rolling throughout the floor

1440 hrs in spastic movements. (O) Detainee received a cut to his left eye that is approx. Bacitracin

BP 131/86 was applied to the cut. Detainees vision is not compromised by the cut.

— 98 VSS. No further injuries to self. Refer to the BHA PA. (b)(6)-2

P 58

R 20

11 July 04 (S) Detainee had another episode in his cell that appeared to be controlled

1040 hrs by himself. He willingly fought off his cellmate. While he was on the

BP 1[illegible]/80 ground, he appeared to be trying to hit his head on the ground. Immediately

P 92 [illegible] as we opened the cell door detainees episode seems to subside. This

R 16 has happened three times that I have seen. Detainee did not further injure

himself. VSS (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

(b)(6)-4

[illegible]

[illegible]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2 00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Jul 04 1745 hrs	BHA Medic called me to the BHA Due to The Fact that this Detainee had another episode @ 1725 hrs. The Guards state the Detainee was crying for 5 minutes before the episode occurred. This time the guards Recorded the episode by ways of camcorder. This time the detainee Received a few small minor bruises to his Forehead & a few minor Abrasions to his neck & arms. Detainees cell mate described that this detainee bit his own arm which did not break skin. - (b)(6)-2
12 Jul 04 [illegible]	I SAW TAPE OF ONE OF THE EPISODES. PT STANDS UP CRYING. AFTER A TIME HE JUMPS UP AND HIS ROOMMATE GRABS HIM HE PUSHES HIS ROOMMATE AWAY AND FALLS (CONTROLLED) TO THE GROUND. THE PATIENT THEN LOG-ROLLS TO THE LEFT AND RIGHT UNTIL HE IS RESTRAINED BY GUARDS. Ø INCONTINENCE, Ø LOC, Ø HYPERVENTILATION Ø AUTOMATISMS, Ø POSTICTAL PERIOD. PT CALM WHEN RESTRAINED AND ABLE TO SPEAK.
	A/ 1. ANXIETY DISORDER VS. PSEUDOSEIZURE.
	P/ 1. PT INFORMED THAT HIS HEALTH IS IMPORTANT AND THAT WE WILL CONTINUE TO SEE HIM UNTIL HE IMPROVES. ALSO, WILL ASK [illegible] HIS OWN CELL SO HE DOESN'T EMBARRASS HIS CELLMATE. [illegible] [illegible] [illegible] [illegible] HE NEEDS TO BE AVOIDED.
	2 LORAZEPAM 2mg PO [illegible].
	3 CALL GUARDS IF S/S REOCCUR. (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

EXHIBIT 3

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible]	I was called to the BHR for the fact that this Detainee had
[illegible]	an other episode. I was told by the guards after my arrival, that the
	detainee started crying, placing his hands over his head. This is the typical phase
	that happens prior to him having an episode. The guards that at this time 1535
	placed the detainee in wrist cuffs, ankle cuffs in attempt to prevent the detainee
	from hurting himself. At 1540 the detainee had an episode. The Detainee still
	hit his face with the restraints. He hit his head c̄ the restraints. The Detainee
	was cuffed c̄ his hands to his front portion of body. After the guards had physically
	restrained the Detainee as to further prevent the detainee to cause further injury
	to self, they moved the wrist restraints from the front portion of body to the
	rear portion of his body, or behind his back. The Detainee also managed to
	hit his left side of head on the ground which left a (b)(6)-2 to knot (b)(6)-2
	his head. He also suffered from this incident some abrasions to his face, Neck, elbows & knees
	Detainee's (b)(6)-2 Ø LOC & Hyperventilation & Incontinence. — (b)(6)-2
2 [illegible] 1520	S: I spoke c̄ detainee and explained that he's having [illegible]
	[illegible] to have a positive effect. He said
	that he would control himself from now on. I asked
	him if he had any intent to hurt himself or
	anyone else. He responded no.
	O: [illegible]
	A: [illegible]
	P: 1. [illegible] 2. [illegible] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

(b)(6)-4

BHR

[illegible], BAGHDAD

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible]	[illegible] (b)(6)-2 [illegible]
[illegible]	
[illegible]	Detainee started his typical seizure phase which always leads to him taking
[illegible]	mildly violent actions against himself. At 1450 Detainee was [illegible]
	Behind his back & while [illegible]. Then @1650 the guards stated that the Detainee
	started jumping between the two Mattresses inside his cell. He then hit his head
	against the wall purposely. It was mild hit. AT this time the guards went into the
	cell to prevent detainee from causing serious bodily harm to himself. With
	the assistance of the SIC SGT (b)(6)-2, the Guards & SIC Restrained Detainee
	c zip ties to Detainees wrist behind his back & to Detainees ankles. They also
	used leather restraints to the same areas listed above. The Detainee was
	then placed in a litter to his back & A litter to his front that was secured
	together with tape. Blankets were placed around the Detainees head to
	prevent hyperextension of the Detainees neck As well as to protect the
	Detainee from trying to Injure himself @ anything. When I arrived @ 1735 hrs
	I checked the detainee's physical appearance, which he appeared to be
	yelling. I checked the Detainees pulse which was rapid from him yelling
	& his breathing was rapid for the same reason. This did not at all seem to
	be endangering the detainee. The Detainee was receiving Adequate O2.
	The detainee was released from his restraints @ 1920 hrs. The PA saw
	the Detainee & stated he was in good condition & hadn't further injured
	himself. The PA said he would follow up in the a.m. to see if anything
	showed up over night. The Detainee has marks over both his wrists due
	to him struggling while he was restrained — (b)(6)-2 [illegible]
[illegible]	Detainee was complaining of pain throughout his body. He stated it was from
[illegible]	jerking when he had an episode. He has some bruising to his lower back &
	he has marks around both wrists from when he was struggling around. [illegible]
	will continue to monitor pt & will continue giving [illegible] (b)(6)-2 [illegible]

STANDARD FORM [illegible]

USAPA V2.00

EXHIBIT 3

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible]	No medical complaints. No episodes (b)(6)-2 [illegible]
No medical complaints - No episodes (b)(6)-2 [illegible]
[illegible]	No medical complaints - No episodes (b)(6)-2 [illegible]
[illegible]	(b)(6)-2
18 Jul 04	No medical complaints - No episodes (b)(6)-2 [illegible]
1130	
18 Jul 04	Transition note
2210	This patient is being [illegible] [illegible] (R) [illegible] and was [illegible] seizures. Pt was restrained and was also on a litter to keep him from hurting himself. He has not had an episode since. I've witnessed his episodes - there is no seizure component. Pt was [illegible] [illegible] [illegible] 8 [illegible] [illegible] to 2 [illegible] PO [illegible] now. (b)(6)-2 LT PA-C (b)(6)-2 BATTALION SURGEON

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

(b)(6)-4

BHP
Complex BAGHDAD

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

0040-04-010789-83990

HOSPITAL REPORT OF DEATH

[FO]R USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

[Prep]are, in one copy only, Items 1 through 10 and sign Item 11. [Print] or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

[1]. PATIENT DATA *(Patient's ward plate will be used to imprint [i]dentifying data if available)*

(b)(6)-4

[P]atient's name (Last, first, middle initial) Grade, [S]ocial Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 1107 22 May 2004

3. MEDICAL EXAMINER/CORONER'S CASE: ☐ YES ☑ NO

4. RELIGION

5. CHAPLAIN NOTIFIED: ☑ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Cardiac Arrest	10 min
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING [T]O THE DEATH, BUT NOT RELATED TO THE DISEASE [C]ONDITION CAUSING IT	a.	
	b.	

9. DATE: 22 May 2004

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)-2

11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE: (b)(6)-2

SECTION B - ADMINISTRATIVE ACTION

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)*: ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE

24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY

25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY

[26.] DATE

27. TYPED NAME AND GRADE OF REGISTRAR

28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPPC V2.00

Ex 2

DOD 040-04-010789-83990

HEALTH RECORD	DETAINEE PREINTEROGATION EVALUATION

DATE: 8 Mar 04

PATIENT COMPLAINT/INTEROGATER CONCERNS:

64 yr o ♂ c/o coughing on + off x 2 yrs. [illegible]. Pt c/o [illegible] R gluteal [illegible] radiating down R leg.

ALLERGIES: NKDA

MEDICATIONS: ~~Diabetes~~ HTN meds BID; Diabetes med BID; Name of meds Unkn

(b)(6)-2

BP: 120/84
P: 85
R: 17
TEMP: 98.6 (b)(6)-2
Pox: 98%
WEIGHT: 75kg

PMHX: (CIRCLE)
HTN
DM Type II
TB Ø

O: GENERAL NAD/W
HEENT benign
NECK Ø LAD
LUNGS CTAB
CARD RRR s M
ABD benign
EXT Ø C/C/E

PSHX: Appendectomy

SOCHX:
TOB Ø
ETOH Ø

A/P: Type II DM → Give Glyburide QD
HTN: not elevated off meds - hold on RX
Hep A #1, Hep B #1, MMR, Td
Accuchecks BID x 2 days & per routine
Ibuprofen 800 TID prn
Dip Urine for glucose & ketones once
DX: Sciatica

(b)(6)-2

ISN (b)(6)-4

SEX M

CAMP: 68

DOB: 1940

DATE ARRIVED CAMP

STANDARD FORM 600 BACK (REV. 5-84)

EX 3

MEDCOM - 660

0040-04-CID789-83990

AUTHORIZED FOR LOCAL REPRODUCTION

EDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
March 04	Glyburide 5mg QD
	Accuchecks BID x 2 days then
	per routine
	Ibuprofen 800mg TID prn
	Dip urine for glucose & ketones once
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth, Rank/Grade.)* | REGISTER NO | WARD NO

Compound

ISN# (b)(6)-4

372nd MP CO (b)(6)-1

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

Ex 3[illegible]

0040-04-CID789-83910

13-110 NSN 7540-00-634-4127

MEDICAL RECORD | CONSULTATION SHEET | (b)(6)-4

REQUEST

TO: EMT

FROM: (Requesting physician or activity)

DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

Elderly gentlem went down @ detention area

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

Elderly moderately obese male c̄ unknown medical history collapses in yard; he had no s/s of life @ yard. Pt was intubated @ EMT by corpsman.

P/E Asystole
Pupils fixed and dilated
Lungs - good air entry c̄ bagging
no pulse

(A) Most likely massive cardiac arrest

(P) ① Code
② Called Code

(Continue on reverse side)

(b)(6)-2 (b)(6)-2 (b)(6)-2

DATE 22 May 04

REGISTER NO. WARD NO.

...TION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

*U.S. GPO: 1994-377-624

(b)(6)-4

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Ex 3

EMERGENCY RESUSCITATION RECORD - PART 1

For use of this form see MEDCOM Cir 40-5

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. DATE: 22 MAY 04-1055

2. LOCATION OF RESUSCITATION EVENT Brought to EMT @ 1055

☐ MICU ☐ SICU ☐ CCU ☐ NICU ☑ ED ☐ PACU ☐ OR ☐ WARD:

☐ DIAGNOSTIC / PROCEDURE AREA:

☐ OUTPATIENT CLINIC:

☐ OTHER (Specify): Pt. collapsed at GANZI 5-brought here c CPR in Place.

3. WITNESSED ARREST?

☐ YES ☐ NO ☑ UNKNOWN

MONITORED AT ONSET?

☐ YES ☐ NO

4. INTERVENTIONS (✓ - IN PLACE AT START OF ARREST) (✓ - INSERTED DURING ARREST) COMMENTS

In place at start of arrest	Inserted during arrest	Comments
☑ IV Access RL 500cc	☐ Time: :	
☐ Endotracheal Tube	☑ Time: 1100:	7.0 ETTube
☐ Mechanical Ventilation	☑ Time: 1055:	Bag Valve Mask
☐ Arterial Line	☐ Time: :	
☐ Central Venous Line	☐ Time: :	
☐ Pulmonary Artery Catheter	☐ Time: :	
☐ Nasogastric Tube	☐ Time: :	
☐ Pacing Device (Specify type):	☐ Time: :	
☐ Implantable Defibrillator / Cardioverter	☐ Time: :	
☐ Other (Specify):	☐ Time: :	

5. IMMEDIATE CAUSE OF ARREST / EVENT *(Check one)*

☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☑ Unknown
☐ Other:

6. RESUSCITATION ATTEMPTED

☐ YES *(Check all that were used)*
☑ Chest Compressions
☐ Defibrillation
☑ Airway Management
☐ NO *(Check one)*
☐ False alarm/arrest (BLS / ALS not needed)
☐ Do not attempt resuscitation (DNAR)
☐ Considered futile ☐ Found dead

7. INITIAL CONDITION

CONSCIOUS
☐ Yes ☑ No
BREATHING
☐ Yes ☑ No
PULSE
☐ Yes ☑ No
Site: Pulse only c CPR

8. INITIAL RHYTHM

☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☑ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)

☐ Returned at: : ☑ Never achieved
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 1107

WHY: ☐ ROSC ☐ DNAR
☐ Considered futile ☑ Death

PATIENT DISPOSITION:

9. EVENT TIMES

(Times are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

	HOUR	MIN
Collapse / Arrest Onset:		
CPR Started: before arrival		
~~1st Defibrillation~~: Pt. arrived	1055	
Airway Achieved:	1100	
1st Dose Epinephrine:	1102	

Code Team Called:
☐ Yes ☐ No Time: :

Code Team Arrived:
☐ Yes ☐ No Time: :

10. GLASGOW COMA SCALE

(Post-resuscitation)
Circle appropriate scores, then total.

EYE OPENING
4 - Spontaneously
3 - To voice
2 - To pain
(1) - No response

VERBAL RESPONSE
5 - Oriented, converses
4 - Disoriented, converses
3 - Inappropriate responses
2 - Incomprehensible sounds
(1) - No response

MOTOR RESPONSE
6 - Obeys verbal commands
5 - Localizes painful stimulus
4 - Withdraws from pain stimulus
3 - Flexion, decorticate posturing
2 - Extension, decerebrate posturing
(1) - No movement

SCORE:

PATIENT IDENTIFICATION
(b)(6)-4

AGE: DOB 1940
GENDER: MALE
HEIGHT (in):
WEIGHT (lbs):

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE MC V2.00

Ex 3 11

EMERGENCY RESUSCITATION RECORD - PAGE 2 0040-04-C1D7K-83990

	TIME (Hr/Min):	1055	*1100	1102	1103	1104	1105	1107					
VITALS	BLOOD PRESSURE	none	none					none					
	HEART RATE (* = CPR)	*CPR	*CPR					asystole					
	RHYTHM	asystole	asystole					CPR					
	PULSE PALPABLE (Y/N)	N	N					N					
	DEFIBRILLATION (Joules: 200, 300, 360)	none	none					—					
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	–	–					–					
	PACING PERFORMED (√)	–	–					–					
	RESPIRATIONS	0	–					0					
AIRWAY	BAGGED w / 100% O2 (√)	✓											
	INTUBATED (√)		✓	Z									
	MASK (Specify type)												
	% OXYGEN		100%	100%	100%	100%	100%						
	O2 SATS		70%	70%	70%	70%	70%						
								PT PRONOUNCED DEAD-1107					
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)			✓		✓							
	ATROPINE (0.5 -1 mg - IV / ET tube)				✓		✓						
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
IV DRIPS	LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
	DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
LABS	POTASSIUM (K)												
	GLUCOSE												
	CALCIUM (Ca)												
	MAGNESIUM (Mg)												
ABGs	PH												
	pCO2												
	pO2												
	HCO3												

PHYSICIAN (Signature & Title)

DR (b)(6)-2

NURSE (Signature & Title) (b)(6)-2

(b)(6)-2

LTC AN

MEDCOM FORM 679-R (TEST)(MCHO) AUG 99, Back

(b)(6)-4

(b)(6)-4

22 MAY 04.

EX 3

0040-04-CID789-83990

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-4
Prisoner (b)(6)-4
Date of Birth: BTB 1940
Date of Death: BTB 23 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 1 June 2004

Autopsy No.: ME04-386
AFIP No.: Pending
Rank: CIV
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody in Abu Ghraib prison.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: BTB, DNA sample obtained

CAUSE OF DEATH: Atherosclerotic cardiovascular disease

MANNER OF DEATH: Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.

14

EX 5

(b)(6)-4

PRELIMINARY AUTOPSY DIAGNOSES:

I. Atherosclerotic cardiovascular disease
   A. Left anterior descending coronary artery with multifocal stenoses ranging from 50-80%
   B. Right coronary artery with mutifocal stenoses ranging from 50-85%
   C. Left circumflex coronary artery with focal 50% stenosis
   D. Moderate to severe atherosclerosis of the distal aorta
   E. Thickening of the mitral valve leaflets
   F. Pulmonary congestion (right 800 grams, left 650 grams)
   G. Prominent facial suffusion
   H. Bilateral earlobe creases (Frank's sign)

II. Pleural adhesions
III. Status post appendectomy, remote
IV. Fractures of the anterior ribs (right #5, left 3-7) consistent with cardiopulmonary resuscitation
V. No significant trauma
VI. Toxicology pending

(b)(6)-2 (b)(6)-2
MD
MAJ, MC, USA
Deputy Medical Examiner

Ex 5

0040.04.719.83990

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
Prisoner # (b)(6)-4
Date of Birth: BTB 1940
Date of Death: BTB 22 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 29 Jun 2004

Autopsy No.: ME04-386
AFIP No.: 2929618
Rank: CIV
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody in Abu Ghraib prison. By report he complained of chest pain to his son and then collapsed.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By CID, DNA sample obtained

CAUSE OF DEATH: Atherosclerotic cardiovascular disease (ASCVD)

MANNER OF DEATH: Natural

Ex 8

FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic cardiovascular disease
   A. Left anterior descending coronary artery with multifocal stenoses ranging from 50-80%
   B. Right coronary artery with multifocal stenoses ranging from 50-85%
   C. Left circumflex coronary artery with focal 50% stenosis
   D. Moderate to severe atherosclerosis of the distal aorta
   E. Thickening of the mitral valve leaflets
   F. Pulmonary congestion (right 800 grams, left 650 grams)
   G. Prominent facial suffusion
   H. Bilateral earlobe creases (Frank's sign)

II. Pleural adhesions

III. Status post appendectomy, remote

IV. Fractures of the anterior ribs (right #5, left #3-7) consistent with cardiopulmonary resuscitation

V. No significant trauma

VI. Toxicology negative

EXTERNAL EXAMINATION

The body is that of a thin male appearing greater than 50 years of age and measuring 69 inches in length and weighing approximately 160 pounds. Lividity is posterior, purple, and fixed. Rigor is passing.

The scalp is covered with gray hair in a normal distribution. There is a gray mustache and beard. Corneal clouding obscures the irides and pupils. The external auditory canals are unremarkable. The ears are significant for bilateral creases of the earlobes (Frank's sign). There is prominent facial suffusion. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural with partial upper plates.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema.

Identifying marks and scars include a 3 ½ inch oblique scar on the right lower quadrant of the abdomen. On the posterior right arm and forearm is a 6 x 3 ½ inch area of depigmentation of the skin and scar. On the midline of the lower back is a ½ inch scar.

There is early decomposition consisting of skin slippage and vascular marbling.

CLOTHING AND PERSONAL EFFECTS

The following clothing items and personal effects are present on the body at the time of autopsy:

- Brown shirt
- Gray underpants
- Gray t-shirt
- White shirt

MEDICAL INTERVENTION

- Endotracheal tube in the oropharynx that enters the trachea
- Intravenous catheter (IV) in the back of the left hand
- Electrocardiograph (EKG) pads on the chest

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the following:
No radiopaque projectiles or foreign matter

EVIDENCE OF INJURY

There are fractures of the right 5th and left 3rd-7th ribs on the anterior aspects.

20

Ex 8

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. Clear cerebrospinal fluid surrounds the 1250 gm brain, which has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

The cervical spine is intact and there is no paraspinous muscular hemorrhage.

BODY CAVITIES:
The sternum and vertebral bodies are visibly and palpably intact. No excess fluid is in the pleural, pericardial, or peritoneal cavities. The organs occupy their usual anatomic positions.

There are fractures of the anterior left ribs 3-7 and the right 5th rib on the anterior aspect.

RESPIRATORY SYSTEM:
There are dense fibrous adhesions of both pleural cavities. The right and left lungs weigh 800 and 650 gm, respectively. The external surfaces are deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 400 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show 50-80% multifocal stenoses of the left anterior descending coronary artery, focal 50% calcific stenosis of the left circumflex coronary artery, and 50-75% multifocal stenoses of the right coronary artery with a focal 85% stenosis. The myocardium is homogenous, red-brown, and firm. The mitral valve is thickened and fibrotic but there are no vegetations. The remaining valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.4 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta has moderate to severe atherosclerosis and gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

By 8

LIVER & BILIARY SYSTEM:
The 1800 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains a minute amount of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is firm and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 175 and 200 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 10 ml of cloudy urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach contains approximately 50 ml of dark green liquid. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is surgically absent.

ADDITIONAL PROCEDURES

- Documentary photographs are taken by PH3 (b)(6)-2
- Specimens retained for toxicologic testing and/or DNA identification are: blood, urine, spleen, liver, lung, kidney, adipose, brain, bile, gastric, and psoas
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, without preparation of histologic slides.

TOXICOLOGY

Toxicologic analysis of blood and bile was negative for ethanol and drugs of abuse. Cyanide was not detected.

OPINION

This elderly Iraqi male died of atherosclerotic cardiovascular disease (blockage of the arteries that supply blood and oxygen to the heart). The rib fractures noted at autopsy are consistent with cardiopulmonary resuscitation (CPR). There was no significant trauma.

The manner of death is natural.

(b)(6)-2

(b)(6)-2 MD (b)(6)-2
MAJ, MC, USA
Deputy Medical Examiner

0040.04.783.83550.

DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

REPLY TO
ATTENTION OF

AFIP-CME-T

PATIENT IDENTIFICATION

AFIP Accessions Number	Sequence
2929618	01

Name
(b)(6)-4

SSAN: **Autopsy:** ME04-386
Toxicology Accession #: 042887
Date Report Generated: June 28, 2004

TO:

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 5/23/2004 **Date Received:** 6/17/2004

VOLATILES: The **BLOOD AND BILE** were examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

CYANIDE: There was no cyanide detected in the blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

DRUGS: The **BLOOD** was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

(b)(6)-2 PhD
Certifying Scientist, Forensic Toxicology Laboratory
Office of the Armed Forces Medical Examiner

(b)(6)-2

(b)(6)-2 PhD, DABFT
Director, Forensic Toxicology Laboratory
Office of the Armed Forces Medical Examiner

24
b 8-

0014-03-CID 714-65732

MEDICATION ADMINISTRATION RECORD

Name: (b)(6)-4 Unit: ____________ Month: ____________

Medication /Dose /Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PZA 500mg 4 pills each day																															
Rifanpin 300mg 2 P.O. daily																															
INH 300mg one each day																															
Ethambutol 400mg 3 pills each day																															

FOR OFFICIAL USE ONLY

MEDCOM - 674

0014-03-CID919-63732

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Turks [illegible] & [illegible]
	HAS Tuberculosis
	Recommend Compassionate D/c to Medical City
	he has 4 days of Medication
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

FOR OFFICIAL USE ONLY

0014-03-CID919-63732

OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
BAGHDAD DETACHMENT

PRELIMINARY AUTOPSY REPORT

Name: (b)(6)-2
Date of Birth: 01 January 1977
PW Number: 11672
Date of Death: 12 July 2003
Place of Death: EPW Camp, Baghdad International Airport, Baghdad, Iraq
Date of Autopsy: 13 July 2003
Place of Autopsy: Baghdad International Airport Compound, Baghdad, Iraq

CLINICAL DIAGNOSES:

1. Hemoptysis
2. Death in Custody

PATHOLOGIC DIAGNOSES:

A. RESPIRATORY SYSTEM:
   1. Cavitary Lesion- Right Lung
   2. Multiple Caseating Granulomata- Right Lung
   3. Blood Within Tracheobroncial Tree
   4. Focal Consolidation- Bilateral Lungs
   5. Bilateral Pleural Adhesions

B. CARDIOVASCULAR SYSTEM
   1. Pericardial Effusion- 30 cc.

C. GENITOURINARY SYSTEM
   1. Absent Right Testicle

D. NO EVIDENCE OF SIGNIFICANT TRAUMA

CAUSE OF DEATH: MASSIVE HEMOPTYSIS DUE TO CAVITARY PULMONARY TUBERCULOSIS

MANNER OF DEATH: NATURAL

(b)(6)-2

(b)(6)-2 MD
CAPT MC USN
Regional Armed Forces Medical

FOR OFFICIAL USE ONLY

0014-03-CID919-63132

TO:	FORWARD FINAL REPORT TO:
ARMED FORCES INSTITUTE OF PATHOLOGY ATTN: DIVISION OF FORENSIC TOXICOLOGY BUILDING 54 6825 16TH STREET, N.W. WASHINGTON, DC 20306-6000	COMMANDER (b)(3)-1 MP DET (CID) MP BN (CID) APO AE 09335

NAME OF PATIENT (Last, First, MI)	SOCIAL SECURITY #	AGE	SEX	RACE
(b)(6)-4	DETAINEE # (b)(6)-4	26	MALE	IRAQI

DATE OF INCIDENT/ ACCIDENT	TIME AND DATE OF DEATH	AUTOPSY #
12 JUL 03	12JUL03 / 0515	EPW 071303

MEDICATION HISTORY (Prescribed or administered, in patient's possession, containers found near body, etc.)

N/A NOTE: TUBERCULOSIS VICTIM

SPECIMEN/ AMOUNT	SPECIMEN/ AMOUNT	SPECIMEN/ AMOUNT
1. LIVER	5. RIGHT LUNG	9. EPW CAPTURE TAG # (b)(6)-4
2. SPLEEN	6. BRAIN	10. INDEX CARD WITH NAME (b)(6)-4
3. KIDNEY	7. RIGHT HAND FINGERPRINT CARD	11.
4. LEFT LUNG	8. LEFT HAND FINGERPRINT CARD	12.

INCIDENT/ ACCIDENT DETAILS (Include pertinent information regarding crash site, autopsy or investigation: (e.g., What happened?)

VICTIM (b)(6)-4 WAS APPREHENDED ON 10 JUL 03 IN POSSESSION OF A PIPE BOMB. HE WAS SUBSEQUENTLY TRANSPORTED TO CAMP CROPPER DETENTION FACILITY AT BIAP. AT APPROXIMATELY 0445, 12 JUL03, VICTIM (b)(6)-4 WAS OBSERVED COUGHING UP BLOOD. MEDICAL PERSONNEL ATTEMPTED TO ASSIST BUT WAS NEGATIVE. HE DIED 0515.

PRINTED NAME OF REQUESTER/ TITLE	SIGNATURE	DATE	TELEPHONE #:
(b)(6)-1 /SAC	(b)(6)-1 (b)(6)-1	13 JUL 03	COMM: DSN: 302-550-2525 FAX:

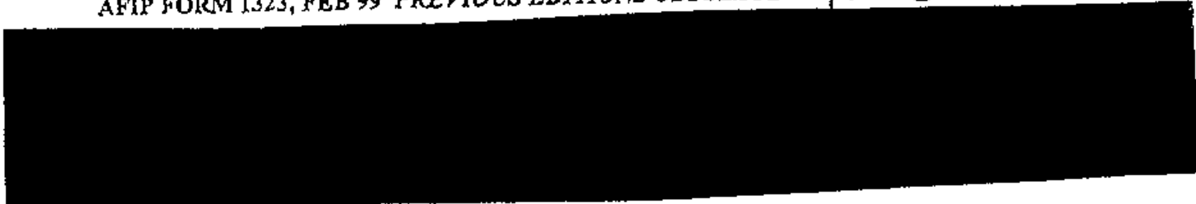
CHAIN OF CUSTODY (CC)

Each individual charged with custody of specimens must complete information below (continue CC on reverse as required).

RELEASED BY	RECEIVED BY	DATE & TIME	PURPOSE OF TRANSFER
(b)(6)-1	SIGNATURE PRINTED NAME		
SIGNATURE PRINTED NAME	SIGNATURE PRINTED NAME		
SIGNATURE PRINTED NAME	SIGNATURE PRINTED NAME		
SIGNATURE PRINTED NAME	SIGNATURE PRINTED NAME		
SIGNATURE PRINTED NAME	SIGNATURE PRINTED NAME		

AFIP FORM 1323, FEB 99 *PREVIOUS EDITIONS OBSOLETE.*

FOR OFFICIAL USE ONLY



13

30

0014-03-CID919-63732

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4	N/A	N/A	# X/D

ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
			☐ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant	OTHER *(Specify)* Autre *(Spécifier)*
NEGROID Négroïde	MARRIED Marié		CATHOLIC Catholique	
✓ OTHER (Specify) Autre (Spécifier)	WIDOWED Veuf	SEPARATED Séparé	JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit

STREET ADDRESS Domicile à (Rue)	CITY OR TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)		INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]	~~Tuberculosis~~ Cardiac Arrest	
ANTECEDENT CAUSES Symptômes précurseurs de la mort. — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Tuberculosis	
UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]	Unknown	

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☑ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
✓ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	Unknown
ACCIDENT Mort accidentelle		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès
12 Jul 03 1100	BIAP

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin sanitaire	TITLE OR DEGREE Titre ou diplôme
(b)(6)-2	MD

GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
Lt Col	EMED (b)(3)- (b)(6)-2

DATE Date	SIGNATURE
12 Jul 03	(b)(6)-2 Lt Col, USAF, MC Chief, Ortho Sports Med. (b)(6)-2 WHMC PC: (b)(3)-1

[1] State disease, injury or complication wh[...]
[2] State conditions contributing to the de[...]
[1] Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.
[2] Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

DD FORM 1 APR 77 **2064** REPLACES AF FORM 716, MAR 59, WHICH IS OBSOLETE.

FOR OFFICIAL USE ONLY

1021-03-C10519_62147

(b)(6)-4

63yo ♂ presenta con
Corto de respiración y
Tociendo mucho con Sangre
por favor De cojer
placa Del pecho
(CXR) PA y Lateral
R/O Bronchitis o Tuberculosis

Gracias

(b)(6)-2

CPT MC

FOR OFFICIAL USE ONLY

Ruego venga a las 20,00h. de [illegible]
hoy (13-V-03) para realizar la RX
[illegible] el [illegible] [illegible]deado por el →

Chronological Record

13 May 03	(L) shoulder HA constipation x4
66 yr old male	
1350 hrs	c/o dyspnea x today
PO_2 88%	O- Rales, pitting edema (L) leg only.
@ 1350 hrs 100% c O_2 Therapy @ 4L/min	A.
	P- refer to Spanish for CXR
1500 →	Spanish X Ray is down. Return @ 1700 hrs. SSG (b)(6)-1 (b)(3)-1 MP BN
	[illegible]
13 May 03 2055	Rec'd CXR. Will hold pt. in Medical Holding Tent c intent of further eval. & possible expediting his release. SSG (b)(6)-1 (b)(3)-1 MP BN

NAME
US/ (b)(6)-4
(b)(6)-4

CHRONOLOGICAL RECORD

14 Mayo03 – Paciente con tos y espectoración hemoptoica

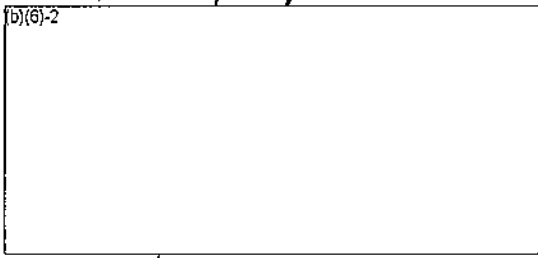
AP: roncus a base de predominio dcho

Rx: Imágenes condensantes nodulares y a lóbulo medio superior de pulmón tuberculoso con foco neumónico asociado

El paciente es aconsejable que sea liberado o aislado para recibir Tto específico

J. Clínico: Tuberculosis pulmonar.

Tt: Iniciamos Tto con Ciprofloxacino



NAME: (b)(6)-4 # (b)(6)-4

DOB: 17 Jan 38

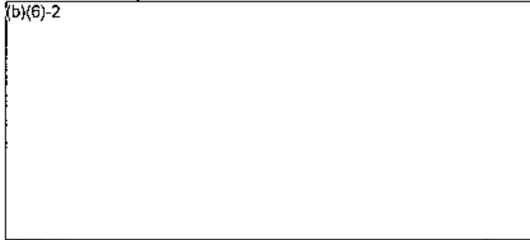
FOR OFFICIAL USE ONLY
FOR OFF...

4 May 03 | ~~[illegible]~~, chest pain

Fractura por arma de fuego de tibia dcha
1 mes de evolución, tratado con fijador
externo y después con escayola

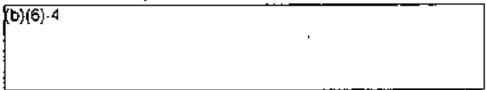
Rx: Fractura en evolución

Tt: - Mantener escayola
- " descarga 3 semanas mas



~~[illegible]~~

US



FOR OFFICIAL USE ONLY

EXHIBIT 34

IO91-03-CID519-62147

CHRONOLOGICAL RECORD

17 MAY 03

Paciente que refiere fue golpeado hace 4 días desde entonces presenta dolor a la movilización articulación hombro (I) y muñeca izqd.
No hematomas, ni signos de contusión en hombro; inflamac muñeca
Rx de hombro (I) / muñeca ~~[illegible]~~

Presenta además una erosión en región coxigea como consecuencia (según refiere) de haber sido arrastrado.

Tto: - Cura local de la ~~úlcera~~
- Inmovilización y vendaje de la muñeca
- Bufren 600 1c/12h

(b)(6)-2

MEDICO

(b)(6)-2

US (b)(6)-4

(b)(6)-4

EXHIBIT 34

FOR OFFICIAL USE ONLY

0031-03-CID519-62147

PACIENT: (b)(6)-4
US (b)(6)-4 EPW

CLINIC HISTORY:

Traumatic osteoartritis of right elbow (4 days ago) in old injury (Gulf war).
When he was 6 years old probably epiphisiolysis or fracture-dislocation.
Nothing to do, only pills analgesics-AINE,s.

DIAGNOSTIC: Traumatic osteoartritis of right elbow.

26, may, 2003

(b)(6)-2
Tcol.Commander EMATCEN.

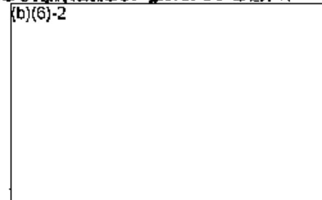


EXHIBIT 34

FOR OFFICIAL USE ONLY

031-03-CID519-62147

PACIENT: (b)(6)-4
ISN # (b)(6)-4 EPW

CLINIC HISTORY:

Hamatoma in posterior region of left elbow with pain in epitroclea and epicondyle. X-rays suggest small fragment (acute or old) of epicondile, becouse he was operated in the past of humeral fracture, consolidated actually (with osteosynthesis).

I recomended brachial splent that was refused by the patient waiting for evolution.

He wanted pills AINE,s and so it was done.

DIAGNOSTIC: Traumatic hematoma of left elbow.

26, may, 2003

Tcol.Commander EMATCEN.

(b)(6)-2

EXHIBIT 34

MEDICAL RECORD | **PROGRESS NOTES**

DATE	
21 March 04	S/ EPW states interrogated last evening
	↑ pain this c̄ swelling + blisters.
	Reports thermal burn left ...
	Noted Δ'S c̄ wounds Ant. Bi Knee
	O/ AVSS
	EXT: (B) LE : Ant Knees noted ↑ erythema
	+ multiple blisters. noted ? single
	tissue appears 2ND degree burns c̄
	necrotic margins.
	A/P ? 2ND degree burn c̄ blister R>L.
	(1) Continue Bacitracin topically
	to affected areas.
	(2) start Percocet 4-6° PRN for
	Severe pain
	(3) Continued daily dressing Δ'S. will
	use silverdene daily
	[signature] L. G. Dupuis LT [redacted]
	B6-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

AUTHORITY: SOME REGULATION
PURPOSE: To provide a standard means of documenting combat trauma for care at echelons 1-3
ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF DESIGNATION:
CASUALTY NAME: (b)(6)-4 (b)(6)-4
CASUALTY SSN: DETAINEE # (b)(6)-4

Arrive DTG: 081200L MAR04
Rank
Date of Birth
Gender ☐ Male ☐ Female
Unit

ARRIVAL METHOD: ☒ WALKED ☐ Non-MED GND ☐ SHIP EVAC ☐ GND AMB ☐ DUSTOFF ☐ Other ARRIVAL

Nation ☐ US

Service ☐ Civilian ☐ Combatant ☐ Contractor ☐ USA ☐ USN ☐ USMC ☐ USAF ☐ SOF ☐ NGO

Wound DTG:

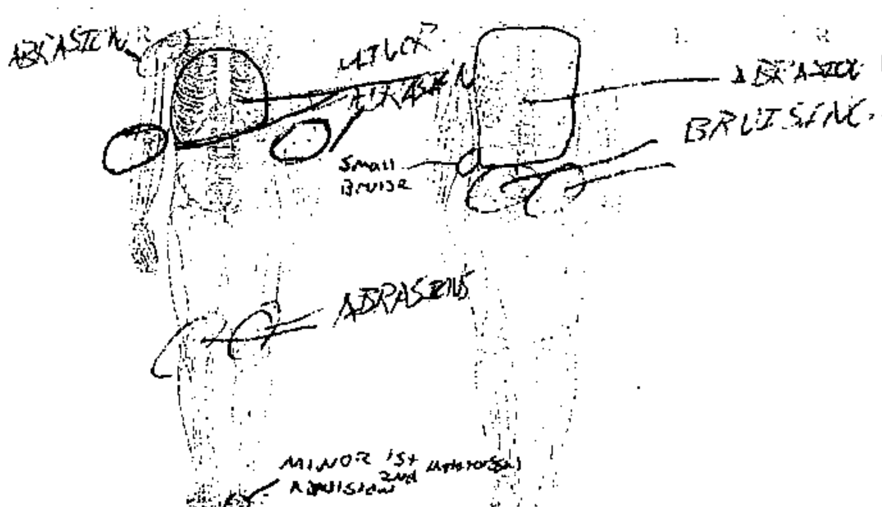
PROTECTION: Not Worn / Worn / Struck / Penetrated

TRIAGE CATEGORY: ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL ☐ EXPECTANT

GCS: 12

MECHANISM OF INJURY: ☐ GSW BULLET ☐ BLUNT TRAUMA ☐ GUNSHOT FRAGMENT ☐ OTHER FRAGMENT ☐ MVC ☐ CBRNE ☐ BURN ☐ FALL

Time	1245	1318	1451
Pulse	100	94	108
Temp	98.4 oral	–	–
BP	124/90	–	–
Resp	16	16	14



Vent On / Off
DISPOSITION: RTD DECEASED
EVACUATED to: ☐ URGENT ☐ URGENT SURGICAL

0180-04-CID259-80227

(b)(6)-4

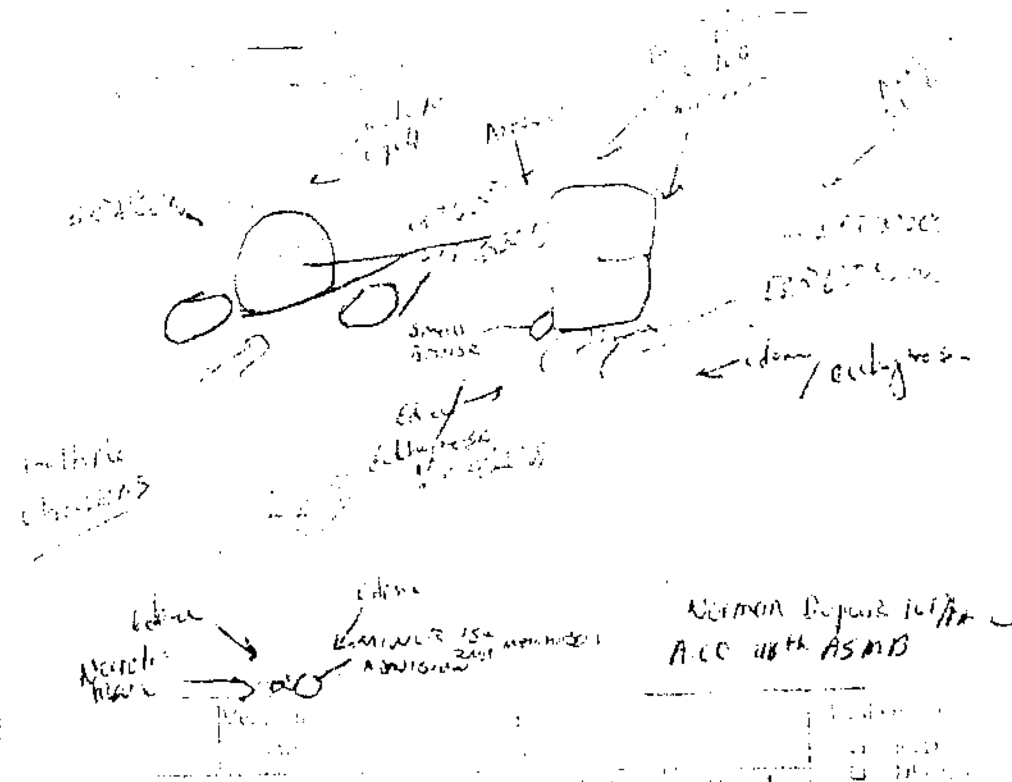
(b)(6) -4

(b)(6)-4

Date of Birth

Gender

Unit



FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Jul 04	31 year old ♂ detainee for physical
	PMH- "beaten badly" 4 mo ago
	PSH- ∅ Meds- ∅ Allergies ∅
	SH- ∅
	vitals HT 6'0" wt 69 KG 132/62 P61 R16
	healthy fit appearing young ♂
	HEENT- Mouth moist + pink multiple fillings.
	no evidence of active disease.
	PERRL, EOMI ∅nystagmus
	Neck- spine aligned, no spasm
	Chest- CTA (B) good AE
	CV- S1 S2 ∅M A
	Abd- soft NT BS⊕
	ext- ∅CCE multiple areas of callousness over (B) knees
	Skin- several old scars on back no bruising
	Neuro- 2+ reflexes All 4 limbs good strength
	no muscle wasting no bowel/bladder problems
	A/P- ① healthy young ♂ c̄ no acute injury or illness
	② old trauma evident by scarring.

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	(b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

ISN: (b)(6)-4

COMPOUND: 1973 31 yr.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

FOR OFFICIAL USE ONLY

Theater Trauma Registry Record 0180-04-CID259-80227

For use of this form, see DA PAM XXX; the proponent agency is OTSG

AUTHORITY: SOME REGULATION
PURPOSE: To provide a standard means of documenting combat trauma for care at echelons 1-3
ROUTINE USES: The "Blanket Routine Uses" set forth at the beginning of the Army compilation of systems of records notice apply.
DISCLOSURE: This is protected health information. HIPAA laws apply

MTF DESIGNATION:

CASUALTY NAME: (b)(6)-4

CASUALTY SSN:

Arrive DTG:

Birth

Gender: ☒ Male ☐ Female

Unit

ARRIVAL METHOD: ☐ WALKED ☐ CARRIED ☐ Non-MED AIR ☐ OTHER ☐ Non-MED GND ☐ SHIP EVAC ☐ GND AMB ☐ DUSTOFF

Nation: ☐ US ☐ Host Nation ☐ Enemy( ) ☐ Coalition( )

Service: ☐ Civilian ☐ Combatant ☐ Contractor ☐ USA ☐ USN ☐ USMC ☐ USAF ☐ SOF ☐ NGO (☐ Other

Wound DTG:

WOUNDED BY: ☐ ENEMY ☐ UNK ☐ FRIENDLY ☐ CIVILIAN (Host Country) ☐ TRAINING ☐ SELF ACCIDENT ☐ SELF NON-ACCIDENT ☐ SPORTS-RECREATION ☐ OTHER:

PROTECTION:	Not Worn	Worn	Struck	Penetrated
HELMET				
FLAK VEST				
CERAMIC PLATE				
EYE PROTECTION				
OTHER:				

TRIAGE CATEGORY: ☐ IMMEDIATE ☐ DELAYED ☐ MINIMAL ☐ EXPECTANT

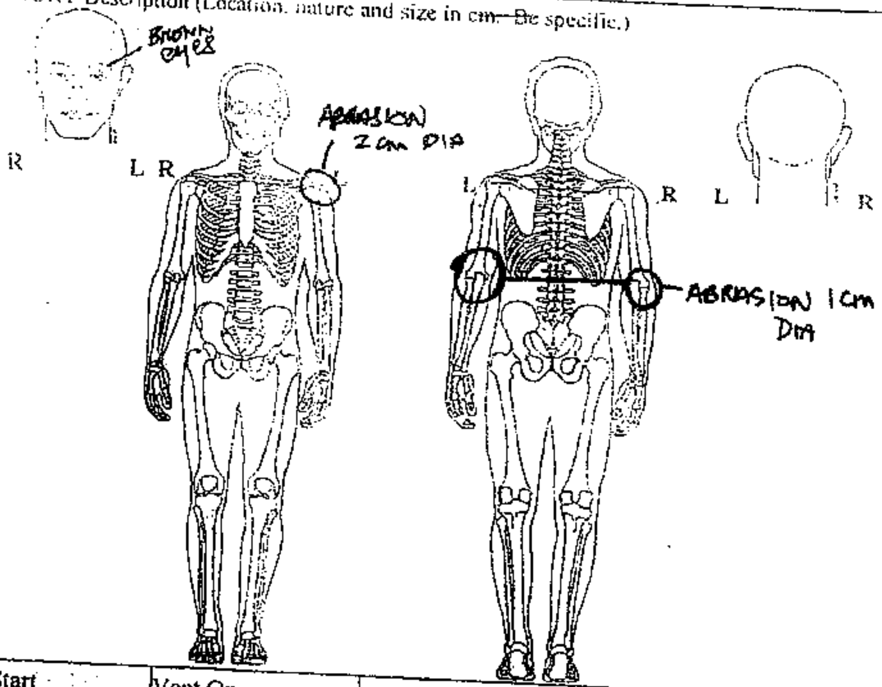
GLASCOW COMA SCALE (circle one): 3 UNC 8 STUPOR 12 LETHARGY 15 ALERT

MECHANISM OF INJURY: ☐ GSW/BULLET ☐ BLUNT TRAUMA ☐ SINGLE FRAGMENT ☐ MULTI FRAGMENT ☐ MVC ☐ AIRCRAFT CRASH ☐ KNIFE/EDGE ☐ CBRNE ☐ BLAST ☐ BURN 1° 2° 3° ____ %TBSA ☐ CRUSH ☐ FALL ☐ IED ☐ OTHER

VITALS:

TIME	2000	2132	2250
Pulse	140	100	120
Temp	98.6	—	98.4
B/P	—	—	
Resp	16	12	18
SpO2	—		

INJURY Description (Location, nature and size in cm. Be specific.)



TX & PROCEDURES:

SEDATED	
CHEM	
PARALYZED	
INTUBATED	ett
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	
OXYGEN	Liters/min
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
HBOC	ml
Fresh Whole Bld	Units

OR Start / Stop — Vent On / Off — ICU in / Out

PROVIDER: — SPECIALTY: — DATE:

DISPOSITION: ☐ RTD ☐ DECEASED DTG:

EVACUATED to ☐ URGENT ☐ URGENT SURGICAL ☐ ROUTINE ☐ MINIMAL

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

MEDCOM Test Form 1381, OCT 2003

MEDCOM - 690

0180-04-CID259-80227

Theater Trauma Registry Record

For use of this form, see DA PAM XXX; the proponent agency is OTSG

Observations/Notes (Holding, En route, etc.)

TIME	BP		PULSE	RESP	SpO_2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
0005			110	18		A V P U				
0100			112	16		A V P U				
0215			110	16	T97.0	A V P U				
0310			110	16		A V P U				
0500			100	18		A V P U				
						A V P U				

NOTES: PT. RECIEVED H2O / MRE / 4 HOURS SLEEP DURING THIS SHIFT.

(b)(6)-2

Hm

MEDICATIONS: ?

LABS:

XRAYS:

PMH:

Allergies:

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck:

Chest:

Abdomen:

Upper:

Pelvis:

Lower:

Skin:

Cause of Death at ____________

ANATOMIC:

☐Airway ☐Head ☐ Neck ☐ Chest ☐Abdomen ☐Pelvis ☐ Extremity (Upper/Lower) ☐Other

PHYSIOLOGIC:

☐ Breathing ☐CNS ☐Hemorrhage ☐Total Body Disruption ☐Sepsis ☐Multi-organ failure ☐Other

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 16

7

(b)(6)-4

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
04MAR04	20:58 SHOWERED, DRANK 500CC WATER
05MAR04	0000-0030 Slept 30 MIN SLEPT > 00:30
05MAR04	0115 Drank 6oz
05MAR04	Denied water 0300 SLEEPING SLEPT > 00:30
0400	SLEEPING
0700	SLEEPING. SLEPT > 03:00
0730	RETURN TO DETENTION CENTER 4:00 TOTAL SLEEP

(b)(6)-2

/USN

B6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST) (b)(6)-4
SSN:
DOB:
UNIT:
RANK:
SEX:

STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 7

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | B6-2 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 MAR 04	[redacted] ASSUMES MEDICAL DUTIES @ 1245.
1245	PT ARRIVES A+O x3 AND IN NO APPARENT DISTRESS.
	EXAMINATION REVEALS MULTIPLE ERYTHEMATOUS AND ECCHYMOTIC [illegible]
	PATCHES THROUGHOUT ABDOMEN AND POSTERIOR TORSO [illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB: (b)(6)-4
UNIT:
RANK:
SEX:

STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

120

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

MEDICAL RECORD	CHRONOLOGICAL RECORD OF ME[illegible]AL CARE
	0180-04-CID259-80227
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3/8/04	1700 - P 100 Resp 16 Pt Doing leg lift exercises for 30 min
	1800 - P 110 R 16 Pt Denied water Pt Doing Stand up Sit Down Exercise
	for 30 min 1845 Pt Placed next to fire to get warm
	1900 P 112 R 18 Core Temp Taken Pt WNL 98.2°
	2010 P 114 R 18 Pt Placed in Stress position on knees
	w/ chest on wall. Pt Received abrasions on (L) and (R)
	Knees
	2043 P 114 R 16 Core Temp 99.0° 20cc H2O
	[signature] (b)(6)-2
	NFETD

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX: STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 131

MEDICAL RECORD	CHRONOLOGICAL RECORD OF ME[illegible]AL CARE 0180-04-CID259-80227
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
08MARCH04	Pt presents A+OX3 T [illegible] P[illegible] R18 APROX 45 [illegible]
2100	2100 PT Placed in [illegible] Position on Gluteus Maximus or [illegible]
|	2200 PT sleeping T [illegible] P70 R12
	2300 Pt [illegible] T 96.0°F P70 R12
2400	2400 Pt AOX3 T 96.0°F P70 R12
	[illegible] Turnover [illegible] C
	HM3 (b)(6)-2
	HM1 (b)(6)-2
	[illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX:

STATUS: (AD, NG, R)

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT [illegible]

MEDICAL RECORD | CHRONOLOGICAL RECORD OF ME[illegible]AL CARE

0180-04-CID259-80227

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Ø9MAR Ø4	HM2 (b)(6)-2 Assumed HM WATCH
ØØØØ	VS: P 70 R 12 T 97.0 PT REVIEWED & A&O X3.
ØØ45	(b)(6)-4 BY FIRE, SLEPT 30 MIN.
Ø1ØØ	T 97 P 70 R 12
Ø215	Pulse 90 R16
Ø245	PT DRANK 12oz H2O s̄ ASISTANCE
Ø315	P 80 R12
Ø405	P 80 R12 Pt cooperative A&O x3 SITTING BY
	FIRE c̄ warm blanket x45 MIN. Pt unstable / falls
	limp while ~~transporting~~ —— (b)(6)-2 HM2
	NFETP
	(b)(6)-2
	HM2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX: STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 5-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 123

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
04 MAR 04	
0441	ATE CHOC CHIP COOKIE, ALERT ORIENT x3
	SITTING BY FIRE. V/S, P 82 R 12
[illegible]	ATE MRE, [illegible] H2O, STANDING.
0511	PT SITTING BY CAMPFIRE, KEEPING WARM
	c̄ BLANKET.
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	STANDING ALERT, [illegible] ORIENT. x3
[illegible]	[illegible]

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN: (b)(6)-4
DOB:
UNIT:
RANK:
SEX:
STATUS:(AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 1[illegible]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09 MAR '04	HM' (b)(6)-2 ASSUMES MEDICAL DUTIES @ 0800.
0800	PT AXO P 80 R10, TEMP 98° (R)
0900	P76 R10
1000	P80 R10, SHOWERED
1100	P80 R10
1115	DRANK 500CC WATER
1200	P80 R12 TURN-OVER TO HM (b)(6)-2

NFETP

HM' D...

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB: (b)(6)-4
UNIT:
RANK:
SEX:

STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

7 1 3 ...

MEDICAL RECORD	CHRONOLOGICAL RECORD OF ...DICAL CARE 0180-04-CID[illegible]
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3/9/04	1200 Sleeping 1hr 3:59 Total Sleep time P 90 R 12
	1300 Awake To Eat MRE Wheat snack Bread 50cc H2O P 88 R 12
	1400 Sleeping 1hr 4:59 Total sleep time P 88 R 12
	1523 [illegible] 20cc H20 P 86 R 12
	Hur2 (b)(6)-2
	NFETP

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX:
STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 5-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 126

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09MARCH04 1600	1600 Assumed the Watch Pt Sleeping NAD P 90 R 16
	(b)(6)-2
	1700 Pt Sleeping P 90SR R 20 18 DR
	1800 Pt Sleeping P 90SR R 16 DR
	1900 Pt awake H2O 500cc + Food P 110SR R20 DR
	2000 Pt awake P 110SR 20 DR
	2005 Turned over Watch [illegible] conductor
	HM1 (b)(6)-2
	(b)(6)-2
	USN TDC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Ø9MARØ4	Assumed WATCH, HM2 (b)(6)-2
2ØØØ	P 110 R 20 T 97
2Ø1Ø	Pt by fire, sitting on blanket. A&O x3 verbaly responds to questions/comments. Pt falls limp while transporting
2Ø5Ø	15 MIN Sleep.
21ØØ	P 110 R 20 T 96.5R
2145	Pt drank 12cc Sunkist (ORANGE) 5oz H2O
2200	P 106 P 18 T 97.0
2215	Slept 15 MIN by fire, A&O x3
23ØØ	P 110 Resp 18 temp — 97.6°F (b)(6)-2
233Ø	Pt cleaned c̄ SOAP & H2O. ADDRESSED KNEES c̄ ABRASIONS betadine SOLUTION. PT AMBULATED UNDER OWN CONTROL TO HEAD c̄ SHOES. Pt Deficated & URINATED. (R) 4th METATARSAL c̄ SMALL ABRASION (1cm) from Rocks. PLACED Shoes ON FOR All further ambulations
2340-2350	SITTING IN Chair by fire. DRANK 10cc H2O. (b)(6)-2
	NFETP (b)(6)-2 HM2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX:
STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 8-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 138

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 MAR 04	PT IS AWAKE ORIENTED X3, SITTING
0001	DOWN - FED RICE / DRANK 200 cc H_2O
	V/S P 88 R 16 NAD
0030	NOTED CONTUSIONS TO GLUTEUS MAXIMUS
	REGION, ABRASIONS NOTED TO KNEES
	-CLEANED C̄ BETADINE. D/C SITTING ON GRAVEL.
0045	PT IS IN PRONE POSITION, SLEEPING
0145	PT STILL SLEEPING
0200	200 cc H_2O GIVEN P.O.
0300	SLEEPING, NAD.
0400	SLEEPING, NAD.

(b)(6)-2

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN: (b)(6)-4
DOB:
UNIT:
RANK:
SEX:
STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 159

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
03-11-04	0000 Pt in Recumbent Pos Feet elevated on cot w/ Blanket
	Pt kept awake. P 128 R 18 T 98.6. NO new Abrasions Noted
	All Abrasions seem Appear to be Healing very well as expected
	All Abrasions treated w/ bacitracin. Pt AOX3 Talkative
	Pt Denies water at this time.
	0100 Pt stood up and walked to Port-a-John and Defecated /
	URinated Pt walked under own Power no Stumbling or
	falling. Pt very compliant. P 118 R 16 T 99.6°
	0127 Pt Drank 50 cc (Approx) H2O
	0214 Pt Denies water P 113 R 16 T 97.°
	0252 Pt laying By fire on cot keeping him awake P 110 R [illegible] T [illegible]
	0255 Pt [illegible] Relieved By [illegible] (b)(6)-2

[illegible] MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

[illegible] NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 130

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3/11/04	ASSUMED MEDICAL DUTIES, PT. AWAKE, ON
0300	SIDE, NAD, ORIENTED x 3, TALKING c̄ TRANSLATOR
	SITTING UPRIGHT IN CHAIR, TALKING c̄ TRANSLATOR
0342	PT. DRANK APPROX 20cc H_2O. P82 R12 T98.6
0424	DRANK 20 cc H_2O, SITTING BY FIRE, NAD
0440	SLEEPING ON SIDE, NAD.
0530	AWAKE, SUPINE, P. 82 R 12 T. 98.6
	NAD.
0606	AWAKE, RESPONSIVE, ORIENTED X 3, NAD.
	PROPERLY RELIEVED BY HM2 (b)(6)-2

(b)(6)-2

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23/11/04	MEDICAL WATCH ASSUMED BY HM'O (b)(6)-2 @ 0611 V/S P84
	R12 T. 98.2 (?) PT ASLEEP WRAP BLANKET. AWAKENED
	FOR VITALS A+OX3 THEN ASLEEP AGAIN ON SIDE ON COT.
0652	P86 R12 PT AWAKENED FOR 250cc WATER AND EGG
	SANDWICH c̄ POTATO FRIED. TOLERATED WELL. BACK SLEEP.
0741	PT AMBULATED TO TOILET c̄ ASSISTANCE. DRANK 250cc WATER.
0815	P82 R16 ASLEEP.
0900	P94 R16 AWAKE. SIT ON CHAIR A+O x3
0952	WATCH PROPERLY RELIEVED BY HM (b)(6)-2

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 132

MEDCOM - 705

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3-11-04	Pt laying Down on cot edema on blebs Marked change in color
1900	was Pink (b)(6)-2 Purple. Appears to be healing very Rapidly. P 100 R 12 T 98.6°
1100	Pt laying on Back on cot P 86 R 12 T 98.5°
	Lungs Sound clear X3 fields heart is RRR. Pt AOX3
	Pt is compliant
1200	Pt Defecated walked w/no help to Port-o-John and There
	Was no Stumbling or Falling. Pt is standing w/ Steady with
	hands raised above head P 88 R 12 T 98.5°
1230	Pt Drank 30cc water
1310	Pt laying on cot P 86 R 12 T 99.7°
1349	Pt Drank 300cc H_2O

SPECIAL OF MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

First name: ___ Second name: ___ EPW Tag# 0180-04-CID259-80227

Date of screening: 3/16/04 Time of Screening: 19:48

Blood Type

MOI:

HPI:

PMHX:
PSHX:
Meds:
Allergies:

Primary Survey

Airway: Patent Mechanically maintained by N/A
Breathing: Spontaneous Assisted by N/A
Circulation:
Pulse: (Present) Absent CPR
Color: (Normal) Abnormal
Cap refill: Normal (Delayed) 4SEC (PEDAL)

Secondary Survey

@1949
Initial Vital Signs: b/p ___/___ pulse 110 Resp 12 Pulse Ox N/A Temp 98.4 (R)

GEN: SEE P.2 NOTES

HEAD: NORMOCEPHALIC, ATRAUMATIC, (B) PERRLA (NEG) ... SEPTUM MIDLINE,

NECK: SUPPLE, (NEG) JVD, TRACHEA MIDLINE

HEART: WNL

LUNGS: EQUAL RISE + FALL, (NEG) DEFORMITIES, DISCOLORATIONS OR STEP-OFFS NORMAL B.S.

CHEST: CLEAR TO 6 FIELDS

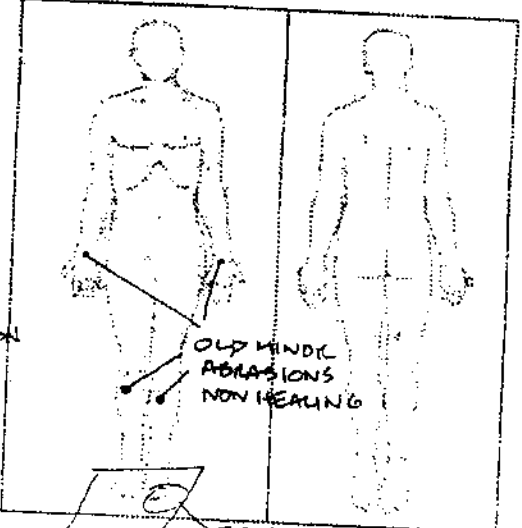
ABD: (POS) BOWEL SOUNDS x 4 QUADRANTS (NEG) GRIMACE, DISTENTION, DISCOLORATION

PELVIS: ATRAUMATIC (NEG) GRIMACE, CREPITUS

EXT: SEE P.2 NOTES

RECTAL: N/A

NEURO: ORIENTED X 3



GLASCOW COMA		
EYES OPEN	Spontaneously	(4)
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	(5)
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	(6)
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	15

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

ay:

Breathing:

Circulation:

Other:

Time	Drug	Dose	Route	Initials

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	BP	Pulse	Resp	Pulse Ox	Temp	GCS
19:49	—	110	12	—	98.4 (L)	15
20:30	—	100	12	—	—	15

Transfer Instructions:

NOTES: PT A+Ox3 @19:50 SITTING IN CHAIR BY FIRE, ANSWERING QUESTIONS. HE IS COMFORTABLE AND IN NO DISTRESS. P110 R12. WE HAVE RECEIVED HIM FROM FROM DETENTION FACILITY WHERE HE HAS RECEIVED MEDICAL ATTENTION HM (b)(6)-2 ON DUTY @ 19:50 3/16/04. 2005 PT HAS DIFFICULTY WALKING. HE GUARDS (L) FOOT. (L) FOOT RED + SWOLLEN c̄ BROKEN 1" BLISTERS ON THE TIPS OF 1ST + SECOND TOES (NEG) CREPITUS (+) ERR (+) ECCHY. (+) PEDAL PULSE, SLOW CAP REFIL (+) GUMMACE UPON PALP. (R) FOOT RED + SWOLLEN c̄ 1.5" UNBROKEN BLISTER ON 1ST TOE (NEG) CREPITUS (+) ERR AND ECCHY (+) PEDAL PULSE c̄ SLOW CAP REFIL APPROX 4SEC. BOTH FEET. (R) FOOT (+) GRIMMACE BUT LESS THAN (L) FOOT UPON PALP. PT UNCOOPERATIVE FOR STRENGTH TESTS. — RELIEVED OF DUTY CORPSMAN WATCH BY HM1 (b)(6)-2 @2145 PT. SITTING, HX AS ABOVE. NO Δ'S. UNREMARKABLE CONDITION OTHER THAN EDEMA TO (L) PEDIS, ANTERIOR ASPECT CAP REFILL +02, DISTAL PULSES PRESENT.

(CONT.)

Prepared By: [redacted]

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

...y:

Breathing:

Circulation:

Other:

MEDICATIONS

Time	Drug	Dose	Route	Initials

Blood Components

Unit #	Type	Time	Response

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
	/					
	/					
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES: V/S AS ABOVE. H_2O + MRE PROVIDED
1200 - TAKEN BY HUMV TO
INTERNMENT CAMP.

(b)(6)-2

HM1/USN/18D

Prepared By:

[redacted]

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 130

(b)(6)-4

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2100	PULSE 110, R 14 B/P 132/78
19 MAR 04	AWAKE, O X 3, TALKING c̄ INTERROGATOR
	THE PT (DETAINEE) WAS TRANSFERRED HERE FROM
	MOSUL INTERNMENT CAMP HE HAS A HISTORY OF
	SEVERAL VISITS IN THE LAST WEEK, P.E. FORMS ARE
	ON RECORD. P.E.
	- GEN A/O X 3 ATRAUMATIC ARAB ♂, 31 Y.O. AMBULATES BY
	HIMSELF, SLOWLY. NKA c̄ MEDS
	- HEAD: ATRAUMATIC E: PERRLA, E: TM'S WNL, VALSALVA ⊕
	- NECK: ATRAUMATIC, TRA. MIDLINE ⊖ JVD
	- HEART: NORMAL H.S. ⊖ MURMUR PMI NOTED
	- CHEST - ATRAUMATIC, LUNG SOUNDS, CLEAR BILAT
	- ABD ATRAUMATIC, [illegible] c̄ MASSES, ⊖ REBOUND [illegible]
	⊖ [illegible] BOWEL SOUNDS ⊕
	- PELVIS: ATRAUMATIC, STABLE
	- RECTAL: WNL, ATRAUMATIC
	- NEURO: A/O X 3, 12 CRANIAL N. WNL, REFLEXES WNL
	- ABRASION NOTED TO Ⓛ KNEE. TX'ED PRIOR TO
	DELIVERY HERE. SAME TYPE NOTED TO Ⓡ KNEE
	ANTERIOR ASPECT. 5-6 CM IN DIAMETER.
	- ABRASIONS CLEANED/DRESSED, BETADINE, BACITRACIN
	APPLIED c̄ DRY STERILE DSG.

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME:(LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX:

(b)(6)-4

STATUS(ADMIN, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 197

#2

MEDCOM - 710

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2200	CONDUCTING INTERROGATION, PT IS SITTING, CALM, ANSWERING QUESTIONS. VERY COMPLIANT.
2324	STILL UNDERGOING INTERROGATION. NAD.
Mar 14 0100	SITTING BY FIRE NAD.
0300	S&A RELIEVED BY HM2 (b)(6)-2
0300	PT SITTING BY FIRE NAD
0610	PT SITTING IN STALL IN CHAIR NAD
0840	PT SLEEPING IN CHAIR IN STALL
0900	A+OX3 P120 R12 SITTING COMFORTABLY AND NO APPARENT DISTRESS DRANK 250cc water
1200	P110 R10 AMBULATES TO TOILET c̄ ASSISTANCE. DRANK 250cc [illegible]
1215	ASLEEP IN CHAIR
1330	AWAKENED P 100 R10 DRANK 250cc
1450	P124 R12 SITS QUIETLY NO DISTRESS
1500	ASSUMED MEDICAL WATCH, PT IS AWAKE, A/OX3 SITTING, NAD.
1700	DSG Δ TO ABRASIONS ON KNEE'S BOTH CLEANED c̄ BETADINE, BACITRACIN APPLIED c̄ DRY STERILE DSG. ALSO (L) 1ST + 2ND DIGITS OF (L) PEDIS, CLEANED + DRESSED IN THE SAME MANNER. SLIGHT SWELLING NOTED TO (L) FOOT, PT IS SITTING c̄ (L) FOOT ELEVATED.
1800	STILL SITTING c̄ FOOT ELEVATED. NO Δ. T 98.6 P. 100, R 12 B/P 130/78
2000	RETURN TO DETAINMENT CAMP, AMBULATED WELL, SLIGHT EDEMA TO (L) FOOT. ATE 3 MEALS/DAY, SLEPT 4 HOURS EACH NIGHT (b)(6)-2

138

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

(b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

EXHIBIT
HM 1

MEDCOM - 711

MEDICAL RECORD | PROGRESS NOTES

DATE

1March 04 S/ EPW states interrogated last evening.
c/o pain this c̄ swelling + blisters.
Reports thermal burn left arm
Noted Δ'S c̄ wounds Ant- knee
O/ AVSS
EXT: (B) LE: Ant knees noted ↑ erythema
+ multiple blisters. noted ? singed
tissue appears 2ND degree burns c̄
necrotic margins.
A/P ? 2ND degree burn c̄ blister R>L.
(1) Continue Bacitracin topically
to affected areas.
(2) start Percocet 4-6° PRN for
severe pain
(3) Continued daily dressing Δ'S. will
use Silvadene daily

(b)(6)-2

LT/PA

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES

Medical Record

STANDARD FORM 509 (REV 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-4

OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 13 Mar 04 | TIME OF ORDER: 11:16 HOURS | LIST TIME ORDER NOTED AND SIGN (b)(6)-2

1. LFTs, CK x 1 Now
2. ↓ IV Fluid rate to 75cc/hr

(b)(6)-2

(b)(6)-2 CPT, MC, USA

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Mar 04 | TIME OF ORDER: 0802 HOURS

1. LFTs, CK this AM
2. Pt may shower, c̄ guard in attendance

(b)(6)-2

(b)(6)-2 CPT, MC, USA

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 Mar 04 | TIME OF ORDER: 0805 HOURS | (b)(6)- (b)(6)-2 (b)(6)-2

1. Flexeril 10 mg po bid prn muscle spasm (neck pain)

(b)(6)-2

(b)(6)-2 CPT, MC, USA

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT

EXHIBIT

0180-04-CID259-80227

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 Mar 04 TIME OF ORDER: 1805 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW
2. DX: multiple abrasions/contusions.
3. Condition: stable
4. Allergies: NKDA
5. Vital signs per ward protocol
6. Activity: bedrest c̄ bedpan/urinal
7. Record I/O

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

8. Encourage hydration
9. Diet: regular, may supplement c̄ Ensure if patient desires
10. IVF: NS @ 125 cc/hr until first bag done, then LR @ 125cc/hr
11. Meds: Toradol 15mg IV Q6hr
Morphine sulfate 2-4mg Q3-4° prn pain not

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

controlled c̄ toradol
Reglan 10mg IV Q6° prn nausea
12. CBC, Metlyte 8, Liver panel, coags x1 in AM please
13. Call Dr (b)(6)-2 for questions
14. Elevate feet on pillows

NURSING UNIT | ROOM NO. | BED NO. (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 12 Mar 04 TIME OF ORDER: 1054 (b)(6)-2 HOURS — CPT, MC

1. D/C IV toradol
2. Begin Motrin 800mg po tid
3. Colace 100mg po bid
4. Keflex 250 mg po QID
5. Demerol 25-50mg po Q4° prn breakthrough pain
6. D/C IV morphine

Noted 12 Mar 04 (b)(6)-2

(b)(6)-2 (b)(6)-2 (b)(6)-2

ONLY

U.S. GOVERNMENT PRINTING OFFICE: 2002-488-041

MEDCOM - 714

558-103

(See Instructions on Back of this Sheet) 0180-04-CID259-80227 NSN 7540-01-075-378

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL — DATE: DAY 11 MONTH 03 YR. 04 — TIME 1625

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): PRIVATE VEHICLE [ ] AMBULANCE [x] OTHER (Specify) [ ]

CURRENT MEDS. (tetanus immunization and other data): Cryptoheptidine

HISTORY OBTAINED FROM: PATIENT [ ] OTHER (Specify) [x] pt through interpreter

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): EPW

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): abrasions over body, neck pain

SEX: M — AGE: 31

POSSIBLE THIRD PARTY PAYER? YES [ ] NO [ ]

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	1628
BP	129/84
PULSE	116
RESP.	17
TEMP.	99.5
WT. (Child)	98

CATEGORY (See reverse): EMERGENT / URGENT / NON-URGENT

ORDERS	INITS.	
CBC, Chem	(b)(6)-2	
Coag		
Xrays (B) legs / knees / ankles	(b)(6)-2	1700
Morphine Sulfate 4 mg		1800

ASSESSMENT/DIAGNOSIS: multiple abrasions / ecchymosis

DISPOSITION (Check all that apply): HOME / FULL DUTY / QUARTERS: 24 Hrs. / 48 Hrs. / 72 Hrs. / MODIFIED DUTY UNTIL: DAY MONTH YEAR / REFERRED TO (Indicate clinic) / EMERGENCY / TODAY / 72 HOURS / ROUTINE / ✓ ADMIT. TO HOSP. UNIT/SERVICE: ICW

CONDITION UPON RELEASE: IMPROVED / UNCHANGED / DETERIORATED

TIME OF RELEASE: 1805

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

31 y/o male c̄ abrasion on back, (L) shoulder chest. Pt presents c̄ bruises and scrapes on both legs. Pt c/o neck pain

(b)(6)-2

(S) 31yo Iraqi ♂ EPW picked up [illegible] SF raid 3-4d ago brought to EPW camp today - noted to be bruised and unable to ambulate 2° ↑ foot pain. States "fell down stairs several times" during raid, was dragged through stones and "someone tried to turn feet completely around".

Pro Hx - [illegible] / PSHx - [illegible]

(O): 129/84 P116 R17 T97.5°F Sat 98% RA
Gen: A+O x3 CV: tachycardic ∅ murmur Resp: CTA(B)
MS: Multiple superficial abrasions to back, chest, legs. Ecchymoses to (R) chest/ribs, (R) ASIS area, (B) knees. Swelling to (B) knee joints. Able to actively range knees, elbows, fingers. ∅ spinous process tenderness. (+) Ecchymoses/swelling/tenderness to (B) ankles feet/toes. Blood collection vs. necrosis to (B) 1st/2nd toes. Pain c̄ attempt @ range of motion of ankles. Grossly neurovascularly intact

Xrays → ∅ Fx.

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

(b)(6)-4

31 years old

SIGNATURE: (b)(6)-2 , DO, CPT, MC (b)(6)-2

INSTRUCTIONS (medications ordered, any limitations and follow-up plans)

(A): Multiple abrasions/ecchymoses
(P): (1) admit to ICW
(2) cleanse wounds
(3) pain control

(b)(6)-4

FOR OFFICIAL USE ONLY / LAW ENFORCEMENT

EMERGENCY CARE AND TREATMENT — STANDARD FORM 558 (Rev. 6-82)

EXHIBIT

MEDICAL RECORD - PATIENT RELEASE / DISCHARGE

For use of this form see MEDCOM Circular 40-5

DIRECTIONS: To be completed by attending provider and other staff at time of patient release following an outpatient procedure, extended care treatment or discharge from an inpatient hospital stay.

SECTION I — TO BE COMPLETED BY PRIVILEGED PROVIDER

1. DATE OF PROCEDURE/ADMISSION: 11 MAR 04
2. ADMITTING DIAGNOSIS: multiple contusions/abrasions
3. PERTINENT LAB, X-RAY FINDINGS:
   No fracture on xrays.
   ↑ CK, ↑ LFTs
   3/14 - CK >5,000; ALT 158; AST 338 tbili 2.0
4. PROCEDURES, TREATMENT, HOSPITAL COURSE:
   Pain control c̄ Motrin, occasional Demerol.
   Muscle spasm treated c̄ Flexeril
   Keflex x 4 days.
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
   Condition improved; pt ambulatory.
   DX: multiple contusions/abrasions.
6. ACTIVITY: as tolerated
7. DIET: Regular
8. MEDICATIONS:
   ☐ Medications have been prescribed for home use. See separate list and special instructions or see below.
   Motrin 800mg po tid
   Flexeril 10mg po bid
   Keflex 250mg po QID X 3 more days.
9. INSTRUCTIONS (To Home Health Providers, Patient, etc.):
   To P.A. → may need to periodically ✓ CK, LFTs to continue to document decreasing levels; bloodwork can be brought to CSH and processed
10. DISCHARGING PROVIDER: (b)(6)-2
    (Signature) (Printed or Stamped Name) CPT, MC, USA

SECTION II — TO BE COMPLETED BY OTHER STAFF, AS APPROPRIATE

1. DISPOSITIONED TO: ☐ ☐ ☑ ... ☐ AMBULATORY ☐ CRUTCHES ☑ ... ☐ ...
2. ACCOMPANIED BY: ☐ ☐ ☑ ...
3. PATIENT EDUCATION
   Completed and patient prepared for home care. ☐ ☐
   If no, explain:
   Patient ☐ states ☐ demonstrates understanding of home care needs
   Printed educational materials provided:
   NA
4. Clinical outcomes met and post-discharge release referrals made:
   ☐ Yes ☐ No If no, explain:
5. If transferred to another health care facility, report called to agency:
   ☐ Yes ☐ No If no, explain:
6. NUTRITION CARE (Comments):
   NA
7. MEDICATIONS
   Explained by: ☐ ☐ ☐
   Printed medication literature provided: ☐ ☐
   Patient states understanding of prescribed medications: ☐ ☐
8. EQUIPMENT/SUPPLIES PROVIDED:
   NA
9. FOLLOW-UP APPOINTMENTS: POINT OF CONTACT & PHONE
   NA
10. FOR PROBLEMS OR EMERGENCY, CONTACT & PHONE:
11. COMPLETED BY: (b)(6)-2 15 MAR 04
    (Signature and Title) (Date and Time)

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

X
(Patient/Responsible Adult's Signature) (Date and Time)

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT

MEDCOM FORM 691-R (TEST) (MCHO) MAR 99 — PREVIOUS EDITIONS ARE OBSOLETE

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES 0180-04-CID259-80227

DATE	NOTES
11 mar 04	
1830	Admit note: Pt. brought over from ER @ 1750.
	Pt. laying flat, A&Ox3, translator assisting
	pt. Iward @ BS. IV running in (L) AC.
	Toradol 15mg given on admission for pain.
	Lungs CTA, abd. non-tender. Bruises noted
	on back & chest. (B) knees are swollen & dark
	red, (B) feet are swollen & red, ecchymosis
	noted on 3 toes. Legs elevated on one pillow
	Pt. states most pain is in his feet. Pt. on
	a reg. diet, toler. s N/V. Pt does not
	report any diff. breathing or SOB @ this time
	Con't to monitor. (b)(6)-2
12MAR04	Pt awake. Scattered abrasions to chest and back, (B) knees
0130	swollen, dark red, small abrasions to legs, (B) feet swollen
	c̄ +1 pedal pulses, ecchymoses (B) feet and toes, cap refill
	< 3secs, pt able to slightly move toes, unable to flex
	and extend ankles. IVF infusing to (L) AC. Toradol
	15mg IV given as scheduled. Pt c/o slight pain to (L)
	ribs. Pt stated he was hungry, ate 2 rolls and is
	currently sleeping. (b)(6)-2 2LT AN
12MAR04	
0200	Second bag LR @ 125/° hung. 2LT AN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

(b)(6)-4

(b)(6)-4

FOR OFFICIAL USE ONLY LAW ENFORCEMENT SENSITIVE EXHIBIT

0180-04-CID259-80227

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 Mar 04 1100	NSG Note. PT lying flat in bed on (R) side. (B) feet ↑ on blankets. A+Ox3 Speaks some english. Guard @ bedside. PT has multiple abrasions and scratches to face, Torso anterior + posteriorly, (B)LE (-) active drainage noted (-) s/s of infection. +1 pitting edema in (B) hands ↓ ROM c̄ tenderness cap refill < 3 sec to all nail beds +2 radial pulses. (+)2 non pitting edema to (B) ankles and feet. Able to ambulate c̄ slow shuffle slightly unsteady. Voided 600cc of amber color urine s̄ diff. Tol Reg diet. (+) flatulence. IV of LR @ 125cc/° 18G to (L) FA patent Ø s/s of infection. will cont to monitor comfort level and med PRN. SSG (b)(6)-2 91W30 M6 LPN
12 Mar Ø4 1400	PT ambulated to void. voided 800 cc of dark yellow urine. (B) low extrem ↑ on pillows. Tol 30% of Kosher diet s̄ diff. SSG (b)(6)-2 LPN
12 Mar 04 1730	PT tol 40% of Kosher meal. States pain level 1 of 3 but declines pain meds. Ambulated X1 for void. voided 650cc straw color urine. SSG (b)(6)-2 91W30 M6 LPN
12 MAR 04 1900	NSG note: Pt awake. Scratches and abrasions unchanged, Ø oozing or bleeding. Pedal pulses +2 currently, feet still swollen, cap refill < 3 secs to all extremities. Pt c/o slight ache to (L) foot and belly button, pt refuses pain med. IVF infusing s̄ difficulty. New bag of LR @ 125cc/° hung. Pt talking c̄ guard at bedside. Feet elevated. (b)(6)-2 2LT AN

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE ONLY

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

EXHIBIT

364

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Physician Progress Note
12Mar04	(S): HD#2 admitted last evening for pain control/
1045	monitoring of multiple abrasions/ecchymoses +
	foot swelling sustained during capture. Tolerated
	regular diet overnight. Less pain in feet
	but able to ambulate c̄ assist for using
	restroom. ∅ fevers.
	(O): 108/64 P76 T98.6°F R16 I/O 1700/600
	Gen: A+OX3, cooperative, conversant
14.3 / 5.2 / 41.8 / 135	MS: (B) feet/ankles c̄ slight ↓ in swelling
	Erythema noted. Dorsalis pedis pulses
133 / 98 / 18 / 4.0 / 27 / 1.2 / 74	now palpable. Edema on feet pitting to ankle
	(A): Multiple abrasions/ecchymosis
alb 3.4	(B) Pedal to ankle edema.
ALP 62	
ALT 185	(P): (1) Will begin Keflex to prophylax for infection
amy 51	
AST 572	(2) Will change to oral pain meds c̄
Tbili 3.1	Motrin + Demerol
CK >10,000	
GGT 7	(3) Begin colace
~~t prot 5.7~~	
	(4) May ambulate c̄ assist as tolerated.
PT 14.9	(b)(6)-2
PTT 31.6	
	(b)(6)-2 CPT, MC USA

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

(b)(6)-4

FOR OFFICIAL USE ONLY

PROGRESS NOTES
Medical Record
EXHIBIT
STANDARD FORM 509 (REV 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-4

0180-04-CID259-80227

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont)
13Mar04 1115	MS- ↓ swelling/edema in feet+ankles, persistent blood blisters, ecchymoses to knees/ant tibia improving. (+) dorsalis pedis pulses equal bilaterally. ↓ tenderness to palpation of feet. Abrasions healing s̄ evidence of infection.
	(A): Multiple abrasions/contusions
	(B) foot swelling - resolving.
	(P): (1) Will recheck LFTs, CK today
	(2) ↓ IV fluid rate to 75cc/hr + encourage po fluids.
	(3) Continue pain control.
	(b)(6)-2 , D.O.
	(b)(6)-2 CPT, MC, USA

FOR OFF[illegible]Y
LAW ENF[illegible] ONLY

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

EXHIBIT

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 MAR 04 0330	NSG note: Pt pulled IV out while sleeping, 20G to (R) FA inserted c̄ another bag of LR infusing. Pt back to sleep. (b)(6)-2
13 Mar 04 0930	Nsg note: Scattered abrasions to upper chest + (B) arms. Large abrasions to bilat knees + shins. Bilat feet swollen c̄ black scabs on toes. Pedal pulses 2+. Pt ambulates well c̄ little assistance. IV to (R) forearm running LR @ 125 cc/° s̄ redness or swelling to site. Pt c/o pain @ neck states unable to turn head from side to side or look up. 25 mg Demerol IV given per prn pain orders. Pt sitting up in bed eating breakfast @ this time. (b)(6)-2
13 Mar 04 1115	Progress Note
	(S): HD#3 → receiving pain control/hydration for multiple abrasions/contusions. ↓ pain in feet → (R) better than (L) per pt. Able to ambulate better for short distances. Pain meds helping. Tolerating regular diet. ∅ fevers.
	(O): 117/70 P75 R18 T97.3°F T_{max} 99.2
	I/O ~2500/2190
	Gen: A+OX3, in NAD, conversant, cooperative
	↓ (cont)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS (b)(6)-2 CPT, MC, USA

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN, Sex, Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

(b)(6)-4

(b)(6)-4

FOR OFFICIAL USE ONLY

PROGRESS NOTES
Medical Record
EXHIBIT
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 721

0180-04-CID259-80227

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont)
14 Mar 04 0808	in feet. Ambulating better. C/o (L) shoulder + neck pain this AM. Tolerating regular diet. Pain control mainly c Motrin.
	(O): 103/66 P75 R16 T97.9°F I/O ~1800/1825
	Gen: A+OX3, in NAD
	MS: Full ROM to shoulders, some discomfort c (L) shoulder abduction, mild tenderness to cervical musculature - no deformity; resolving ecchymoses on legs ↓ swelling to feet. (+) dorsalis pedis pulses.
	(A): Multiple abrasions/contusions Resolving swelling of feet. Cervical muscle strain
	(P): (1) ✓ CK, LFB this Am (2) Flexeril 10mg po bid for muscle spasm (3) Pt may shower c guard in attendance (4) Will consider d/c later today or tomorrow.
	(b)(6)-2 DO.
	(b)(6)-2 CPT, MC, USA.
14 MAR 04 0900	NSG - Pt. resting in bed. IV running @ 75 ml/hr. (B) feet are slightly less swollen, pedal pulse present. Pt. c/o pain in (L) shoulder; refuses pain med. except toradol. Approx 50% of meals tol. s N/V. Guard @ BDS. USS. (b)(6)-2

LAW ENFORCEMENT SENSITIVE / FOR OFFICIAL USE ONLY

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

EXHIBIT

MEDCOM - 722

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 MAR 04 2020	PT stable VSS. IVF's: LR running @ 75cc/hr in (R) FA. IV site benign of infection. PT currently only c/o sm amt of pain in (L) shoulder area. Gave scheduled Motrin 800mg PO and scheduled Colace 100 mg PO @ 2000 per MD order. PT instructed to inform me if pain gets worse. PT verbalized understanding. Scattered abrasion/ecchymosis to chest, back, (B) arms, (B) knees/legs and (B) feet. (B) feet edematous (+2) c̄ black color moved to (L) foot on first and second digits. PT ambulates well to bathroom c̄ assistance. Dorsalis pedis pulses +2 bilaterally on feet. Capillary refill <3 sec. (B) feet elevated on 2 blankets. PT has calm, cooperative, and talkative affect. PT is pleasant. Will monitor. (b)(6)-2 /AT
13 MAR 04 2040	PT has good present of Restite. /AT
14 MAR 04 0010	Gave scheduled Keflex 250 mg PO per MD order (b)(6)-2 /AT
14 MAR 04 [illegible]	PT stable & Δ in pt condition. Gave Keflex 250 mg PO @ 0600 and Motrin 800mg PO @ 0600 per MD order. PT still c/o pain in (L) shoulder. PT states pain has increase, but does ∅ want any pain med stronger than Motrin. More specific, PT does ∅ want narcotics. PT currently sleeping. PT desires to shower today and speak to Dr. about shoulder (b)(6)-2. Will inform dayshift nurse. (b)(6)-2 /AT
14 MAR 04 0808	Progress Note (S): HD#4 - improving discomfort from multiple abrasions/contusions, improvement in swelling ↓ (cont)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS (b)(6)-2 DO

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. CPT, MCUSA | WARD NO. 3E9

(b)(6)-4

FOR ... Y ... ONLY

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5/1999) EXHIBIT
Prescribed by GSA/ICMR FPMR (41CFR) 101-11 203(b)(10)
USAPA V1.00

MEDCOM - 723

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14MAR04	NSG Note: (R) shoulder abrasion ~~turned a bit~~ oozing AA c̄ some white pus.
2330	2x2 c̄ bacitracin applied to shoulder. ↓ swelling to feet,
	pulses +2, capreifill < 3 secs to all extremities. IVF
	infusing. Pt resting c̄ eyes open. ——— (b)(6)-2 2LT AN
14 MAR04 2345	NSG note: Pt c/o body pain, after explaining side effects
	of Flexeril, pt accepted the pain med. Flexeril
	10mg PO given. ——— (b)(6)-2 2LT AN
15Mar04	Progress Note
1030	(S): HD#5 - improving contusions / abrasions; ↓ foot swelling
	Ambulating better. Pain in neck better p̄ Flexeril.
	Tolerating regular diet but no appetite. Showered
	yesterday c̄ guard present.
	(O): 115/57 P69 R14 T98.1°F. Urine output 1200cc
3/14 CK > 5,000	Gen: A+O X 3, in NAD.
	MS: bruising healing, ↓ swelling to feet, only
LFTs improving	+1 edema, (+) dorsalis pedis pulses.
	(A): Multiple abrasions / contusions
	Improved foot swelling
	(P): (1) Pt meets criteria for transfer to EPW
	camp.
	(2) Will continue Motrin + Flexeril.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	SPONSOR'S ID NUMBER
			(b)(6)-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS NO.
		(b)(6)-2 CPT, MC, USA

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

(b)(6)-4

(b)(6)-4

FOR OFFICIAL USE ONLY

0180-04-CID259-80227

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION *(Enter date of admission)*

31yo Iraqi ♂ EPW captured in raid 4d ago sustained multiple abrasions, contusions and ecchymosis during episode & subsequent questioning. Brought to EPW camp today unable to walk 2° pain in feet / legs. ø chest pain / difficulty breathing ø bladder / bowel problems.

PMHx - migraine HA, h/o hepatitis +
PSHx - none
Meds - cyproheptadine
All - NKDA

PHYSICAL EXAMINATION 129/84 P116 R17 T97.5°F O2 sat 98%

Gen alert, oriented, cooperative, conversant through interpreter
CV tachycardic but regular ø murmurs Regs: (RRB)
Chest / back multiple abrasions to back, (B) shoulders, chest bruising to chest, (B) ASIS.
Abd flat, soft, non tender to palpation.
MS: ø gross deformities, ⊕ active ROM to shoulders/elbows/wrists/fingers/knees (B) ankles/feet/knees c edema + tenderness to ankles/feet toes. Multiple ecchymoses to (B) knees, ant tibia, thighs

PROGRESS *(Enter date of discharge and final diagnosis)*

Imp multiple abrasions / ecchymoses
(B) feet pain / swelling

118 > 16.7 / 47.1 < 239 — 24 / 1.0 < 105 — albumin, alk phos, ALT 2[illegible], amylase, AST 8[illegible], Chol 3[illegible]

PT 27.4
PTT 61.0

Plan: ① Admit to ICW for observation + IV hydration
② Pain control
Xrays of (B) legs/feet CXR / pelvis - [illegible]

(b)(6)-2	DATE	IDENTIFICATION NO.	ORGANIZATION
	[illegible] 11 MAR 04		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)* | REGISTER NO. | WARD NO.

(b)(6)-4

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER [illegible]
USAPPC

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE ONLY

EXHIBIT

INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/SEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION

26. DATE OF DISPOSITION

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Multiple abrasions / ecchymoses

(b)(6)-2

(b)(6)-2

DA FORM 3647-1, 1 MAY 79 ... TION OF 1 AUG ... IS OBSOLETE.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10FEB'04	0400 Assumed the watch Received
	Passdown from HM1 (b)(6)-2
	Pt sleeping P 90 R 18 T 98°F
	0500 Pt sleeping P 92 R 16 T 97.6°F
	0600 Pt awake P 90 R 14 T 96.0°F
	0700 Pt Requested to use latrine, [illegible]
	[illegible]
	P 90 R [illegible] T 96.0°F (b)(6)-2
	0800 Pt sleeping P 90 R 14 T 95.8°F
	0800 [illegible] (b)(6)-2
	(b)(6)-2
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

0180-04-CID259-80227
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)
10 (b)(6)-2	0822 Pt awakened, put in standing position P88 R14 T 96.9°
10 Mar 04	0902 Pt in standing position Drank 15 cc water P82 R12 T97.8
	0919 Pt fed 1 piece of MRE wheat bread 20 Skittles and drank
	1 Liter of water
	1000 Pt AOX3 Awake Alert Responsive to All Commands
	P 82 R 12 T 98.1°
	1037 Neg color change on buttocks (L) Foot 1st and 2nd Anterior Metatarsal major avulsion from stubbing toes
	when moving to standing position from Recumbent
	Position
	1100 P 88 R14 T 97.8
	1200 P 86 R12 T 97.8 Turned over Pt to
	(b)(6)-2
	(b)(6)-2
	NEEP

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION (*For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.*) | REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 116

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3/10/04	HM1 (b)(6)-2 ASSUMES MEDICAL DUTIES @ 1200.
1200	P110 R12 FEET SWOLLEN FROM STANDING. FEET ELEVATED.
1310	P100 R16
1345	CLEANED AND WASHED ABRASIONS TO (R) 1ST + 2ND METATARSALS
1350	DRANK 500cc WATER
1354	PROPERLY RELIEVED BY HM2 (b)(6)-2
1410	Pt Sleeping
1411	Properly Relieved BY HM1 (b)(6)-2
1415	P88 R12
1500	PT AMBULATES WITH ASSISTANCE TO TOILET.
1510	P86 R14
1515	PT DRANK 330mL ORANGE SODA, BUT REFUSED FOOD.
1520	PT SLEEPING
1553	Duty HM NOTED FEET SWOLLEN AND ELEVATED c̄ BLANKETS.
1605	PT: P90 R10, C/O PAINFUL FEET. NO DISCOLORATIONS EXCEPT ABRASIONS NOTED ABOVE. GOOD CAP REFIL, (POS) PEDAL PULSES (BILAT), (NEG) CREPITUS (BILAT), (POS) GRIMACE upon palpation (BILAT). FEET continue to BE ELEVATED.
1644	PROPERLY RELIEVED BY HM (b)(6)-2
	NFETP (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

7

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 MAR 04	PT. IS IN SUPINE POSITION, FEET ELEVATED
1702	NAD V/S P 86 R 12 T. 98.1
1717	25cc (APPROX) H_2O GIVEN, STILL SUPINE
	c̄ FEET ELEVATED.
1826	ATE 2 MRE CRACKERS, 20 cc H_2O.
1907	AWAKE, SUPINE NAD
2019	SUPINE, LEGS ELEVATED TO REDUCE EDEMA
	TO PEDIS BILAT. ⊖ PITTING EDEMA.
	DISTAL PULSES INTACT. CAP. REFILL WNL (TOI)
2030	PROPERLY RELIEVED BY HM2 (b)(6)-2

(b)(6)-2

[signature] (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

0180-04-CID259-80227

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
ØMARØ4	ASSUMED WATCH FROM PO (b)(6)-2 THE TIME 2030.
2100	2040-2100 (b)(6)-4 AMBULATED TO HEAD c̄ Shoes UNDER
	his own CONTROL. Pt A&O x3. Pt ~~APEARS TO be~~ VERY
	TALKATIVE. Pt DRANK 10 oz Coke Cola. VS P120 R14
	RESP ~~DEEP~~ DEEP & REGULAR. (b)(6)-2
2215	Pt A&O x3 T:99.2 R:14 Pulse: 118 RRR Lungs clear all fields.
	PEARL x2. ALL ABRASIONS cleaned c̄ Betadine & COVERED c̄ BACTROBAN.
	All ABRASIONS healing s̄ signs of infection. Pt tolerated procedure
	well/very cooperative. Pt sitting in chair by fire, feet
	elevated. (b)(6)-2
2300	P: ~~64~~ 138 R:16. Pulse RRR by Ausctn.
2317	Placed pt. on cot next to fire (R) LAT. RECUMBENT pos.
2350	(b)(6)-4 SLEEPT 1 hr. Pt DRANK 20 oz H2O.
	[illegible]
	[illegible] (b)(6)-2
	NFETP
	(b)(6)-2
	HM2

... OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
...'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

...ENT'S IDENTIFICATION *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

MEDCOM - 731

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

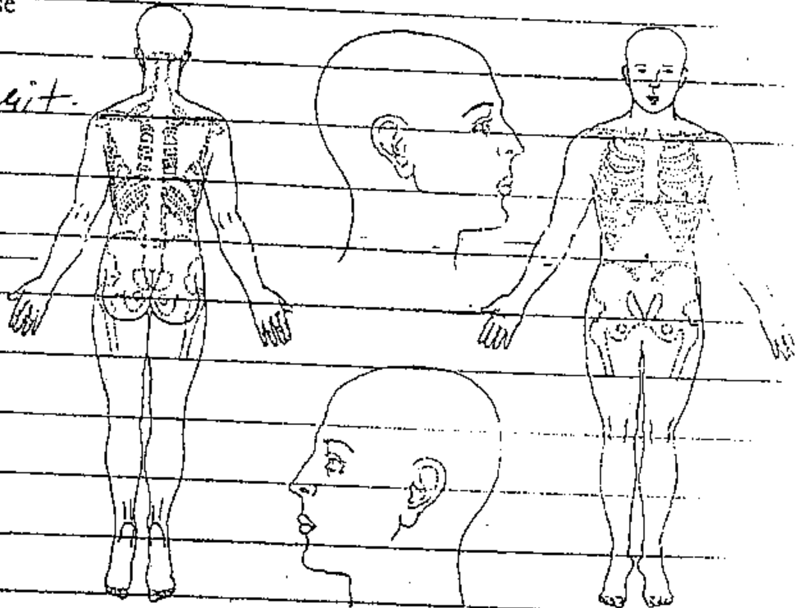
CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 June 04	**REPORT OF DETAINEE MEDICAL SCREENING:**
1023 hrs.	History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding Ulcers, Chronic Bowel problems, Thyroid Dz
	Neck PN x 6 yrs
	Medication Allergies: (NO) (YES) List -
	Current Medications: (Name/Dose/Frequency/Last Taken) (NONE) PN meds of unknown type
	Recent Injuries: (NO) (YES) Describe -

Exam Findings: BP: 151 / 80 Pulse: 103 Resp: 12 T: 98.3 (T)

Utilize Diagram and Space Below to Indicate Examination Findings.
If additional space required, continue on reverse

Gen: Well, NAD, Nl gait.
Lungs: CTAB
EXT: WNL
HEENT: WNL



(FIT) (UNFIT) For Confinement

(Does) (Does Not) Require Further Eval

(b)(6)-2 CPT, SP, PA-C

Name/Rank/Unit of Screener (b)(3)-1

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO	WARD NO.

Detainee Information:
Name: ______________
Last, First Middle
Control Number: (b)(6)-4
Date/Time of Detention: ______________

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V

For Official Use Only
Law Enforcement Sensitive

EXHIBIT 7-1

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 June 04	DETAINEE IN-PROCESSING MEDICAL SCREEN
	SUBJECTIVE: AGE 27 (M) F DOB: 1977
	ANY NEW MEDICAL ILLNESS OR INJURY?
	pain in back of neck
	ANY HISTORY OF TB? YES / (NO) IF YES, WHEN AND HOW WERE YOU TREATED?
	COUGH > 2 WEEKS? YES / (NO)
	COUGHING UP BLOOD: YES (NO)
	ANY WEIGHT LOSS? YES / (NO) IF YES, HOW MUCH AND IN WHAT TIME FRAME?
	ANY HISTORY OF HTN? YES / (NO)
	ANY HISTORY OF CAD? YES / (NO) IF YES, ANY HISTORY OF MI? YES / NO WHEN?
	ANY HISTORY OF DM? YES / (NO) IF YES, HOW LONG?
	ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE? YES / NO
	none
	CURRENT MEDICATIONS: (b)(6)-2 [illegible] dioxx
	MEDICATION ALLERGIES: none
	ABLE TO WALK UNASSISTED? (YES) / NO ABLE TO FEED YOURSELF? (YES) / NO
	ANY MISTREATMENT SINCE BEING DETAINED? (YES) / NO
	HISTORY OBTAINED THROUGH TRANLATOR? (YES) / NO NAME: (b)(6)-4

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

(b)(6)-4

(b)(6)-4

REGISTER NO. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

For Official Use Only
Law Enforcement Sensitive

For Official Use Only
Law Enforcement Sensitive

FOR OFFICIAL USE ONLY

EXHIBIT 7-2

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

OBJECTIVE:

HEIGHT: 5'4' WEIGHT: (b)(6)-2 243

BP: 131/79 PULSE: 97 RESP: 20 O2%: TEMP:

MEDICS SIGNATURE: (b)(6)-2

REFER TO PA OR MD IMMEDIATELY IF:

CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS

MD/PA REVIEW NOTE:

S) 27 y/o ♂ detainee presents for inprocessing. Pt reports he was punched in the stomach 4 days ago by coalition forces. He denies any current bruising or scabs from incident

O) WDWN ♂ NAD VSS [illegible]
integumentary - no acute ecchymosis or scars

A) 1. Alleged Abuse

P) 1. Refer to CID
2. case and plan discussed @ length c̄ pt through interpreter.

(b)(6)-2 PA-C
1LT, SP USA

For Official Use Only
Law Enforcement Sensitive

STANDARD FORM 600 (REV) BACK
USAPA V2.00

FOR OFFICIAL USE ONLY

Exhibit 7-3

MEDCOM - 734

0087-04-CID789

0224-04-CID259-80258

MEDICAL RECORD | AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 JUN 04	DETAINEE IN-PROCESSING MEDICAL SCREEN
	SUBJECTIVE: AGE 22 (M) F DOB: 1982
	ANY NEW MEDICAL ILLNESS OR INJURY?
	Hyperpigmentation 3-7 days
	ANY HISTORY OF TB? YES / (NO) IF YES, WHEN AND HOW WERE YOU TREATED?
	COUGH > 2 WEEKS? YES / (NO)
	COUGHING UP BLOOD: YES / (NO)
	ANY WEIGHT LOSS? YES / (NO) IF YES, HOW MUCH AND IN WHAT TIME FRAME?
	ANY HISTORY OF HTN? YES / (NO)
	ANY HISTORY OF CAD? YES / (NO) IF YES, ANY HISTORY OF MI? YES / NO WHEN?
	ANY HISTORY OF DM? YES / (NO) IF YES, HOW LONG?
	ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE? YES / (NO)
	CURRENT MEDICATIONS: NONE
	MEDICATION ALLERGIES: KNDA
	ABLE TO WALK UNASSISTED? (YES) / NO ABLE TO FEED YOURSELF? (YES) / NO
	ANY MISTREATMENT SINCE BEING DETAINED? (YES) / NO
	HISTORY OBTAINED THROUGH TRANSLATOR? (YES) / NO NAME: (b)(6)-4

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

NAME: (b)(6)-4

SSN: (b)(6)-4

COMPOUND:

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

FOR OFFICIAL USE ONLY

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

6

EXHIBIT 2

0087-04-CID789

0224-04-CID259-80258

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 JUN 04	OBJECTIVE:
	HEIGHT: 5'5" WEIGHT: 117
	BP: 125/79 PULSE: 86 RESP: O2%: TEMP:
	MEDICS SIGNATURE: N/A
	REFER TO PA OR MD IMMEDIATELY IF:
	CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS
	MD/PA REVIEW NOTE:
26 JUN 04	S) 22 y/o ♂ detainee presents for medical inprocessing and
	reports while being interrogated he was punched in the
PMH	chest, and choked, and punched in the back. He
PSH - ø	reports this happened 6 days ago at the Al-muthna airport
FH - single [illegible]	He denies any current bruising.
SH - ø ETOH / - 1 pk/yr smoker	O) WNWD ♂ NAD VSS GAIT - NL
MED -	Neuro: CN II - XII, C4 - T1 motor, L1 - S2 motor grossly intact (B)
Allergies - NKDA	DTRS 2+ (B)
	HEENT - NL Neck - supple s̄ adenopathy/thyromegaly
	Lungs - CTA (B) Heart RRR Abd - benign
	Genitals - NL ♂ ↓ testes Ext - moves all well
	integumentary - no acute echymoses ⊕ area of hyperpigmentation on (R) forearm
	A) 1. Alleged abuse
	2. Derm hyperpigmentation ? etiology
	P) 1. Refer to CID (b)(6)-2
	2. F/U PRN PA-C
	[illegible] USA

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

STANDARD FORM 600 (REV. 6-97) BACK 7
USAPA V2.00

EXHIBIT 2

MEDCOM - 736

0147-04-CID259-80210

PRISONER IN-PROCESSING MEDICAL SCREEN

NAME: (b)(6)-4

DATE: 5 May 04 | COMPOUND: | ISN: (b)(6)-4

HISTORY BY TRANSLATOR: (YES) NO | DOB: 1974 | AGE: 30

NAME OF TRANSLATOR: (b)(6)-4

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?
Severe lacerations secondary to cuffs (on both wrists) Was hit on the head from pistol [illegible] repeatedly (See pt abuse form)

2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN AND HOW WERE YOU TREATED?
No

A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS? YES (NO)
B) HAVE YOU BEEN COUGHING UP BLOOD? YES (NO)
C) HAVE YOU BEEN LOSING WEIGHT? YES (NO)

3) CHRONIC MEDICAL PROBLEMS (DIABETES, HYPERTENSION, HEART DISEASE):
none

4) MEDICATIONS:
none

5) ARE YOU ABLE TO WALK UNASSISTED? (YES) NO
6) ARE YOU ABLE TO FEED YOURSELF? (YES) NO
7) ALLERGIES? none

8) PULSE: 100 BLOOD PRESSURE: 100/88 RESPIRATORY RATE: 16

WEIGHT: 176 lbs HEIGHT: 5'7"

SIGNATURE: (b)(6)-2

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO MD OR PA, UNLESS MINOR PROBLEM FOR QUESTION 1. A NO TO QUESTION 6 OR 7 ALSO REQUIRES MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE DATE: 5 MAY 04

ASSESMENT:

Refer to SF 600
Dated 5 MAY 04

RECCOMENDATIONS:

SIGNATURE: (b)(6)-2

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 4 37

0147-04-CID259-80210

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 MAY 04	S) 30 y/o ♂ referred by medic for evaluation. Pt reports
BP 118/76	he was hit on the head repeatedly and hit on (R) side and
P - 78	(B) shoulders. He reports this happened approx 3 wks ago.
T - 98.3	Otherwise history was obtained through interpreter.
R - 16	O) WNWD ♂ NAD VS stable/afebrile GAIT - NL
	NEURO: CN II - XII, C4-T1 "motor" + L1-S2 motor grossly intact ATRS 2+(B) (b)(6)-2
	HEENT - (L) ear (+) erythema + scab what appears to be dried blood
	otherwise NL
PMH -	NECK - supple s̄ adenopathy LUNGS - CTA (b)(6)-2
PSH -	HEART - RRR s̄ murmurs, clicks or gallops
FH - single	[illegible] ABD - (+) BS 4 quad neg HSM neg guarding neg rebound
SH - 12 pk/yr smoker	Genitals - NL male ↓ testicles s̄ scrotal masses
MED - ∅	integumentary —
Allergies - NKDA	
	A) 1. Multiple well healing wounds/
	scars - consistent c̄ H/O
	possible blunt trauma to head + extremities
	2. Otherwise NL PE
	P) 1. F/U PRN on sick call
	2. Case and plan discussed c̄ Pt
	(b)(6)-2
	(b)(6)-2 PA-C
	(b)(6)-2

2 obvious well healing scars > 10 days

well healing scars & scabs > 10 days

Hyperpigmentation consistent c̄ blunt trauma

Abrasion [illegible]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO.

ISN # (b)(6)-4

COMPOUND #

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

EXHIBIT 4

0140-04-CID259-80204
0041-04-CID789

HEALTH RECORD

DETAINEE PREINTEROGATION EVALUATION

DATE: 23 MAY 04

PATIENT COMPLAINT / CONCERNS: 30 y/o ♂ detainee who reports 23 days ago receiving maltreatment for 3 days at the Mosul airport location.

ALLERGIES: NKDA
MEDS: Ø
SOC Hx: Tob: Ø ETOH: Ø
PSHx: I&A Salivary Gland Removed 2° swelling in past

BP: 124/78
P: 84
R: 16
WEIGHT: 76 Kg

O:

GENERAL: Normal Abnormal
HEENT: Normal Abnormal
NECK: Normal Abnormal
LUNGS: Normal Abnormal
CARDIAC: Normal Abnormal
ABDOMEN: Normal Abnormal
EXTREMETIES: Normal Abnormal

scar (L) shoulder 3 top, well healed compared to prior appearance per pt

PMHX:
HTN: Y (N)
DM: Y (N)
TB: Y (N)
CAD: Y (N)

ROS: Occasional headache symptoms

A/P: callous formation

Hep A, Hep B, MMR, Td: Given (Patient Refused)

Penallezic
CID Report made - t/w Deputy Commander
Pictures is at file already per [illegible]
Tylenol 325-650 mg Q4-6H prn headache,

(b)(6)-2 M.D.
M.C. [illegible] (b)(6)-2

ISN: (b)(6)-4
SEX: M
CAMP: V-C
DOB: 1974

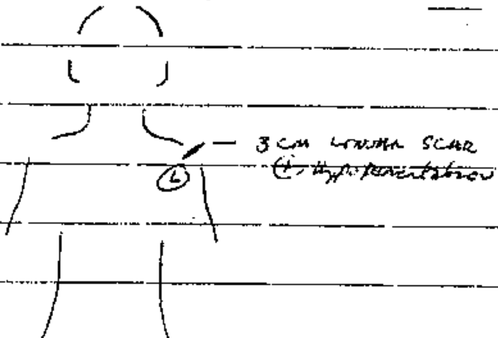
67

0140-04-CID259-80204

0041-04-CID789

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 May 04	S- 30 y/o ♂ DETAINEE referred by CSM for complete
	H+P Pt reports approx 30-32 days ago he was
BP- 150/98	beaten by coalition forces. He reports he was kicked
P- 85	and on his Ⓛ shoulder he has a scar where they
T- 99.6	kicked him. Otherwise his BP was ↑ today in clinic
R- 18	
	O) WNWD ♂ NAD. is BP ↑ AFEBRILE GAIT - NL
	NEURO: CN II - XII, C4-T1 MOTOR AND L1-S2 MOTOR CREMASTERIC REFLEX, DTRs 2+
PMH.	HEENT NL NECK - Supple s̄ adenopathy or Thyromegaly
PSH - partial thyroidectomy 91, tonsilectomy	LUNGS - CTA HEART - RRR s̄ MURMURS
FH - Married, 3 children, Shopper	ABD - BENIGN Genitals - ♂ NL ♂ ↓ TESTES
SH - ø Tobacco	Rectal - NEG MASSES OR HEMORRHOIDS, NL sphincter tone, stool brown [illegible]
MED - no current	Prostate - smooth, symmetrical neg for nodules
Allergies - NKDA	EXT - MOVES ALL WELL
	Integumentary ⟶
	A) 1) Ⓛ Shoulder scar consistent c̄ blunt trauma > 7-14 days
	2. ↑ BP
	P) 1 F/U on sickcall for periodic BP checks
	2. case and plan discussed @ length c̄ patient through interpreter



(b)(6)-2 PA-C

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

NAME: (b)(6)-4

RANK:

SSN:

DOB:

UNIT: G2

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

FOR OFFICIAL USE ONLY

MEDCOM - 740

0140-04-C10259-80204

Last name (b)(6)-4 First name (b)(6)-4 Second name (b)(6)-4 EPW T (b)(6)-4

Blood Type

Date of screening: 3 MAY 04 Time of Screening: 0115

MOI:

HPI: Pt states in past he has had (R) knee pain. Extraction from (R) side mandible molar being rotten. Pt states he currently has no medical problems.

PMHX: ∅

PSHX:

Meds: ∅

Allergies: PCN

Primary Survey

Airway: Patent Mechanically maintained by

Breathing: Spontaneous Assisted by

Circulation:

Pulse: Present Absent CPR

Color: Normal Abnormal

Cap refill: Normal Delayed

Secondary Survey

Initial Vital Signs: b/p 156/98 pulse 115 Resp 20 Pulse Ox 99% Temp 98.8

GEN: WDWN AoOx3 Amb ♂

HEAD: Normocephalic PERRLA, EOMI Tm intact bilat. no ... noted. Nasal septum midline. Severe teeth decay noted upper/lower molars. Tongue intact

NECK: ∅ JVD; Trachea midline FROM ∅ pain.

HEART: Regular Rate, Rhythm ∅ Murmurs/Gallops

LUNGS: CTAB x 6 Fields

CHEST: (L) shoulder abrasion approx location acromion. Chest equal rise & fall, otherwise unremarkable

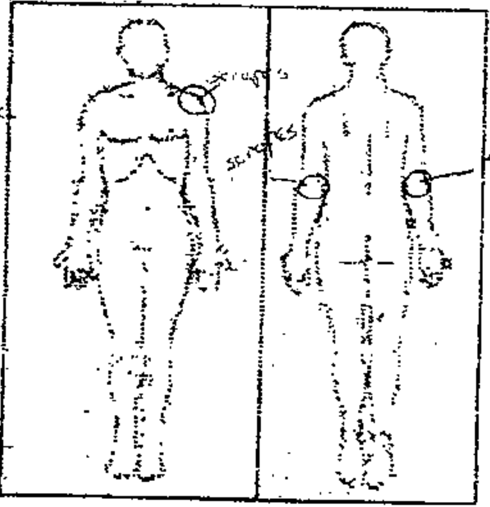
ABD: Bowel sounds noted x 4 quads, ∅ Masses, deformity or rigidity felt.

PELVIS: Stable

EXT: Abrasion bilat at posterior of elbow

RECTAL: Deferred

NEURO: AoOx3



GLASCOW COMA		
EYES OPEN	Spontaneously	(4)
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	(5)
	Confused	4
	Inappropriate words	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	(6)
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	15

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	(4)
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	(4)
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	(4)
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	16

(b)(6)-2

FOR (b)(6)-2

MEDCOM - 741

EPW MEDICAL REC[illegible] PRECONFINEM[illegible]T SC[illegible]EENING

DATE 4/MAI/04 التاريخ	TIME الوقت	CAGE # #4 رقم السجن

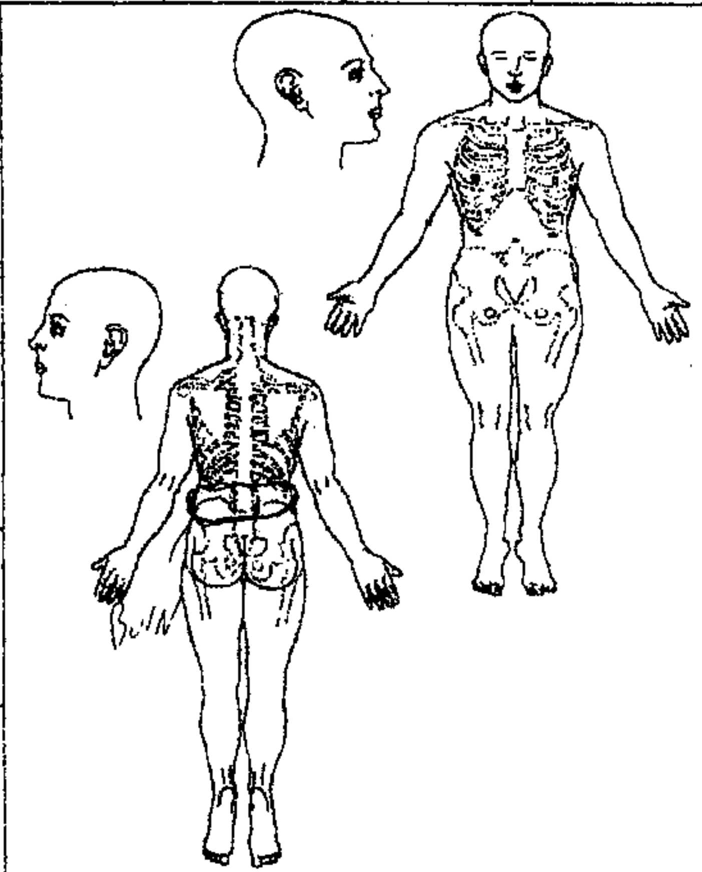
DETAINEE # (b)(6)-4	NAME (b)(6)-4 الاسم	DOB 22/Feb-1970 تاريخ الولادة	AGE 33 العمر

Cell # 4

PHYSICIAN	UNIT	PHONE #

BP	Pulse	Resp.	Temp	Height	Weight
		15		175 الطول	75 الوزن

Question	YES	NO
Allergies to any medications? (If yes explain) لديك حساسية من الأدوية ؟	☐	☒
Currently taking any medications? (If yes explain) حاليا تستعمل اي علاج ؟	☐	☒
Past Medical History? (If yes explain) لديك مرض مزمن سابقا ؟	☐	☒
Past surgical History? (If yes explain) قمت باجراء عملية جراحية ؟	☐	☒
Communicable Diseases? (If yes explain) Typhoid - 2 year ago لديك أمراض انتقالية (جنسية) ؟	☒	☒



Physical Exam:

HEENT:

LUNGS:

HEART:

ABDOMEN:

SKIN:

IDENTIFYING MARKS:

FIT FOR QUESTIONING?	YES	NO

REMAKS:
- Seen Already
Burn Lower Back

SCREENING REPORT

Screener, Team #:		DTG:	
Capture Tag Number:		Capturing Unit:	

Biographical Information

First: (b)(6)-4		Middle: (b)(6)-4	
Last: (b)(6)-4		Nickname: (b)(6)-4	
Sex: (M) / F	DOB/POB: 22 FEB 70, MOSUL		
Marital Status: S (M) D W	Spound Name: (b)(6)-4		
Children/Name/Age: (b)(6)-4 (b)(6)-4			
(b)(6)-4		Religion: SUNNI MUSLIM	
Citizenship: IRAQI		Nationality: IZ	
Tribe: AL SABAWI		Ethnicity: ARAB	
Height:	Weight:		Hair Color:
Home address: AL KARAMA, MOSUL, TGT 121			
		Phone #:	
Lives with: WIFE, KIDS, & MOTHER			

Reason for Capture (Target #, Known Extremist/Terrorist.......)

TGT 121

Capture Data

Date/Time of Capture	Place of Capture TGT 121
Captured Documents/Currency:	
Captured Weapons/Equipment:	
Circumstances of Capture / Mission at time of capture:	

Education

EXHIBIT: 3
2 of 6 [illegible] 8

Level of Education: 9TH GRADE		Degree:		
School:				
Specialized Training: ELECTRICIAN				
Language Proficiency 1 = Native 2 = Good 3 = Poor				
Lang: ARABIC (1) 2 3		Lang: 1 2 3	Lang: 1 2 3	
Employment				
Current NINEVA POWER PLANT			Position	
Duties ELECTRICIAN			Location NINEVA, MOSUL	
Previous			Position	
Duties			Location	
Previous			Position	
Duties			Location	
Additional Skills				
Military Service				
Branch of Serv: ARMY	Rank: PVT		Service Number:	
Military Training: DRIVER				
Military Experience				
Full Unit Designation IRBIL BASIC TRAINING (INF)			Dates 05 MAR 88 - 90	
Duty Pos: DRIVER		Add Duties:		
Full Unit Des:			Dates	
Duty Pos:		Add Duties:		
Full Unit Des:			Dates	
Duty Pos:		Add Duties:		
Category (1A = Highest / 3C = Lowest)				
Cooperation (1) 2 3			Knowledge A B C	
Screener Observations				
Physical Condition: GOOD			Mental State: ALERT	
Attitude:	Additional Observations:			
Recommended Approach:				
Screener Comments:				

SCREENING REPORT

Screener, Team #: (b)(6)-4		DTG: 29 Apr 04 0523	
Capture Tag Number: (b)(6)-4		Capturing Unit:	

Biographical Information

First: (b)(6)-4		Middle: (b)(6)-4	
Last: (b)(6)-4		Nickname:	
Sex: (M) / F	DOB/POB: 22 Feb 70 Mosul Karama		
Marital Status: S (M) D W	Spouse Name: (b)(6)-4		
Children/Name/Age: 6 kids			
		Religion: Sunni	
Citizenship: IZ		Nationality: IZ	
Tribe: Al Sabawi		Ethnicity: Arab	
Height: 173	Weight: 75		Hair Color: black
Home address: Al Karama, Mosul			
		Phone #: NA	
Lives with: Mother, wife and kids			

Reason for Capture (Target #, Known Extremist/Terrorist.......)

- DNK

Capture Data

Date/Time of Capture	Place of Capture
Captured Documents/Currency:	
Captured Weapons/Equipment:	
Circumstances of Capture / Mission at time of capture:	

EXHIBIT: 3
4 of 6 .. 10

0106-04-CID789
0253-04-CID259-80287

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19May04	ISN # (b)(6)-4
	Camp: V-A
	Valium 5mg i po q HS prn insomnia - max 3 tab/week

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)

REGISTER NO. | WARD NO.

Compound V-A

ISN# (b)(6)-4

2nd MP CO

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

EXHIBIT 3

5 of 11

0106-04-CID789
0253-04-CID259-80287

DETAINEE PRE-INTEROGATION EVALUATION

HEALTH RECORD

ALLERGIES: NKDA

DATE: 19 May 04

PATIENT COMPLAINT / CONCERNS:
Pt is 26 y/o ♂
Ø acute complaints.

MEDS: pt [illegible] med for anxiety
Soc Hx: Tob: Ø
ETOH: Ø
PSHx: (—)

BP: 112/74
P: 84
R: 16
WEIGHT: 73kg

O:

GENERAL:	(Normal)	Abnormal
HEENT:	(Normal)	Abnormal
NECK:	(Normal)	Abnormal
LUNGS:	(Normal)	Abnormal
CARDIAC:	(Normal)	Abnormal
ABDOMEN:	(Normal)	Abnormal
EXTREMETIES:	(Normal)	Abnormal

PMHX:
HTN: Y (N)
DM: Y (N)
TB: Y (N)
CAD: Y (N)

Pt c occ anxiety takes meds occ to help sleep

A/P: ① NL exam ② Episodic anxiety

Hep A, Hep B, MMR, Td: (Given) / Patient Refused

Valium 5mg i po q HS prn max 3 tabs/week

Med — Noted — [illegible signature]

(b)(6)-2

Timothy J Kosmatka, M.D.
Major, USAF, MC

ISN: (b)(6)-4

SEX: M

CAMP: V-A

DOB: 1978

STANDARD FORM 600 BACK (REV. 5-84)

EXHIBIT: 3

6 of 6

Brigade Surgeon

(b)(3)-1

DETAINEE MEDICAL SCREENING FORM

DATE: 9 May

NAME: (b)(6)-4 AGE: 37 HEIGHT: 58 WEIGHT: 150

ALLERGIES: ☐ NO ☒ YES: skin allergy

MEDICATIONS: [illegible] does not know what

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS

DISEASES: ____________, ☐ OPIUM USE

SMOKER: ☒ YES ☐ NO

EXAM:

P: 100 BP: 144/74 APPEARANCE: ☒ HEALTHY, ☐ MALNOURISHED, ☐ ILL

HEENT: PERRLA CHEST: CTA

CV: RRR [illegible], gallop, [illegible] ABDOMEN: S/NT [illegible]

MS: MAE [illegible] SKIN: W/D

DENTAL: NO ORAL TRAUMA noted

GENERAL ASSESSMENT: [illegible]

SIGNED: SSG (b)(6)-2 (CLS, 91 W) MEDICAL OFFICER: (b)(6)-2 (MC, DC, MS)

SICK CALL:

DATE 10MAY04 COMPLAINT DX/TX

chest pain when breath w/ [illegible] x 2-3 wks

CTA [illegible]

[illegible]

14May04 - [illegible] Deep breathing - (b)(6)-2

[illegible]

DISCHARGE NOTE: ☒ NO CHANGE IN HEALTH STATUS DATE: 13 May 04

C/O [illegible] pain [illegible] Deep Breathing - (b)(6)-2

14May04 - [illegible] SSG (b)(6)-2 [illegible]

SIGNED: SSG (b)(6)-2 (CLS, 91W) MEDICAL OFFICER: (b)(6)-2 (MC, DC, MS)

over 16May04

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 May	38 male c/o Ribs hurt when breath 1x days / chest hurts when
(b)(3)-1	breath w/ X 1yr. c/o liver problems & c/o ears hurt from being
TIME	hit
B/P	pt has contusion bruising (L) Ribs. pt TTP all 4 quad of Ab. clear breath sounds
P	
R	X-Ray good, pt has contusion of Ribs
T	S as above
PULSE OX	O. [illegible]
ALLERGIES NKA	[illegible]
	[illegible] Rt Arm
MEDS	[illegible]
	[illegible]
TOBACCO yes	[illegible]
PMH	[illegible]
	X-R [illegible] Rib [illegible]
PSH	A Contused Ribs
	P. [illegible]
FMH	Ibuprofen 600 [illegible] PO QID [illegible]
	[illegible] x 4-6 [illegible] (b)(6)-2 (b)(6)-2
	[illegible] ST

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

EPW 10 May (b)(6)-4

X RAY only [illegible]

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

RCAS V1.0

D-102

Brigade Surgeon
(b)(6)-2

DETAINEE MEDICAL SCREENING FORM

DATE: 9 May 04

NAME: (b)(6)-4 (b)(6)-4 AGE: 30 HEIGHT: 180cm WEIGHT: 90

ALLERGIES: ☒ NO ☐ YES:

MEDICATIONS:

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS

DISEASES: No ☐ OPIUM USE

SMOKER: ☒ YES ☐ NO

EXAM:

P: 102 BP: 118/68 APPEARANCE: ☒ HEALTHY, ☐ MALNOURISHED, ☐ ILL

HEENT: PERLA CHEST: [illegible] CTA

CV: RRR ABDOMEN: S/NT

MS: MA SKIN: W/D

DENTAL: Good. no oral Trauma-

GENERAL ASSESSMENT: Good- (b)(6)-2

SIGNED: SSG (b)(6)-2 (CLS, 91 W) MEDICAL OFFICER: (b)(6)-2 (b)(6)-2 CPT SP (MC, DC, MS)

SICK CALL:

DATE	① COMPLAINT	DX/TX
11 May 04	① c/o Bil ↓ Rib pain Reports "Being Tortured."	
	② Chest pain - Reports "Being Shocked During Interrogation"	
	③ Insect Bites Both Feet.	
11 MAY 04 0900	Reports being beaten by U.S. forces about 2 weeks ago with resultant pain from being kicked in his chest and where he reports electricity was applied to his groin	

Exam: PERRL, EOMI, OP clear of lesions, NC AT, [illegible] conjunctival hemorrhage. CNs intact
Heart RRR no M/R/G Chest CTA ⓑ Good expansion ⊕ TTP over lateral chest wall
No healing ecchymoses anywhere. Scattered insect bites. Gait & speech WNL.
Will give Motrin PRN chest wall pain.

(b)(6)-2
CPT, MC

DISCHARGE NOTE: ☐ NO CHANGE IN HEALTH STATUS DATE:

11 May 04 As Above

SIGNED: SSG (b)(6)-2 [illegible] (CLS, 91W) MEDICAL OFFICER: (b)(6)-2 [illegible] MC (MC, DC, MS)

14 May 04
No New medical
Dental problems
noted. [illegible]
(b)(6)-2

12 May 04 No obvious MS changes
[illegible]

OVER FOR 16MAY04
EXAM

000033

Brigade Surgeon

(b)(3)-1

DETAINEE MEDICAL SCREENING FORM

DATE: 9 May

NAME: (b)(6)-4 AGE: 37 HEIGHT: 5'8 WEIGHT: 150

ALLERGIES: ☐ NO ☒ YES: Skin allergy

MEDICATIONS: Must medicine does not know what

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS

DISEASES: ______ ☐ OPIUM USE

SMOKER: ☒ YES ☐ NO

EXAM:

P: 100 BP: 144/74 APPEARANCE: ☒ HEALTHY, ☐ MALNOURISHED, ☐ ILL

HEENT: PERRLA CHEST: CTA slight Bruising on (R) side / no palpable defo[illegible]

CV: RRR S (m), gallops, rub, ABDOMEN: S/NT

MS: MAE s pn SKIN: C/D

DENTAL: NO ORAL TRAUMA noted -

GENERAL ASSESSMENT: Pt is a healthy male c slight pain in [illegible] [illegible]. States to be from [illegible]. (b)(6)-2

SIGNED: SSG (b)(6)-2 G/WMG (CLS, 91 W) MEDICAL OFFICER: (b)(6)-2 (b)(6)-2 [illegible] (MC, DC, MS)

SICK CALL:

DATE 10 MAY 04 COMPLAINT DX/TX

chest pain when breath w/ lyl / cough x 2-3 wks

CTA

Plan - F/U @ CMA today for X-ray [illegible] [illegible] Px.

(b)(6)-2

DISCHARGE NOTE: ☐ NO CHANGE IN HEALTH STATUS DATE: ______

SIGNED: ______ (CLS, 91W) MEDICAL OFFICER: ______ (MC, DC, MS)

46

D-102

Brigade Surgeon

(b)(3)-1

DETAINEE MEDICAL SCREENING FORM

DATE: 9 May 04

NAME: (b)(6)-4 AGE: 30 HEIGHT: 180 cm WEIGHT: 90

ALLERGIES: ☒ NO ☐ YES: ______

MEDICATIONS: ______

MEDICAL HISTORY: ☐ ASTHMA, ☐ DIABETES, ☐ HEART DISEASE, ☐ TUBERCULOSIS, ☐ OTHER INFECTIOUS

DISEASES: No ☐ OPIUM USE

SMOKER: ☒ YES ☐ NO

EXAM:

P: 102 BP: 114/68 APPEARANCE: ☒ HEALTHY, ☐ MALNOURISHED, ☐ ILL

HEENT: PERRLA CHEST: painful (L)-(R) lat. CTA

CV: RRR ABDOMEN: S/NT

MS: MA SKIN: W/D

DENTAL: Good. no oral trauma -

GENERAL ASSESSMENT: Good -

(b)(6)-2

SIGNED: SSG (b)(6)-2 (CLS, 91 W) MEDICAL OFFICER: (b)(6)-2 DC SP (MC, DC, MS)

SICK CALL:

DATE ① COMPLAINT DX/TX

11 May 04 ① Bil ↓ Rib pain Reports "Being Tortured."
② Chest Pain - Reports "Being Shocked During Interrogation"
③ Insect Bites Both Feet.

11 MAY 04 0900 Reports being beaten by U.S. forces about 2 weeks ago with resultant pain from being kicked in his chest and where he reports electricity was applied to his groin

Exam: PERRL, EOMI, OP clear of lesions, NCAT, no conjunctival hemorrhage. CNs intact
Heart RRR ØM/G Chest CTA (B) bad expansion ⊕ TTP over lateral chest wall
No healing ecchymoses anywhere. Scattered insect bites. Gait & speech WNL.

DISCHARGE NOTE: ☐ NO CHANGE IN HEALTH STATUS DATE: ______ Will give Motrin PRN chest wall pain.

(b)(6)-2

CPT, MC

SIGNED: ______ (CLS, 91W) MEDICAL OFFICER: ______ (MC, DC, MS)

48

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198901	2004/03/02	8:02:07 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/03/03	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: Earache primary to injury in a fight x 2 daysO: Erythemia presentA: Otitis externaP: Tylenol 500 mg tid x 5 days, Gentec ointment bid x 3 days, Augmentin 500 mg bid x 5 days

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EPW/CI Medical Report 0084-04-CID 519-8116

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198902	2004/03/06	8:00:17 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/03/07	12:00:00 AM

Immunizations

Medical Officer Performing Exam

00178

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

Diagnosis (From Page 1)	Internment Serial Num.
	(b)(6)-4 0084-04-CID 519-8116

S: tried o hang himself in tent, spent one minute suspendedO: r 20, p 92, no abrasions on neck, lungs clearA: Major depressionP: Restraints x 2 h, 5 mg fast acign haldol IM, 40 mg qd Paxil x 30 d

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198903	2004/03/10	9:13:09 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/03/12	12:00:00 AM

Immunizations

Medical Officer Performing Exam

000078

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

0084-04-CID019-21169

S: c/o MP's beating him upO: no abrasions found anywhere(ankles, wrists, elbows, etc.) no lacerations, no contusionsA: depression (pt has hx of depression)P: continue to monitor

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

000079

Comments (From Page 1)	Internment Serial Num. (b)(6)-4 [redacted] 0[illegible]-04-CID 519-81169

Medic witnessed incident and states that the MP's took the detainee to the ground in order to handcuff him because he was resisting them. Pt. has been refusing rx's.

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

[illegible] 8[illegible]

0084-04-CID 019-81165

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198904	2004/03/19	6:10:59 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/03/19	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

Exhibit 18

000087

MEDCOM - 760

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4	084 - 04 - C 10 519 - 81160

S: corn on rt footO:corn on footA: removal of plantar corn neededP: removal under LA, keflex 500 mg qid x 5 d, tylenol 500 tid x5 d

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18
... 82

84-04-CI 519-8110

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198905	2004/03/29	1:49:04 AM	BC-TO BE DEFINED	DIS-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/06	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4 1084-04-CID 519-81159

S: suture removal right foo t

O: wound healing appropriate

A: sutures need removed

P: Sutures removed

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 15

84

0004-04-CID 519-81160

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198906	2004/04/04	2:30:26 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/10	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

85

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

S: corn

O: corn on R foot

A: needs removal

P: surgical removal under LA, 5cc Marcaine, 4 sutures

Amoxil 500 tid x 7d, tylenol 500 tid x 5d, dsg chge 8 Apr, sut rem 11 Apr

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

0084-04-CID 519-81169

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198907	2004/04/06	9:15:57 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/11	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18
87

MEDCOM - 766

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

0084-04-CID519-81168

S: dsg change

O: wound dirty

A: 0 s/s infection

P: dsg changed, returned to sick call 11APR04 for suture removal

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 14
88

0 04-CID-19-81169

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198908	2004/04/07	2:49:14 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/12	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18

86

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4

04-CID 019-81169

S: Dsg chge to R foot

O: suture p surgery

A: healing wound s infection

P: cleaned and dressed as ordered

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

0? - CID 519 - 81169

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198909	2004/04/09	9:57:15 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/13	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18 [illegible] 9?

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4 C0[illegible]-04-CI[illegible] 81169

S: DSG CHNG, S/P CORN REMOVAL

O: GOOD MARGIN/GRANULATION, 0 S/S INF. NOTED

A: SUTURE REMOVAL & DRSG CHNG

P: BACITRACIN APPLIED DSG CHNG, LOCALIZED CLEANSING, RTC IF S/S INF NOTED

0[illegible]-[illegible]4-CI[illegible] 5[illegible]9 81169

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
11618910	2004/04/09	9:59:55 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/13	12:00:00 AM

Immunizations

Medical Officer Performing Exam

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4)US- 4 - CID 519 - 81165

S: MULTIPLE SMALL SEBACIOUS CYSTS IN THE FACE AND BOTH EYELIDS

O:

A: REMOVAL OF SEBACIOUS CYSTS

P: KEFLEX CAP 250MG QID 5D

IBUPROFEN 800MG TID 5D

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18
94

04-CID 519-81169

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198912	2004/04/10	2:08:10 PM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/04/15	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 16-95

Diagnosis (From Page 1)	Internment Serial Num.
	(b)(6)-4

00- -04-CID 519- 81169

S: dsg change, some pain

O: wound open, stitches removed, 0 s/s infection

A: needs dsg change

P: IB 800mg TID x5d, dsg changed

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

0[illegible]-04-CID 519-81169

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198911	2004/06/23	1:12:10 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/24	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

Serial 18-97

Diagnosis (From Page 1)	Internment Serial Num.
	(b)(6)-4

...-04-CID 519-81106

refill meds: paxil 20mg bid--16 pills for 8 days

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 9 - 98

EPW/CI Medical Report

Last Name	First Name, MI	Internment Serial Num.
(b)(6)-4	(b)(6)-4	(b)(6)-4

EPW/CI Location	BirthDate	Sex	Height	Weight
T-TRANSFER	1979/01/01	M	69	154

Physical Condition	Education	Religion	Marital Status
F-FAIR	B-ELEMENTARY SCHOOL	33-SUNNI-ISLAM	M-MARRIED

Distinguishing Marks:

Remarks

Hair Color	Eye Color	Race	Blood Type	Diet
		X-OTHER		

Examination Information

Examination Number	Date	Time	Exam Category	Type of Case
15198913	2004/06/24	1:19:14 AM	A1-TO BE DEFINED	BC-TO BE DEFINED

Diagnosis	Comments
Please see attached page	Please see attached page

Disposition Type	Disposition Date	Disposition Time
	2004/06/25	12:00:00 AM

Immunizations

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

EXHIBIT 18 - 96

Diagnosis (From Page 1)	Internment Serial Num. (b)(6)-4	0084-04-C10519-81109

S: c/o n/v dizziness, tooth pain

O: 0 emesis noted

bp 120/96, p 80, t 98.7, r 20, pso2 98%

A: dyspepsia

P: zantac 150mg bid x14d

acetaminophen 500mg bid x14d

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

0204-04-CID259-80242

0099-04-CID519

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)

7/28/04

PRE-TRANSFER MEDICAL ASSESSMENT

**LIST ANY YES RESPONSES IN RAMARKS SECTION ON REVERSE SIDE OF FORM

AGE: 27

(Y) (N)		(Y) (N)	
( ) (✓)	Allergies	(✓) (X)	Recent illness/injury left Thigh GSW
(✓) ( )	Dental Problems pain	( ) (✓)	History of psychological problems (Date)
( ) (✓)	HIV positive	( ) (✓)	Chronic health problems or infectious diseases
( ) (✓)	Previous Suicide Attempts (Date)	( ) ( )	Females only; Are you pregnant?
( ) (✓)	History of alcohol abuse/treatment (Date)	( ) (✓)	Current medications
( ) ( )	Current physical complaint(s)		1.
✓	1. Cough/Sputum Production		2.
✓	2. Rash		3.
✓	3. Diarrhea/Vomiting		
✓	4. Night sweats		
✓	5. Pain Teeth		
✓	6. Exposure to TB		
✓	7. Lice/Other infestation		
✓	8. Contagious disease in the past 12 months?		
	9. Other:		

***** FOR MEDICAL PERSONNEL USE ONLY DETAINEE'S INITIALS ( )

HIV/TUBERCULOSIS QU ESTIONAIRE

Do you have a history or, or do you presently have any of the following symptoms or conditions:

(Y) (N)		(Y) (N)	
( ) (✓)	Persistent cough/shortness of breath	( ) (✓)	Cough with blood and/or dry cough
( ) (✓)	Unexplained weight loss/diarrhea X 2 weeks	( ) (✓)	Unexplained persistent fever
( ) (✓)	Night Sweats	( ) (✓)	Swollen glands/lymph nodes
( ) (✓)	Prolonged fatigue or run -down feeling	( ) (✓)	Loss of appetite and or whit e patches in mouth
( ) (✓)	Recent exposure to someone with TB	( ) (✓)	Past abnormal X -Ray (Date)
( ) (✓)	Hepatitis B series completed /	( ) (✓)	Previous TB infection or treatment
( ) (✓)	Stomach surgery, Kidney failu re, Blood disorders		
( ) (✓)	Scars, birthmarks, tattoos:		
	1.		4.
	2.		5.
	3.		6.

States he was forced to the ground by an MP about 5 days ago when he did not sit down for the count – at TCN – abrasions to R elbow and R shoulder

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)

(b)(6)-4

RECORDS MAINTAINED AT: CAMP BUCCA

(b)(6)-4

SEX: M

RELATIONSHIP TO SPONSOR

STATUS: DETAINEE

RANK/GRADE: 6

FOR OFFICIAL USE ONLY
Law Enforcement Sens

MEDCOM - 780

ORGANIZATION

-------------BELOW PORTION TO BE COMPLETED BY MEDICAL STAFF------------- 0099-04-CID519

0204-04-CID259-80242

PHYSICAL APPEARANCE

Clean, well groomed	(Y) (N)	Tremors, sweating	(Y) (N)
Rashes, needle marks	(Y) (N)	Exposure to tuberculosis	(Y) (N)
Body deformities	(Y) (N)	Infestations	(Y) (N)
Cuts, bruises, lesions	(Y) (N)	Confinement Phys. Date:	

VITAL SIGNS: Weight: Height: Temp: 97.5 B/P: 120/78 Pulse: 70 Resp:

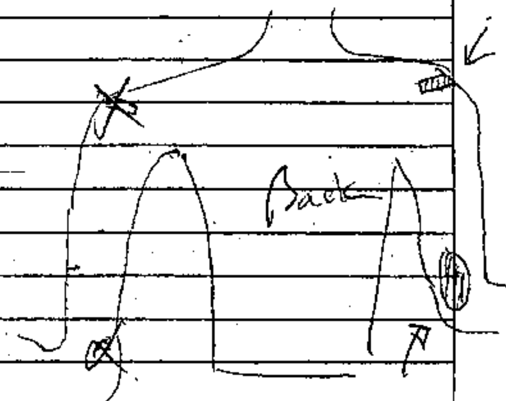
PPD given: HIV drawn: RPR drawn:

Physical Exam: Within normal limits	(Y) (N)	See remarks for any (N) answers	
Head	(✓) ( )		
Lungs/Chest	(✓) ( )	LAB (If available)	
Back	(✓) ( )		CBC:
Heart	(✓) ( )		U/A:
Extremities	(✓) ( )		Chest X-Ray:

Skin abrasion (R) elbow area 4cm & (R) shoulder 3x1cm

MENTAL STATUS

(Y) (N)
( ) ( ) Alert, well oriented
( ) ( ) Long and short term memory intact
( ) ( ) Experiencing hallucinations, delusions, or feelings of paranoia
( ) ( ) Calm, cooperative



DISPOSITION

(Y) (N) Prescriptions:
( ) ( ) **Cleared for basic transfer procedures**
( ) ( ) **Cleared for litter transfer procedures**
( ) ( ) **NOT** medically cleared for transfer _______________(days/weeks)

Recommended type of confinement ( ) Normal ( ) Solitary ( ) Other -explain:

I do not have any SUICIDAL and or HOMICIDAL feelings at this time. If I develop any such ideas or plans, I will notify a staff member before acting on such feelings or ideas. (SIG.) (b)(6)-2

Date/Time information transmitted to component surgeon's office

Infection Control recommendations
( ) Standard Precautions
( ) Contact/Droplet Precautions
( ) Airborne Precautions

SCREENER
MEDICAL STAFF SIGNATURE (b)(6)-2

SCREENER (b)(6)-2
MEDICAL STAFF SIGNATURE

7

FOR OFFICIAL USE ONLY

Exhibit 3