FCN

DEPARTMENT OF THE ARMY
BAGHDAD CENTRAL DETENTION FACILITY HOSPITAL
APO AE 09342

Today's Date: 20 MAY 2004

Transfer Information Sheet

A. PURPOSE: To identify required information needed to facilitate patient transfer into the Baghdad Central Detention Facility Hospital (BCDFH).

B. GENERAL:

1. **TOC/PAD**

a) ISN number: (b)(6)-4 _____

OR

Coalition Provision Authority Apprehension form completed with following information:

- Name of Detainee
- Offense
- Capturing unit's identification number
- Capturing Unit's point of contact with DNVT phone number

AND

- **2 sworn statements from the capturing unit.**

b) Detainee Classification: ☐ High Value Detainee

☒ Security Detainee

FOR BCDFH STAFF USE ONLY	**TOC INFORMATION SUFFICIENT: YES ☐ NO ☐**

2. **MEDICAL INFORMATION:**

- **Date of Admission** 10 MAY 29 APRIL
- **Diagnosis:** RSW ABDOMEN, EXP LAP COLOSTOMY

ALHAMRA

SUBJECT: Transfer Information Sheet

- **Attending Physician's name and contact phone number/ or email:** (b)(2)-1

3. **NURSING INFORMATION:**

- **Patient mobility status:** ☒ Bed bound ☐ Ambulatory

☐ Paralysis: _____ ☐ Other: _____

- **All routine and special treatments:** (wound, tracheostomy, or colostomy care, etc.) Abdominal dressing changes PRN, pleural drain, colostomy.

- **Feeding needs:**

Diet: NPO

Tube feeding via: N/A with —

Assistance needed with meals? N/A.

- **Bowel and bladder issues:** FOLEY CATHETER/U.O.

- **Visual/hearing/speech impairment:** ØENGLISH.

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-62; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:
Prepare, 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 identifying data if available)*
(b)(6)-4

Patient's name (Last, first, middle initial) Grade,
Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*
- 0208

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.	
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) GSW Abd 9; multiple Ex-lap's (B) Chest tube	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. SIGNATURE OF MEDICAL OFFICER IN ATTENDANCE
24 May 04	(b)(6)-2 CPT, MC	(b)(6)-2 MD

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 hour)*	21. AUTOPSY ORDERED BY *(Signature)*
☐ YES ☒ NO	

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

0074-04 (b)(2)-1

PRISONER IN-PROCESSING MEDICAL SCREEN

NAME: (b)(6)-4 COMPOUND: ISN: (b)(6)-4
DATE: 15 June 04 DOB: 7485 AGE: 19
HISTORY BY TRANSLATOR: (YES) NO
NAME OF TRANSLATOR: AI

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?
rash - itching

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

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? 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 TO MEDICATIONS? none

8) PULSE: 127 BLOOD PRESSURE: 154/114 RESPIRATORY RATE: 16

WEIGHT: 153 HEIGHT: 5'8" 132/90 manual

9) HAVE YOU BEEN MISTREATED SINCE BEING IN US CUSTODY? (YES) NO
If Yes Explain:

At Iconis he was struck in the chest and mouth by coalition forces
He reports this occured in a bradly at Allatifiz on 3 JUN 04.
He is without any bruises or scabs,

↳ will refer to CID

SIGNATURE: (b)(6)-1

A 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. A YES TO QUESTION 9 REQUIRES IMMEDIATE MD/PA NOTIFICATION.

MD/PA FOLLOW UP NOTE DATE: 15 JUN 04
ASSESMENT:
RECCOMENDATION:
SIGNATURE: LT PA-C

(b)(6)-4

~~For Official Use Only / Law Enforcement Only~~ 0139-04-CID789-83995

Trauma Record

(4)

For use of this form, see DoD Memeo Subject :Trauma Record, dtd 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS

CASUALTY NAME: FIRST Lnu #1 LAST Name

CASUALTY SSN:

Arrive Date-Time Group (DTG): 18 Aug 04 0600

Rank —

Date of Birth 24/0

Gender ☒ Male ☐ Female

Unit

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

Nation
- ☐ US
- ☐ Host Nation
- ☒ Enemy( )
- ☐ Coalition( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☒ Other

Wound DTG: 18 Aug 04

WOUNDED BY:
- ☒ US/COALITION(Nation_____)
- ☐ ENEMY " ☐ NonENEMY
- ☐ CIVILIAN (Nation_____)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION: ☐ UNK

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

TRIAGE CATEGORY:
- ☐ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASGOW COMA SCALE (circle one)

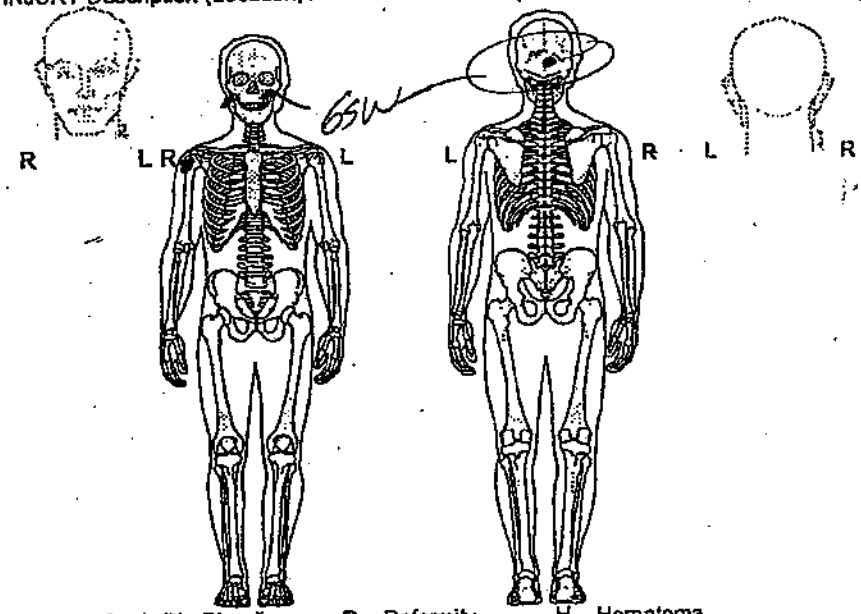
3 8 12 15

UNC STUPOR LETHARGY ALERT

MECHANISM OF INJURY:
- ☒ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, per
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER _____

TIME	0605
Pulse	91
Temp	
B/P	132/101
Resp	
SpO_2	99%

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:	
SEDATED	0610 / 0624
CHEM PARALYZED	0610
INTUBATED	0625
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on / Time off
Collar / C-spine Back board	0605
HEMOSTATIC DEVICE	
OXYGEN	10L Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
EXT Fix /splnt	

OR Start DTG: Stop DTG:

Vent On DTG Off

ICU in DTG: Out DTG:

PR[redacted] MD

SPECIALTY:

(b)(6)-2

~~cial Use Only / Law Enforcement Use Only~~

Exhibit 15

000649

Theater Trauma Registry Record

For [redacted]icial Use Only / Law Enforceme[redacted]Only
[redacted] this form, see DA PAM XXX; the proponent agen[redacted]OTSG

0139-04-CID789-83995

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

TIME	BP		PULSE	RESP	SpO2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
0610:	172	119	55		54%	A V P (U)	100 mg Lidocaine	100 mg	IVP	DTG:
0610	172	119	55		54%	A V P (U)	20 mg Etomidate	20mg	IVP	
0615	163	110	61		58%	A V P (U)	5 a Succi	5mg	IVP	
0623	158	88	94		89%	A V P (U)	20 mg Etomidate	20mg	IVP	
0624	158	88	94		89%	A V P (U)	100mg Succ	100 mg	IVP	
0635						A V P (U)	10mg Vec	~~5~~ 10mg	IVP	
CHIEF COMPLAINT: 0635	130	78	91		97%		~~5mg Fentanyl~~ 5mg Versed	5mg	IVP	
0640	130	67	89				2gm Ancef		IVP.	
							0.5ml Tetanus		IM	

CURRENT MEDICATION: None; NKA

CONDITION UPON RELEASE:
- ☒ IMPROVED
- _ UNCHANGED
- _ DETERIORATED

DISCHARGE INSTRUCTION:

NOTES:
Foley started & ~~intubated~~ removed @ ~~06~~ 0615, 18# to (R) AC & 20# to (L) AC infusing NS. (b)(6)-2 [redacted]
Tetanus & 2gm Ancef
C-spine Xray @ 0640.
♂ s/p multi GSW to head / face / (L) shoulder.
pt brought in GCS 15, declined → BD, pt intubated immediately. c̄ 100 mg lidocaine, 20 mg succ, etomidate
Sats came up to 100%. Very difficult airway, lots of blood, likely aspiration. PMH: None Allergy NKDA meds: none
→ subsequently placed CXR taken.

Trauma Reco[redacted]

DISCHARGE SUMMARY

MEDICATIONS:	LABS:	XRAYS:	PMH:
None.		Lat C-spine	Allergies:

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	GSW to face (L) maxilla, (R) face (preauricular), (R) occipital
Head & Neck (incl C-spine)	Ø stepoffs, Pt in C-collar (on arrival placed)
Chest (incl T-spine)	CTA (B), Agonal resp. Hypoventilated
Abdomen (incl L-spine)	(+) BS soft flat. Rectal: tone, NL, Ø gross blood.
Pelvis	Stable.
UPPER /LOWER Extremities	(R) post shoulder c̄ entrance wound.
Skin	
DISPOSTION DTG:	☒ EVAC to 31st CSH Pt stable condition ☐ RTD ☐ RT CAMP ☐ DECEASED (see below)

Evacuation Priority
- ☐ ROUTINE
- ☐ PRIORITY
- ☐ URGENT

Damage Control Procedures? Y / N   Hypothermic (< 34°C)? Y / N   Coagulopathy? Y / N

Cause of Death at DTG ______ C-spine lat & CXR taken. (Preaccurate films)

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

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

COMMENTS: SURGEON: (printedName)

MEDCOM Test Form 1381, JAN 2004

Exhibit 15

000051

Pt given [illegible], [illegible], Lido, [illegible], [illegible], 1-3 [illegible] 100% O2

[illegible] 2 < 1

MEDCOM - 990

(b)(6)-4

(5) 0138-04-CID769-83996

For Official Use Only / Law Enforcement Only
Trauma Record

For use of this form, see DoD Memeo Subject :Trauma Record, did 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS

CASUALTY NAME: FIRST LAST (b)(6)-4

CASUALTY SSN: (b)(6)-4

Arrive Date-Time Group (DTG): 18 Aug 04 0630

Rank Date of Birth Gender ☒ Male ☐ Female Unit

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

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

Service
- ☐ Civilian
- ☒ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☐ Other

Wound DTG: 18 Aug 04

WOUNDED BY:
- ☐ US/COALITION(Nation_____)
- ☐ ENEMY ☐ NonENEMY
- ☐ CIVILIAN (Nation_____)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION: ☐ UNK

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

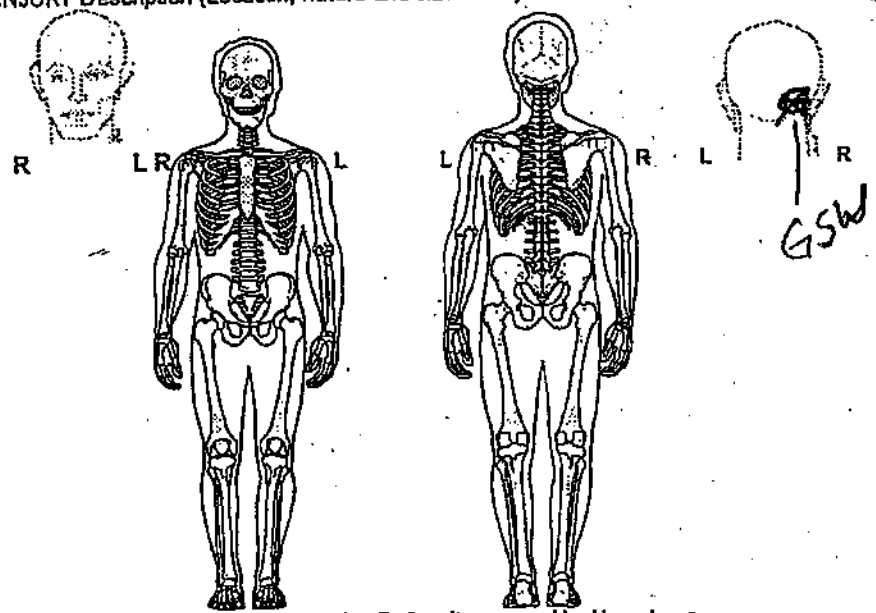
TRIAGE CATEGORY:
- ☒ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

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

MECHANISM OF INJURY:
- ☒ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, pe
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER

TIME	0610
Pulse	94
Temp	
B/P	103/68
Resp	
SpO_2	98%

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:	
SEDATED	Syqetom
CHEM PARALYZED	Succ.
INTUBATED	7.0
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LRNS/HTS ml 500
TOURNIQUET	Time on / Time off
Collar / C-spine / Back board	
HEMOSTATIC DEVICE	
OXYGEN	10 Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
EXT Fix /splint	Splint

OR Start DTG: Stop DTG:	Vent On DTG Off DTG:	ICU in DTG: Out DTG:
PROVIDER:		SPECIALTY:

For Official Use Only / Law Enforcement Use Only

Exhibit 16
000052

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
0625	178	136	131	20	99	A V P (U)	Tetanus	.5cc	IM	0632
0631	144	102	126	20	97	A V P (U)	Ancef	2gm	IV	0635
0634	137	90	129	20	94	A V P (U)				
0639	167	106	125	20	100	A V P (U)				
0641	148	95	121	20	100	A V P (U)				
0644	153/111		111	20	98%	A V P (U)				

CHIEF COMPLAINT: GSW to head

CURRENT MEDICATION: 2gm Ancef, Td

CONDITION UPON RELEASE:
- _IMPROVED
- XUNCHANGED
- _DETERIORATED

DISCHARGE INSTRUCTION:

NOTES:

Trauma Record
DISCHARGE SUMMARY

MEDICATIONS:	LABS:	XRAYS:	PMH: Allergies:
Ancef Etom Succ.			

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	pupils fixed / dilated, ruptured TM (L) side → (R) intact blood oropharynx
Head & Neck (incl C-spine)	Brain matter exruding → wrap head @1630 c-collar @ 0630 1 entrance wound, no exit wound. → (R) occipital
Chest (incl T-spine)	BS (B)
Abdomen (incl L-spine)	NG Nubc @ 16:19 soft
Pelvis	FOLEY CATHETER - yellow/amber & rectal tone 18 G x 2
UPPER /LOWER Extremities	2 IV's in, have not moved any body part since the time he came in. IV #1 - LR #2 - SALINE
Skin	warm/dry

DISPOSTION		Evacuation Priority
DTG: 0654 18 Aug 04	☒ EVAC to Baghdad ☐ RTD ☐ RT CAMP ☐ DECEASED (see below)	☐ ROUTINE ☐ PRIORITY ☒ URGENT

Damage Control Procedures? Y / N Hypothermic (< 34°C)? Y / N Coagulopathy? Y / N

Cause of Death at DTG

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

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

COMMENTS:

SURGEON: (b)(6)-2 HAJ (printed Name)

MEDCOM Test Form 1381, JAN 2004

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

NAME OF DECEASED (Last, First, Middle) Nom du défunt (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Armée	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4 (BELIEVED TO BE)			
ORGANIZATION Organisation: DETAINEE NUMBER (b)(6)-4	NATION (e.g., United States) Pays: IRAQ	DATE OF BIRTH Date de naissance: UNKNOWN	SEX Sexe: [X] MALE Masculin [ ] FEMALE Féminin

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du défunt avec le susdit
UNKNOWN	
STREET ADDRESS Domicile (Rue): UNKNOWN	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'instant et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort	SHOTGUN WOUND OF THE CHEST	SECONDS
ANTECEDENT CAUSES Morbid conditions, if any, leading to primary cause Condition morbide, s'il y a lieu, amenant à la cause primitive		
Underlying cause, if any, giving rise to primary cause Maladie fondamentale, s'il y a lieu, ayant suscité la cause primitive		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives		

MODE OF DEATH Condition du décès	AUTOPSY PERFORMED Autopsie effectuée	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort survenue par des causes extérieures
[ ] NATURAL Mort naturelle	[X] YES Oui [ ] NO Non	
[ ] ACCIDENT Mort accidentelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
[ ] SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste: (b)(6)-2 CDR, MC, USN	
[X] HOMICIDE Homicide	SIGNATURE (b)(6)-2, M.D. DATE Date: 30 AUG 2004	AVIATION ACCIDENT Accident d'Aviation: [ ] YES Oui [X] NO Non

DATE OF DEATH (Hour, day, month, year) Date du décès (Heure, le jour, le mois, l'année)	PLACE OF DEATH Lieu du décès
18 AUGUST 2004	BAGHDAD, 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 défunt et je constate 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 assistant	TITLE OR DEGREE Titre ou diplôme
(b)(6)-2	CHIEF DEPUTY MEDICAL EXAMINER
GRADE Grade: CDR, MC, USN	INSTALLATION OR ADDRESS Installation ou adresse: OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
DATE Date: 30 AUG 2004	SIGNATURE (b)(6)-2, M.D.

[1] State disease, injury or complication which caused death, but not mode of dying such as 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 2064 APR 73 REPLACES AF FORM 714, MAR 69, WHICH IS OBSOLETE.

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: Unknown
Date of Death: 18 AUG 2004
Date of Autopsy: 30 AUG 2004
Date of Report: 30 AUG 2004

Autopsy No.: ME04-629
AFIP No.: Pending
Rank: Detainee in U.S. Custody
Place of Death: Iraq
Place of Autopsy: BIAP Mortuary, Baghdad, Iraq

Circumstances of Death: This Iraqi male was a detainee in U.S. custody at Abu Ghraib prison in Baghdad, Iraq. A group of prisoners became unruly and the guards used lethal force to subdue the crowd. A shotgun was fired and this detainee was struck and killed.

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

Identification: Circumstantial identity is established by paperwork accompanying the detainee and his designation as detainee number (b)(6)-4

CAUSE OF DEATH: Shotgun Wound of the Head

MANNER OF DEATH: Homicide

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

Autopsy ME04-629

(b)(6)-4

PRELIMINARY AUTOPSY DIAGNOSES:

I. **Shotgun Wound of the Head**

A. **Penetrating Shotgun Wound of the Head**
1. **Entrance: Right side of the back of the head; no evidence of close-range discharge of a firearm on the surrounding scalp**
2. **Wound Path: Right parietal-occipital scalp, parietal-occipital skull, right cerebrum, left cerebrum**
3. **Recovered: Deformed metallic foreign body located between the medial aspect of the left frontal lobe and the overlying dura**
4. **Wound Direction: Right to left, back to front, and upward**
5. **Associated Injuries: Subdural and subarachnoid hemorrhages, bilateral basilar skull fractures, cerebral contusions, and bone fragments along the hemorrhagic wound path**

II. **No evidence of significant natural disease processes, within the limitations of the examination**

III. **Evidence of medical therapy**
A. **Vascular access devices in the left arm, both antecubital fossae, and the left subclavian area**
B. **Oral-gastric intubation**
C. **Endotracheal intubation**
D. **Foley catheterization**
E. **Electrocardiogram monitoring pads on the upper right chest and the left hip**
F. **Contusion over the sternum, consistent with cardiopulmonary resuscitation**

IV. **Changes of early to moderate decomposition**

V. **The recovered projectile is placed in a labeled container and given to the investigating agent who was present at the autopsy**

VI. **Toxicology is pending**

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographer, HM1 (b)(6)-2 (b)(6)-2 USN
- Specimens retained for toxicologic testing and/or DNA identification are: heart blood, spleen, liver, brain, bile, lung, kidney, and psoas muscle
- Full body radiographs are obtained and demonstrate the metallic foreign body subsequently recovered from the brain
- Selected portions of organs are retained in formalin, without preparation of histologic slides
- The dissected organs are forwarded with body

(b)(6)-2 (b)(6)-2 M.D.

(b)(6)-2 M.D., DMO/FS
CDR MC USN
Chief Deputy Medical Examiner

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

NAME OF DECEASED (Last, First, Middle) Nom du décédé (Nom et prénoms): (BELIEVED TO BE) [b)(6)-4]	GRADE Grade	BRANCH OF SERVICE Armée	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation: DETAINEE NUMBER [b)(6)-4]	NATION (U.S., United States) Pays: IRAQ	DATE OF BIRTH Date de naissance: UNKNOWN	SEX Sexe: [X] MALE Masculin [ ] FEMALE Féminin

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

NAME OF NEXT OF KIN Nom du plus proche parent: UNKNOWN

RELATIONSHIP TO DECEASED Parenté du décédé avec le parent:

STREET ADDRESS Domicile (Rue): UNKNOWN

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]: SHOTGUN WOUND OF THE HEAD	MINUTES
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	
ANTECEDENT CAUSES Symptômes précurseurs de la mort — UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant conduit la cause primaire	
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]	

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

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

MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie:

NAME OF PATHOLOGIST Nom du pathologiste: [b)(6)-2] CDR, MC, USN

SIGNATURE [b)(6)-2] M.D.

DATE Date: 30 AUG 2004

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

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

DATE OF DEATH (Hour, day, month, year) Date du décès (Heure, le jour, le mois, l'année): 19 AUGUST 2004

PLACE OF DEATH Lieu de décès: BAGHDAD, 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 défunt et je constate 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 assermenté: [b)(6)-2]

TITLE OR DEGREE Titre ou diplôme: CHIEF DEPUTY MEDICAL EXAMINER

GRADE Grade: CDR, MC, USN

INSTALLATION OR ADDRESS Installation ou adresse: OFFICE OF THE ARMED FORCES MEDICAL EXAMINER

DATE Date: 30 AUG 2004

SIGNATURE [b)(6)-2] M.D.

[1] State disease, injury or complication which caused death, and not mode of dying, such as heart failure, asphyxia, 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 le mode de mourir, telle qu'un arrêt du cœur, 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 2064 APR 77 REPLACES AF FORM 716, MAR 69, WHICH IS OBSOLETE.

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: Unknown
Date of Death: 18 AUG 2004
Date of Autopsy: 30 AUG 2004
Date of Report: 30 AUG 2004

Autopsy No.: ME04-630
AFIP No.: Pending
Rank: Detainee in U.S. Custody
Place of Death: Iraq
Place of Autopsy: BIAP Mortuary, Baghdad, Iraq

Circumstances of Death: This Iraqi male was a detainee in U.S. custody at Abu Ghraib prison in Baghdad, Iraq. A group of prisoners became unruly and the guards used lethal force to subdue the crowd. A shotgun was fired and this detainee was struck and killed.

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

Identification: Circumstantial identity is established by paperwork accompanying the detainee and his designation as detainee number (b)(6)-4

CAUSE OF DEATH: Shotgun Wound of the Chest

MANNER OF DEATH: Homicide

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

PRELIMINARY AUTOPSY DIAGNOSES:

I. **Shotgun Wounds of the Chest and Both Arms**

A. **Penetrating Shotgun Wound of the Chest**
1. **Entrance: Left side of the back; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the left back, posterior left 9th rib (with fracture), lower lobe of left lung, left atrium, right atrium, upper lobe of the right lung, intercostal space below the anterior aspect of the right 2nd rib, muscle and subcutaneous tissue of the right upper chest**
3. **Recovered: Deformed metallic foreign body located in the subcutaneous tissue of the right upper chest**
4. **Wound Direction: Left to right, back to front, and upward**
5. **Associated Injuries: Bilateral hemothoraces (right 1400-milliliters; left 2100-milliliters), hemopericardium (50-milliliters)**

B. **Perforating Shotgun Wound of the Right Upper Back**
1. **Entrance: Right upper back; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin and subcutaneous tissue of the right upper back (tangential wound path)**
3. **Exit: Right upper back; no projectile recovered**
4. **Wound Direction: Left to right and slightly upward**

C. **Perforating Shotgun Wound of the Right Arm**
1. **Entrance: Posterior right arm; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the posterior right arm; muscle, subcutaneous tissue, and skin of the anterior right arm**
3. **Exit: Anterior right arm; no projectile recovered**
4. **Wound Direction: Left to right, back to front, and slightly downward (with the body in anatomic position)**

D. **Perforating Shotgun Wound of the Left Arm**
1. **Entrance: Posterior left arm; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the posterior left arm; muscle, subcutaneous tissue, and skin of the anterior left arm**
3. **Exit: Anterior left arm; no projectile recovered**
4. **Wound Direction: Left to right, back to front, and downward (with the body in anatomic position)**

II. **No evidence of significant natural disease processes, within the limitations of the examination**

III. **Changes of early to moderate decomposition**

IV. **The recovered projectile is placed in a labeled container and turned over to the investigating agent who was present at the autopsy**

V. **Toxicology is pending**

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographer, HM1 (b)(6)-2 (b)(6)-2 USN
- Specimens retained for toxicologic testing and/or DNA identification are: cavity blood, vitreous fluid, spleen, liver, brain, bile, urine, lung, gastric contents, kidney, and psoas muscle
- Full body radiographs are obtained and demonstrate the metallic foreign body subsequently recovered from the right chest wall
- Selected portions of organs are retained in formalin, without preparation of histologic slides
- The dissected organs and clothing are forwarded with body

(b)(6)-2
(b)(6)-2 **M.D., DMO/FS**
CDR MC USN
Chief Deputy Medical Examiner

Trauma Record

For use of this form, see DoD Memco Subject :Trauma Record, dtd 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS
CASUALTY NAME: FIRST LAST
CASUA (b)(6)-4
Arrive Date-Time Group (DTG): 18 0416 0725
Rank
Date of Birth
Gender ☒ Male ☐ Female
Unit GANG 3

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

Nation
- ☐ US
- ☒ Host Nation
- ☐ Enemy( )
- ☐ Coalition( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☒ Other Detainee

Wound DTG: 18 0605 45

WOUNDED BY:
- ☐ US/COALITION(Nation MP)
- ☒ ENEMY
- ☐ NonENEMY
- ☐ CIVILIAN (Nation)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION:
- ☐ UNK.

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

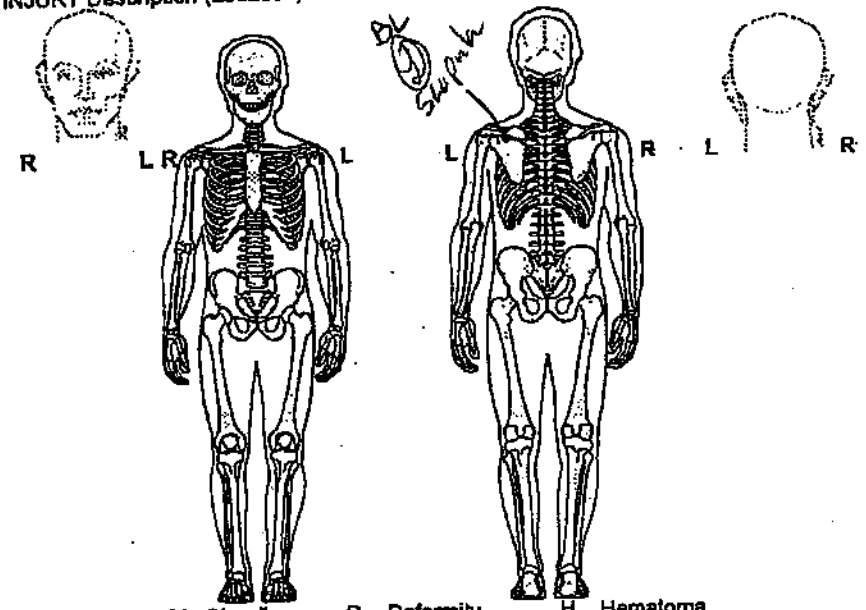
TRIAGE CATEGORY:
- ☐ IMMEDIATE
- ☒ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

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

MECHANISM OF INJURY:
- ☒ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, ped)
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER

TIME	0720
Pulse	103
Temp	98.8
B/P	131/82
Resp	32
SpO_2	96

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:	
SEDATED	
CHEM PARALYZED	
INTUBATED	
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
	Time off
Collar / C-spine Back board	
HEMOSTATIC DEVICE	
OXYGEN NC	2 Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
FXT Fix /splint	Extremity

OR Start DTG:
Stop DTG:
Vent On DTG
Off DTG:
ICU In DTG: Fow
Out DTG: 1150

PROVIDER: (b)(6)-2

For Official Use Only / Law Enforcement Use Only

Exhibit 24 1057

(b)(6)-4

LAT | Scalp Y

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
0810						(A) V P U	Ancef	1gm	IVPB	DTG:
RCN 0710	128	68	70		99	A V P U	Tetnerus Boost	.5ml	IM	18Aug@0900
0845	148	82	86	20	96	A V P U				
1000	140	85	108	18	98	A V P U				
1130	142	98	104	15	91	A V P U				
						A V P U				

CHIEF COMPLAINT:
GSW to (L) Scapula no exit wound found. Min bleeding Pt complains of SOB. Breath sounds all fields. No signs of cyanosis. O_2 Sat @ 96% on RA

CURRENT MEDICATION	CONDITION UPON RELEASE:	DISCHARGE INSTRUCTION:
	_IMPROVED _UNCHANGED _DETERIORATED	

NOTES: 0745 no acute distress at this time. Started 16g in (L) AC. NS@ KVO open.
0810 Started 1 gms Ancef. CXR results back neg pneumo. O_2 Sats ↓ 93% increased O_2 to 3½ L/NC.
0820 Pt c/o pain 7/10, gave 2mg more of morphine. xray done of (L) shoulder.

Morphine 2mg @ 1010 & 12.5 phenergan
Morphine 2mg @ 1020

1110 16F foley inserted. Pt has no complaints. Draining clear amber urine. UA specimen collected. Bear hugger on. CXR obtained. Pt has received 4500cc NS total.

000068

(b)(6)-4

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2 mg morphine IVP
@ 12:50 hrs Phenergan IVP

4 mg morphine IVP

VCCUS.
AP / Lateral
Left Shoulder Lateral
Left Shoulder Y

2 mg morphine } Total
2 mg Morphine @ 2010 hrs

Trauma Record
DISCHARGE SUMMARY

MEDICATIONS:	LABS:	XRAYS:	PMH:
~~Morphine~~ 1 gm Ancef @ 0610 hrs TD Booster @ 0900 hrs	H&H, Chem 7 Stool IV UA	CXR - Left Shoulder	Allergies:

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	Hgmt. Perrla EOMI
Head & Neck (incl C-spine)	No C Spine Tenderness.
Chest (incl T-spine)	Both
Abdomen (incl L-spine)	NO (+)BS (B) ØTenderness
Pelvis	ØTenderness
UPPER /LOWER Extremities	Good Peripheral Pulse
Skin	W, Rash

DISPOSTION		Evacuation Priority
DTG:	☐ EVAC to _____ ☐ RTD ☐ RT Camp ☐ DECEASED (see below)	☐ ROUTINE ☐ PRIORITY ☐ URGENT

Damage Control Procedures? Y / N Hypothermic (< 34°C)? Y / N Coagulopathy? Y / N

Cause of Death at DTG .

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

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

COMMENTS: SURGEON:

For Official Use Only / Law Enforcement Use Only (printedName) Exhibit 24

000059

For Official Use Only / Law Enforcement Only

0139-04-CID678-83995

LOG # 07

Trauma Record

For use of this form, see DoD Memco Subject :Trauma Record, dtd 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS

CASUALTY NAME: FIRST LAST CA (b)(6)-4

Arrive Date-Time Group (DTG): 18 AUG 04 @ 0725

Rank Date of Birth 01/19/de Gender ☒ Male ☐ Female GAINCI 3

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

Nation
- ☐ US
- ☐ Host Nation
- ☒ Enemy( )
- ☐ Coalition( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☐ Other DETAINEE

Wound DTG: 18 AUG 04 @ 0545

WOUNDED BY:
- ☐ US/COALITION(Nation)
- ☐ ENEMY " ☐ NonENEMY
- ☐ CIVILIAN (Nation)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION: ☐ UNK

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

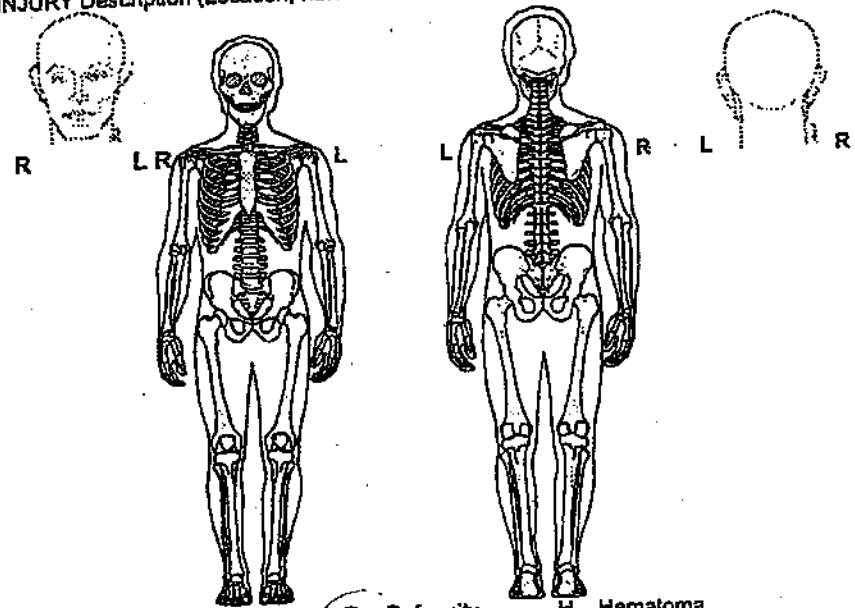
TRIAGE CATEGORY:
- ☐ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

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

MECHANISM OF INJURY:
- ☐ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, pe
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER

TIME	0725
Pulse	77
Temp	
B/P	148/95
Resp	15
SpO_2	98% RA

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:	
SEDATED	
CHEM PARALYZED	
INTUBATED	
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on / Time off
Collar / C-spine Back board	
HEMOSTATIC DEVICE	
OXYGEN	Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
EXT Fix /splint	

OR Start DTG: Stop DTG:

Vent On DTG Off DTG:

ICU in DTG: 1645 Out DTG:

SPECIALTY:

P (b)(6)-2

(b)(6)-2

For Official Use Only / Law Enforcement Use Only

Exhibit

250070

(b)(6)-4

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
0930	118	76	67	18	95%	(A) V P U	0.5ml Td		IM	DTG Pollard 07
1050	120	80	72	20		A V P U	5mg Morphine		IM	c̄ Pollard 075
						A V P U				
						A V P U				
						A V P U				
						A V P U				

(b)(6)-2

CHIEF COMPLAINT: 0720 PT states he was beat up c̄ tent pole

NO Tetnus PHA,

CURRENT MEDICATION: Ø

CONDITION UPON RELEASE:
_ IMPROVED
_ UNCHANGED
_ DETERIORATED

DISCHARGE INSTRUCTION:

NOTES:
♂ s/p beating w/ cups & tent poles. ⊕ trauma to back/flank
Ø urine Δ's, ØHA, Ø neck pain, ØSOB, ØCP
ØLOC pt c/o pain.
Ø abd pain

PMH: "Psych issues"
PSH: none. (⊕ superficial knife scars to abd, not surg)
meds: none
Allergy NKDA

Trauma Record
DISCHARGE SUMMARY

MEDICATIONS: 0.5 TP, 5mg Morphine	LABS: UA	XRAYS: CXR, pelvis	PMH: Allergies: PCN

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	NCAT, MMM, PERR EOMI NCAT, Nasal septum ̄s hematoma, poor dentition (+) trauma & ecchymos
Head & Neck (incl C-spine)	(+) (L) Buccal mucosa, ø blood; Neck - supple ø stepoff
Chest (incl T-spine)	CTA(B), shallow 2° pain; (+) bruising & induration to back (B) TTP of all ribs, ø T spine TTP ø stepoff, (+) flank ecchymosis, (+) TTP
Abdomen (incl L-spine)	(+) BS, obese, ø ecchymosis, ø TTP; FAST scan (-), (+) healed superficial wounds ant.
Pelvis	(+) NL GU exam, ø blood @ meatus, ø scrotal hematoma; ø test of [illegible]; pelvis stable
UPPER /LOWER Extremities	Motor 5/5, Ambulates ̄c difficulty, NCI (throughout), pulses 2+ throughout, sensation [illegible]
Skin	mult ecchymotic sites, (+) TTP, small abrasion ≈ 3

DISPOSTION		Evacuation Priority
DTG:	☐ EVAC to ______	☐ ROUTINE
	☐ RTD ☒ RT CAMP	☐ PRIORITY
	☐ DECEASED (see below)	☒ URGENT

Damage Control Procedures? Y / N Hypothermic (< 34°C)? Y / N Coagulopathy? Y / N

Cause of Death at DTG ______. CXR (-) for fx, ptx, pulm contusion
UA (-) for blood
FAST (-)

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

Reassessment @0950. Pt stable, pain controlled ̄c 5mg IM Morphine, will d/c to camp

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

COMMENTS: SURGEON (b)(6)-2 [redacted] (printedName) Exhibit 25

Trauma Record

For use of this form, see DoD Memeo Subject :Trauma Record, did 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS

CASUALTY NAME: FIRST LAST (b)(6)-4

CASUALTY SSN: (b)(6)-4

Arrive Date-Time Group (DTG): 18Aug 0725

Rank

Date of Birth 1/1/1982

Gender ☑ Male ☐ Female

Unit Grid 3

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

Nation
- ☐ US
- ☑ Host Nation
- ☐ Enemy( )
- ☐ Coalition( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO (~~Detainee~~)
- ☑ Other Detainee

Wound DTG: 18 Aug 0545

WOUNDED BY:
- ☑ US/COALITION(Nation MP)
- ☐ ENEMY
- ☐ NonENEMY
- ☐ CIVILIAN (Nation)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION:
- ☐ UNK

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

TRIAGE CATEGORY:
- ☐ IMMEDIATE
- ☑ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASCOW COMA SCALE (circle one)

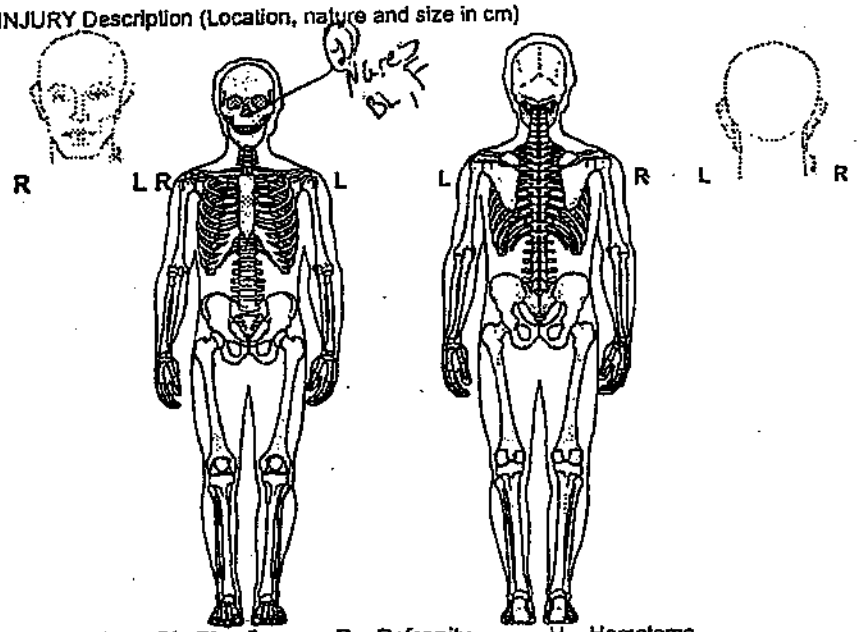
3 8 12 (15)

UNC STUPOR LETHARGY ALERT

MECHANISM OF INJURY:
- ☐ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☑ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, pe
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER

TIME	0720
Pulse	70
Temp	98.1
B/P	129/68
Resp	14
SpO_2	99

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:	
SEDATED	
CHEM PARALYZED	
INTUBATED	
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml 500
TOURNIQUET	Time on
	Time off
Collar / C-spine Back board	
HEMOSTATIC DEVICE	
OXYGEN	Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
EXT Fix /splint	

OR Start DTG:
Stop DTG:

Vent On DTG
Off DTG:

ICU in DTG: Evac 3/st
Out DTG: 1140

PROVIDER (b)(6)-2

SPECIALTY: ER

(b)(6)-4 [redacted]

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	SpO2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
0830	118	80	68	18	99	(A) V P U	Toradol 30mg	30mg	IV.	(b)(6)-2 [redacted]
~~0923~~	~~117~~	~~71~~	~~87~~	~~18~~	~~99~~	(A) V P U	Ancef 2g	2g	IV	(b)(6)-2 [redacted]
0930	123	69	69	18	100	(A) V P U	Booster	.5mg	IM	[redacted]
0915						A V P U	GENT	15Dmg	IV	[redacted]
						A V P U				
						A V P U				

CHIEF COMPLAINT: bleeding from nose / minimal pain

CURRENT MEDICATION	CONDITION UPON RELEASE:	DISCHARGE INSTRUCTION:
none	~~IMPROVED~~ / (UNCHANGED) / DETERIORATED	TRANSPORT TO BAGDAD

NOTES:

19 yo m Trauma Left nostril 2° Puncture Projectile (BW)

No loc TMs Intact PERRLA EOMI Intact

CN II - XII

Left Nostral entrance wound IDed - Extends into cribriform plate

Left Nostral entrance wound IDed - Extends into cribriform plate Nasal Turbinates well visualized. No Trauma Nasal oral Pharyngeal scope used (NP scope) Apparent. Posterior Pharynx well visualized No Trauma Seen. Facial Films: No FB Identified facial Area. One Fragment seen in occipital Area.

A/P: BW to left Nasal fold ē unidentified Tract - Need CT Scanner To Identify Tract since none are on site. Patient states occipital Area was dd Pellet gun wound since we are unable To Identify Tract will arrange

Transport TO Bagdad for CT Scan Head. (b)(6)-2 [redacted], M.D.

(b)(6)-4

Trauma Record
DISCHARGE SUMMARY

CEFT 150 IVP

MEDICATIONS: TD Boost	LABS:	XRAYS:	PMH: Ø
Toradol 30mg IM 2gm Rocephin	H+H / Chem 7 Start IV	FACIAL Series AP Lat	Allergies: NKDA

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	Hematoma Left Lateral Forehead
Head & Neck (incl C-spine)	NO C Spine Tenderness Full ROM
Chest (incl T-spine)	BCTA
Abdomen (incl L-spine)	NO CT/US
Pelvis	NO TILT NO Tenderness
UPPER /LOWER Extremities	Good Pulses
Skin	Abrasions

DISPOSTION	☒ EVAC to 31 CSH	Evacuation Priority
DTG:	☐ RTD ☐ RT CAMP ☐ DECEASED (see below)	☐ ROUTINE ☒ PRIORITY ☐ URGENT Air evac

Damage Control Procedures? Y / N Hypothermic (< 34°C)? Y / N Coagulopathy? Y / N

Cause of Death at DTG

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

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

COMMENTS:

SURGEON:

Exhibit 26

000075

(b)(6)-4

Fo[illegible]ficia[illegible]

Trauma Record

(4)

For use of this form, see DoD Memeo Subject :Trauma Record, dtd 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS

CASUALTY NAME: FIRST Last #1 Name

CASUALTY SSN: - -

Arrive Date-Time Group (DTG): 18 Aug 04 0600

Rank

Date of Birth 26y/o

Gender ☑ Male ☐ Female

Unit

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

Nation
- ☐ US
- ☐ Host Nation
- ☑ Enemy( )
- ☐ Coalition( )

Service
- ☐ Civilian
- ☐ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☑ Other

Wound DTG: 18 Aug 04

WOUNDED BY:
- ☑ US/COALITION(Nation_____)
- ☐ ENEMY " ☐ NonENEMY
- ☐ CIVILIAN (Nation_____)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION: ☐ UNK

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

TRIAGE CATEGORY:
- ☐ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASGOW COMA SCALE (circle one)

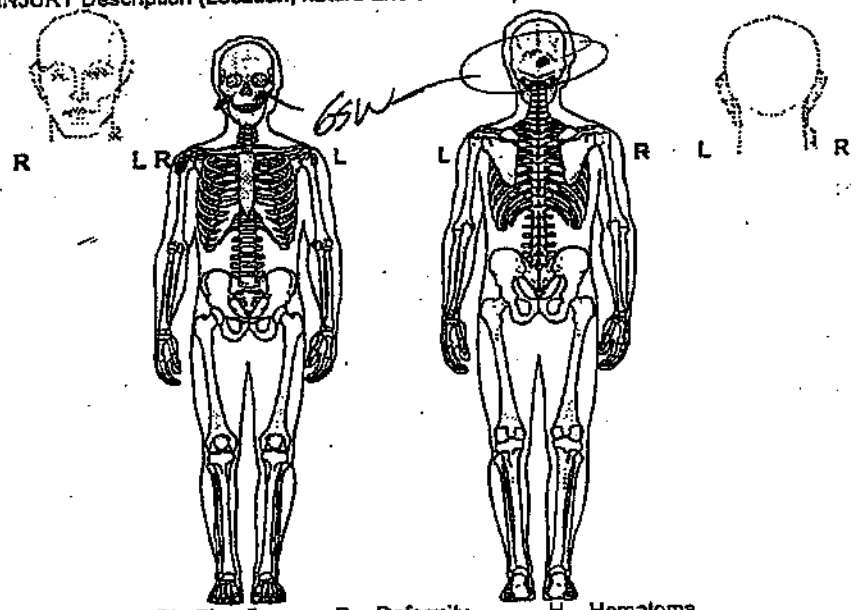
3 8 12 15

UNC STUPOR LETHARGY ALERT

MECHANISM OF INJURY:
- ☑ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, pe
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER _____

TIME	0605
Pulse	91
Temp	
B/P	132/101
Resp	
SpO_2	99%

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES:	
SEDATED	0610 / 0624
CHEM PARALYZED	0610
INTUBATED	0625
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on / Time off
Collar / C-spine Back board	0605
HEMOSTATIC DEVICE	
OXYGEN	100% Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg
EXT Fix /splint	

OR Start DTG: Stop DTG:

Vent On DTG Off

ICU in DTG: Out DTG:

PRO[illegible]MD

SPECIALTY:

(b)(6)-2

[illegible]cial Use Only / Law Enforcement Use Only

Exhibit 27
000076

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	SpO2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
0605:	172	119	55		54%	A V P (U)	100 mg Lidocaine	100mg	IVP	DTG:
0610	172	119	55		54%	A V P (U)	20 mg Etomidate	20mg	IVP	
0615	163	110	61		58%	A V P (U)	5 c Succi	5mg	IVP	
0623	158	88	94		89%	A V P (U)	20 mg Etomidate	20mg	IVP	
0624	158	88	94		89%	A V P (U)	100mg Succ	100mg	IVP	
0635						A V P (U)	10mg Vec	10mg	IVP	

CHIEF COMPLAINT:

0635	130	78	91		97%	~~5mg Versed~~ 5mg Versed	5mg	IVP
0640	130	67	89			2gm Ancef		IVP
						0.5ml Tetanus		IM

CURRENT MEDICATION	CONDITION UPON RELEASE:	DISCHARGE INSTRUCTION:
None NKA	X IMPROVED _ UNCHANGED _ DETERIORATED	

NOTES:

Foley started c̄ ~~intubated~~ removed @ 0615, 18# to (R) AC + 20# to (L) AC infusing NS. (b)(6)-2

Tetanus + 2gm Ancef

C-spine XRay @ 0640.

♂ s/p mult GSW to head / face / (R) shoulder. pt brought in GCS 15, declined - BD, pt intubated immediately c̄ 100 mg lidocaine, 20mg succ, etomidate sats came up to 100%. Very difficult airway, lots of blood, likely aspiration. PMH: none (b)(6)-2 NKDA male was subsequently placed CXR taken.

MEDCOM - 1012

For Official Use Only / Law Enforc [redacted] 95

Trauma Re

DISCHARGE SUM

MEDICATIONS:	LABS:	XRAYS:	PMH:
None.		Lat C-spine	Allergies:

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	GSW to face (L) maxilla, (R) face, (R) occipital (preauricular)
Head & Neck (incl C-spine)	ϕ Stepoffs, NT c-collar (on arrival placed)
Chest (incl T-spine)	CTA (B), Agonal resp Hypoventilated
Abdomen (incl L-spine)	(B)s soft NT. Normal tone, NL, ϕ groin blood.
Pelvis	Stable.
UPPER /LOWER Extremities	(R) post shoulder & forearm wound.
Skin	
DISPOSTION DTG:	☒ EVAC to 31st CSH ☐ RTD ☐ RT CAMP ☐ DECEASED (see below)

Evacuation Priority
- ☐ ROUTINE
- ☐ PRIORITY
- ☐ URGENT

Damage Control Procedures? Y / N Hypothermic (< 34°C)? Y / N Coagulopathy? Y / N

Cause of Death at DTG _____. C-Spine Lat & CXR taken. (Prearrival films)

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

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

COMMENTS: SURGEON: _____ (printedName)

MEDCOM Test Form 1381, JAN 2004

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Exhibit 27

000078

MEDCOM - 1013

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)-4
SSAN:
Date of Birth: Unknown
Date of Death: 18 AUG 2004
Date of Autopsy: 30 AUG 2004
Date of Report: 12 OCT 2004

Autopsy No.: ME04-630
AFIP No.: 2940933
Rank: Detainee in U.S. Custody
Place of Death: Iraq
Place of Autopsy: BIAP Mortuary, Baghdad, Iraq

Circumstances of Death: This Iraqi male was a detainee in U.S. custody at Abu Ghraib prison in Baghdad, Iraq. A group of prisoners became unruly and the guards used lethal force to subdue the crowd. A shotgun was fired and this detainee was struck and killed.

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

Identification: Circumstantial identity is established by paperwork accompanying the detainee and his designation as detainee number (b)(6)-4

CAUSE OF DEATH: Shotgun Wound of the Chest

MANNER OF DEATH: Homicide

FINAL AUTOPSY DIAGNOSES:

I. **Shotgun Wounds of the Torso and Both Arms**

A. **Penetrating Shotgun Wound of the Chest**
1. **Entrance: Left side of the back; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the left back, posterior left 9th rib (with fracture), lower lobe of left lung, left atrium, right atrium, upper lobe of the right lung, intercostal space below the anterior aspect of the right 2nd rib, muscle and subcutaneous tissue of the right upper chest**
3. **Recovered: Deformed metallic foreign body located in the subcutaneous tissue of the right upper chest**
4. **Wound Direction: Left to right, back to front, and upward**
5. **Associated Injuries: Bilateral hemothoraces (right 1400-milliliters; left 2100-milliliters), hemopericardium (50-milliliters)**

B. **Perforating Shotgun Wound of the Right Upper Back**
1. **Entrance: Right upper back; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin and subcutaneous tissue of the right upper back (tangential wound path)**
3. **Exit: Right upper back; no projectile recovered**
4. **Wound Direction: Left to right and slightly upward**

C. **Perforating Shotgun Wound of the Right Arm**
1. **Entrance: Posterior right arm; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the posterior right arm; muscle, subcutaneous tissue, and skin of the anterior right arm**
3. **Exit: Anterior right arm; no projectile recovered**
4. **Wound Direction: Left to right and back to front (with the body in anatomic position)**

D. **Perforating Shotgun Wound of the Left Arm**
1. **Entrance: Posterior left arm; no evidence of close-range discharge of a firearm on the surrounding skin**
2. **Wound Path: Skin, subcutaneous tissue, and muscle of the posterior left arm; muscle, subcutaneous tissue, and skin of the anterior left arm**
3. **Exit: Anterior left arm; no projectile recovered**
4. **Wound Direction: Left to right, back to front, and downward (with the body in anatomic position)**

Autopsy ME04-630

(b)(6)-4

II. **No evidence of significant natural disease processes, within the limitations of the examination**

III. **Changes of early to moderate decomposition**

IV. **The recovered projectile is placed in a labeled container and turned over to the investigating agent who was present at the autopsy**

V. **Toxicology is negative for ethanol and drugs of abuse**

EXTERNAL EXAMINATION

The remains are received clad in a cut away green shirt and white, boxer type shorts. No identification band is noted on the body, but the sequence of numbers (b)(6)-4 is written on the lower chest left of the anterior midline. The body is in an early to moderate state of decomposition, with changes that include clouding of the corneae, loss of turgor of the globes of the eyes, marbling of the soft tissue, and generalized skin slippage. Bloody fluid is present in the oral cavity.

The body is that of a well-developed, well-nourished appearing, 70 ½-inches, 180-pounds (estimated), White male. The age of the individual is unknown. Lividity is posterior and fixed, except in areas exposed to pressure. Rigor has passed. The body temperature is that of the refrigeration unit.

The scalp is covered with medium length, black hair in a normal distribution. Facial hair consists of a black beard. The irides are brown and the pupils are round and equal in diameter. The external ears are unremarkable. The nose and maxillae are palpably stable. The teeth are natural and in fair condition.

The neck is mobile and the trachea is midline. The chest is symmetric. The abdomen is flat. The external genitalia are those of a normal adult, circumcised, male. Both testes are descended into the scrotum. Pubic hair is present in a normal distribution. There is no evidence of external trauma to the urogenital area. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema. The fingernails are intact. No tattoos or other significant identifying body marks are noted.

EVIDENCE OF MEDICAL INTERVENTION

- Electrocardiogram monitoring pads on both sides of the upper chest and on the left lower quadrant of the abdomen
- Gauze dressing is tied around the wrists and feet

RADIOGRAPHS

Full body radiographs are obtained and show a metallic foreign body on the right side of the upper torso.

EVIDENCE OF INJURY

I. Shotgun Wounds of the Torso and Both Arms

A. Penetrating Shotgun Wound of the Chest

There is an entrance shotgun wound on the left side of the back, situated 18-inches below the top of the head and 3 ½-inches left of the posterior midline. No soot deposition or gunpowder stippling is present on the surrounding skin. The 3/16-inch wound has a 1/8-inch marginal abrasion between 5 and 8 o'clock. The wound path goes through the skin, subcutaneous tissue, and muscle of the left side

of the back and enters the pleural cavity through the posterior aspect of the left 9th rib, which is fractured. The path then continues through the lower lobe of the left lung, the pericardium, both atria of the heart, the pericardium, and the upper lobe of the right lung. The wound path then exits the right pleural cavity below the anterior aspect of the right 2nd rib and perforates the chest wall musculature. A deformed, metallic projectile is recovered from the subcutaneous tissue of the right upper chest. The projectile is placed in a labeled container and turned over to the investigating USACID agent. Injuries associated with the wound path include bilateral hemothoraces (right 1400 milliliters; left 2100-milliliters) and hemopericardium (50-milliliters). The direction of the wound path is left to right, back to front, and upward.

B. Perforating Shotgun Wound of the Right Upper Back
There is an entrance shotgun wound on the right upper back, situated 16-inches below the top of the head and 7 1/8-inches right of the posterior midline of the body. The 5/16-inch wound has a ½ x 5/8-inch eccentric marginal abrasion between 6 and 12 o'clock. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through skin and subcutaneous tissue prior to exiting the body through a ¼-inch skin defect situated 15-inches below the top of the head and 8-inches right of the posterior midline. A ¼ x ¼-inch eccentric marginal abrasion is present between 12 and 6 o'clock. No bullet or bullet fragments are recovered. The direction of the wound path is left to right and slightly upward.

C. Perforating Shotgun Wound of the Right Arm
There is an entrance shotgun wound on the posterior aspect of the right arm, situated 6-inches below the top of the right shoulder and 2-inches medial of the posterior midline of the right arm. The 1/4-inch, irregular, defect is surrounded by a minimal ring of contusion. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the skin, subcutaneous tissue, and muscle of the posterior right arm and the muscle, subcutaneous tissue, and skin of the anterior right arm. A ¼-inch exit wound within a 1 ½ x 1-inch area of contusion is situated 6-inches below the top of the right shoulder and 1 ¾-inches lateral to the anterior midline of the right arm. No bullet or bullet fragments are recovered. The direction of the wound path is left to right and back to front.

D. Perforating Shotgun Wound of the Left Arm
There is an entrance shotgun wound on the posterior aspect of the left arm, situated 5-inches below the top of the left shoulder and 2-inches medial to the posterior midline of the left arm. The 1/4-inch, irregular, ovoid defect has no associated abrasion or contusion. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the skin, subcutaneous tissue, and muscle of the posterior left arm and the muscle, subcutaneous tissue, and skin of the anterior left arm. A ¼-inch exit wound within a 1-inch area of contusion is situated 7 1/4-inches below the top of the left

shoulder and ¼-inch medial to the anterior midline of the left arm. No bullet or bullet fragments are recovered. The direction of the wound path is left to right, back to front, and downward.

INTERNAL EXAMINATION

HEAD:
The scalp is uninjured. There are no skull fractures or other evidence of significant trauma present. The calvarium is removed to demonstrate an absence of epidural or subdural hemorrhage. Examination of the brain reveals a normal pattern of gyri and sulci. Serial sectioning reveals no evidence of traumatic or atraumatic abnormalities. The vessels at the base of the brain have a normal distribution and appearance. The brain weighs 1380-grams.

NECK:
The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact 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. Injuries to the chest and mediastinum have been described previously. There is no abnormal accumulation of fluid in the peritoneal cavity. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 320 and 180-grams, respectively, and have the previously described injuries. The external surfaces are deep red-purple. No mass lesions or areas of consolidation are present. The pulmonary arteries are free of emboli.

CARDIOVASCULAR SYSTEM:
The 310-gram heart has the previously described injuries. 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 1.4 and 0.5-centimeters 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-gram 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 is empty. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

Autopsy ME04-630

(b)(6)-4

SPLEEN:
The 180-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is soft, maroon, and congested, with early decompositional changes.

PANCREAS:
The pancreas exhibits early to moderate decompositional changes.

ADRENAL GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices, gray medullae, and early decompositional changes. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 140 and 110-grams, 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 urinary bladder contains 150-milliliters of light yellow urine.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, hemorrhagic appearing mucosa. The stomach contains approximately 100-milliliters food particles, including beans and rice. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present.

MUSCULOSKELETAL:
No non-traumatic abnormalities of muscle or bone are identified.

MICROSCOPIC EXAMINATION

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

Autopsy ME04-630

(b)(6)-4

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographer, HM1 (b)(6)-2 (b)(6)-2 USN
- Specimens retained for toxicologic testing and/or DNA identification are: cavity blood, spleen, liver, brain, bile, urine, lung, gastric contents, kidney, and psoas muscle
- Full body radiographs are obtained and demonstrate the metallic foreign body subsequently recovered from the right chest wall
- The dissected organs and clothing are forwarded with body

OPINION

This White male detainee in U.S. custody died as a result of a shotgun wound to the chest that caused injury to the lungs and heart. There was also extensive bleeding into the chest cavity. A metallic projectile was recovered from the subcutaneous tissue of the right upper chest and turned over to the USACID Agent who was present at the autopsy. Additional shotgun wound paths involved the right upper back and both arms. The location and appearance of the wound paths involving the right upper back and right arm make it likely that a single projectile resulted in both wounds, with re-entry of the projectile into the right arm after exiting the right back. The manner of death is homicide.

(b)(6)-2 (b)(6)-2 M.D.

M.D., DMO/FS
CDR MC USN
Chief Deputy Medical Examiner

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	Sequence
2940933	00

Name (b)(6)-4

SSAN: **Autopsy:** ME04-630
Toxicology Accession #: 044549
Date Report Generated: September 13, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 8/18/2004 **Date Received:** 9/7/2004

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

DRUGS: The **BLOOD** was screened for acetaminophen, amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, chloroquine, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, salicylates, 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

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)-4
SSAN:
Date of Birth: Unknown
Date of Death: 18 AUG 2004
Date of Autopsy: 30 AUG 2004
Date of Report: 12 OCT 2004

Autopsy No.: ME04-629
AFIP No.: 2940934
Rank: Detainee in U.S. Custody
Place of Death: Iraq
Place of Autopsy: BIAP Mortuary, Baghdad, Iraq

Circumstances of Death: This Iraqi male was a detainee in U.S. custody at Abu Ghraib prison in Baghdad, Iraq. A group of prisoners became unruly and the guards used lethal force to subdue the crowd. A shotgun was fired and this detainee was struck and killed.

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

Identification: Circumstantial identity is established by paperwork accompanying the detainee and his designation as detainee number (b)(6)-4

CAUSE OF DEATH: Shotgun Wound of the Head

MANNER OF DEATH: Homicide

(b)(6)-4

FINAL AUTOPSY DIAGNOSES:

I. Shotgun Wound of the Head

A. Penetrating Shotgun Wound of the Head

1. **Entrance: Right side of the back of the head; no evidence of close-range discharge of a firearm on the surrounding scalp**
2. **Wound Path: Right parietal-occipital scalp, parietal-occipital skull, right cerebrum, left cerebrum**
3. **Recovered: Deformed metallic foreign body located between the medial aspect of the left frontal lobe and the overlying dura**
4. **Wound Direction: Right to left, back to front, and upward**
5. **Associated Injuries: Subgaleal, subdural and subarachnoid hemorrhages, bilateral basilar skull fractures, cerebral contusions, and bone fragments along the hemorrhagic wound path**

II. No evidence of significant natural disease processes, within the limitations of the examination

III. Changes of early to moderate decomposition

IV. The recovered projectile is placed in a labeled container and given to the investigating agent who was present at the autopsy

V. Toxicology is positive for morphine at a concentration of 0.23 mg/L in the blood. No ethanol or other drugs of abuse are detected.

EXTERNAL EXAMINATION

The remains are received without clothing. No identification bands are present on the body. The unclad body is that of a well-developed, well-nourished appearing, 69-inches, 140-pounds (estimated), White male. The age of the individual is not known. Lividity is posterior and fixed, except in areas exposed to pressure. Rigor has passed. The body temperature is that of the refrigeration unit. Early to moderate decomposition changes are present, including mild skin slippage, prominent vascular marbling, and clouding of the corneae.

The scalp is covered with medium length, brown hair in a normal distribution. Facial hair consists of a beard and mustache. The irides are brown and the pupils are round and equal in diameter. The external ears are unremarkable. The nose and maxillae are palpably stable. Bloody fluid is present in the nares. The teeth are natural and in fair condition.

The neck is mobile and the trachea is midline. The chest is symmetric. The abdomen is flat. The external genitalia are those of a normal adult male. Pubic hair is shaved. There is no evidence of external trauma to the urogenital area. The buttocks and anus are unremarkable. There are areas of hypopigmentation present on the lower trunk and the extremities.

The upper and lower extremities are symmetric and without clubbing or edema. The fingernails are intact. No tattoos or significant identifying body marks are present. Black writing is present on both sides of the chest; "log #2" is on the right side and a series of illegible numbers is on the left side.

EVIDENCE OF MEDICAL INTERVENTION

- Vascular access devices in the left arm, both antecubital fossae, and the left subclavian area
- Oral-gastric intubation
- Endotracheal intubation
- Foley catheterization
- Electrocardiogram monitoring pads on the upper right chest and the left hip
- Contusion over the sternum, consistent with cardiopulmonary resuscitation

RADIOGRAPHS

Full body radiographs are obtained and show a metallic foreign body in the head.

EVIDENCE OF INJURY

I. Shotgun Wound of the Head

There is a penetrating ballistic entrance wound on the right side of the back of the head, situated 4 3/8-inches below the top of the head and 2 ¼-inches right of the posterior midline. The ovoid wound is ¼ x 3/16-inches, with a 1/16-inch marginal

(b)(6)-4

abrasion from the 3 to 6 o'clock positions. No soot deposition or gunpowder stippling is present on the surrounding skin. The wound path goes through the occipital scalp and includes a 5/16 x 3/8-inch defect in the right side of the occipital bone, with appropriate beveling. The wound path through the brain perforates the right occipital, right parietal, and both frontal lobes. A slightly deformed, round, metallic projectile is recovered from the dura overlying the medial aspect of the left frontal lobe of the brain at the anterior midline. The projectile is placed in a labeled container and turned over to the investigating USACID agent present at the autopsy. The wound direction is right to left, back to front, and upward. Injuries associated with the wound path include fine linear fractures extending across the middle fossae of the basilar skull, a 1-inch linear fracture of the occipital bone extending from the 4 o'clock position of the entrance wound skull defect, and subgaleal, subdural, and subarachnoid hemorrhages. Scattered cerebral contusions and bone fragments along the hemorrhagic wound path are also present.

INTERNAL EXAMINATION

HEAD:
Injuries of the head have been described previously. The vessels at the base of the brain have a normal distribution and appearance. The brain weighs 1150-grams.

NECK:
The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact 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. Both pleural cavities contain 100-milliliters of decomposition fluid and the pericardial sac contains 20-milliliters of decomposition fluid. There is no abnormal accumulation of fluid in the peritoneal cavity. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 580 and 550-grams, respectively. The external surfaces are smooth and deep red-purple, with moderate anthracotic mottling. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present. The pulmonary arteries are unremarkable.

CARDIOVASCULAR SYSTEM:
The 220-gram 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 soft, with early decompositional changes. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.1 and 0.3-centimeters thick, respectively. The endocardium is smooth. The aorta gives rise to three intact and patent arch vessels. Fatty streaking of the aorta is noted. The renal and mesenteric vessels are unremarkable.

(b)(6)-4

LIVER & BILIARY SYSTEM:
The 1050-gram liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture and changes of early decomposition. No mass lesions or other abnormalities are seen. The gallbladder contains 15-milliliters of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 240-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is soft, maroon, and congested, with changes of early decomposition.

PANCREAS:
The pancreas has the usual lobular architecture and early decompositional changes. No mass lesions or other abnormalities are seen.

ADRENAL GLANDS:
The right and left adrenal glands are symmetric, with yellow cortices, gray medullae, and decompositional changes. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 150 and 120-grams, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and distinct corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The urinary bladder is empty. The prostate gland is unremarkable. The testes have no masses and exhibit no evidence of trauma.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, hemorrhagic appearing mucosa. The stomach contains approximately 70-milliliters of dark brown fluid. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present.

MUSCULOSKELETAL:
No non-traumatic abnormalities of muscle or bone are identified.

MICROSCOPIC EXAMINATION

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

Autopsy ME04-629

(b)(6)-4

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by OAFME staff photographer, HM1 (b)(6)-2 (b)(6)-2, USN
- Specimens retained for toxicologic testing and/or DNA identification are: heart blood, spleen, liver, brain, bile, lung, kidney, adipose, and psoas muscle
- Full body radiographs are obtained and demonstrate the metallic foreign body subsequently recovered from the brain
- The dissected organs are forwarded with body

OPINION

This White male detainee in U.S. custody died as a result of a shotgun wound of the head that caused injury to the skull and brain. Toxicology was positive for morphine, which was likely the result of medical therapy received prior to death. One metallic projectile was recovered from the head and turned over to the investigating USACID agent who was present at the autopsy. The manner of death is homicide.

(b)(6)-2 **M.D., DMO/FS**
CDR MC USN
Chief Deputy Medical Examiner

(b)(6)-2

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 Accession Number	Sequence
2940934	00

Name (b)(6)-4

SSAN: **Autopsy:** ME04-629
Toxicology Accession #: 044550
Date Report Generated: September 27, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 8/18/2004 **Date Received:** 9/7/2004

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

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

Positive Opiate: Morphine was detected in the blood by immunoassay and confirmed by gas chromatography/mass spectrometry. The blood contained 0.23 mg/L of morphine as quantitated by gas chromatography/mass spectrometry.

(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

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr	2. Name					3. Grade	Admission Remarks
(b)(6)-2	(b)(6)-4						
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		OTH	MUSLIM				
11. FMP	12. SSN	13. Organization				14. Ward	
20	(b)(6)-4					EMT	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K91-HUMANITARIAN			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		07:34	ABO - TRAUMA CENTER				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		CRO/ER	2004-08-18				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2004-08-18	(b)(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
1180 - 31st CSH							

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: GSW TO HEAD

34. Diagnosis / Operations and Special Procedures:

TRAUMATIC BRAIN INJURY

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending Medical Officer Signature of TAC or Medical Records Officer

HOSPITAL REPORT OF DEATH

FOR 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:
Prepare, 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 identifying data if available)*
(b)(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 0900 18 AUG 2004

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

4. RELIGION: MUSLIM

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)*: Traumatic Brain Injury	
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): GSW Head	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE: 18 AUG 2004

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

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

000036

EXHIBIT 30

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 Armée	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
	Iraq	?	[X] MALE Masculin [ ] FEMALE Féminin

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
Unknown	
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	Traumatic Brain Injury	
ANTECEDENT CAUSES — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide s'il y a lieu, menant à la cause primaire	GSW Head	
Successively, to the primary cause de la mort — 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		

MODE OF DEATH Genre de décès	AUTOPSY PERFORMED Autopsie effectuée [ ] YES Oui [ ] NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort s'il y a lieu par des causes extérieures
[ ] NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
[ ] ACCIDENT Mort accidentelle		
[ ] SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
[ ] HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident d'Aviation [ ] 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 susnoms 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 sanitaire	TITLE OR DEGREE Titre ou diplôme
(b)(6)-2	DO

SIGNATURE Signature	INSTALLATION OR ADDRESS Installation ou adresse
MHJ	(b)(3)-1
LT Col USA	(b)(6)-2

000037

TIME	PROCEDURE	SIZE	SITE	RESULTS
	ET Intubation	7	☐ Oral ☐ Nasal Teeth 23	☐ ETCO2 Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube	16	☒ Oral ☐ Nasal	☐ Air ☐ Contents ☐ Verified Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public	☐ Return ___cc ☐ Hoche Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed	☐ Grossly: + - Cell count Sent @ ___
	Chest Tube # 1		L R	☐ Air ☐ Blood ☐ Pleuravac ___cm ☐ Autotransfuser
	Chest Tube # 2		L R	☐ Air ☐ Blood ☐ Pleuravac ___cm ☐ Autotransfuser
	12 Lead	Rhythm	Comments	

ABG SITE	TIME	%O2	PR	BE	PCO2	PO2	% Sat	HCO3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick ___ ☐ Shot ___
	☐ D-stick ___ ☐ Shot ___
	☒ CBC ☒ Chem ☒ PT/PTT
	☐ ETOH ☒ T&S ☐ T&C x ___
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐
	☐

TIME	PROC	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☒ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T-L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	LAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
721	2	14	Y	N	(L) AC			
	1	20	Y	N	(L) Ecup			
			Y	N				
			Y	N				

MEDICATIONS

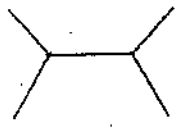
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Labetalol	731	2mg	IV						

BLOOD PRODUCTS

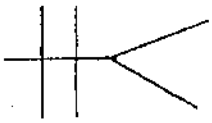
START	#	TYPE	UNIT #	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC.



Chem.



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	b(6)-2	0	0	0
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3649	
	Other See Nursing Notes	

DISPOSITION

☐ Home ☐ ___

Admitted to ___

Transferred to: ___

000038

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form see AR 40-66 the proponent agency is the Office of The Surgeon General

REPORT TITLE | TRAUMA FLOWSHEET
The proponent is Dept of Surgery | OTSG APPROVED (Date)

EMS REPORT

TIME: ______ ETA: ______ UNIT: ______
MED COM: [Y] [N]

2 De formed Gste
to head

ARRIVAL STATUS

TIME ______ ☐IV x ______ ☐O2 ______ 1/min ☐ C-Spine Immob
Meds: ☐UKN ☐None ☐Yes: ______
Allergies: ☐UKN ☐None ☐Yes: ______
Tetanus: ☐UKN ☐Current Last Meal/Fluid Intake ______ hrs
LMP: ______ ☐ ______

PRIMARY SURVEY

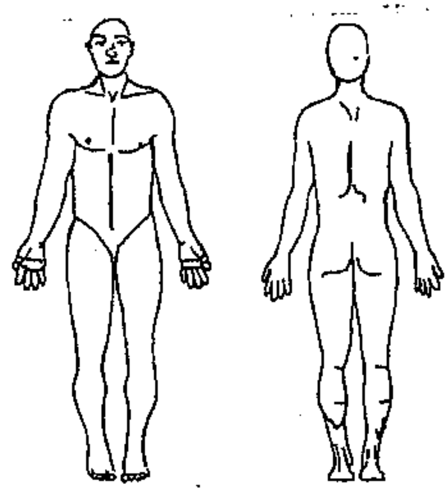
AIRWAY	BRETHING	CIRCULATION	
☐Natural Patient [Y] [N]	☐Labored ☐Unlabored ☐Absent	PULSE: ☒Present ☐Absent	SKIN ☐Warm ☐Cool ☐Hot
☒ETT ______ ☐ ______	TRACHEA: ☒Midline ☐Deviated [L] [R]	BLEEDING: [Y] [N]	☐Pink ☐Pale ☐Cyanotic ☐ ______
☐Secretions ______	CHEST SYMMETRY: [L] (=) [R]	HEART TONES: ☒Clear ☐Muffled	☐Dry ☐Moist ☐Diaphoretic

SECONDARY SURVEY

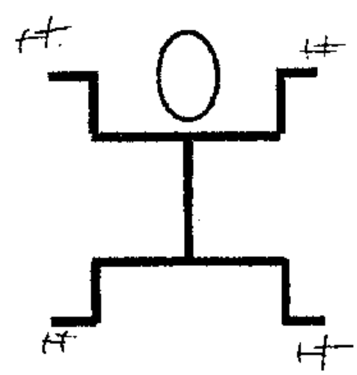
DISABILITY	HEAD	HEART	ABDOMEN
GCS E ______	PUPILS ☐Equal ☒Fixed ☐React ☒Dilated [L] [R] Blown	RHYTHM: ☐Regular ☒ ST	☒Soft ☐Rigid Non-Tender
3 V ______	TM ☐Clear ☐Blood [L] [R]	PULSES: ☒Central ☒Peripheral	☐Tender
	NECK	LUNGS	PELVIS
M ______	C-Spine Tenderness [Y] [N]	BREATH SOUNDS: ☒Bilat ☒Equal ☒Clear	☒Stable ☐Unstable ☐ ______
SPHINCTER TONE: ☐WNL	Pain @ ______	Decreased [L] [R] Absent [L] [R]	Blood at meatus vagina
☐None	JVD: [Y] [N]	Wheezes [L] [R] Crackles [L] [R]	Heme + - Prostate ☐WNL ☐Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



+ + Strong | + Palpable | D Dopler

RN (b)(6)-2

PREP

PHYSICIAN (b)(6)-2

(Continue on reverse)

DEPARTMENT SERVICE CLINIC EMT | DATE

PATIENTS IDENTIFICATION (For typed or written entries give: Name--Last, First, middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES

000039

VITAL SIGNS

Rectal Temp: 98   GCS: 3

TIME	BP	HR	RHY	RR	SAO2	FIO2	MODE	E	V	M	T
0724	170/130	98	ST	14	100	Vent		1	1	1	3
0740	/	79	SR	13	100	vent					
	/										
	/										
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GLASGOW COMA SCALE

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY
	Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

young Iraqi-looking ♂ reported to be shot in head while at Abu Ghraib. See assessment. CT shows bullet [illegible] [illegible], Dr. (b)(6)-2 calls him expectant.

000100

EXHIBIT 30

Trauma Record
DISCHARGE SUMMARY

MEDICATIONS:	LABS:	XRAYS:	PMH: Allergies:
Morph from Succ.			

REGION	DIAGNOSIS, PROCEDURES and COMPLICATONS
Face	pupils fixed / dilated, ruptured TM (L) side → (R) intact blood oropharynx
Head & Neck (incl C-spine)	Brain matter exruding → wrap head @1630 c-collar @ 0630 1 entrance wound, no exit wound. → (R) occipital
Chest (incl T-spine)	BS (B)
Abdomen (incl L-spine)	NG Nubc @ 0619 soft
Pelvis	FOLEY CATHETER - yellow/amber & rectal tone 16 Fr x 2
UPPER /LOWER Extremities	2 IV's in, have not moved any body part since the time he came in. IV #1 - LR #2 - SALINE
Skin	warm/dry

DISPOSTION		Evacuation Priority
DTG: 0654 16 Aug 04	☒ EVAC to Baghdad ☐ RTD ☐ RT CAMP ☐ DECEASED (see below)	☐ ROUTINE ☐ PRIORITY ☒ URGENT

Damage Control Procedures? Y / N Hypothermic (< 34°C)? Y / N Coagulopathy? Y / N

Cause of Death at DTG

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

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

000101

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

TIME	BP		PULSE	RESP	SpO2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
0620	176	84	50	22	97	A V P (U)	Atropine	1 Amp	IV	DTG: 0623
0625	178	136	131	20	99	A V P (U)	Tetanus	.5cc	IM	0632
0631	144	102	126	20	97	A V P (U)	Ancef	2gm	IV	0635
0634	137	90	129	20	94	A V P (U)				
0639	167	106	125	20	100	A V P (U)				
0641	148	95	121	20	100	A V P (U)				

CHIEF COMPLAINT:
GSW to head

0644	153/111	111	20	98%	(U)	

CURRENT MEDICATION
2gm Ancef
Td

CONDITION UPON RELEASE:
_IMPROVED
X UNCHANGED
_DETERIORATED

DISCHARGE INSTRUCTION:

NOTES:

000102

LOG # 2

(b)(6)-4

Trauma Record

For use of this form, see DoD Memeo Subject :Trauma Record, dtd 1 APR 04; the proponent agency is OTSG

AUTHORITY: AR 40-66
PURPOSE: To provide a standard means of documenting all trauma 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: Number BCCF TYPE TF OASIS

CASUALTY NAME: FIRST LAST (b)(6)-4 CASUALTY SSN: (b)(6)-4

Rank Date of Birth Gender ☒ Male ☐ Female Unit

Arrive Date-Time Group (DTG): 15 Aug 04 0610

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

Nation
- ☐ US
- ☐ Host Nation
- ☒ Enemy( )
- ☐ Coalition( )

Service
- ☐ Civilian
- ☒ Combatant
- ☐ Contractor
- ☐ USA
- ☐ USN
- ☐ USMC
- ☐ USAF
- ☐ SOF
- ☐ NGO ( )
- ☐ Other

Wound DTG: 15 Aug 04

WOUNDED BY:
- ☐ US/COALITION(Nation_____)
- ☐ ENEMY ☐ NonENEMY
- ☐ CIVILIAN (Nation_____)
- ☐ TRAINING
- ☐ SELF ACCIDENT
- ☐ SELF NON-ACCIDENT
- ☐ SPORTS-RECREATION
- ☐ OTHER:

PROTECTION:
- ☐ UNK

	Alert Worn	Worn	Struck	Penetrate
HELMET				
FLAK VEST				
CERAMIC PLATE				
EYE PROTECTION				
OTHER:				

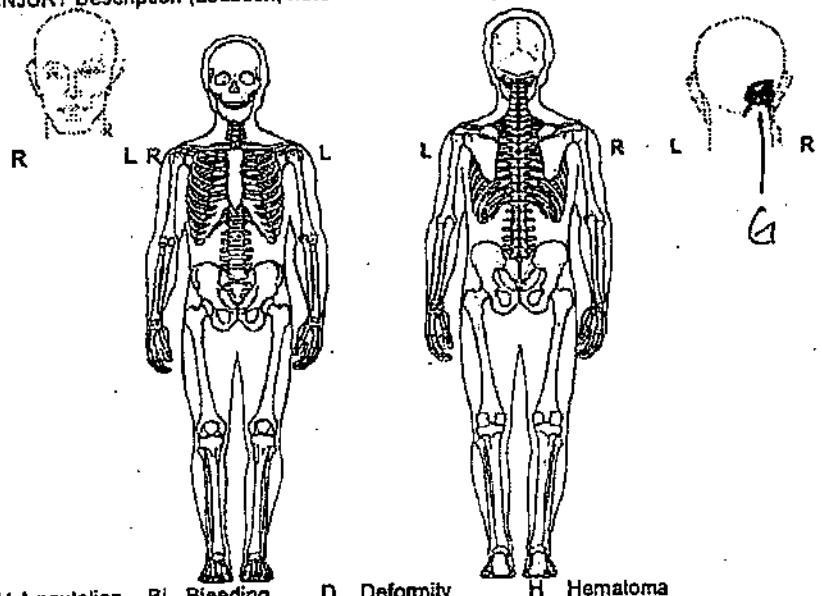
TRIAGE CATEGORY:
- ☒ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

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

MECHANISM OF INJURY:
- ☒ GSW/BULLET
- ☐ BLUNT TRAUMA
- ☐ SINGLE FRAGMENT
- ☐ MULTI FRAGMENT
- ☐ KNIFE / EDGE
- ☐ BLAST
- ☐ CRASH(a/c, veh, per
- ☐ Chem/Rad/Nucl
- ☐ BURN (thermal, flash)
- ☐ CRUSH
- ☐ FALL
- ☐ SMOKE Inhalation
- ☐ HEAT
- ☐ COLD
- ☐ BITE / STING
- ☐ OTHER _____

TIME	0610
Pulse	94
Temp	
B/P	140/108
Resp	
SpO_2	96%

INJURY Description (Location, nature and size in cm)



AM Amputation BL Bleeding D Deformity H Hematoma
AV Avulsion B Burn F Foreign Body L Laceration
P Puncture X Fracture S Stab Wnd G Gunsh Wnd

TX & PROCEDURES	
SEDATED	Sux + Ketam
CHEM PARALYZED	Succ
INTUBATED	7.0
CRIC	
NEEDLE DECOMP	
Chest Tube	L R air/blood
IO line	
COLLOID	ml
CRYSTALLOID	LR NS/HTS 500 ml
TOURNIQUET	Time on / Time off
Collar / C-spine / Back board	
HEMOSTATIC DEVICE	
OXYGEN	10 Liters/min.
RBC	Units
FFP	Units
CRYO	Units
Plts	Packs
Fresh Whole Bld	Units
rFVIIa	mcg/kg

OR Start DTG: Stop DTG:
Vent On DTG Off
ICU in DTG: Out DTG:

000153

NN 7540-01-165-7294 519-1

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Chest		CAT	
	FILM NO.		PREGNANT ☐ YES ☐ NO
	REQU(b)(6)-2		TELEPHONE/PAGE NO
	SIGNATURE OF REQUESTOR		DATE REQUESTED 18 Aug 07

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

S/P GSW HEAD

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)* | LOCATION OF MEDICAL RECORDS

000134

EXHIBIT 30

ABQ AE 003469

Result Form

Patient Name	(b)(6)-4	SSN#	
Ward	EMS	Doctor	(b)(6)-2
Date	8/18/2004	Time	0000

Chemistries test	Results	Normal Ranges
Glucose GLU	134	70-105 mg
BUN	12	M: 9-20 m F: 7-17 mg
Creatinine	1.0	M: 0.8-1.5 F: 0.7-1.2 m
Sodium NA	137	Serum 137-1
Potassium K	2.3	Serum 3.6-5. Plasma 0.1-0.
Chloride Cl	106	98-107 mmol/
ECO2	17	22-30 mmol/L
Amylase AMY		50-130 U/L
Calcium CA+	8.6	8.4-10.2 mg/dL
Magnesium Mg		1.6-2.3 mg/dL
Phosphorus PHOS		2.5-4.5 mg/dL
Total Protein TP		6.3-8.2 mg/dL
Aspartate Aminotransferase AST		M: 17-59 U/L F: 14-36 U/L
Alanine Aminotransferase ALT		M: 21-72 U/L F: 5-52 U/L
Lactate Dehydrogenase LDH		313-618 U/L
Creatine Kinase CK		M: 55-170 F: 30-135
Cholesterol		140-200 mg/dL
CK-MB		Any result 16 u/l or g
Alkaline Phosphatase		38-126 U/L
Gamma Glutamyl Transferase GGT		M: 15-73 U/L F: 12-43 U/L
Total Bilirubin TBIL		0.2-1.3 mg/dL
Conjugated Bilirubin		Adult: 0.0-0.3 mg/dL Neo: 0.0-0.6 mg/dL
Unconjugated Bilirubin		Adult: 0.0-1.1 mg/dL Neo: 0.6-10.5 mg/dL
Albumin ALB		3.5-5.0 g/dL
HIV Rapid		NEG
Troponin-1		NEG
Myoglobin		NEG

+H

i-STAT G3+

Pt: 2306

Pt Name:_____

TCO2_____20 mmol/L

At 37C

pH_____7.441

PCO2_____27.8 mmHg

PO2_____124 mmHg

HCO3_____19 mmol/L

BEecf_____-5 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

18AUG04 07:29

Oper:

Physician:_____

Ser# 42015

Ver: JAM5048D
CLEW A95

PT 7/50 INR ____ PTT 133.7

000135

Admission and Coding Information

For use of this form, see AR 40-400; the proponent agency is OTSG

1. Reporting MTF 1180 - 31st CSH	2. MTF Loc IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race OTH	9. Ethnicity Z	Religion MUSLIM
10. Length of Service	ETS	11. FMP 20	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 07:34	Branch / Corps:
14. Flying Status	15. Beneficiary Category K91-HUMANITARIAN		16. Zip Code of Residence:	
17. Unit Location IZ	18. MOS	19. Trauma BC	Prev. Admission	
20. Source of Admission Direct from ER	Ward: EMT	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 1180 - ;		Telephone Number of Emergency Addressee		
21. Type of Disposition CRO/ER	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2004-08-18		
24. Clinic Svc - Admitting ABO - TRAUMA CENTER	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2004-08-18		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Diagnosis Narrative: TRAUMATIC BRAIN INJURY

Procedure Narrative(s):

Cause of Injury Narrative: GSW TO HEAD

Admitting Officer (Signature, as required) (b)(6)-2

Signature of Admitting Clerk (b)(6)-2

000136

EXHIBIT 30

VC16-04-C10259

0139-04-C10785-83355

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			(b)(6)-4

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

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

Unknown

Unknown

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
Unknown	
STREET ADDRESS Domicilé à (Rue)	**CITY OF 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		Traumatic Brain Injury	
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	GSW Head	
	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
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à 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

NAME OF MEDICAL OFFICER Nom du médecin sanitaire	TITLE OR DEGREE Titre ou diplômé
(b)(6)-2	DO
GRADE Grade MAJ	**INSTALLATION OR ADDRESS** Installation ou adresse (b)(3)-1
DATE Date 18 AUG 04	(b)(6)-2

[1] *State disease, injury or complication which caused death, not mode of dying, such as 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 ayant provoqué la mort, mais non le mode de décès, 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.*

FOR OFFICIAL USE ONLY

000158

DD FORM 2064, APR 1977 REPLACES DA FORM 3565-R, APR 74, WHICH IS OBSOLETE. USAPA V1.00

LAW ENFORCEMENT SENSITIVE

MEDCOM - 1042

Exh 32

0139-04-C10789-93995

HOSPITAL REPORT OF DEATH

FOR 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:

Prepare, 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 identifying data if available)*

(b)(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 0900 18 AUG 2004

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

4. RELIGION: MUSLIM

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)*: Traumatic Brain Injury	
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): GSW Head	
	(2):	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE: 18 AUG 204

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

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

USAPPC V2.00

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

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

MEDCOM - 1043

000189

Ex 82

PRISONER IN-PROCESSING MEDICAL SCREEN

NAME: (b)(6)-4 COMPOUND: ISN: (b)(6)-4
DATE: MAY 9, 04 DOB: 1962 AGE: 42
HISTORY BY TRANSLATOR: YES NO
NAME OF TRANSLATOR: (b)(6)-2

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW? Ø

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

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): Ø

4) MEDICATIONS: Ø

5) ARE YOU ABLE TO WALK UNASSISTED? (YES) NO
6) ARE YOU ABLE TO FEED YOURSELF? (YES) NO
7) ALLERGIES? Ø

8) PULSE: 66 BLOOD PRESSURE: 110/70 RESPIRATORY RATE: 10

WEIGHT: 154 HEIGHT: 5'6"

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:

ASSESMENT:

RECCOMENDATIONS:

SIGNATURE:

[illegible]

Theater Trauma Registry Record

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

rvations/Notes (Holding, En route, etc)

ME	BP		PULSE	RESP	SpO_2	MENTAL Status	DRUG	DOSE	ROUTE	DTG
						A V P U	See 1079-R			DTG:
G:						A V P U				
						A V P U				
						A V P U				
						A V P U				
						A V P U				

TES:

ICATIONS:	LABS:	XRAYS:	PMH:
1079-R	N/A	N/A	unknown Allergies: unknown

scharge Summary Information (Diagnosis, Procedures and Complications)

ad and Neck:

est: Code 41 y/o c̄ CPR ~ progress

pulseless apneic

domen: flatline cardiac shock x3

intubation and IV access obtained

per: see code sheet

lvis: A: sudden cardiac death

wer: (b)(6)-2

in:

ause of Death at Cardiorespiratory arrest

NATOMIC:

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

HYSIOLOGIC:

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

000010

Theater Trauma Registry Record

For use of this form, see AR 40-66; 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: BCCF Iraq

(b)(6)-4 | CASUALTY SSN: (b)(6)-4 | Unit: Garci 4

Rank: N/A | 1962 | Gender: Male ☐ Female

Arrive DTG: 0224 14Jun04

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 detainee

Wound DTG: N/A

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

N/A

PROTECTION: N/A

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

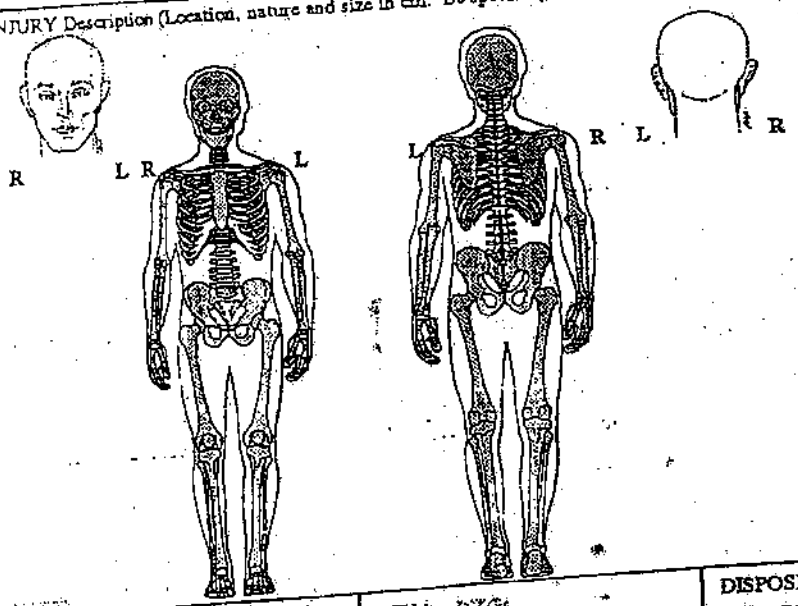
TRIAGE CATEGORY:
- ☒ IMMEDIATE
- ☐ DELAYED
- ☐ MINIMAL
- ☐ EXPECTANT

GLASGOW COMA SCALE (circle one)

3	8	12	15
UNC	STUPOR	LETHARGY	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 cardiac arrest

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



VITALS: CPR

TIME	0225		
Pulse	0		
Temp	—		
B/P	0		
Resp	0		
SpO_2	0		

TX & PROCEDURES:

SEDATED/ IMMOB	Y/N
INTUBATED	Y/N 0230
CRIC	Y/N
NEEDLE DECOMP	Y/N
Chest Tube	L R air/blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	Y/N specify:
OXYGEN	15L Liters/min
RBC	Units
FFP	Units
CRYO	Packs
Plts	ml
HBOC	Units
Fresh Whole Bld	Units

R Start 0225 Stop 0238 | Vent On DTG: Off DTG: | ICU in DTG: Out DTG:

PROVID(b)(6)-2 | SPECIALTY: | DATE:

EDCO

DISPOSITION:
- ☐ RTD
- ☒ DECEASED DTG: 0238 14Jun04

EVACUATED to ____
- ☐ URGENT
- ☐ URGENT SURGICAL
- ☐ ROUTINE
- ☐ MINIMAL

EXHIBIT 3

000011

EMERGENCY RESUSCITATION RECORD - PAGE 2

	TIME (Hr/Min):												
VITALS	BLOOD PRESSURE	0											
	HEART RATE (* = CPR)	0											
	RHYTHM	Flat line											
	PULSE PALPABLE (Y/N)	N											
	DEFIBRILLATION (Joules: 200, 300, 360)	0227 200J	0228 300J	0228 360J	0238 360J								
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	—											
	PACING PERFORMED (√)	—											
	RESPIRATIONS	0											
AIRWAY	BAGGED w / 100% O2 (√)	0226											
	INTUBATED (√)	0230											
	MASK (Specify type)	Simple											
	% OXYGEN	100% 15L											
	O2 SATS	N/A											
MEDICATIONS	EPINEPHRINE (1 mg - IV / ET tube)	0231 1V-1mg	0235 IV	0238 IV									
	ATROPINE (0.5 -1 mg - IV / ET tube)	0234 IV-1mg	0237 IV-1mg										
	LIDOCAINE (1-1.5 mg / kg - IV / ET tube)	—											
	Bicarb	0236 IV-50mg											
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 (b)(6)-2 & Title

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

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

EXHIBIT 3

000612

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: 14 June 2004

2. LOCATION OF RESUSCITATION EVENT
☐ MICU ☐ SICU ☐ CCU ☐ NICU ☒ ED ☐ PACU ☐ OR ☐ WARD: _____
☐ DIAGNOSTIC / PROCEDURE AREA: _____
☐ OUTPATIENT CLINIC: _____
☐ OTHER (Specify): _____

3. WITNESSED ARREST?
☐ YES ☐ NO ☒ UNKNOWN

MONITORED AT ONSET?
☐ YES ☒ NO

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

		Time	COMMENTS
☑ IV Access	☑	02:30	
☑ Endotracheal Tube	☑	02:30	7.5
☐ Mechanical Ventilation	☐	:	
☐ Arterial Line	☐	:	
☐ Central Venous Line	☐	:	
☐ Pulmonary Artery Catheter	☐	:	
☐ Nasogastric Tube	☐	:	
☐ Pacing Device (Specify type): _____	☐	:	
☐ Implantable Defibrillator / Cardioverter	☐	:	
☐ Other (Specify): _____	☐	:	

5. IMMEDIATE CAUSE OF ARREST / EVENT (Check one)
☐ Lethal Arrhythmias
☐ Hypotension
☐ Respiratory Depression
☐ Metabolic
☐ Myocardial Infarction or Ischemia
☐ Unknown
☒ Other: Cardiorespiratory arrest

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: _____

8. INITIAL RHYTHM
☐ Ventricular Fibrillation ☐ Perfusing Rhythm
☐ Ventricular Tachycardia ☐ Bradycardia
☐ Pulseless Electrical Activity ☑ Asystole

RETURN OF SPONTANEOUS CIRCULATION (ROSC)
☑ Never achieved
☐ Returned at: ____ : ____
☐ Unsustained ROSC: ☐ < 20 min ☐ > 20 min

CPR STOPPED AT: 02:38

WHY: ☐ ROSC ☐ DNAR
☐ Considered futile ☑ Death

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:	unknown	≈0210
CPR Started:	≈02:	10
1st Defibrillation:	02:	27
Airway Achieved:	02:	30
1st Dose Epinephrine:	02:	31
Code Team Called: ☑ Yes ☐ No Time:	02:	20
Code Team Arrived: ☑ Yes ☐ No Time:	02:	22

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: 3

PATIENT DISPOSITION:
deceased

PATIENT IDENTIFICATION
P.(b)(6)-4
Ganci 4

AGE: 42
GENDER: male
HEIGHT (in): unk
WEIGHT (lbs): unk

MC V2.00

MEDCOM FORM 679-R (TEST) (MCHO) AUG 99 PREVIOUS EDITIONS ARE OBSOLETE

000613

CERTIFICATE OF DEATH
For use of this form, see AR 190-8; the proponent agency is DCSPER.

INTERNMENT SERIAL NUMBER

FROM:

TO:

[b)(6)-4]
Bana 4

NAME [b)(6)-4] | GRADE | SERVICE NUMBER

NAT /INTERNMENT AND DATE

-F2/1

PLACE OF BIRTH | DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN | FIRST NAME OF FATHER

PLACE OF DEATH | DATE OF DEATH | CAUSE OF DEATH
[illegible] Hospital | 6/12/04 PT DIED | Sudden Cardiac Death

PLACE OF BURIAL | DATE OF BURIAL

IDENTIFICATION OF GRAVE

PERSONAL EFFECTS *(To be filled in by Office of Deputy Chief of Staff for Personnel)*

___ RETAINED BY DETAINING POWER ___ FORWARDED WITH DEATH CERTIFICATE TO *(Specify)* ___ FORWARDED SEPARATELY TO *(Specify)*

BRIEF DETAILS OF DEATH/BURIAL BY PERSON WHO CARED FOR THE DECEASED DURING ILLNESS OR DURING LAST MOMENTS *(Doctor, Nurse, Minister of Religion, Fellow Internee).* IF CREMATED, GIVE REASON. *(If more space is required, continue on reverse side).*

[illegible] See SF600.

[b)(6)-2] MD
OFFICER

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE

SIGNATURE OF COMMANDING OFFICER

WITNESSES

SIGNATU [b)(6)-2] ADDRESS
1LT [illegible]

SIGNATURE ADDRESS

DA FORM 2669-R, May 82 EDITION OF 1 JUL 63 IS OBSOLETE.

NSN 7540-00-634-4176

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
	Code note 41 yo Male
6/14/04	0224 Detainee presented ER via ambulance
	and 3714 MP Medics pt was found down
	for at least 5 min and chest compressions
	and no rescue breathing begun done by fellow detainee
	MP's initiated CPR and brought to ER with an
	15 additional minutes pt arrived at ER agonal
	pulseless
	Quick look paddles showed fib line pt given
	3 sequential shocks from 200 - 360 J
	continued CPR and IV established and intubated
	on second try with 7.5 ET tube
	Pt given a total of 3 amp atropine 1 [illegible]
	and total of 4 DC counter shocks never reestablished
	a rhythm [illegible] fixed dilated pupils
	and no response after TOD 0238.
	Cause of death sudden cardiac death
	(b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

(b)(6)-4

Jane 4

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

EXHIBIT 3

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL: CBCSH - Abu Ghraib

Instructions - Medical Officer in attendance will:

Prepare, 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 identifying data if available)*

(b)(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 0239 14 06 04

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: N/A

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)*: Sudden Cardiac Death	30 Min
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying conditions)*	DUE TO *(or as a consequence of)* (1): Unknown	
	(2):	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b.	

9. DATE: 6/14/04

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

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

SECTION B - ADMINISTRATIVE ACT

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

USAPA V2.01

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

EXHIBIT 3

000616

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 REPORT

Name: (b)(6)-4
National Detainee Reporting System: (b)(6)-4
Date of Birth: 1 January 1962
Date of Death: 14 June 2004
Date of Autopsy: 19 June 2004
Date of Report: 13 October 2004

Autopsy No.: ME04-434
AFIP No.: 2931951
Rank: Iraqi civilian
Place of Death: Abu Ghraib, Iraq
Place of Autopsy: Baghdad, Iraq

Circumstances of Death: This 42 year-old male Iraqi civilian was in US custody at the Baghdad Central Confinement Facility in Abu Ghruyeb, Iraq. By report, he began making gasping sounds, which awoke another detainee. The decedent was found to be unresponsive and pulseless, and resuscitation efforts were unsuccessful.

Authorization for Autopsy: The Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Visual and documentation accompanying the body; fingerprints and DNA sample obtained

CAUSE OF DEATH: Undetermined

MANNER OF DEATH: Undetermined

b)(6)-4

FINAL AUTOPSY DIAGNOSES:

I. No evidence of any definitive significant trauma
   a. Minor contusions of abdomen and left arm

II. Cardiovascular Findings (AFIP Cardiovascular Pathology consultation)
   a. Mild coronary atherosclerosis
      i. 40% luminal narrowing of proximal left anterior descending coronary artery
      ii. 20% luminal narrowing of proximal left circumflex coronary artery
      iii. 30% luminal narrowing of proximal right coronary artery by intimal thickening
   b. Moderate dysplasia of atrioventricular nodal artery
      i. No increased fibrosis of septum

III. Additional Findings; probable artifacts of resuscitation or freezing of body
   a. Film of peritoneal blood of upper abdomen, < 50 ml
   b. Hepatic findings
      i. Subcapsular accumulation of blood over right lobe of liver; capsule grossly intact
      ii. Parenchymal clefts and focal disruption of right lobe of liver
         1. Histologically, no inflammatory response, fibrin or clot formation, or other evidence of any vital reaction

IV. Medical Intervention
   a. Endotracheal tube in place
   b. Intravenous catheter in left antecubital fossa
   c. One adhesive EKG tab on abdomen

V. Early to moderate decomposition
   a. Marbling of torso, arms and legs
   b. Marked facial and scalp congestion and dark discoloration
   c. Corneal opacification

VI. Toxicology (AFIP)
   a. Volatiles: Heart blood and urine negative for ethanol
   b. Cyanide: Heart blood negative
   c. Drugs: Heart blood negative for screened medications and drugs of abuse

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EXTERNAL EXAMINATION

The body is that of a well developed, well-nourished male clad in a pair of yellow "Reebok" shorts, a pair of grey drawstring pants, and a previously cut, white t-shirt. The body weighs approximately 150 pounds, is 67" in height and appears compatible with the reported age of 42 years. The body is cold, the temperature that of the refrigeration unit. Rigor is waning. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure, and over the face and head.

Early to moderate decompositonal changes are present, consisting of diffuse marbling of the back, upper arms and legs; early marbling of the sides of the abdomen; partial corneal opacification; and dark discoloration and congestion of the face, scalp and neck.

The scalp is covered with black hair with frontal and parietal alopecia but otherwise in a normal distribution, averaging 3 cm in length. Facial hair consists of a dark mustache and full beard. The irides appear dark, but are partially obscured by corneal clouding. The sclerae and conjunctivae are congested, especially of the left eye, but there are no petechiae. The earlobes are not pierced. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton is palpably intact. The lips are without evident injury. The teeth are natural and in good condition.

Examination of the neck reveals the trachea to be midline and mobile. The chest is symmetric and well developed. No injury of the ribs or sternum is evident externally. The abdomen is slightly protuberant and soft. There is a 2 x 1 cm dark macule on the mid right side of the back.

The extremities are well developed with normal range of motion. There is a 2 x 1 cm hyperpigmented patch on the back of the right wrist. There are thick calluses on lateral aspect of the right ankle and on the soles of the feet, which are also dirt stained. The fingernails are short and intact. No tattoos are noted. The external genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. Pubic hair is partially shaved but present in a normal distribution. The buttocks and anus are unremarkable.

There is an identification band with the name and photograph of the decedent around the left wrist, and there is an identification tag with the name of the decedent and date of death on the first toe of the left foot. There are creases around the lateral aspects of the ankles consistent with postmortem securing of the body.

EVIDENCE OF THERAPY

There is an endotracheal tube in place secured with white tape around the head, and there is an adhesive EKG tab on the lower right side of the abdomen. There is a needle puncture mark with surrounding ecchymosis in the right antecubital fossa, and there is an intravenous catheter secured with white tape in the left antecubital fossa.

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EVIDENCE OF INJURY

There is a 2 x 0.3 cm red contusion just above the umbilicus, and there is a 3.5 x 2.5 cm red contusion of the lower right aspect of the abdomen. On the anterior (palmar) aspect of the left lower forearm and wrist, there is a 4 x 3 cm red brown contusion, and there is a 3 x 2 cm contusion of the left thenar region.

On external examination of the body, there is no other evidence of trauma.

INTERNAL EXAMINATION

BODY CAVITIES:
The body is opened by the usual thoraco-abdominal incision, and the chest plate is removed. No adhesions or abnormal collections of fluid are present in the pleural or pericardial cavities. There is a film of blood in the upper peritoneal cavity, less than 50 ml. No adhesions or abnormal collections of fluid are present in the peritoneal cavity. All body organs are present in the normal anatomical position. The subcutaneous fat layer of the abdominal wall is 2 cm thick. There is no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

HEAD: (CENTRAL NERVOUS SYSTEM)
The scalp is reflected, and there is marked subgaleal congestion and fixed lividity, but no subgaleal hemorrhage or skull fractures found. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. There is no epidural or subdural hemorrhage present. The leptomeninges are thin and delicate. The cerebrospinal fluid is dark with decompositional change, most prominent over the occiput; however, there is no evidence of any subarachnoid hemorrhage. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact. Coronal sections through the cerebral hemispheres revealed no lesions, and there is no evidence of infection, tumor, or trauma. Transverse sections through the brain stem and cerebellum are unremarkable. The dura is stripped from the basilar skull, and no fractures are found. The atlanto-occipital joint is stable. The brain weighs 1455 grams.

NECK:
Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, reveals no abnormalities. The anterior strap muscles of the neck are homogeneous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact white mucosa and is unobstructed. The thyroid gland is symmetric and red-brown, without cystic or nodular change. There is no evidence of infection, tumor, or trauma, and the airway is patent. Incision and dissection of the posterior neck demonstrates no deep paracervical muscular injury, hemorrhage, or fractures of the dorsal spinous processes.

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(b)(6)-4

CARDIOVASCULAR SYSTEM:
See "Cardiovascular Pathology Report" below. The pericardial surfaces are smooth, glistening and unremarkable; the pericardial sac is free of significant fluid and adhesions. A moderate amount of epicardial fat is present. The coronary arteries arise normally in a right dominant pattern and follow the usual distribution. There is mild atherosclerosis with focal areas of luminal stenosis of the coronary arteries, without evidence of thrombosis. The myocardium is dark red-brown, firm and unremarkable; the atrial and ventricular septa are intact. The left ventricle is 1.5 cm in thickness and the right ventricle is 0.4 cm in thickness. The aorta and its major branches arise normally, follow the usual course and are widely patent, free of significant atherosclerosis and other abnormality. The venae cavae and their major tributaries return to the heart in the usual distribution and are free of thrombi. The heart weighs 435 grams.

RESPIRATORY SYSTEM:
The upper airway is clear of debris and foreign material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma is red-purple and edematous, exuding a moderate amount of bloody fluid; no focal lesions are noted. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 605 grams; the left 480 grams.

LIVER & BILIARY SYSTEM:
The hepatic capsule is smooth, glistening and intact, covering dark red-brown, moderately congested parenchyma. There is focal accumulation of subcapsular blood and underlying parenchymal disruption, with clefts and splitting of the parenchyma without associated hemorrhage, consistent with resuscitation or postmortem changes. The gallbladder contains 5 ml of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The liver weighs 1940 grams.

ALIMENTARY TRACT:
The tongue exhibits no evidence of recent injury. The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains a film of dark fluid. The small and large bowel are unremarkable. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear. The appendix is present and is unremarkable.

GENITOURINARY SYSTEM:
The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. There is a single dark calculus in the right renal pelvis. The calyces, pelves and ureters are otherwise unremarkable. White bladder mucosa overlies an intact bladder wall. The urinary bladder contains 20 ml of cloudy, yellow urine. The prostate gland is symmetrical with lobular, yellow-tan parenchyma and no nodules or masses. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities. The right kidney weighs 210 grams; the left 220 grams.

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RETICULOENDOTHELIAL SYSTEM:
The spleen has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The spleen weighs 260 grams.

ENDOCRINE SYSTEM:
The pituitary, thyroid and adrenal glands are unremarkable.

MUSCULOSKELETAL SYSTEM:
Muscle development is normal. No bone or joint abnormalities are noted.

MICROSCOPIC EXAMINATION

HEART: See "Cardiovascular Pathology Report" below.

BRAIN: See "Neuropathology Report" below.

LUNGS: The alveolar spaces and small air passages are expanded and contain no significant inflammatory component or edema fluid. The alveolar walls are thin and mildly congested. The arterial and venous vascular systems are normal. The peribronchial lymphatics are unremarkable.

LIVER: There are numerous clefts and splits of the parenchyma, focally with lakes of red blood cells. However, there is no inflammatory response or evidence of organization of the hemorrhage, with no fibrin or clot formation. The hepatic architecture is otherwise intact. The portal areas show no increased inflammatory component or fibrous tissue. The hepatic parenchymal cells are well-preserved with mild focal steatosis but no evidence of cholestasis, or sinusoidal abnormalities.

SPLEEN: The capsule and white pulp are unremarkable. There is moderate congestion of the red pulp.

ADRENALS: The cortical zones are distinctive and well supplied with lipoid. The medullae are not remarkable.

KIDNEYS: The subcapsular zones are unremarkable. The glomeruli are mildly congested without cellular proliferation, mesangial prominence, or sclerosis. The tubules are well preserved. There is no interstitial fibrosis or significant inflammation. There is no thickening of the walls of the arterioles or small arterial channels. The transitional epithelium of the collecting system is normal.

TESTES: Unremarkable

THYROID GLAND: Unremarkable

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AUTOPSY REPORT ME04-434 7

(b)(6)-4

CARDIOVASCULAR PATHOLOGY REPORT

Department of Cardiovascular Pathology, AFIP:

"**AFIP DIAGNOSIS: ME04-434**

1. **Moderate dysplasia of atrioventricular nodal artery**
2. **Mild coronary artery atherosclerosis**

History: 42 year old male Iraqi detainee, 67", 150 lbs, death in custody
Heart: 435 grams (predicted normal value 322 grams, upper limit 425 grams for a 150 lbs male); normal epicardial fat; closed foramen ovale; left ventricular hypertrophy: left ventricular cavity diameter 35 mm, left ventricular free wall thickness 15 mm, ventricular septum thickness 15 mm; right ventricle thickness 4 mm, without gross scars or abnormal fat infiltrates; grossly unremarkable valves and endocardium; enlarged membranous septum; no gross myocardial fibrosis or necrosis; histologic sections show mild left ventricular myocyte hypertrophy, otherwise unremarkable
Coronary arteries: Normal ostia; right dominance; mild atherosclerosis: 40% luminal narrowing of proximal left anterior descending, 20% narrowing of proximal left circumflex, and 30% narrowing of proximal right coronary artery by pathologic intimal thickening
Conduction System: The sinoatrial node is unremarkable. The sinus nodal artery shows minimally increased proteoglycan. The atrioventricular (AV) nodal artery shows moderate dysplasia in its posterior approaches to the compact AV node and in its penetrating branches in the ventricular septum, but fibrosis is not significantly increased in the septum. The penetrating bundle is centrally located between the node and ventricular septum. The right proximal bundle branch is unremarkable. The left proximal bundle is not seen in these sections.
Comment: We do not see an obvious cardiac cause of death. Moderate dysplasia of the atrioventricular nodal artery is often associated with increased fibrosis in the crest of the ventricular septum, representing a potential substrate for cardiac arrhythmia. However, increased fibrosis is not seen in this case. We cannot exclude the possibility of cardiac arrhythmia related to various ion channelopathies or coronary vasospasm."

NEUROPATHOLOGY REPORT

Department of Neuropathology and Ophthalmic Pathology, AFIP:

"We reviewed multiple small fragments of dura, cerebrum, brainstem and cerebellum submitted in formalin in reference to this case. No gross abnormalities are present. Representative sections were processed in paraffin and sections stained with H&E, and immunohistochemical methods for beta amyloid precursor protein (BAPP), and glial fibrillary acidic protein (GFAP). This material was reviewed in conference by the staff of Neuropathology. Sections show few neurons within the cerebral cortex with shrunken or vacuolated cytoplasm and hyperchromatic nuclei, findings interpreted as non-specific acute neuronal injury. Stains for BAPP and GFAP are negative."

000032

AUTOPSY REPORT ME04-434

(b)(6)-4

ADDITIONAL PROCEDURES

- Documentary photographs are taken by OAFME photographers
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous fluid, heart blood, urine, and bile
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representative

OPINION

Based on available investigation and complete autopsy examination, no definitive cause of death for this 42 year-old male Iraqi civilian in US custody in Iraq could be determined. There is no evidence of any significant trauma to explain the death. There is a film of blood in the upper abdomen, and a small accumulation of subcapsular blood over the right lobe of the liver with associated subcapsular parenchymal disruption. However, the minimal amount of hemorrhage, lack of capsular laceration, and microscopic lack of vital reaction indicates this is likely a post-mortem artifact, either from resuscitation efforts or freezing of the body. There are non-specific cardiac findings, including moderate dysplasia of the atrioventricular nodal artery. However, there is no associated increased septal fibrosis, which can be a potential substrate for cardiac arrhythmia. There is also mild coronary artery atherosclerosis, but no luminal narrowing greater than 40% was found. A cardiac arrhythmia related to various ion channelopathies or coronary vasospasm cannot be excluded.

Therefore, the cause of death is best classified as undetermined, and the manner of death is undetermined.

(b)(6)-2

(b)(6)-2, MD
LtCol, USAF, MC, FS
First Chief Deputy Medical Examiner

000033

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	Sequence
2931951	01

Name (b)(6)-4

SSAN: **Autopsy:** ME04-434
Toxicology Accession #: 043002
Date Report Generated: June 30, 2004

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: **Date Received:** 6/22/2004

VOLATILES: The **HEART BLOOD AND URINE** 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 heart 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

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EXHIBIT 8

Various Documents

From Detainee Medical Records

(b)(3)-1

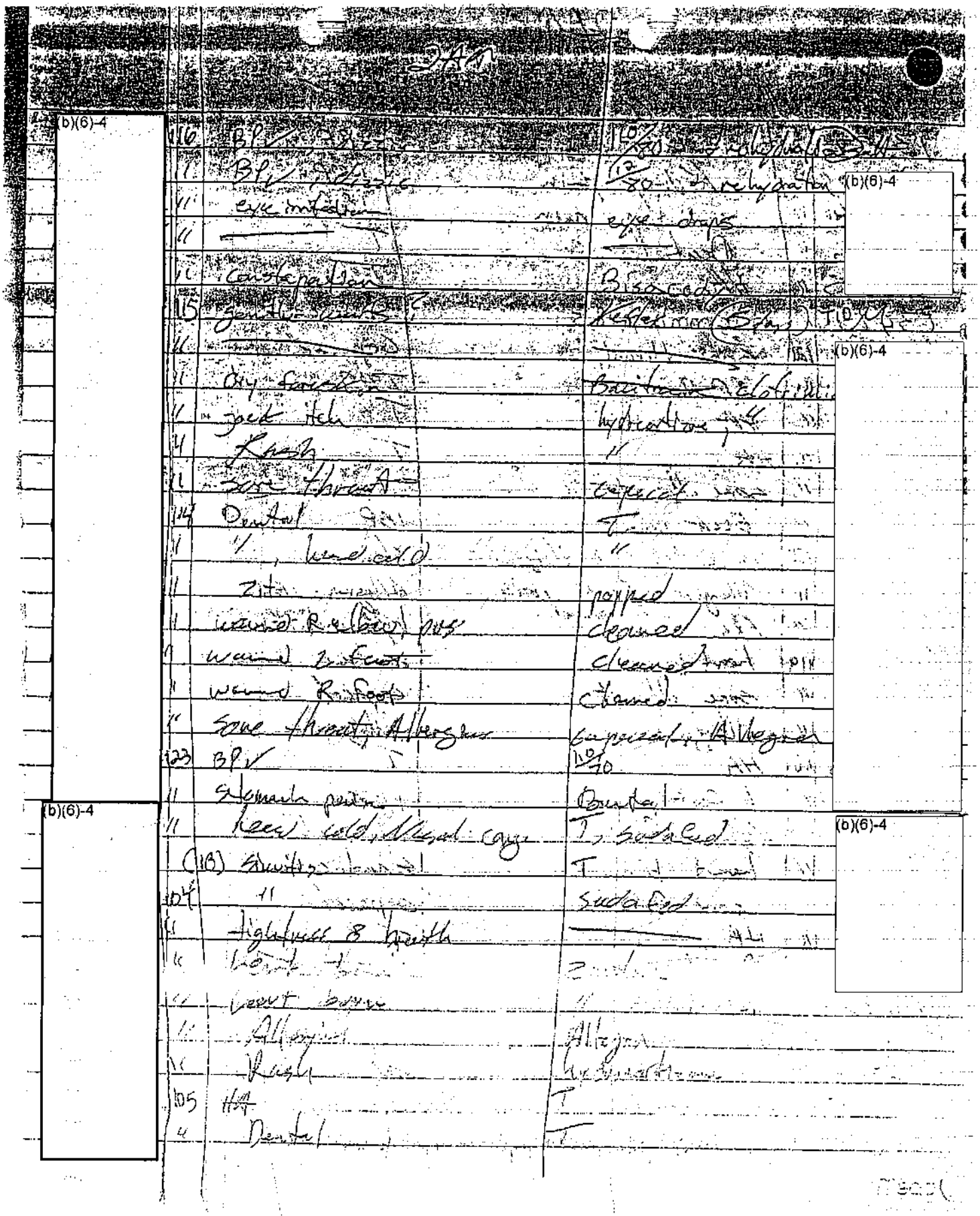
Medical Section

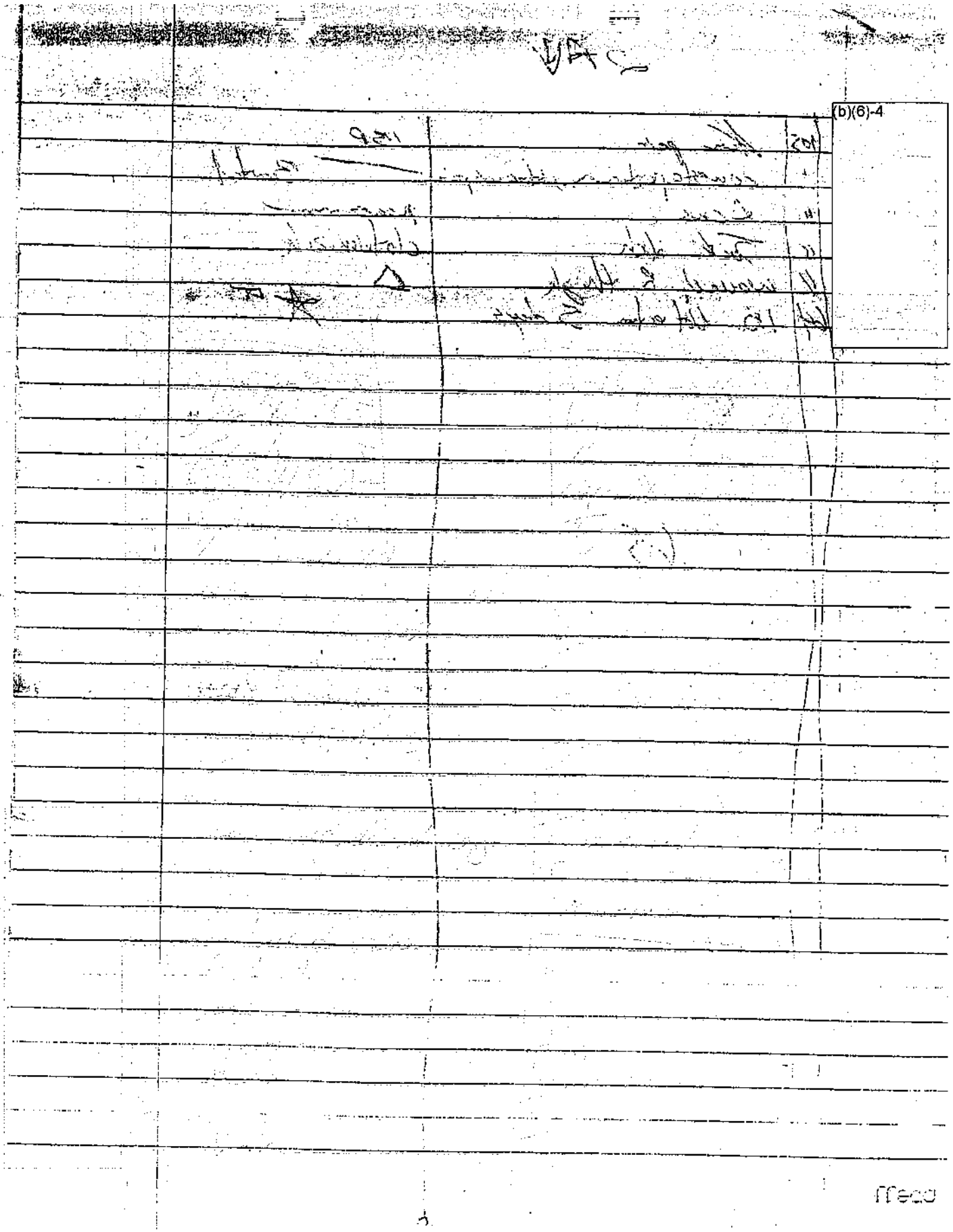
Abu Ghraib

TAG#	COM	C/Complaint	Tx
(b)(6)-4	D ★	Ⓡ foot infection	Motrin
	D	kidney pain	Motrin
	D ★	(?) Copitil/Aspirin (-> BP	146/92/Aspirin
	D ★	Chest pain/Percocet/Aspirin BP	110/82
	D	Arthritis	IBU
	D	~~Heartburn/HTA~~	Aspirin
	D	Rash	
	D	Flu/Sore throat	Allegra/Cepacol
	D	Hemmhroids	Dibucaine
	D	Sore throat	Cepacol
	D	Flu/sore throat	Tylenol/Cepacol
	D	Nasal congestion	Antihistimine
	D (A)	Joint pain/constipation	IBU/
	D	Ⓡ skin abrasion	IBU
	D	Neck pain	IBU
	D	Neck pain	IBU
	D (Med)	swollen Ⓛ knee//	ACE/IBU
(b)(6)-4	D	HA/	IBU/H2OT
	(★)	Stomach	Tagament
	D ★	Cyst on head	Doc AM sickcall
	D	Ⓛ ankle lac.	Clean/Dress
	(★)	Stomach/Skin Allergy	Tagament/H2OT
	D (★)	Ulcer/Flu.	Tagament/Tylenol
	D ★	~~Bronchitis~~ Asthma	~~Tylenol~~ Mac Inhaler
	D	Cardiac BP	124/84
	D	LBP	
	D (★)	Ulcer	Tagament
	D	Tooth pain	Tylenol
	D (★)	Di...	Loperamide

TAG#	Comp	CC	Tx
(b)(6)-4	D	Diarrhea	Loperamide
	D	Cardiac pain/BP (Atenolol/ASA Anderol)	116/84/ Later ASA/Cepacol
	D	Pulled muscle	IBU
	D	Back pain	IBU
	D	Cardiac/Flu	140/90/Cepacol
	D	Hyprochondriac	
	D	Joint pain	Motrin

	CC	TX
(b)(6)-4		
12	↑ IBP	IBP
"	Kidney pain	IBP
"	radiating pain	IBP
"	Dental	T
"	HA	T
"	Hemmhoroids	Dibucaine
121	Sore throat	Cepacol
"	IBP	IBP
"	HA	T
"	HA	T
"	sore throat	
"	Back pain	IBP
120	Wound back & thigh	cleaned
"	Allergies, Back pain	Allegra, IBP
"	Exam	hydrocortizone
119	heart burn	zantac
"	sore throat	cepacol
"	Allergies	Allegra
118	HA	T
"	L foot pain	IBP
(b)(6)-4		
117	~~Extreme~~ Rash	hydrocortizone
"	heart burn	Zantac
"	sore throat	cepacol
"	HA	T
"	Dental	T
"	Allergies	Allegra
"	UTI	cipro (5 days)
116	L rib pain	IBP
"	Sore throat	cepacol
"	L breast pain, muscle spasm	Flexeril




(b)(6)-4

DSN	Cell	CC	tx
(b)(6)-4	113	Dental	tylenol
	"	Headache	tylenol
	"	Heartburn	zantac
	"	Rash underarms	Hydrocortisone
	"	sinus	tyl
	112	indigestion/diarrhea/nausea	loperamide
	"	sinus	tyl
	"	dizzy	tyl ↑H2O
	111	sore throat	Tyl
	"	indigestion	zan
	"	hemorhoids	dibucaine
	110	Low back pain	Ibu
	"	Flu	Tyl
	"	constipation	bisacodyl
	"	kidney pain	naproxen
(b)(6)-4	"	dental	Tyl
	"	Flu	Tyl
	109	Dizzy/nausea	Ibu
	"	HA	Tyl
		joint pn	Tyl
	"	HA	Tyl
	"	Back pn	Ibu
	108	exzema	
	107	sinus	Tyl
	"	rhoids/indigestion	dibucaine/zantac
	106		Ibu

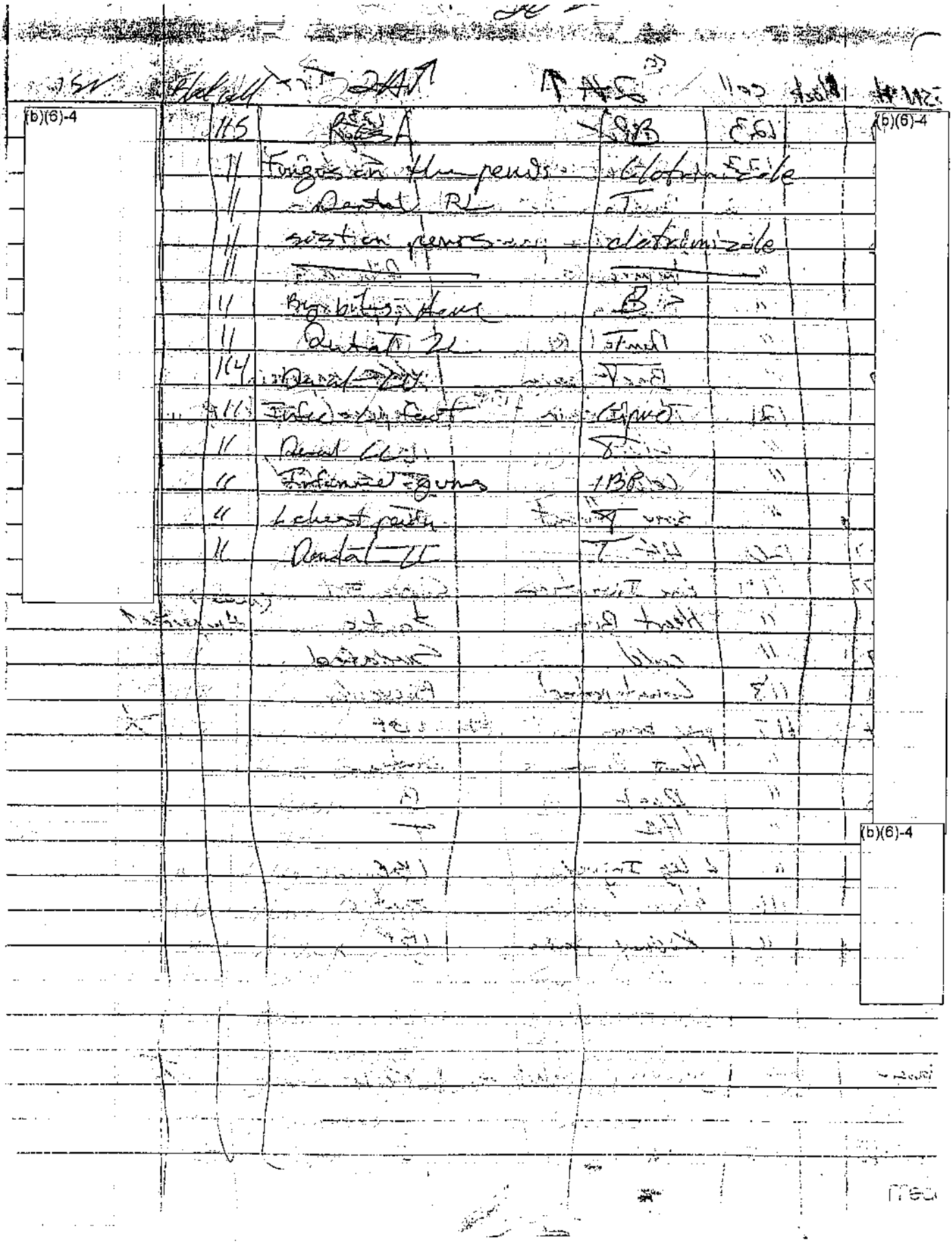
ISN	Cell	CC	Tx
(b)(6)-4	106	☆ cast @ leg 3 mos	Ibu / refer
	"	Ear infection	ear drops
	"	☆ nerves / shakes	refer
	"	sinus	tyl
	"	sinus	"
	105	Dental	"
	"	"	"
	"	"	"
	"	allergies	benadryl
	"	sinus	sudafed
	"	Ⓡ lat pain	cyclobenzaprine
	104	indigestion	zantac
	"	"	"
	"	Flu	sudafed
	"	Flu	"
(b)(6)-4	"	indig.	zantac
	"	kidney pain	Ibu
	123	H/A	tyl
	"	Flu / BP 130/82	sudafed
		flu	tylenol
	"	Flu "	
	122	leg pain	~~Motrin~~ IBU
	"	low back pn.	IBU
	"	joint pain	IBU
	"	Dental	Tyl

SN	Cell	CC	TX
(b)(6)-4	121	Sore throat	tyl
	"	muscle pain	IBU
	"	bk pn	IBU / hydro
	"	Dental	Tyl
	"	Jnt pn	Ibu
	"	HA	Tyl
	"	HA	Tyl
	120"	knuckle pn	Ibu
	"	exzema	hydrocort
	"	"	"
	"	flu	sudafed
	119	nose bleeds	hydrocort
	"	congestion/sore	suda
	"	Allergies	—
	118	back pn.	Naproxen
	"	stomach pn.	Zantac
(b)(6)-4	"	back pn.	Ibu
	117	Indiges	zantac
	"	jnt pn.	Tyl
	"	chest pain	Tyl
	"	heart burn	zan
	"	eye pn	tyl
	"	conjunctivitis	erythromycin
	"	HA	Tyl
	116	bk pn	Ibu

DN	Cell	CC	Tx
(b)(6)-4	116	sore throat	Tyl
	"	eye pn.	eye drops
	"	H/A	Tyl
	" ☆	skin discoloration	refer
	"	[redacted]roids	dibucaine
	"	boil bk	drained
	115	rash	hydrocort
	"	Genital Warts	—
	"	sore throat	Tyl
	"	bug bites	hydrocort
	"	Dental	Tyl
	"	Acne	+
	"	sore throat	Tyl

(19)

ISN #	Block cell	2A	TX / Trx	
(b)(6)-4 [redacted]	123	[illegible]	123/74	(b)(6)-4 [redacted]
	123	Sinuses	Sudafed	
	122	Back pain, Siatica	naproxin	
	"	Both knee pain	IBP	
	"	hemroids	Dibucain	
	"	Siatica	naproxen	
	"	Dental, Rt	T	
	"	Back pain	~~IBP~~ naproxin	
	121	Throat pain LBP	Cepacol ~~T~~ IBP	
	"	LBP	IBP	
	"	cold	~~T~~ Sudafed	
	"	sore throat	T	
	120	HA	T	
	119	Ear Infection	Cipro #1	
	"	Heart Burn	Zantac	(lines) Amperoxe
	"	cold	Sudafed	
	118	Constipated	Bicycola	
	117	prev. broken Jaw diff. eating	IBP	☆
	"	Heart Burn	Zantac	
	"	Rash	B	
(b)(6)-4 [redacted]	"	HA	T	
	"	L Leg Injury	IBP	
	116	Stomach pain	Zantac	
	"	Kidney pain	IBP	
	"	cold	Sudafed	
	"	Rash	Hydrocortizone	
	"	Sore throat	T, Cepacol	
	"	growth on shoulder	Kenlax	☆
	"	Sinuses	Sudafed	
	115	Rash	B	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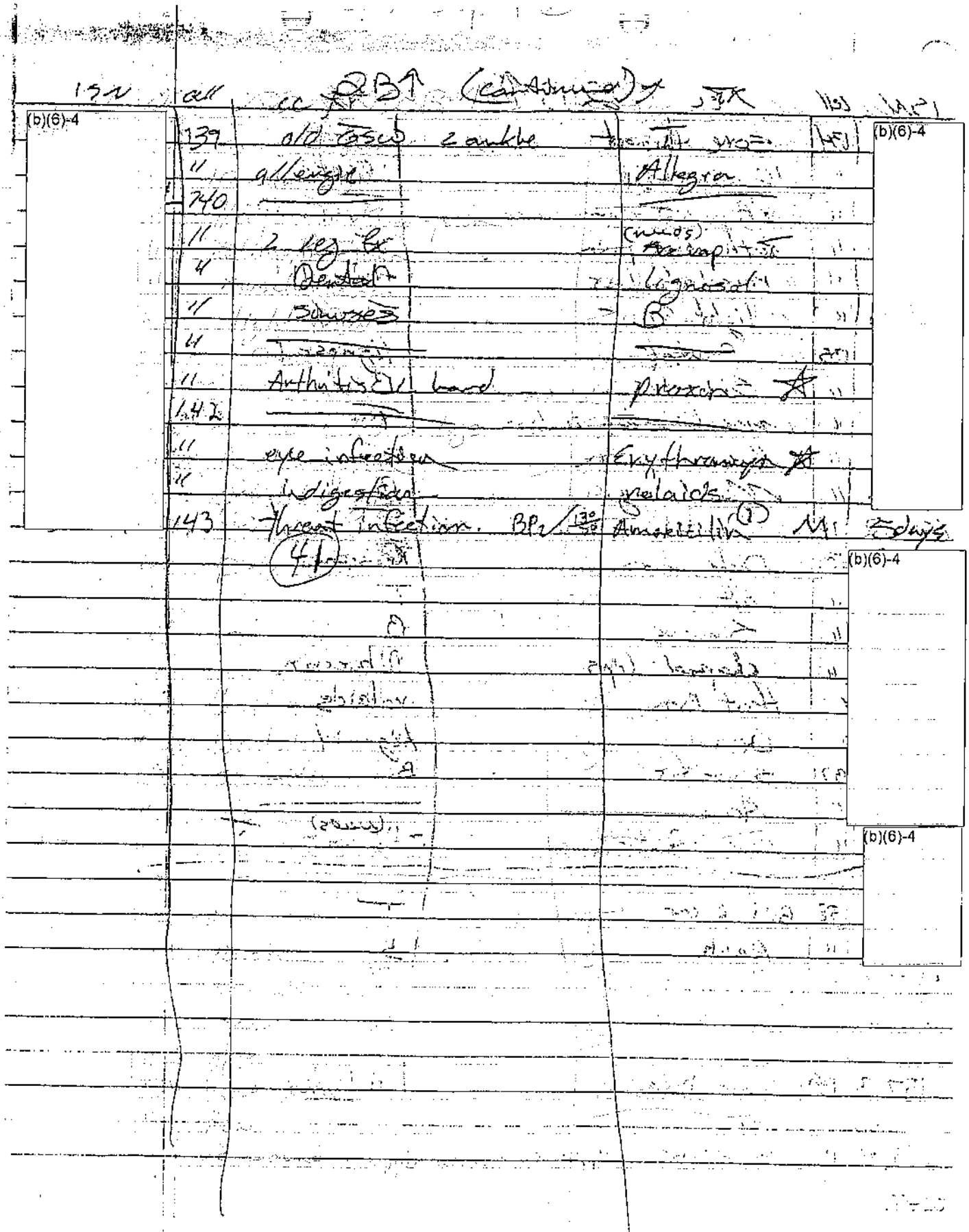
(b)(6)-4 (b)(6)-4

ISN	Cell		
	134	sore throat	proxin
	"	10 pains LBA	proxin
	"	HA, knee pain	T, proxin
	"	Bathing knee pain	T
	"	muscle aches	flexeril
	"	light fever	T
	135	Dental	lignosal
	"	Sinusitis	B
	"	muscle aches in legs	T
	"	R shoulder pain	T
	"	Nasal cong.	B
	17	Dental	T
	136	Dirty ears	Reassurance
	"	HA	T
	"	Sinuses	B
	"	chapped lips	Oil [illegible]
	"	Heart Burn	rolaids
	"	Dental	lignosol
	137	Sinusitis	B
	"	Acne	
(b)(6)-4	"	ear infection	Zithromax (meds) T
	138	Boil R ear	T
	"	Rash	B
	"	shoulder pain	Flexeril
	"	Rash	B
	"	HA	T
	139	heart burn	rolaids
	"	Acne	
	"	old wound L upper arm	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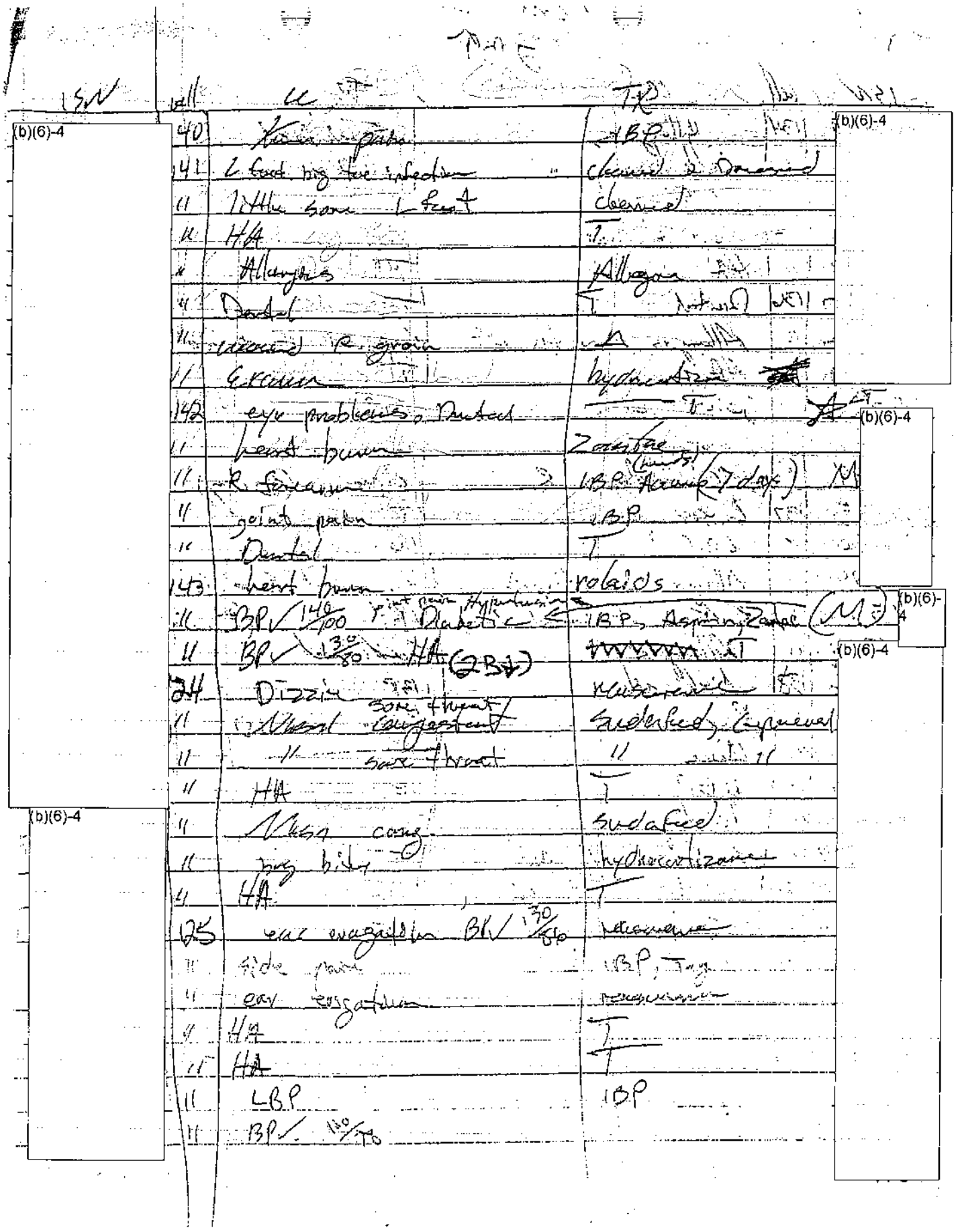
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(b)(6)-4

26	HA	Ibuprofen
"	HA BP 124/80	
"	gonorrhea	Rocephin
"	Sore throat, Rash	Cephalexin, hydrocortisone
"	L foot wound underneath	cleaned
"	Allergies	Allegra
"	Joint pain	IBP
27	Fever	T
"	Allergies	Allegra
"	Nausea, sore throat	Sudafed, Cephalexin
"	" "	" "
"	Sore throat, HA	Cephalexin, T
"	Diarrhea, sore throat, HA	Cephalexin, T
"	Sore throat, HA	" "
28	heart burn	
"	———	———
"	L shin pain	IBP
"	L pinky sore	cleaned
"	shot on eye	eye drops
"	L leg pain	IBP

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Oct 03	cc: Fever
Time: 1310	S) Started this morning, says he vomited. Pt says
P:	chest and lower side hurts. Drinks one bottle of
BP:	water a day.
T: 100.2	O) felt head and it was warm. Told him he needs
R:	to drink 3 more bottles of H_2O before he goes to
SpO2:	bed. Capillary refill a little slow
Meds Ø	A) Fever
before here:	
	P) tylenol 500mg po TID #3
provided by us:	SPC (b)(6)-2
ALL: Ø	
PMHX: Ø	
Tob:	
	Treated by:
	Morning Sick call needed? (circle one) YES (NO)

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

AGE: 24

Compound/Cell: 2B (125)

Known Chronic Conditions:

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

Detainee Medical Records

From the (b)(3)-1

Medical Section

Abu Ghraib

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Oct 03	Detainee (b)(6)-4 Detainee was seen by
	2Lt (b)(6)-2 for a foreign body in the (L)
P: WNL	inner thigh. Small foreign body protruding
BP: WNL	from skin. Healed entry wound on top of
T: afebrile	(R) thigh.
R: WNL	
	Exam: Revealed a foreign body
All:	protruding from (R) thigh.
Meds:	3cc Lidocaine injected to anesthetize
	the wound. A small incision
	was created to remove the foreign
PMHX:	body. Wound was dressed.
	No infectious processes noted.
LMC:	
	IA: Superficial retained bullet
TOB:	
	P: Bullet removed
Time out:	follow up daily to good for
	wound evaluation
	Patient seen by 2LT [redacted] PA-C for wound eval by (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS B6-2	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 (b)(6)-4
Hard Cell 1A (1)
Baghdad Correctional Facility

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

MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
22Oct03	cc: 38 y/o ♂ who is alert but refuses to cooperate with exam. History impossible due to patients refusal to cooperate.
P: 108	
BP: 138/98	
T: 97.2	Exam: VSS unknown level of orientation
R: ~~18~~ 18	PERRLA EOM's grossly intact at abnormal gaze.
All: unknown	CN II - XII grossly intact
	III IV VI PERRLA
Meds: Unknown	V VII observed smile, eyes open/close ⊕ response to painful stim w/ reflexes
	Lungs: CTA ⊕ ø wheezes, rales, rhonchi (-) percussion
PMHX: Unknown	Heart: RRR S1 S2 ø murmurs
	ABD: soft NT ND + BS (+) ø organomegaly (-) rebound tenderness
LMC:	GU: NL male genitalia ø deficits or deformity
TOB:	Musculoskeletal: thirty year old male with several old scars from previous wounds
old scars	(x) - eschar
Time out:	⊗ - old scar

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.

1A - 4

DOB: 1/1/65 (38)

(b)(6)-4

Now in 1A-24

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

318 @ 1340 To room
246 @ 1356

IV started 1325 L. antecubital fossa
500 ml 5% Dextrose given x 25 ml D50

No appreciated change in orientation if
Prisoner continues to respond to stimuli and
performs voluntary movements. No verbal response
or cooperation with commands.

" Ekg = NSR @ 90 BPM
No Abnormal Rhythm

A: Normal physical examination
Patient uncooperative

P: Return Prisoner to Hard cell and
Continue to monitor.
follow up as needed.

(b)(6)-2

MEDCOM - 1081

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 Oct 03	46 y/o ♂ c/o ⓓ sided chest pain. Pt. was laying on the
P: 67	Conscious & breathing fine. Pt.'s vitals are fine. Pt.
R: 24	takes ASA QD & Atenolol 100mg QD. Pt. always compliant
BP: 150/90 ~~140/90~~ 140/90 Standing	of cholesterol. Pt. stopped meds at med punch
T:	talking about cholesterol. During sick call @ 24 ~~00~~ meds
O2 96	were called to this pt.'s cell because he supposedly
	collapsed. Pt. told medic he only eats crackers & drinks
Meds prior to US:	water. Pt. does not want to eat Chalan or beef because
	of ↑ chol. & Sodium of food. Pt. was instructed that
Current meds:	he does not have a choice of ~~food~~ because he is a
Atenolol 100mg QD	prisoner. Pt. acted like he fainted by falling backward
ASA QD	with eyes open. Pt. did not even hit his head &
	he braced himself. The medics feeling ~~was~~ was that
	he was faking. Pt. was again instructed to eat & drink
24 OCT 03	46 y/o ♂ resting quietly in his cell. C/o his food contains to
	much cholesterol. States Cholesterol is controled & med @ 1955
	Has not taken anti-hyperlipemia med since he has been here.
	talked at length about cholesterol and lack of immediate change.
	prisoner states he will begin eating and I will look into his
	medication needs. (b)(6)-2

HOSPITAL OR MEDICAL FACILITY | STATUS | DECISION MAINTAINED AT

SPONSOR'S NAME | ISNHD 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: 1A

Cell: 39

Age 46

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 OF ...IZATION. (Sign each entry)
25Oct03	↓ 20-40 lbs ↑ refuses to eat or drink for unknown time pt. is extremely combative
P-82	
BP-12/10	
SpO_2-97	D- Skin turgor slow
	A- Dehydration
	P- fluid replacement via IV 1 L LR
21Nov03	Pt was eating large amts of food, then would induce vomiting. This has been happening for ~1wk. Before this time pt was on a hunger strike. When pt was remove from cell he was combative at procedure to swing at the MP's. Pt had to be restrained for safety of soldiers at this and personal safety. At present in a weakened state & poor skin turgor. Pt is alert but delusional. States Saddam will return to kill all of us. Also stat he will kill it is unknown how long has to live this way. Pt is dehydrated at moment. Fluid replacement to maintain hydration. Pt received 2L of LR via 20ga IV started in (R) Arm. Pt needs a psych eval.

(b)(6)-4

IB 57

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDICAL RECORD

CHRONOLOGICAL RECORD OF ...ICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 Oct 03	CC: Patient was raped in Landstuhl, needs check up
P:	(P - 107 SPO2 97) For any injury to Rectum area
R:	BP 130/80 15yo. male. Speaks reluctantly, fearfully.
BP:	Through interpreter, states he was threatened by 2 other
T:	inmates with dao if unless he complied. Then his head
	was wrapped in a cloth, his face was held down in
	a pillow on a bed with the cloth pulled very tight
Meds prior to US:	over his eyes. Ran behind, and he was raped anally
	by the 2 other inmates in succession. This event
Current meds:	occurred between 2000 and 0100 hrs 25 Oct 03
	and victim has since showered. He notes no
	bleeding, no dysuria, no pain anywhere Today.
	O: Young ♂ in no acute distress, alert & communicative.
	Vitals as above. Chest clear to auscultation.
All:	NL. S1&S2 s extra sounds, DTRs wnl x 4 extremities
	NL. Strength arms, legs, NL. gait.
	PERRLA, intact. EOMs. Oropharynx nl.
	No bruising noted on chest, back.
	Anus w/ evidence of hemorrhage, no lacerations
	no fluids noted. No DNA evidence of swabs
	done per instruction of CPT (b)(6)-1 of MPs.

HOSPITAL OR MEDICAL FACILITY	STATUS	SERVICE OR AGENCY	RECORD MAINTAINED AT
SPONSOR'S NAME	SOCIAL SECURITY 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.)

ISN: (b)(6)-4

Compound: 13

Cell: 75

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

Discharge

No bruising noted on arms or legs.

A: Case of detainee with history of being anally raped ~12 hrs ago. Now with no evidence of trauma physically, but gives evidence of fearfulness and guilt.

P: No physical ailment noted for treatment.

Detainee may benefit from counseling in future.

(b)(6)-4

[redacted]

LTC

MEDICAL RECORD – CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
[illegible]	[illegible]
	Compound 1A # (b)(6)-4 cell - 57
[illegible]	[illegible]
29 Oct 03	cc. # (b)(6)-4 refuses to eat or drink I.V. given 6-Bags
30 Oct 03	cc # (b)(6)-4 refuses to eat or drink, IV given 6 Bags
31 Oct 03	cc: # (b)(6)-4 refuses to eat or drink, I.V. given 3-Bags
1 Nov. 02	cc: # (b)(6)-4 refuses to eat or drink, I.V. given 3-Bags
2 Nov. 02	cc: # (b)(6)-4 refuses to eat or drink, I.V. NO given.
Laying down	B/P: - 120/84 P: - 79 Rectal temp: 97.8 Spo2: - 99
Sitting	B/P: - 114/80 P: - 97 Spo2: - 98
Standing	B/P - 110/80 P - 107 Spo2 - 98
2 NOV 03	1820 – Went to check on pt. Initially very lethargic, mucous membranes still moist however. Considering cause of weakness/lethargy as starvation vs dehydration, but pt- requested time for urination, proceeded to get up & ambulate (with mild difficulty) to his toilet & passed est. 300 cc of clear urine by my direct observation. Then returned on his own power to his bed. Decided pt. with good u/o is not signif dehydrated will consider need for more I.V. fluids in A.M. (b)(6)-4

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPARTMENT/SERVICE

SPONSOR'S NAME | SERVICE 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.

SSN: (b)(6)-4

compound/cell: 1A – 57

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MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1 Nov 03 1700	SI Saw pt. in cell block 1a at 1030 hrs. Stated he was to die & will not take anything from enemies. O: Pt. unable to stand, dry mucous membranes, dry eyes, dry. Hydration ~ 4 L LR ⇒ less weakness. Pt has been hydrated daily ~ 4-6 L LR for several days. Pt. does sl. lethargic B4 hydration, less lethargy after. Today ribs are noted to be sl. prominent whereas yesterday I could not see rib outlines. A: Pt. refusing food ⇒ starvation. Req. daily hydration due to refusing water. P: Called Dr. (b)(6)-2 of Prison Hospital facility in for consultation. After speaking w pt., Dr. (b)(6)-2 felt that he would eat & drink if transferred to the Prison Hospital. Pt initially agreed, but on beginning transfer, stated he must go to a Baghdad Hospital. Dr. (b)(6)-2 suggested allowing pt to believe he was going to Baghdad but bringing him to Prison Hospital so prisoner/pt. would save face and feel it was OK to eat, though once in Prison facility would know he was not in Baghdad. Dr. (b)(6)-2 then told pt this. Pt transferred by FLA, but apparently became disruptive @ Prison Hospital, was therefore denied admission by Dr. (b)(6)-2 there, also denied because pt had been told he was

INSTALLATION OR MEDICAL FACILITY	STATUS	DISPOSITION/REMARKS	RECORDS FURNISHED 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; Nationality.) REGISTER NO. WARD NO.

ISN: (b)(6)-4

compound/cell: 1 B

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	26 OCT: Pt. Was Taking Glibenclamide 5 mg BID +
	Atenolol 50 mg QD - Pt. Will Receive Same
P:	Meds + Doses. - Spec (b)(6)-2 9 W
BP:	27 OCT - Pt Rec Meds - Pmt
R:	28 Oct: Pt. Rec. Meds. IP
T:	29 Oct: Pt. Rec Meds - IP
SPO2:	30 Oct PT Done w/ meds
All:	
Previous meds:	
Current Meds:	
PMHX:	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	ARMED 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.)*

ISN (b)(6)-4

Comound/cell #: 1A 14

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 NOV 03	Pt. has chronic stuffy nose & needs one 120 mg QD Allegra
	7 NOV - pt rec meds - (b)(6)-2
	8 Nov - pt rec meds
	9 NOV - pt rec meds - (b)(6)-2
	10 Nov - pt rec meds -
	11 NOV - pt rec meds
	12 NOV - pt rec meds
	13 NOV pt rec meds (b)(6)-2
	14 Nov pt rec meds
	15 NOV - pt rec meds
	16 NOV - pt rec. meds -
	17 NOV (b)(6)-2 (b)(6)-2
	18 NOV
	19 Nov (b)(6)-2
	20 NOV
20 NOV	Pt with start Z-Pak on NOV 21 (b)(6)-2
	21 NOV prn
	22 NOV prn D2

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 (Year/Month/Day))* | REGISTER NO. | WARD NO.

ISN: (b)(6)-4

Compoun/cell: 1A-42

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B6-2

attendance @ Ft [redacted] Hospital @ time of [redacted] arrival. Dr [redacted] also felt that this was not an emergency. Further discussion w Dr [b)(6)-2] & Dr [b)(6)-2] provided their opinion they continued hydration of pt as needed will be sufficient for pt. eventually deciding to eat. I disagree, and feel that pt. may starve himself to death. Problem remains where to send pt since he is potentially disruptive, & Drs [b)(6)-2] [redacted] do not wish to place prison Hospital guards & personnel @ risk by pt's presence.

(Note: This record is prepared @ 1700 hrs although attempted transfer of pt. occurred @ 1200 hrs today. I had believed that pt. was Dr [b)(6)-2] admission and failed to provide a document for the ambulance transfer).

[b)(6)-2]

LTC MC

04 Nov 03. pt. refused to eat or drink

Started I.V. 11:30 A.M. N.S. 1000 ML. (L) Arm.

12:30 1,000 ML. infused and d/c'd counted. SPC [b)(6)-2] 9/w/o

SPC [b)(6)-2]

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6 Nov 03 1300	S: Asked to examine detainee's mouth because he states he has oral cancer as a result of chewing Khat for a number of years in Yemen + Notes his tongue and two areas of missing teeth as the area of concern O: Tongue upper surface shows thickened surface which is white in color, but this is not a plaque-rather appears to be hyperkeratotic papillary epithelium w/ resultant deepening of crypts. Generalized black staining of bases of teeth. Two missing upper tooth areas bilat which appear to be in area of former bicuspids - these areas show papillary structures suggesting of possible tooth roots which are stained black on the tips. No definite masses, no ulceration, No hemorrhage. A: No definite tumor seen; however biopsy of tongue + other unusual areas would be needed for a definite diagnosis P: No therapy @ this time - follow up check in one month suggested. (b)(6)-2 LTC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
PERSON'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; Date of Birth; Rank/Grade.)

(b)(6)-4

REGISTER NO.	WARD NO.

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Hard cells (MI)

MEDICAL RECORD

CHRONOLOGICAL RECORD OF [redacted]ICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12NOV03	Needs Ft Tagament (b)(6)-2
	14 NOV - pt. rec. med - (b)(6)-2
	15 NOV - pt rec. med -
	16 NOV - pt rec. meds
	17 NOV (b)(6)-2
	18 NOV
	19 Nov (b)(6)-2
	20 NOV (b)(6)-2
	21 NOV
	22 NOV

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/SERVICE	ACCOUNT MAINTAINED AT
SPONSOR'S NAME	SPONSOR 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/cell:

1A-49

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MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
12NOV03	Pt c/o back pain + sciatica as well as left testicle pain. Pt is referred to Tragi Clinic (b)(6)-

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPARTMENT/SERVICE | RECORDS MAINTAINED BY

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.)

ISN: (b)(6)-2

REGISTER NO. | WARD NO.

Compound/cell: 1A-35

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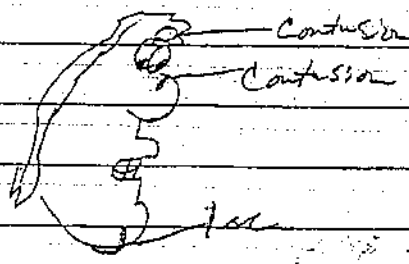
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING OR[illegible]IZATION (Sign each entry)
14NOV03	Medic was called down to Tier 1 for a prisoner that hit his head. Pt. had blood down front of clothes & sandbag over head. When cleaned pt. had Contusion over (R) eyes & contusion on nose. Pt. had lac to (R) side of chin about 1½ to 2" in length. Pt. was sutured w/ 3-0 sutures.



A - Pt. had injuries sustained during apprehension.

P - Sutures in (R) chin numbering in 8.
Pt. Cleaned & ointment & bandage.

SGT (b)(6)-2 9/2

STANDARD FORM 600 (REV. 6-97) BACK

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1A - (b)(6)-4

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MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17NOV03	Pt. Was seen in hardcot for medical screening.
BP 122/94	
P 111	
R 99%	O— Pt. has small contusions to bilat. wrists from flexi cuffs. Pt. states he takes "Thyroxine" otherw. o known medical hx. Pt.'s pupils are equal + reactive
	A: Healthy pt. takes Thyroxine. (b)(6)-2 q1w
	P: Pt. needs f/u (b)(6)-2
18Nov 03 1130	Addn'l Hx: 100mg/day 200mg next day 4-5 days 5 mos (tired feeling now) USA - Synthroid or Levothyroid or Levoxyl
	P: Will give 200 mcg Synthroid Today, 150 tomorrow, etc as per pt's dosage schedule. Follow to assure pt. does well. (b)(6)-2 L7C "H"
19Nov 03 1530	S: Pt. on quest. says he is feeling well (@ 200mcg Synthr yesterday).
	O: Alert, communicative.
	A: Back on Thyroid repl. Therapy, follow
	P: 150 mcg Synthroid given Today, 200 planned tomorrow (b)(6)-2 RC

PATIENT OR MEDICAL FACILITY	STATUS	REPORT 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.) (b)(6)-4

REGISTER NO. | WARD NO.

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1A-19

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF ... ICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

17 NOV 03 Pt. was seen in holdcell for medical screening

BP 132/92

P 112

98%

S – Pt. has minimal lac. to (L) wrist & some redness to same wrist from flexicuffs. Pt. also has small contusion (R) hairline. Pt. has no known medical hx. Pt. states he does take Rx. Tagamet for HB. Pt's pupils are equal & reactive

A: healthy Pt. (b)(6)-2 SGT, 91W

P: requires no f/u (b)(3)-1

HOSPITAL OR MEDICAL FACILITY	STATION	OUTPATIENT NUMBER	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

REGISTER NO. | WARD NO.

Call 1A-22

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Nov 03	chest pain two days B/P 130/98 says he
	Needs meds - was seen two days ago.
17 Nov 03	42 y/o ♂ with Hx chronic LBP and HTN. Was Seen
	in the CSH for Heart, and back problems.
B/P 176/125	Was found to have a Normal EKG and
HR 90	Suffering from HTN.
SpO_2 98%	
	Exam: Healthy adult ♂ NAD
Allergies:	∅ Acute Sx's
Meds: Atenolol 100mg	GOM's Normal PERRLA
Valium 5mg	Normocephalic s̄ deformity/injury
	Lungs CTA (B) ∅ wheezes, rales, cough
	Heart RRR found to have NSR
PMHx: HTN	at CSH ∅ arrythmias
LBP (chronic)	∅ JVD or apical impulse
MVA 9yrs ago	Abd soft NT ND ∅ organomegally
	∅ masses
	A/P Hypertensive [illegible] male on atenolol
	100mg qd - Continue s̄ B/P [illegible]
	(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.

(b)(6)-4 -(E) 1A-29

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 NOV 03	C/O Swollen Testicle. NAD. (R) testicle Meds: ty, lenol

HOSPITAL OR MEDICAL FACILITY | STATUS | BRANCH (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

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