DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Bucca CID Office
CAMP BUCCA CID OFFICE, 3D MILITARY POLICE GROUP (CID), Camp Bucca, Umm Qasr, Iraq, APO AE, Iraq

16 Sep 2007

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL/SSI - 0026-2007-CID579-24073 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 01 JUL 2007, 0950 - 01 JUL 2007, 1014; INTENSIVE CARE UNIT (ICU), THEATER INTERNMENT FACILITY (TIF) HOSPITAL, CAMP BUCCA, APO AE 09375, IRAQ

DATE/TIME REPORTED: 01 JUL 2007, 1030

INVESTIGATED BY:
SA (b)(6), (b)(7)(C), (b)(7)(F)
SA (b)(6), (b)(7)(C), (b)(7)(F)

SUBJECT:
1. NONE, ; [DEATH BY NATURAL CAUSES] (NFI)

VICTIM:
1. AMHED, RAFAH ABDUL AL KADER (DECEASED); CIV; IRAQ; 1 JAN 1938; BAGHDAD, IRAQ; MALE; OTHER; INTERNMENT SERIAL NUMBER (ISN) (b)(6), (b)(7)(C) THEATER INTERNMENT FACILITY (TIF), HOSPITAL, CAMP BUCCA, APO AE 09375, IZ; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

"This is an Operation Iraqi Freedom Investigation"

About 1030, 1 Jul 07, this office was notified by Dr. (CPT)(b)(6), (b)(7)(C) 36th Area Support Medical Company, attending physician, Theater Internment Facility (TIF) Hospital, Camp Bucca, of a detainee who died while in the Intensive Care Unit (ICU), TIF Hospital, Camp Bucca.

Investigation revealed Detainee AMHED, was admitted for suspected Tuberculosis, on 7 Jun 07 and was subsequently removed from his medication due to the discovery of liver damage caused by the medication. At which point, Detainee AMHED was then placed on antibiotics and monitored by EKG. On 1 Jul 07, upon activation of the EKG alarm, Detainee AMHED was administered Cardiopulmonary Resuscitation, Epinephrine, and Atropine, all of which met with no response. Dr.(b)(6), (b)(7)(C) pronounced Detainee AMHED dead at 1014, 1 Jul 07.

An autopsy conducted determined the cause of death to be Metastatic Mucinous Adenocarcinoma and the manner of death to be of natural causes. The results of our investigation are consistent with that finding.

STATUTES:

N/A

EXHIBITS/SUBSTANTIATION:

Attached:

1. Agent's Investigation Report (AIR) of SA(b)(6), (b)(7)(C), 2 Jul 07.

2. Photographic Packet. (Detainee AMHED)

3. CD containing all original images associated with Exhibit 2. (USACRC, USACIDC, and file copy only)

4. Hospital Report of Death pertaining to Detainee AMHED, 1 Jul 07.

5. Certificate of Death pertaining to Detainee AMHED, 1 Jul 07.

6. Patient Medical Records pertaining to Detainee AMHED, various dates.

7. AIR of SA (b)(6), (b)(7)(C), Aberdeen Resident Agency, 9 Jul 07.

8. Photographic Packet. (Autopsy)(USACRC, USACIDC, and file copy only)

9. AIR of SA (b)(6), (b)(7)(C), 27 Aug 07.

10. Final Autopsy Report pertaining to Detainee AMHED, 23 Aug 07.

11. Report of Toxicological Examination pertaining to Detainee AMHED, 18 Jul 07.

12. Certificate of Death pertaining to Detainee AMHED, 23 Aug 07.

Not Attached:

None.

The original of Exhibits 1 thru 3, and 7 thru 9 are attached to the USACRC copy of this report. The original of Exhibits 4 thru 6 are retained in the files of the Patient Administration Division, TIF Hospital, Camp Bucca, Iraq. The original of Exhibits 10 thru 12 are retained in the files of the Armed Forces Institute of Pathology, Rockville, MD.

STATUS: This is a final report. Commanders Report of Disciplinary or Administrative Action (DA Form 4833) is not required.

Report Prepared By:

(b)(6), (b)(7)(C)

Special Agent

Report Approved By:

(b)(6), (b)(7)(C)

Special Agent in Charge

DISTRIBUTION:
1-Dir, USACRC, Ft Belvoir, VA
1-Commander, USACIDC, ATTN: CIOP-ZA, 6010 6th Street, Ft Belvoir, VA 22060
1-DIR AFIP AFME WASH, DC
1-AFIP DOVER OAFME
1-22nd MP BN (CID)(OPERATIONS)
1-280th MP DETACHMENT (CID), ARIFJAN, KUWAIT
1-31ST COMBAT SUPPORT HOSPITAL (CSH), CAMP BUCCA, UMM QASR, IRAQ, APO AE 09375
1-CDR, 3D MP GROUP (CID)(OPERATIONS)
1-COMMANDER, 705TH MP BN, TIF, UMM QASR, IRAQ, APO AE 09375
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1-Forensic Science Officer
1-CAMP BUCCA CID OFFICE, 280th MP DET (CID), UMM QASR, IRAQ, APO AE 09375
1-STAFF JUDGE ADVOCATE, CAMP BUCCA, UMM QASR, IRAQ, APO AE 09375
1-FILE

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

For Official Use Only-Law Enforcement Sensitive

ROI NUMBER 0026-07-CID579-24073

BASIS FOR INVESTIGATION: About 1030, 1 Jul 07, this office was notified by Dr. (CPT) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) attending physician, 36th Area Support Medical Company (ASMC), Camp Bucca, that Detainee Rafah Abdul Al Kader AMHED, Internment Serial Number (ISN): (b)(6), (b)(7)(C) had died while in the Intensive Care Unit (ICU), Theater Internment Facility (TIF) Hospital, Camp Bucca.

About 1050, 1 Jul 07, SA (b)(6), (b)(7)(C) exposed digital photographs of the remains of Detainee AMHED, while in the ICU, TIF Hospital, Camp Bucca, using a Nikon Coolpix 996 digital camera. (See Photographic Packet for details)

About 1100, 1 Jul 07, SA (b)(6), (b)(7)(C) this office, interviewed Dr. (CPT) (b)(6), (b)(7)(C) who stated he was in the ICU, TIF Hospital, when Detainee AMHED had died and how Detainee AMHED was admitted to the hospital on 7 Jun 07, for suspected Tuberculosis (TB) and was treated for TB until 27 Jun 07 when he was removed from the medication due to his deteriorating health. Dr. (b)(6), (b)(7)(C) further stated on 1 Jul 07, Detainee AMHED'S vital signs were being monitored by a PROPAQ (EKG) machine when the alarm sounded indicating an emergency situation. Detainee AMHED did not have a pulse and was unresponsive. Medical personnel began to administer Cardiopulmonary Resuscitation (CPR) with Epinephrine and Atropine which met with no response. After several minutes of life saving efforts, Detainee AMHED was found to have no pulse, pupils fixed and dilated with no corneal reflex. Dr. (b)(6), (b)(7)(C) pronounced Detainee AMHED dead at 1014, 1 Jul 07.

About 1500, 2 Jul 07, SA (b)(6), (b)(7)(C) obtained the medical records of Detainee AMHED from the Patient Administration Division (PAD), TIF Hospital, Camp Bucca. A review of the medical records revealed they contained the Hospital Report of Death, Certificate of Death and all medical records. The Hospital Report of Death and the Certificate of Death both listed the cause of death as being due to Multilobar Pneumonia. (See Hospital Report of Death, Certificate of Death, and Patient Medical Records for details)

//LAST ENTRY//

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
b(6), b(7)(C), b(7)(F) (b)(6), (b)(7)(C)	280th MP Detachment(CID), Camp Bucca, APO AE 09375	
	DATE: 2 Jul 07	EXHIBIT

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40400; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL 0026 CID 579 2407 3

Camp Bucca, Iraq, TF 31/Combat Support 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)*

Rafah Abdul Al Kader Amhed
SI (b)(6)
D.O.B.- (b)(6) 1938
(b)(6)

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)*

1014- (b)(6) 2007

3. MEDICAL EXAMINER/ CORONER'S CASE

☐ YES ☒ NO

4. RELIGION

Sunni Islam

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)* Multilobar Pneumonia	2 months
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING 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
(b)(6) 2007	(b)(6) MD (b)(6)	(b)(6) 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 place)* ☐ YES ☒ NO	21. AUTOPSY ORDERED BY *(Signature)*
22. PROVISIONAL PATHOLOGICAL FINDINGS	

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPA V2.01

FOUO

CERTIFICATE OF DEATH

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

GOVERNMENT SERIAL NUMBER
500-30-4654

FROM:

0026 07 CID579 24073

LAW ENFORCEMENT SENSITIVE

TO:

NAME *(Last, first, MI)*	GRADE	SERVICE NUMBER
Rafah Abdul Al Kader Amhed	SI	

NATIONALITY	POWER SERVED	PLACE OF CAPTURE/INTERNMENT AND DATE
Iraqi		

PLACE OF BIRTH	DATE OF BIRTH
Baghdad, Iraq	(b)(6) 1938

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

PLACE OF DEATH	DATE OF DEATH	CAUSE OF DEATH
Camp Bucca, Iraq 31st CSH	(b)(6) 2007	Multilobar Pneumonia

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).*

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE
(b)(6) 2007

SIGNATURE OF MEDICAL OFFICER
(b)(6)

SIGNATURE OF COMMANDING OFFICER
(b)(6)

WITNESSES

SIGNATURE
(b)(6)

(b)(6)

SIGNATURE
(b)(6)

(b)(6)

FOUO

ACLU-DDI-GID ROI 25463

DA FORM 2669-R, MAY 82 EDITION OF 1 JUL 63 IS OBSOLETE USAPPC V1.00

LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5547 p.7

EXHIBIT 5

Camp Bucca TIF

FOUO

LABORATORY CAPABILITY/RESULT FORM

(Subject to Privacy Act of 1974)

0026 07 CID579 2407

Patient Info (Must be filled out)		
Last, First MI (Service Branch)		
Rank:		
ISN/SSN: (b)(6)		
DOB:		
Male	Female	
Physician:		
STAT	ASAP	Routine
Collection Date&Time:		
Lab Use Only:		
CH-	IMM-	SP-
CO-	MI-	TB-
HE-	OP-	UA-
Initials:	Date:	Time:

Urinalysis		
Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative
Urobilinogen		0.1-1.0
Nitrite		Negative
Leuko		Negative

Urine Microscopic			
WBC:		Casts:	
RBC:		Cryst:	
Bacteria:		Yeast:	
EPI:			
Mucus:			
Other:			
Back up tests:			

MISC Urine (Must Coordinate w/Lab)		
Creatinine		24hr: 800-2800 mg/day
Drug Screen:		Negative
K		24hr:25-125 mmol/day
Microalbumin		24hr:0-30 mg/L
Na		Ran:30-90 mmol/L
		24hr: 40-220 mmol/day
Protein		Ran: <12 mg/dl
		24hr: 42-225 mg/day

Miscellaneous Rapid Test		
H. Pylori (G)		Negative
HgBA1C (P)		<10.0 %
hCG (Red)		Negative
Mono (G)		Negative
RPR (Red)		Negative

Chemistry (Piccolo Analyzer): Green Top Chem 13 Met8 BMP Liver CMP Renal Lipid		
TEST	RESULT	REF. RANGE
ALB		3.5-5.0 g/dL
ALP		38-126 U/L
ALT		11-66 U/L
AMY		30-110 U/L
AST		15-46 U/L
Tbil		0.2-1.3 mg/dL
BUN		M: 9-20 mg/dL
Ca		8.4-10.2 mg/dL
Phos		2.5-4.5 mg/dL
CK		M: 55-170 U/L
URIC		M: 3.5-8.5 mg/dL
CL		98-107 mmol/L
TCO2		22-30 mmol/L
Creat		0.8-1.5 mg/dL
GGT		12-58 U/L
Glu		75-110 mg/dL
K		3.6-5.0 mmol/L
TProtein		6.3-8.2 g/dL
Na		137-145 mmol/L
Chol		100-200 mg/dL
HDL Chol		30-75 mg/dL
LDL Chol		50-130 mg/dL
TG		60-160 mg/dL
VLDL		≤30 mg/dL
C/HDL RAT		≤4.5

Chemistry (i-STAT): Heparanized Syringe Bld Gas - Bld Gas w/Lact-Glu-Crea		
TEST	RESULT	REF. RANGE
pH	7.432	7.35-7.45
PCO2	39.4	35-45 mmHg
PO2	104	80-100 mmHg
TCO2	27	18-33 mmol/L
HCO3	26.2	22-26 mmol/L
sO2	98	95-99%
BEecf	2	(-2) - (+3)

Cardiac Panel / Purple Top		
Myoglobin		NEG / 0-107 ng/mL
CK-MB		NEG / 0-4.3 ng/mL
Troponin		NEG / 0.0-0.4 ng/mL

Special Chemistries/Marble/Red		
TSH		0.25-5 ulU/ml
FT4		9-20 pmol/L
FT3		4.0-8.3 pmol/L
T4		60-120 nmol/L
T3		0.92-2.33 nmol/L
PSA		0.0-4.0 ng/ml
HBsAg		Negative
HBcAb		Negative
HCV		Negative
HIV		Negative

Hematology: Purple Top		
Test	Result	Ref. Range
WBC		4.8-10.8 x10(3)/ul
RBC		4.2-6.1x10(6)/uL
Hgb		12.0-18.0 g/dL
Hct		M: 42.0-52.0%
		F: 37-47 %
MCV		80.0-99.0 fl
MCH		27.0-31.0 pg
MCHC		33.0-37.0 g/dL
Plt		130-400x10(3)/uL
LY%		20.0-44.0 %
LY#		0.7-4.3x10(3)/uL

Manual Differential	
Segs (50-70%)	Mono(4-10%)
Bands (1-10%)	Eos (0-4%)
Lymphs (20-44%)	Baso (0-2%)
Atyp Lymphs	Imm cells
Plt Est.	
RBC Morph:	
WBC Morph:	

Malaria Smear/Purple Top		
Thin		No Plasm Sp. Seen
Thick		No Plasm Sp. Seen

ESR/Purple Top	
	0-20 mm/1 hr

Hemoglobin S/Purple Top		
Hb S		Negative

Coagulation/Blue Top		
PT		7.0-14.0 sec
INR		0.5-1.5/therp 2-3
APTT		21.0-50.0 sec
D-Dimer		Negative

MICROBIOLOGY	
Culture	Source
BLOOD	
CSF/FLUID	
GENITAL	
SPUTUM	
STOOL	
THROAT	
URINE	
WOUND	

MISC	Result
AFB Smear	
C. Difficile	
KOH/Wet Mount	
Fecal Leukocytes	
Flu A/B	
Occult Blood	
O&P	
Rapid Chlamydia	
Rapid Strep A	

FOUO CID RDI 25464

LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: (b)(6) 07 - (b)(6) 07

Report requested by: (b)(6)

0026 07 CID579 24073

BUCCA, (b)(6) (b)(6) M/27 Reg #: (b)(6)

Ph: Military Unit: UNKNOWN

(b)(6) 07 @ 0517 (Coll) BLOOD

DIFFERENTIAL. . . . . PENDING

(b)(6) 07 @ 0450 (Coll) BLOOD

WBC	13.3	H	(4.8-10.8)	x10 3/uL
RBC CNT	3.87	L	(4.2-6.1)	x10 6/uL
HGB	11.0	L	(12.0-18.0)	g/dL
HCT	35.0	L	(42.0-52.0)	%
MCV	90.3		(80.0-99.9)	fl
MCH	28.3		(27.0-31.0)	pg
MCHC	31.4	L	(33.0-37.0)	g/dL
PLATELETS	272		(130-400)	x 10(3)/uL
LYMPHS/100 WBC	13.0	L	(20.0-44.0)	%
LYMPH#	1.7		(0.7-4.3)	x10 3/uL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

(b)(6) 2007@0524

31 TFS

Personal Data Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: (b)(6) 07 - (b)(6) 07

0026 07 CID579 24073

Report requested by: (b)(6)

(b)(6) M/27 Reg #: (b)(6)

BUCCA (b)(6) Military Unit: UNKNOWN

Ph:

BLOOD

(b)(6) 07 @ 0430 (Coll)

BANDS/100 WBC	1			%
LYMPHS/100 WBC	15.0	L	(20.0-44.0)	%
MONO/100 WBC	4		(0-4)	%
EOS/100 WBC	0.0			%
BASO/100 WBC	0			
LYM ATYP/100WBC	0			
PLT EST	ADEQUATE			
NEUT/100 WBC	80			
RBC MORPH	NORMAL CYTIC/NORMAL CHROMIC			
WBC	NORMAL CYTIC			

SERUM

(b)(6) 07 @ 0408 (Coll)

NA+	133	L	(137-145)	mmol/L
K	3.9		(3.6-5.0)	mmol/L
CL-	98		(98-107)	mmol/L
GLUCOSE	172	H	(75-110)	mg/dl
BUN	12		(9-20)	mg/dL
CREAT	0.5	L	(0.8-1.5)	mg/dL
CA	8.3	L	(8.4-10.2)	mg/dL
PROTEIN TOTAL	6.5		(6.3-8.2)	g/dL
ALBUMIN	2.0	L	(3.5-5.0)	g/dL
ALK PHOS	494	H	(38-126)	U/L
AST	434	H	(15-46)	U/L
ALT	144	H	(11-66)	U/L
TBILI	2.3	H	(.2-1.3)	mg/dL
TCO2	22		(22-30)	mmol/L

BLOOD

(b)(6) 07 @ 0408 (Coll)

WBC	14.7	H	(4.8-10.8)	x10 3/uL
RBC CNT	4.21		(4.2-6.1)	x10 6/uL
HGB	11.9	L	(12.0-18.0)	g/dL
HCT	38.1	L	(42.0-52.0)	%
MCV	90.5		(80.0-99.9)	fl
MCH	28.4		(27.0-31.0)	pg
MCHC	31.3	L	(33.0-37.0)	g/dL
PLATELETS	338		(130-400)	x 10(3)/uL
LYMPHS/100 WBC	14.8	L	(20.0-44.0)	%
LYMPH#	2.2		(0.7-4.3)	x10 3/uL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

EXHIBIT 6

1w
31 TFS

0026 07 CID579 24073

Personal Data-Privacy Act of 1974 (PL 93-579) (b)(6) 2007@0627

PATIENT LAB INQUIRY

For: (b)(6) 07 - (b)(6) 07

Report requested by: (b)(6)

BUCCA,B304654 (b)(6) M/27 Reg #: (b)(6)
Ph: Military Unit: UNKNOWN

(b)(6) 07 @ 0452 (Coll) BLOOD

DIFFERENTIAL	PENDING			

(b)(6) 07 @ 0425 (Coll) BLOOD

WBC	20.7	H	(4.8-10.8)	x10 3/uL
RBC CNT	3.31	L	(4.2-6.1)	x10 6/uL
HGB	9.6	L	(12.0-18.0)	g/dL
HCT	30.3	L	(42.0-52.0)	%
MCV	91.7		(80.0-99.9)	fl
MCH	29.1		(27.0-31.0)	pg
MCHC	31.8	L	(33.0-37.0)	g/dL
PLATELETS	258		(130-400)	x 10(3)/uL
LYMPHS/100 WBC	4.6	L	(20.0-44.0)	%
LYMPH#	0.9		(0.7-4.3)	x10 3/uL

==========

L=Lo H=Hi *=Critical *R=Resist S=Susc *MS=Mod Susc I=Intermed

*** End of report ***

EXHIBIT 6

1w
31 TFS

0026 07 CIE579 24073

 (b)(6) 2007@0320 Page

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: (b)(6) 07 - (b)(6) 07

Report requested by: (b)(6)

BUCCA, (b)(6)
Ph:

(b)(6)

M/27 Reg #: (b)(6)

Military Unit: UNKNOWN

(b)(6) 07 @ 0225 (Coll) SERUM

	NA+	142	(137-145)	mmol/L
	K	4.1	(3.6-5.0)	mmol/L
	CL-	101	(98-107)	mmol/L
	GLUCOSE	215 H	(75-110)	mg/dl
	BUN	30 H	(9-20)	mg/dL
	CREAT	0.7 L	(0.8-1.5)	mg/dL
	CK	77	(55-170)	U/L
	TCO2	33 H	(22-30)	mmol/L
STAT	PH BG	7.380		
	PCO2	53.5		
	PO2	79		
	TCO2	33 H	(22-30)	mmol/L
	HCO3 POCT	31.7		
	BASE EXCESS	7	(-2-+3)	
	O2 SAT %	95	(95-99)	%

Pt on 10l NRB / PT T° 98° Ax

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

EXHIBIT 6

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: (b)(6) 07 - (b)(6) 07

Report requested by: (b)(6)

BUCCA (b)(6) (b)(6) M/27 Reg #: (b)(6)
Ph: Military Unit: UNKNOWN

(b)(6) 07 @ 0444 (Coll) SERUM

TROPONIN I	<0.1	(<0.050)
MYOGLOBIN	217	(<107.0)
CK-MB	1.5	(<2.0)

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

GE Medical Systems IT HELLIGE CONTRAST® 226 166 05 CE D 753

EMS IT MAC1200 ST

HR 112bpm

easurement Results:

RS			ms
T/QTcB		/	ms
R			ms
			ms
R/PP		/	ms
QRS/T		/ /	degrees
TD/QTcBD:		ms	
pkolow			mV

Interpretation:

Unconfirmed report.

I
II
III
AVR
AVL
AVF
V1
V2
V3
V4
V5
V6

[redacted] (b)(6) RDI5547 p.14

2007 03:41:47 25mm/s 10mm/mV ADS 60Hz 0.08 - 20Hz 6_F1 Automatic V5.21 (1)

GE Medical Systems IT HELLIGE CONTRAST® 226 166 05 CE D 753

MS IT MAC1200 ST

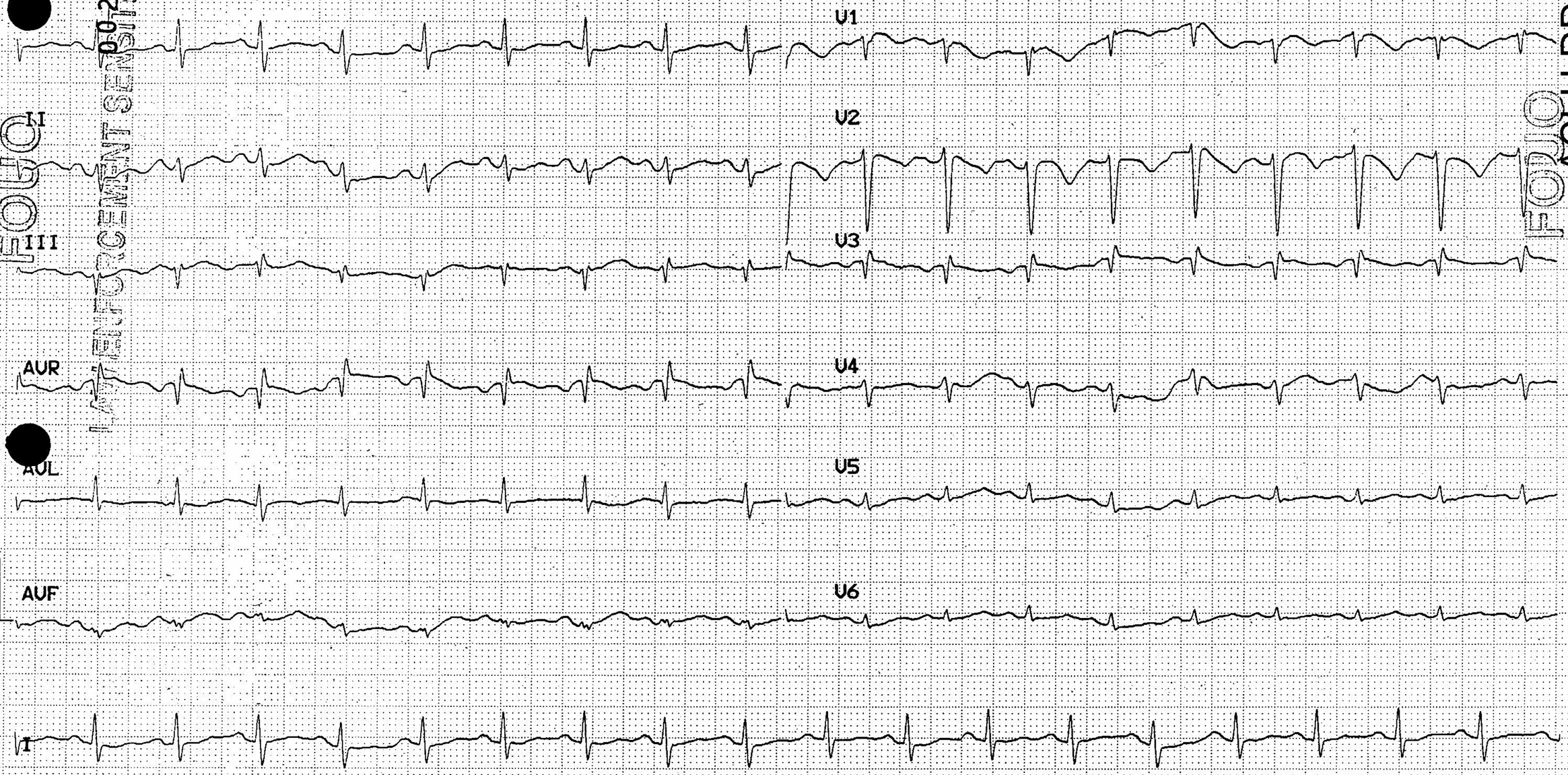
HR 113 bpm

easurement Results:

S	:		ms
/QTcB	:	/	ms
	:		ms
	:		ms
/PP	:	/	ms
QRS/T	:	/ /	degrees
D/QTcBD	:	ms	
kolow	:		mV

Interpretation:

Unconfirmed report.



2007 03:43:10 25mm/s 10mm/mV ADS 60Hz 0.08 - 20Hz 6_F1 Automatic U5.21 (1)

TFS

Personal Data - Privacy Act of 1974 (PL 9[redacted]579)
PATIENT LAB INQUIRY
For: (b)(6) 07 - (b)(6) 07

0026 07 CID579 24073

port requested by: (b)(6) Reg #: (b)(6)

M/27 Military Unit: UNKNOWN

CCA, (b)(6)

SERUM

(b)(6) 07 @ 0444 (Coll)

NA+	144		(137-145)	mmol/L
K	4.1		(3.6-5.0)	mmol/L
CL-	95	L	(98-107)	mmol/L
GLUCOSE	206	H	(75-110)	mg/dl
BUN	35	H*	(9-20)	mg/dL

esult Comment: (b)(6) IN ICW2 ON (b)(6) @0450. RESUTLS VERIFIED
CALLED CRITICAL TO [redacted]
BY READBACK.YHP

CREAT	0.8		(0.8-1.5)	mg/dL
CK	63		(55-170)	U/L
TCO2	29		(22-30)	mmol/L
TROPONIN I	<0.1		(<0.050)	
MYOGLOBIN	384		(<107.0)	
CK-MB	1.1		(<2.0)	

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

EXHIBIT 6

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	OTSG APPROVED *(Date)*
SIGNATURE SHEET	*(YYYYMMDD)* 2007(b)(6)

NAME	SIGNATURE	INITIALS
(b)(6)	(b)(6)	

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*
(b)(6)	ICW/MCW TF-31 BUCCA	2007(b)(6)

(Continue on reverse)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

HISTORY/PHYSICAL

OTHER EXAMINATION OR EVALUATION

DIAGNOSTIC STUDIES

TREATMENT

FLOW CHART

X OTHER *(Specify)*
SIGNATURE

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-66; the proponent agency is [illegible]

VERIFIED BY (Initials) | NUMBER ORDER RECEIVED (Matching Entry Completion) | DATE COMPLETED

ORDER DATE	CLERK / NURSE	RECURRING ACTIONS / FREQUENCY / TIME	HR	1	30	1	2	3	4
Date required	(b)(6)	Dobhoff advanced to 80cm (ensure @ 80cm no numbers should show)	07	✓ (b)(6)					
			19	(b)(6)					
4/20	(b)(6)	patient requests DO NOT INTUBATE in case of respiratory failure	07	✓ (b)(6)					
			19	(b)(6)					
4/20	(b)(6)	May D/C to lobby on tele room 21 with comfort pt	07	✓ (b)(6)					
			19	(b)(6)					
4/20	(b)(6)	Vital Signs q4h & Pulse Ox	07	✓ (b)(6)					
			19	(b)(6)					
4/20	(b)(6)	Continuous cardiac monitor	16	(b)(6)					
			21	(b)(6)					
4/20	(b)(6)	Droplet Precautions	07	✓ (b)(6)					
			19	(b)(6)					
4/20	(b)(6)	Notify Respiratory Therapy for Aerosol Treatments (Albuterol)	07	✓ (b)(6)					
4/20	(b)(6)	Repositioning pt Q2H due to skin breakdown	07	✓ (b)(6)					
			19	(b)(6)					
	(b)(6)	R/O TB Possible Pneumonia							

(b)(6)

DA FORM 4677, 1 OCT 73 | PREVIOUS EDITIONS ARE OBSOLETE

ACLU DDII CID ROI 25474

ACLU-RDI 5547 p.18

EXHIBIT 6

000040

FOUO

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION-CARE PLAN | PATIENT IDENTIFICATION: 0026 07 C 1 0579, 2407 3

PERIOD COVERED: | INSTRUCTIONS: | DATE/TIME ORDERED FOLLOWING DISCONTINUATION

ORDER DATE	CLERK / NURSE	RECURRING ACTIONS FREQUENCY/TIME	HR 20 1 2 3 4	DATE COMPLETED
4/30	(b)(6)	Ensure pt upright and pulled up in bed for tube feeds (aspiration precautions)	07 (b)(6) 19 (b)(6)	
4/30	(b)(6)	Increase bottled H2O to 15ml/hr per Dobhoff 6/4H	07 (b)(6) 19 (b)(6)	
4/30	(b)(6)	Send for mtz 6AM instead of cmf or BMP until labs focus equip for BMP/CMP	05 (b)(6)	
4/25	(b)(6)	Cross allergies red dye via pt chart (except H2O [illegible] [illegible] open bottles)	07 (b)(6) 19 (b)(6)	
4/30	(b)(6)	[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible]	07 (b)(6)	
4/30	(b)(6)	Check [illegible] [illegible]	07 (b)(6) 19 (b)(6)	
4/30	(b)(6)	R/O TB - Possible Pneumonia		

DATE TIME INITIATION | (b)(6)

FOUO

(b)(6)

DA FORM 1677, 1 OCT 78 | EDITION | ACLU DDII CID ROI 25475

ACLU-RDI 5547 p.19

EXHIBIT L

000041

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
NON-MEDICATION

(b)(6) 07

SIGNATURES

0026 07 C 1057 24 13

Start Date	Stop Date				
(b)(6)	(b)(6)	add cardiac enzymes to 2am blood draw	1301	0400	0400
		Do 12 lead EKG stat	1301	0400	0400

(b)(6)

(b)(6)

(b)(6)

EXHIBIT 6

Date	Time of Arrival in ED	Time & Location of Arrest	Hx of
(b)(6) 07	☒ N/A	0950 ICW 2	(b)(6) walk on PT room 0948. to check AT who. look unresponsive. He crank up O_2 up to 15L and started CPR and call a Code. 0950 at room and continue code. 0955 Epi 1:10000 and Atropine given. 1001 Repeat Epi and Atropine CPR continuous and also switch airway to code. 1006 Epi 1mg and Atropine given. 1014 (b)(6) Called (b)(6)

Type of Arrest: ☒ Cardiac ☐ Respiratory ☐ Witnessed ☐ Unwitnessed

CPR Started		ALS Started		Initial VS	BP	T	P	R	Wt.
0950	☐ EMS ☐ Bystander	0950	☐ EMS ☒ Hospital Staff	▶	PEA		54	0	

Procedures Performed

Artificial Ventilation: Bag/Mask Bag/Endo Tube DNI

Intubated: DNI Time Size By No. Attempts

☐ Oral ☐ Nasal ☐ Cric ☐ Trach Placement Confirmed By

Tube Secured At (cm)

NG/OG Tube: Time Size By

Intraosseous: Time Size & Site By No. Attempts

Venipuncture: Time Size & Site By No. Attempts

Venipuncture: Time Size & Site By No. Attempts

Central Venous Catheter: Time Size & Site By

Foley Cath: Time Size By

Time	HR	Rhythm	BP	RR	SpO2	Defib. Joules	Medications (* if given by ET Tube) EPI 1:1,000	EPI 1:10,000	Atropine	Lidocaine				Rhythm Response	IV Meds/Fluids Dopamine	Lidocaine	IV Fluid Bolus				ABG Drawn (✓)	Nurse's Notes (pO2, pCO2, pH, Color, Mental Status, Temp., Pupils, Procedures, etc.)
0955		PEA			86%		1MG	1MG	1MG													Continue CAR. Copious amount
1001		PEA			60%			1MG	1MG													Vomiting Coffee ground. Continue
1006		PEA			43%			1MG	1MG													Suctioning Medication thru
																						CPR

Was the patient successfully resuscitated? ☐ Yes ☒ No Patient expired at 1014 Pronounced by (b)(6)

Time code terminated 1014 Disposition of Patient: Time Location

Family notified Attending called

Names of all individuals present at code: (b)(6) (b)(6) (b)(6) (b)(6)

Physician Signature/Arrest Order Verification

R.N. S (b)(6)

Cardiopulmonary Resuscitation Flow Sheet

Special Army Security Hospital, Camp Bucca, Iraq

ACLU DDI CID ROI 2

LAW ENFORCEMENT SENSITIVE

FOUO

0026 07 CID579 24073

EYHTRT

6000043

Keep in Chart

PREDICTING PRESSURE SORE RISK: THE BRADEN SCALE

SENSORY PERCEPTION: Ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive to painful stimuli due to diminished level of consciousness or sedation OR Limited ability to feel pain over most of body.	**2. Very Limited.** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR Has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body	**3. Slightly Limited** Responds to verbal commands but cannot always communicate discomfort or the need to be turned. OR Has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
MOISTURE: Degree to which skin is exposed to moisture	**1.Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned	**2. Very Moist** Skin is often, but not always moist. Linen must be changed at least once a shift	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist.** Skin is usually dry, linen only requires changing at routine intervals.
ACTIVITY: Degree of physical activity	**1.Bedfast** Confined to bed	**2. Chair fast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	**4. Walks Frequently** Walks outside room at least twice a day and inside room at least once every two hours during waking hours
MOBILITY: Ability to change and control body position	**1.Completely Immobile** Does not even make slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently	**4. No Limitation** Makes major and frequent changes in position without assistance.
NUTRITION: Usual food intake pattern	**1.Very Poor** Never eats a complete meal. Rarely eats more than 1/2 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IV's for more than 5 days	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings or dairy products per day. Occasionally will take a dietary supplement OR Receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day). Occasionally will refuse a meal but will usually take a supplement when offered OR Is on a tube feeding or TPN regimen which probably meets most of nutritional needs	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat or dairy products. Occasionally eats between meals. Does not require a supplementation
FRICTION & SHEAR:	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent reposition with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down	**3.No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.	

0026 07 CID579 24073

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

OTSG APPROVED (Date) (YYYYMMDD) 20070607

DATE	INITIALS	SENSORY	MOISTURE	ACTIVITY	MOBILITY	NUTRITION	FRICTION & SHEARING	TOTAL
(b)(6)	(b)(6)	4	4	3	3	3	~~2~~ 3	~~17~~ 20
		4	4	3	3	3	3	20

Braden Scale Assessment to be performed on day of admission and then every 7 days

Risk assessment for developing pressures ulcers

15-16 Low Risk
13-14 High Risk
< 12 High Risk

(b)(6)

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU II

DATE (YYYYMMDD): 2007 (b)(6)

written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

(b)(6)

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

DA FORM 4700, FEB 2003 EDITION OF MAY 78 IS OBSOLETE. USAPA V1.00

EXHIBIT 6

000045

0026 07 CID579 24073

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD: 1CW#2

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

DATE: (b)(6)

PATIENT'S NAME: (b)(6)

	BP	HR	RR	T	O^2	Source
(b)(6) ~~0000~~ 2200	146/81	99	23	97.7	97%	3LNC
0200	108/64	97	21	97.9	98%	3LNC
0600	104/70	102	28	97.7	95%	3LNC
1000	134/84	106	25	97.7	96%	3LNC
(b)(6) @ 1400	124/80	100	20	97.4	98%	2LNC
@ 1800	101/67	94	18	97.7	95%	3LNC
(b)(6) @ 2200	115/70	92	18	98.1	95%	3LNC
0000	104/61	87	17	97.6	96%	3LNC
(b)(6) @ 1200	110/62	88	18	97.6	99%	3LNC
@ 2200	111/70	91	23	97.7	97%	3LNC
~~0200~~ 0000	103/60	93	24	97.3	94%	3LNC
0600	125/80	105	21	98.5	98%	3LNC
1400	116/75	104	19	98.0	97%	3LNC
(b)(6) @ 1900	112/64	107	24	97.6	99%	3LNC
(b)(6) @ 0000	116/72	107	40	97.8	95%	3LNC
@ 0600	108/74	110	29	97.6	96%	4LNC
1200	112/80	100	22	97.4	96%	3LNC
(b)(6) @ 1800	94/50	108	22	97.7	100%	face mask
(b)(6) @ 0001	105/70	114	36	97.9	96%	5LNC
@ 0600	95/61	112	32	97.9	96%	5LNC
(b)(6) @ 1200	99/65	123	28	97.8	95%	5LNC
@ 0445		122			95	6LNRB
@ 0810	104/68	[illegible]	32		100	10LNRB
@ 1200		108			100	10LNRB
@ 1300		104	18		100	10LNRB

Appeal be sit 6

DA FORM 3950, JUN 91

Previous editions are obsolete

EXHIBIT

000046

0026 07 CID579 24073

DATE (b)(6) 07

	INTAKE							OUTPUT							ISN
TIME	ORAL	IVF	IV MEDS	IRRIGATION	BLOOD	OTHER	TOTAL	URINE	EMESIS	JP/HEMOVAC	NG	CHEST TUBE	BM	TOTAL	Comment
						NGT									
0700															
0800									350						
0900															
1000	100	100													
1100		100													
1200		300							100		80				
1300		/													
1400		/													
1500		350							150		60				
1600		100									60				
1700		100									60				
1800		100						150			60				
12 HR TOTAL	100	850					950	150	600	Ø	320			1070	
1900		100				60									
2000		100	200			60									
2100		100				60									
2200		100				60			sent						
2300		100				60									
2400	60	100						100							
0100															
0200			100												
0300															
0400															
0500															
0600	60							875							
12 HR TOTAL	120	600	300				2290	975							
24HR TOTAL	240	1450	300			300	1990								

Urine column should be 1475

LAW ENFORCEMENT SENSITIVE 0026 07 CID579 24073

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE (b)(6) 07

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600-1800	Tube feeding	720	Ø
1800-0600	Tube feeding	540	1260
	H2O/Dobhoff	450	1710

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
					Ø
		Primaxin		400	

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
			Ø

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL
				Ø

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE 2110

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

LAW ENFORCEMENT SENSITIVE

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM	HOURS,	TOTAL HOURS COVERED	DATE
TO	HOURS		

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	Water	100	100
0100	Water	100	200
2100	Jevity	540	540
			(840)

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1000	150	Levaquin	150	1130	150
	100	Primaxin	100	1230	250
1800	100	Primaxin	100		350
2400	100	Primaxin	100		450
0600	100	Primaxin	100		(650)
0400	/	NS	250		

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	Dobhoff	75	
		75	(150)

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG)

EDITION OF 1 SEP 54 IS OBSOLETE.

Designed using Perform Pro, WHS/DIOR, Jun 94

1640 in / 400 out

+250 NS

1890 in

FOUO

(b)(6) 07

FOUO

ICAL RECORD - PATIENT REASSESS

For use of this form see MEDCOM Circular 40-

0026 07 CID579 24073

DIRECTIONS: A check (✓) in the small box indicates stated description reflects actual physical findings. An asterisk (*) in the box indicates that divergence exists. A brief explanation of any abnormal findings is required.

LAW ENFORCEMENT SENSITIVE

DATE: (b)(6) 07	TIME: 0700 INITIALS (b)(6)	TIME: INITIALS:	TIME: 1900 INITIALS (b)(6)
1. NEUROLOGICAL. Alert and oriented to time, place, self, and situation. Responds appropriately. Communication is adequate to express needs. Pupils equal bilaterally and reactive to light. Upper/lower extremeties strong and bilaterally equal.	☑	☐	☑
2. CARDIOVASCULAR. Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness or chest discomfort.	☑	☐	☒* Edema thoughout
3. PULMONARY. Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. Lungs clear to auscultation, all lobes. Chest movement is symmetrical.	☑	☐	☒* Moist Sounds @ bases. Cough lacking present productive prod.
4. G.I. Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea, or rectal bleeding. No change in appetite.	☐ Poor appetite, c BM x 3 days	☐	☒ TF @ 20 cc/hr
5. G.U./REPRODUCTIVE. Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual vaginal/ penile/breast discharge.	☐ Voids sporadic usually dark amber-colored	☐	☒ Urine output
6. MUSCULOSKELETAL. Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal ROM without pain. No joint swelling/ tenderness, weakness, or paresthesia.	☐ generalize weakness	☐	☒ Very weak & easily wrinkled
7. SKIN. Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist and intact.	☑	☐	☒ bruising over BUE
PAIN.	☑ Denies pain/discomfort.	☐ Denies pain/discomfort.	☑ Denies pain/discomfort.

Note: If patient complains of pain/discomfort, document the intensity (0-10 item scale), location, and other descriptive information in item 12

8. PSYCHOSOCIAL. Behavior is appropriate the situation. Anxiety is controlled or mild and appropriate. Interacts appropriately with others.	☑	☐	☑
9. SLEEP. Patient expresses he/she slept well and feels rested.	☑	☐	☐

PATIENT'S IDENTIFICATION *(For typed or written entries note: Name - last, first, middle initial; grade; DOB; hospital or medical facility)*

(b)(6)

NOTE: Additional assessment data regarding IV site(s), pain, dressings, etc., is contained on page 2 of this form.

FOUO

ACLU DDII CID ROI 25484

ACLU-RDI 5547 p.28

LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

000050

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

FOUO

For: (b)(6) 07 - (b)(6) 07

Report requested by: (b)(6)

0026 07 CID579 24073

BUCCA, (b)(6) (b)(6) M/27 LAW ENFORCEMENT SENSITIVE Reg#: (b)(6)

Ph: Military Unit: UNKNOWN

(b)(6) 07 @ 0412 (Coll) SERUM

TROPONIN I. . . . . ≤0.1 (<0.050)

==========

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

==========

31 TFS (b)(6) 2007@0614 Pag

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: (b)(6) 07 - (b)(6) 07

Report requested by: (b)(6) 0026 07 L10579 24073

BUCCA,(b)(6) (b)(6) M/27 Reg #: (b)(6)

Ph: Military Unit: UNKNOWN

(b)(6) 07 @ 0509 (Coll) BLOOD

BANDS/100 WBC	0			
LYMPHS/100 WBC	13.0	L	(20.0-44.0)	%
MONO/100 WBC	4			
EOS/100 WBC	0.0		(0-4)	%
BASO/100 WBC	0			%
LYM ATYP/100WBC	0			
PLT EST	ADEQUATE			
NEUT/100 WBC	83			
RBC MORPH	NORMAL CYTIC/NORMAL CHROMIC			
WBC	NORMAL CYTIC			

(b)(6) 07 @ 0412 (Coll) SERUM

NA+	138		(137-145)	mmol/L
K	4.2		(3.6-5.0)	mmol/L
CL-	93	L	(98-107)	mmol/L
GLUCOSE	104		(75-110)	mg/dl
BUN	22	H	(9-20)	mg/dL
CREAT	1.1		(0.8-1.5)	mg/dL
CA	8.4		(8.4-10.2)	mg/dL
PROTEIN TOTAL	6.5		(6.3-8.2)	g/dL
ALBUMIN	2.1	L	(3.5-5.0)	g/dL
ALK PHOS	134	H	(38-126)	U/L
AST	69	H	(15-46)	U/L
ALT	29		(11-66)	U/L
TBILLI	0.7		(.2-1.3)	mg/dL
TCO2	31	H	(22-30)	mmol/L

(b)(6) 07 @ 0412 (Coll) BLOOD

WBC	13.1	H	(4.8-10.8)	x10 3/uL
RBC CNT	3.49	L	(4.2-6.1)	x10 6/uL
HGB	9.9	L	(12.0-18.0)	g/dL
HCT	31.4	L	(42.0-52.0)	%
MCV	90.1		(80.0-99.9)	fl
MCH	28.4		(27.0-31.0)	pg
MCHC	31.5	L	(33.0-37.0)	g/dL
PLATELETS	329		(130-400)	x 10(3)/uL
LYMPHS/100 WBC	13.7	L	(20.0-44.0)	%
LYMPH#	1.8		(0.7-4.3)	x10 3/uL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

EXHIBIT 000052

L RECORD

(b)(6)

PROGRESS NOTES

DO NOT INTUBATE

NOTES

Confirm DNR

FM Pugwash HD#23 Jurisdiction DFS

0740 64 y/o male c Severe multilobar pneumonia.
Suspect TB, but ∅ improved on RIPE & stopped
due to Hepatitis.
S: Pt denies pain, very obsessed c his dry mouth
O: Vitals reviewed. Afebrile 95% 15 L NRB
144/95 | 35 / 4.1 | 29 | 0.8 < 200 Trop < .01 ∴ FIO 1890/400

PE - A+Ox4, tachypneic, needy, dry mouth
Cardiac: tachy, regular, Pulm: ↓ Bases, ∅ crackles, ∅ rales
Abdom: Soft, NT, ND, ↓BS. Extrem: 3+ pitting BLE.
A/P ① Pulm infiltrates - pneumonia - suspect TB, but ∅
responsive to RIPE. Currently on Broad spectrum
Abx for possible CAP/HAP
- Continue Levoflox / Imipenem
- Continue Supportive Care & Oxygen
- Unable to restart RIPE r/o ability to ✓ LFTs
(Lab is out of kits).
② Nutrition - No PO intake, aspirating. Very poor VOP
on Tube feeds, but continually interupted 2/2 clots etc.
Has Not yet had 24 hours of tube feeds + flushes -
- Continue Jevity, Fred rates, Crush all meds
down. dobhoff 2/2 aspiration

SPONSOR

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(b)(6)

PROGRESS NOTES
Medical Record

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

AL RECORD | PROGRESS NOTES

E | NOTES

(b)(6) 07 1900 assumed care from previous shift. See Medcon 689-R-1 + MAR.

(b)(6) 2030 addendum Pt confused and unconsolable possibly due to sleep deprivation and increasing oxygen requirements. Request evaluation of decreasing stimuli in pt room. (ie. monitor use intermittents + small dose ativan or morphine). Pt does not c/o pain but appears anxious. Possible visit by Compound chief to be arranged by (b)(6) Will cont to monitor. (b)(6)

1-10-07 (b)(6) 0100 Pt yelling & screaming; throwing baby wipes at door. Pt consoled by staff for 1/2 hour. Will cont. to monitor. (b)(6) 0130 attempted to add sterile water to humidification. Pt O2 Sat ↓ 78%. action stopped immediately. O2 sat ↑ 93% on 15l NRB. Will cont to monitor. (b)(6) adelendum 0200 RR 35-40/min request valuation to increase pt. comfort and maximize resp effort. (b)(6) addendum 0400 Pt ↑ CP. 12 lead EKG done stat. & ABG ordered. BP 80/40 NS 250 cc bolus given. BP ↑ 90/60. Will cont to monitor.

(b)(6)

SHIP TO SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUMBER (SSN or Other)

LAST | FIRST | MI

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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0026 07 CID579 24075

LAW ENFORCEMENT SENSITIVE — AUTHORIZED FOR LOCAL REPRODUCTION

CAL RECORD — PROGRESS NOTES — Ceftaz D#4 Imipenem D#4

TE

(b)(6)

IM Progress Note NOTES HD# 22 (after restated 27 June)

.07 69yo male c severe multilobar pneumonia,
CV 2025 suspected TB, but ↓ improved on RIPE + stopped
after 13 days due to Hepatitis.
S: Pt denies pain, breathing is "heavy". ↓BM
O: vitals reviewed Temp 97.7 94/61 HR 107 RR 20-40
99% 15L NRB. I/O 29 June: 2110/700
Tube feeds + IVF have been off since 0300 due to
transient desat + coughing fits.
↓CBC due to lab ↓ available 142/4.1 | 101/33 | 30/0.7 < 215
Trop < 0.1
ABG @ ~0400 7.38/53/79/33/95% 10LNRB.
PE: A+Ox4, but ↓ making clear his intent in English.
Tachypneic, but yelling out c mask off for baby wipes.
Card: tachy, regular, ↓murmur. Pulm: Anterior exam
c ↓ crackles or wheezing - upper airway noise.
Abdom: Obese, soft, NT, ND, ↓ Bowel Sounds.
Extrem: 3(+) pitting (B) LE to above knees.
Non-pitting edema (B) distal arms.
Foley, dobhoff + (R) IJ triple lumen in place.
A/P: Severe Multilobar pneumonia - Suspected
TB, but intolerant of RIPE + developed

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

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PROGRESS NOTES

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ACLU DDII CID ROI 25489

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USAPA V1.00

EXHIBIT 6

000055

ACLU-RDI 5547 p.33

L RECORD

(b)(6)

PROGRESS NOTES

NOTES

7M Note (Cont)

Hepatitis necessitating stopping RIPE. Has been tx c levo/lox, then Imipenem w/o clinical improvement. Currently on levo/lox + Imipenem for broad spectrum HAP/CAP to include legionella. Continues c T.O2 requirement. Cough, (B) infiltrates. Does not have significant Pleural effusions to suggest CHF.

-Continue Imipenem, levoflox

-Continue Supportive Care.

- Cannot do C.R due to pt too ill to evac.

- Pt currently requests DO NOT Intubate status, but reserves the right to change this @ anytime.

(2) Nutrition. P.O intolerant, but emesis appears to have subsided. will restart tube feeds + free water via dobhoff.

-NPO due to aspiration.

-Crush all meds down dobhoff

-4 blood sugars (he is ordered diet controlled DM) will ask Nutrition if any dietetic formulation for tube feeds.

O SPONSOR

SPONSOR'S NAME

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HOSPITAL OR MEDICAL FACILITY

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PROGRESS NOTES

Medical Record

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EXHIBIT 6

000056

L RECORD

PROGRESS NOTES

NOTES

(b)(6)

07 @ 1715 Assumed care of pt at 0645. Pt has maintained O_2 sats > 94% throughout the shift except during coughing and vomiting episodes, when he removed O_2 mask and O_2 sats dropped as low as 77%. Upon replacement of O_2 10L via NRB, pt sats rose to > 94%. Pt expectorating dark brown milky sputum. Pt also has sacral skin breakdown, Stage II, Comfil applied this am, but due to frequent position changes and pt's tendency to slide down in bed, Comfil rubbed off and increased skin breakdown. MD notified, wound lft OTA and pt again repositioned. Checking pt frequently to ensure adequate O_2 sats and that pt's positioning is optimal to prevent further breakdown. Will cont to monitor.

(b)(6)

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(b)(6)

NOTES

07 0026 07 CID 579 24073

0300 Resp: Pt remains steadily increasing to 40-45/min O2 sat @ 10L NRB < 88%. Attempted to suction. Unable to ↑ rate. Tube feedings immediately held. EKG & stat portable chest x-ray completed. Results pending ABG demonstating increasing resp acidosis. Cardiac enzymes completed following pt c/o chest pain. (b)(6) to provide follow up. Will cont to monitor.

(b)(6) (b)(6)

0600 Addendum BP 98/64 HR ↓104 RR ↓25 O2 sat 99% on 15L NRB. Report provided to oncoming shift.

(b)(6) (b)(6)

of @ 1630 Assumed care of pt at 0645. Pt on cont pulse ox and 15L O2 via NRB. Pt has fuquent coughing episodes and brings up dark brown milky sputum. Pt's sacral decub ē stage III breakdown. Comfel applied by previous shift found balled up and stuck to pts lumbar area. Removed Comfel and left decub DTA. Wet Pt bathed, weighed in Hoyer lift (197 lbs), and linens changed. Will cont to monitor.

(b)(6)

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RECORD | PROGRESS NOTES LAW ENFORCEMENT SENSITIVE 0026T07ENCID 579 24075

NOTES

(b)(6) 07@0230: 0200 IV Abx hung, pt still awake and having coughing episodes that keep him awake. (b)(6)

(b)(6) :07 7AM Progress Note HD#21 Imipenem restarted. (b)(6)

(stopped. (b)(6)

69yo male c severe pneumonia, suspected TB, but ø improved c 13 Days of RIPE. Currently Critically ill c Severe Bilat Pneumonia.

S: Pt w/ episodes of coughing intermittently c thick sputum; occas. post-tussive emesis. ø Pain.

O: vitals reviewed, hypothermic, 95-98% on 10L NCB. tachy 100-110. BP 100/60 range. Minimal Urine Output - recorded as only 175cc yesterday.

I/O: 1740/375 (+) 1365

PE: AAOx4, tachypneic, but able to speak several words in a row. Denies Pain except at sacrum/decub

Card: tachy, regular ø murmur. Pulm: ↓ BS bases, loud moaning + upper resp noise limits exam, but ø crackles. Abdom: Soft, NT, ND, + Bowel Sounds. Extrem: 3(+) pitting Bilat LE to above knees. Diffuse non-pitting edema in Bilat upper extremeties. Dobhoff, (R) IJ Triple lumen + foley in place. Stage 2 decub sacrum.

O SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUMBER (SSN or Other)

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LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5547 p.37

EXHIBIT 6

000059

TE

(b)(6)

7M Note (Cont) — NOTES

Blood Cx ∅ growth AFB ∅ x2

of 20 | 9.6 / 30.3 | 258 — 137 / 3.7 | 96 / 2.3 | 26 / 1.4 | 199

A/P ① Pulmonary infiltrates Bilat - suspected TB, ∅ response to RIPE x 13 days. RIPE stopped 24 June due to P.O. intolerance + Hepatitis. On Levoflox + Imipenem currently for broad spectrum coverage to include legionella, but previously ∅ improvement ē levofloxacin & Imipenem alone.

- Continue Broad Spectrum Abx for HAP/CAP
- Hold RIPE due to intolerance / Hepatitis
- Long discussion today with patient ē interpreter present about intubation in case ∅ resp failure. He decided he did ∅ want intubation + ventilator support in case of resp failure, but exercises ability to change his mind on that. Currently DO NOT INTUBATE - this does not mean do not aggressively treat him.
- Unable to be compassionately released @ this time, as he is too ill to be transported by air @ altitude ē 15L NRB requirement.

② Nutrition - P.O. intolerant + aspirating. Strict all PO intake. Dobhoff if needs assistance. Very poor urine output ē Tmg Cr. will follow, want to try to avoid restarting IVF. Bottled H2O per

(b)(6)

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LAW ENFORCEMENT SENSITIVE

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(b)(6)

PROGRESS NOTES 0026 07 CID579 24073

NOTES

@ 0130 - FM note - (Cont)

- I am prepped to D/C RIPE today in any case due to an acute TM his Alk Phos + AST. Query if he truely has TB? Had cough for at least 3 weeks prior to admit. Low grade temps, ⊕ hemoptysis (more blood tinged) but ⊘ documented wt loss or night sweats. F.D. does ⊘ feel his CXR is c/w typical TB picture.
- Will stop RIPE, Imipenem today
- Δ IVF to DS½NS + 20 kcl due to low K+. Though he is edematous, must continue IVF as he has ⊘ PO intake
- If unable to tolerate PO by tomorrow, will have to place dobhoff.
- Trend LFT's
- If seems this is TB (though no quick way to gague, as AFB only ⊖x1 even after 15 days here), can slowly add back RIPE meds. A copy of F.D. reply to my consult was placed in the chart.

(b)(6)

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

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FORM PROGRESS NOTES Medical Record

STANDARD FORM 509 (REV. 3/1999)

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LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

000061

ACLU DDII CID ROI 25495

ACLU-RDI 5547 p.39

RECORD

(b)(6)

PROGRESS NOTES

07 JIM Progress Notes HO# 17

@ 0900 69yo man admitted for suspected TB (active) but ↓improved on RIPE (got 13 days, stopped on 24 June due to PO intolerance + using UPTh). ↓improved on 6 days of ciprofloxacin on admit. Now 6 days broad spectrum Abx (also stopped 24 June).

S: Pt continues to be P.O. intolerant. Denies abdom pain, ↓Chest pain. +Cough.

O: Vitals reviewed. Afebrile. 125/80 HR 105 21 94%3 on my exa

133	98	12	
3.9	22	0.5	172

Alk Phos 494 → 434 all Red from yesterday
AST 144
ALT 2.3
Tbili

A+Ox4, in NAD, but tired, mouth + tongue dry that he has trouble talking.
Card: tachy, regular. Pulm: ↓base, ↓crackles, ↓wheezes & rales
Abdom: Obese, BS+, NT, ND, ↓BS.
Extrem: 2+ bilat pitting LE, diffuse non pitting edema
(B) arms. Stage 2 Decub on sacrum @ gluteal cleft.

A/P: ① Pulm: in ↓Nitrate - Suspected active TB due to cough x 3-6 weeks, but ↓responding to RIPE or to tx for CAP or HAP. All Antibiotics stopped

LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1999)
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L RECORD

PROGRESS NOTES

NOTES

(b)(6)

07

PT had dobhoff place today. X-ray showing tip placement Duo. PT Cont. c poor appetite. To keep NPO and start sensitive diet.
TB - 11 CAT I/O.

(b)(6)

07 FM Procedure Note.
C4545 Dobhoff tube placed @ bedside w/o difficulty. Placement confirmed c gastric aspirate + then c CXR by Xray, appears stomach is very enlarged, dobhoff descends midline, but fairly low. PT w/o abdom pain, soft belly, in NAD. (+) emesis ~ 100cc 2 hours after tube placed.
Will try Sensity feeds to start tonight. Hold for emesis. He may need some Reglan due to large stomach. Appreciate Nutrition Consult.
-Pt placed (R) side down to encourage tube progression into small bowel.
-tube @ 78cm.

SPONSOR

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EXHIBIT L
000063

RECORD

(b)(6)

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PROGRESS NOTES

0026 07 LAW ENFORCEMENT SENSITIVE 24073

IM Progress Note (cont) NOTES

broad-spectrum abx D/c'd on 24 June - patient c signficant transaminitis, ↑ Alk phos, bili.

S: Dolthoff placed yesterday, tube feeds started. Patient with continued nausea, however status is stable and did not worsen c tube feeds. States nausea improves c reglan. Denies complaints. Ø F/C. Breathing stable per patient. Ø Abd pain. Ø BM yesterday

108/71, 110, 29, 97.6, 96% 4LNC.

Elderly male, appearing uncomfortable. D/LT in place, NC in place. ↓ BS in bases (R>L). Borderline tachy, rate 90's. Tachypneic c shallow breaths. Ø w/r/g. Abd obese, soft, NT. ↓ BS. 2+ pitting edema (B) LEs to knees. (B) UE pitting edema L>R. Pulses 2+ throughout.

Labs: 137 | 96 | 13 (133) (98) (12) / 4.0 | 28 | 0.6 (3.4) (22) (0.5) < 170
C 8.0 (11.9)
P 2.0 13.3 / 11.0 < 272
A 1.9 (14.7) / 35.0 (38.1) (358)

Bld Cx Neg
Ur Cx Neg
Sputum - candida

CXR yesterday: ↑ing bilateral patchy infiltrate, predominantly lower lobe

A/P: Suspected TB: Film infiltrates not responding to PIPE, CAP tx, on broad-spectrum abx. With some ↑ in RR, ↓ sats requiring ↑ FiO2. Will continue supportive care. Also, pt c increasing peripheral edema. Will hold fluids, give trial of lasix and monitor response. Place foley as ↓ urine and pt states he urinated x 2 today (not recorded/known). Patient c h/o indeterminate troponins, concern that CHF could be contributing to patient's poor respiratory status. Will start ACE-I for possible CHF/CAD, continue B-blocker, ASA

Hepatitis: Lab cannot do LFTs until more supplies arrive. PIPE discontinued. Will monitor. Nausea stable since tube feeds increased to goal. ↑ reglan.

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1/95)

(b)(6)

L RECORD

PROGRESS NOTES

NOTES

0530 (b)(6) 07: Nsg note: Pt continues to vomit periodically, ~ 100-150cc per episode. Red-orange in color and very liquid. Will hold 0600 Metoprolol d/t ↓ SBP

(b)(6) 07 IM Progress Note HD# 19

0900 69 y/o male c suspect Active TB. Hosp Course c/b inability to tolerate PO, tachycardia @ top load, Hepatitis due to RIPE, progressive peripheral edema

S: Pt very tired, can't keep eyes open. Denies any pain. ¢BM, tried yesterday. @ Emesis + Cough all night

O:

10.4 / 33.4 \ 276

126 / 4.0 \ 91 / 20 \ 148

Vitals retrieved 97.9, tachy 112

95/49 96% 5L NC.

7/0 1400/1625

Exam: Awake but lethagic, mouth breathing, tachypneic near 30. Oriented + answers questions approp. 3+ pitting edema @ LE to above knees. Non-pitting edema @ lower arms. Card: tachy, regular, & murmur. PULM: ↓ Breathsounds, ¢ Crackles, ¢ Wheezes & rales.

(b)(6) 07 AFB ×1

(b)(6) 07 AFB ×1

SPONSOR

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

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PROGRESS NOTES
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EXHIBIT 6

L RECORD | PROGRESS NOTES

(b)(6)

(b)(6)

NOTES

~~07 @ 0800 - Assumed~~ Error on Chart to D/C'd

yesterday yesterday

07 IM Progress Note HD# 16 RIPE #3 Improvem 6

@ 0900 69y/o male - suspect active TB, but improved on RIPE or tx for CAP or broad spectrum Abx.

P.O. intolerant for last 6 days, very volume down

Intravascular, but 3rd spacing & T edema.

S: Pt c/o continued emesis, ø nausea, ø abdom pain,

ø able to keep any food down.

O: vitals reviewed 104/61 87 17 97.6 96% 3LNC

7/0 4800/650 = ⊕ 4250 UOP ~ 27cc/hr.

138/97/14 (150 15.6) 11.6/375 (295

35/25/0.5

A 161.7
AP 300
AST 144
ALT 46
Tbili 0.8

Feel from yesterday: 180 → 68

PE Obese elderly male in NAD, but tired. Card RRR, ø murmur

Pulm: ↓ BS bases (B), ø wheezes or rales

Abdom: BOft, NT, ND, ⊕BS

Extrem: non pitting edema (B) lower arms + hands, 2+-3+ pitting L>R LE to above the knees. ø skin breakdown

A/P ① Pulm infiltrates - suspect Active TB. Consulted to ID in the US as his case, as he is totally intolerant to RIPE + not improving on tx for TB, CAP or HAP. They suggest just stopping all Abx if he is afebrile + stable hemodynamically.

next page

O SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other)

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L RECORD

PROGRESS NOTES

NOTES

(b)(6)

lot cont.
needed for results. Pt. 500mL NS Bolus complete. Dt (R) arm edematous bolus. IV infiltrated IV Dlcd. (b)(6) notified. advised for central line assist c procedure. pt. tolerated s difficulty will continue to monitor—

(b)(6)

(b)(6)

07 IM Procedure Note.
@ 463 Right Internal Jugular triple lumen Catheter inserted using sterile technique. Difficult procedure but pt tolerated well, all 3 ports draw + flush well. CXR verifies good placement. OK to use Central line.

(b)(6)

(b)(6)

(b)(6)

07@1715 rolled pt to (Rt) side for position r/t decub ulcer on sacral. pt O2 ↓ to 84% a@ HR↑ to 140, R@ 44. pt denies SOB. (b)(6) aware. O2 ↑ to 6L/min via NC. will follow

(b)(6)

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(b)(6)

PROGRESS NOTES

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EXHIBIT 6

000067

L RECORD | In Progress PROGRESS NOTES

(b)(6)

07 Note (Cont) NOTES

- Hold RIPE, as UFT Ted + ø responding.
- unable to get additional sputum when so tachypneic
APBO x2 thus far.

③ Cardiac Continued tachycardia. Prior troponin leak c tachycardia. No significant CHF on CXR. No resp improvement c lasix despite fluid output. BUN/Cr suggests still intravas volume down.
- Will try to get scheduled Metoprolol in c Bold only if SBP<95
- Continue daily ASA due to CAD / trop leak
- low dose Ace started, hold for SBP<95
- No more lasix @ this time - will try to +IVF + give fluid via dobhoff.

④ GI - Continued intermittent emesis, though appears ↓ vomiting c tube feeds. Dobhoff appeared in duodenum - repeat xray today, ? Ileus - sup ⊕ status.
- Restart Tube feeds once dobhoff position confirmed - advance of Nursay - goal @ 78 cm.
- Will start c tap (bottled) water via dobhoff. small amts - 50 cc @ 6 hours.
- Hepatitis appears improving, though lab unable to get alkphos.

⑤ Renal - ABG shows good pH despite illness.

SVBR

(b)(6)

SPONSOR

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(b)(6)

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PROGRESS NOTES
Medical Record

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EXHIBIT L
000068

CAL RECORD | PROGRESS NOTES

TE | IM Note (Cont) → NOTES

(b)(6)

Meds

Metoprolol 25mg PO Q6°
Lovenox 30mg SQ BID
Colace 200mg PO BID
ASA 325mg PO QD
Prilosec 20mg PO QD
Lisinopril 10mg PO QD
Imipenem 500mg IV Q6
Levaquin 750mg IV QD
Reglan 10mg IV Q6° PRN nausea

PE: A+Ox4, tachypneic, able to sit upinbed.
Card: tachy, regular, & murmur
Pulm: ↓ base, ∅ crackles, & rales, upper airway noise. Abdom: Dfjt, NT, ND, ∅ Bowel Sounds Audible. Extrem: 3+ pitting (B) LE to above knees. Diffuse edema (B) forearms. Central line (R) IJ c/d/i c/s/i infection policy in place. Dobhoff in place. NRB mask.

A/P ① neuro: A+O, no pain, ∅ issues.
② Pulm - Bilat patchy infiltrates, ↑ WBC count, ∅ fever. AFB ×2, sputum cx only candida. Blood cx ∅ growth. Initially suspect TB based on cough x 3-6 weeks prior. ∅ improved c initial 6 Days levofloxacin, 13 Days RIPE, 6 Days Imipenem. Due to hepatitis + PO intolerance, RIPE was stopped. Imipenem stopped when pt afebrile + hemodynamically stable, but restarted yesterday due to worsening resp status + ↑ WBC count. Covering very broadly w/ Imipenem + Levofloxacin for legionella + CAP (or HAP).
ABG on NRB shows good oxygenation & ∅ CO_2 retention.
- Continue Imipenem + Levofloxacin for now
- O_2 to keep sats > 94%

See Next Page

IP TO SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUMBER (SSN or OI (b)(6)

LAST | FIRST | MI

VICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

ENTIFICATION (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)

CAL RECORD | PROGRESS NOTES

TE | NOTES

pt to podable O_2. Sats ↑ to 98%, pt agitated by ↓ O_2. Pt repositioned and comforted. Sats ↑ to 100% on 10L NRB c̄ pulse 10le. Pt calm at this time. Will cont to monitor. ——— (b)(6)

(b)(6) 07 @ 1300 Pt appears to be sleeping at this time. Pt sats 100% on 10L NRB c̄ pulse 104, resp 18, NRB mask in place. Will cont to monitor. pt tilted to @ side at this time. (b)(6)

(b)(6) 07 @ 1414 Pt c̄ episode of nausea/heaving c̄ small amount sputum. VSS, pt tolerated sips of water following episode. Will continue to monitor: ——— (b)(6)

(b)(6) 07 @ 1500 Tube feeding restarted per MD orders. Pt tolerated 50mL water via Dobhoff. Feeds restarted p̄ water at 20mL/hr. Will cont to monitor. ——— (b)(6)

(b)(6) 07 @ 2207: Assumed care of pt @ 1830 and performed assessment. Pt has been resting well c̄ periodic coughing fits. Attempted to give PO meds (Colace) but p̄ pt ingested, he coughed it up as well as the H2O he used to assist c̄ it. Will hold med feel pt may aspirate it. ——— (b)(6)

RP TO SPONSOR | SPONSOR'S NAME | (SSN or Other)

LAST | FIRST | MI

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/1990)
Prescribed by GSA/ICMR FPMR 41 CFR 101-11.206

(b)(6)

From: (b)(6)
Sent: (b)(6) 2007 9:12 PM
To: (b)(6)
Subject: RE: TB patient not tolerant of meds

Dr (b)(6)

A very challenging case with your limitations in resources. I guess I would start by asking myself how suspicious I am that he has tuberculosis. The CXR attached is not the classic upper lobe findings of TB, but certainly could be consistent with this diagnosis. How long had the patient had a cough prior to presentation? Cough longer then 3-4 weeks certainly would go with TB. Other associated s/s include weight loss, night sweats, and hemoptysis..

Did he respond to the levofloxacin? You state the infiltrates did not change. I would not expect infiltrates from community-acquired pneumonia to improve in 7 days. Did he clinically improve or worsen prior to starting RIPE? Was he febrile at any point in this presentation?

Based on your responses to the above questions, the next decision is whether to continue with TB (or any) antibiotics.

If he is afebrile, hemodynamically stable, and repeat CXR find no new infiltrates, I would consider stopping the imipenem and RIPE. If you are still highly suspicious for TB, I would suggest you then slowly add RIPE back, one drug at a time, perhaps spaced 2 days apart to observe for tolerance.

If he appears to be progressing or not improving, and you feel it is likely TB, you could stop RIPE as above, start amikacin and a fluoroquinolone (moxifloxacin or levofloxacin) as second line TB meds, and then add RIPE back slowly, stopping the amikacin and fluoroquinolone when/if he is able to tolerate these.

Regards,
(b)(6)

(b)(6)

From: (b)(6)
Sent: -07 3:21 AM
To: (b)(6)
Subject: TB patient not tolerant of meds

Hello,
I am hoping for some guidance on a patient that I suspect has Tb, but is very intollerant to RIPE. I have a 69 year old male Iraqi detainee who was admitted to our hospital isolation room 15 days ago with suspected Tb based on his chest xray and sx of cough. He was initially started on Levofloxacin 500mg PO daily for possible CAP, while AFB were

obtained, but delays in AFB results (they have to be sent out and take weeks) prompted initiation of RIPE therapy 13 days ago. The levofloxacin was continued for 7 days with no change in his pulmonary infiltrates, so it was stopped. Six days ago he took a turn for the worst (had been on RIPE for 7 days at that point) and became intollerant to PO, tachycardic to the 120s, and hypotensive with increased oxygen requirement (3 L NC). It is possible he had a PE, though we have no way to diagnose that here (NO CT scanner, no D Dimer), and he is on heparin prophylaxis. Due to the tachycardia, he even had a "bump" in his troponin, but not a true MI. With more aggressive fluids, he has improved to stable BP's, but still tachy to 100s, and completely intolerant to PO, though he does not regurgitate his RIPE meds.

We have tried to get him to eat, but to no avail. We have spaced out the TB meds, with no change. He has been on zofran, reglan and phenergan, all with no improvement in his PO intollerance. LFTs are essentially normal. He did have an increase in his WBC count at day 7 up to 20, and given his hypotension and some hypothermia, there was concern for sepsis, so he was started on broad spectrum antibiotics (Currently on day 6 of Imipenem 500mg IV Q 6 hours, as our pharmacy is out of essentially all other antibiotics). He has remained afebrile, WBC count still elevated at 15 today. His infiltrates are unchanged.

I have read in the IDSA guidelines that you should avoid stopping RIPE in the initial phase, even if nausea develops. He has no sign of liver toxicity and renal function remains normal. At this point, I am pressed to place a dobhoff as he has not had any PO intake in over 5 days. Can you please give some guidance on whether I can stop his RIPE, part of the RIPE, or reduce the doses? He is obese, and estimate his weight at 95kg.

Current meds:
INH 300mg po qd (Day 13 of all RIPE meds) Rifampin 600mg po qd Ethambutol 1200mg po qd Pyrazinamide 1500mg po qd Imipenem 500mg IV q 6 hours (day 6) Colace 200mg PO Qd Various antiemetics as above PRN Lovenox 30mg SQ BID

Appreciate any guidance.

Respectfully,

(b)(6)

L RECORD | PROGRESS NOTES

NOTES

(b)(6)

07@2000: Nsg note: Assumed care of pt. Foley in place and draining amber color urine c sediment. Dobhoff in place appearance is beyond 70cm mark. placement @ 70cm @ septum. Will continue to monitor pt. (b)(6)

(b)(6)

07@2200: Nsg note: Pt vomited red-orange c clear liquid ~300cc. Stopping TF and will give Rx Phenergan (b)(6)

(b)(6)

07@0001: Nsg note: Check/reassess of pt. Tube now @ 68cm. Readvanced tube to 75cm and secured c tape. Pt had one episode of vomiting during procedure, this happened p pt swallowed ~200cc H20 in assistance of tube advancement. Vomit was clear liquid. Sp02 ↓ to 90%, ↑ O2 rate to 5 LNC sats ↑ to 96-97%. Restarting feeding @20 ~~30~~cc/hr and ~~see~~ (b)(6) check tolerence. (b)(6) (b)(6)

~~27 Jun 07@0100.~~

27 Jun 07@0205: Pt still having difficulty tolerating feedings d/t continue hacking and productive cough. Ø emesis. (b)(6)

(b)(6)

07@0250: Tube feeding stopped per HD.

(b)(6)

07@0345: Pt still has continuous episodes of coughing followed by emetic episodes c productive cough. HOB ↑. Suction unit placed @ BS in case of aspiration (b)(6)

(b)(6)

07@0405: Pt continues to have vomiting episodes x 2 in last 10 mins. volume approx 150cc total (b)(6)

Meds will be given per Rx (b)(6)

(b)(6)

(b)(6)

L RECORD | PROGRESS NOTES

NOTES

(b)(6) 1074@ 1740. pt. 02sats @ 83%, HR@170, Resp @ 46. Dr. (b)(6) @ bedside. ABG ordered and complete. pt c/o SOB c HOBlowered 02sats 90%. pt. coughing up brown/orange frothy sputum. will follow -

(b)(6)

(b)(6)

(b)(6) 1074 23:52: Night ER Coverage

Called to assess patient for respiratory distress. RR-45-50. He is awake and alert, but in obvious distress. He is Coughing up brown frothy sputum. He denies Chest pain. Lung exam: diffuse rhonchorous crackles and RR-50. Plan: STAT CXR, ABG. Currently Vital Signs are RR as above, 130, 114/70, Pulse ox 94-96. Will reassess after ABG + CXR.

(b)(6)

(b)(6) 1074 Night ER Coverage

ABG acceptable with no hypoxia, CO2 retention or acidosis. CXR shows bilateral infiltrate with cephalization of pulm. vasculature and blunting of costophrenic angles. Pts resp still very labored with accessory muscle use and pt tiring when speaking in full sentences. Will hold IVF's given fluid status does appear to be fluid slightly

SPONSOR | SPONSOR'S NAME | SPONSOR'S ID NUMBER (SSN or Other)

LAST | FIRST | MI

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

(b)(6)

IFICATION (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)

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

RECORD | PROGRESS NOTES

NOTES

(b)(6) ~~07~~ Assmed care of PT / Received Report. Assesment

(1900) Complete. PT facing c HA ranging from 109 - 128. RR - 22 - 40. B/P stable, O² sats @ 88% on NC @ 4L. PT placed on NRB @ 7L c Sats ↑ 99%. PT coughing up Blood tinged frothy sputum. (b)(6)

(2330) PT screaming + C/O SOB. O² sats @ 98% on 7L NRB. PT vomiting Blood frothy sputum. PT restless MD Boren notified / ordered ABG STAT CXR and 40 mg Lasix IV x 1 (b)(6)

(0200) PT sitting up in bed, HOB 45 c use of accessory muscles. PT instructed to calm down / breath easy. Complied c HOB & to 26. O² sats @ 99% on 7L/NRB. All IV fluids stopped per MD Boren instructions. (b)(6)

(0600) PT did not sleep at all throughout the night. PT continued c multiple small bouts c vomits estimating a total of 150 - 200 cc's of blood frothy sputum. FSBG was 196 this Am. Ø coverage scheduled NGT feeding and IV fluids stopped @ ~~0100~~ 2330 (b) (6) per MD Boren instructions. PT voided a total of 875 cc's of yellow urine S/P receiving 40 mg Lasix IV push @ ~~2345~~. PT still Remains on 6.5L O² via NRB c sats >98% continuous. B/P range varied c a minimum Systolic of 98 and a maximum Diastolic of 63. PT has Ø temp, HR still labored ranging from 24 - 36 HR 112 - 141, with brief anxiety surge. (b)(6)

O SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other)
	LAST / FIRST / MI		
E	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	
IFICATION (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)

0026 07 CID579 24073

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) TIME OF ORDER 07 @ 0841 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Levofloxacin 750 mg IVPB. (NOT 500)
2. Portable CXR - eval infiltrate - MW
3. Portable Abdomen - flatplate - eval for Ileus, Dobhoff placement. - MW

(b)(6)

(b)(6) @ 1100 noted 28 gauge MW Dressing Intact

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) TIME OF ORDER 07 @ 0800 HOURS

1. Change parameters for Metoprolol to hold for SBP <95 or HR <60.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) TIME OF ORDER 07 @ 1133 HOURS

1. Dobhoff advanced to 80cm - insure @80cm Q shift (no numbers should show)
2. Restart tube feeds @ 20cc/hr, advance to goal 60cc/hr as tolerated.
3. Bottled water 50cc per dobhoff Q 6 hours.

(1400 @ 1400 noted 28 gauge MW Dressing Intact, MW)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

4. Insure patient upright TF'd/ HOURS up in bed for tube feeds (aspiration precautions).

(b)(6)

(b)(6)

24°C 07 @ 0230

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION (b)(6)

noted (b)(6) 1/07 1CTA

DATE OF ORDER (b)(6) 07 TIME OF ORDER @ 1610 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Triple lumen OK to use
2. 500cc NS over 1 hour
3. then NS @ 100cc/hr
4. Central line Care
5. Restart Tube feeds via dobhoff @ 20cc/hr & titrate up to goal 60cc/hr.

current order

current order

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

6. CBC, CMP Q AM (b)(6)

(b)(6)

6/27/07 @ 1825 ~~renal~~
V.O. Re-draw ~~liver fcn~~ (b) (6) panel
only x 1 now (b)(6) (b)(6) 1LAXN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)

noted (b)(6) 1/4 2020

DATE OF ORDER (b)(6) 07 TIME OF ORDER @ 1859 HOURS

1. Imipenem 500mg IV Q 6 hours first dose now
2. Levofloxacin ~~750~~ 500 mg IV QD first now (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER (b)(6) /07 TIME OF ORDER HOURS

ABG
STAT portable CXR (b)(6)
40 lasix IV

24 CHART ✓ (b)(6) 07 @ 0130

NURSING UNIT | ROOM NO. | BED NO.

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

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0026 U7 CID579 24073

LAW ENFORCEMENT SENSITIVE

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6) (b)(6)

NURSING UNIT | ROOM NO. | BED NO.: (b)(6) 24 CC

DATE OF ORDER: (b)(6) TIME OF ORDER: HOURS | LIST TIME ORDER NOTED AND SIGN

Ord: Hold tube feeds until XRAY seen by (b)(6)

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.: (b)(6) 07 @1120

DATE OF ORDER: (b)(6) TIME OF ORDER: 07 @ 0700 HOURS

(1) D/C Phenergan

(2) Reglan 10mg IV Q 6 hours PRN emesis.

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.: (b)(6)

DATE OF ORDER: (b)(6) TIME OF ORDER: 07 @ 0900 HOURS

(1) Restart Tube feeds @ 20 cc/hr & increase to goal 60 cc/hr as tolerated.

(2) Hold TF for 1 hour if emesis and then restart.

(3) NS @ 100 cc/hr (b)(6)

noted

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.:

DATE OF ORDER: (b)(6) TIME OF ORDER: @ 1150 HOURS

(1) Bolus 500 cc NS *1 now then NS @ 100 cc/hr

(b)(6)

FOUO

ACLU DDII CID ROI 25512

LAW ENFORCEMENT SENSITIVE

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

ACLU-RDI 6547 p.5

EXHIBIT 6

000078

0026 07 CID579 24073

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: (b)(6) TIME OF ORDER: 07 @ 1540 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Dobhoff @ 78cm. keep in place & tape dressing on nose.
2. Start tube feeds @ Jevity 1.2 @ 20cc/hr
3. Hold TF for 1 hour if emesis then restart.
4. Titrate up to 60cc/hr
5. As tolerated.
6. Encourage P.O. intake even while getting tube feeds (water, Diet etc)
7. Reglan 10mg IV x 1 now then q6h x 24 hours after tube feeds started

---

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: (b)(6) TIME OF ORDER: 1115 HOURS

- ~~A IVFs to NS@50cc/hr~~ error
- Fingersticks Q6°
- PT Consult - for deconditioning
- D/C IVFs
- Foley to gravity
- Lisinopril 10mg PO Qday (First now)
- Lasix 20mg IV x 1 now

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: (b)(6) 07 TIME OF ORDER: 0001 HOURS

V.O. Dr Boren / R. Chapulis Mg/Tam

- ~~Stomach series~~ & abdominal series
1) PCXR following readvancing of dobhoff tube

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)

NU

DATE OF ORDER | TIME OF ORDER ____ HOURS | LIST TIME ORDER NOTED AND SIGN

(b)(6) 07

Chart Thread

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(b)(6) 07 @ 0300 HOURS

1. Ortall Care Q Shift.
2. Wound care to stage 2 decub on sacrum (Clean + apply Duoderm or similar dressing)
3. Reposition patient Q2 hours due to skin breakdown

PATIENT IDENTIFICATION

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

4. Aspiration precautions- pull patient up in bed and keep HOB elevated @ pt bolt upright for all feedings.
5. Dobhoff feeding tube to be d/c'd.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

(b)(6) 07 @ 1300 HOURS

1. START PCXR for dobhoff placement
2. Place pt on right side x 2 hours for gastric advancement.

(b)(6)

NURSING UNIT | ROOM NO. | BED NO

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

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LAW ENFORCEMENT SENSITIVE

CLINICAL RECORD - DOCTOR'S ORDERS 07 CID579 24073

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) 07 TIME OF ORDER @ 0745 HOURS

LIST TIME ORDER NOTED AND SIGN

1 D/C IVF from
2 D/C Keflex
3 Phenergem 12.5 mg IV before TB med and PRN q 6 hours nausea/emesis

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) 07 TIME OF ORDER @ 0135 HOURS

1 D/C RIPE (Rifampin, INH pyrazinamide, ethambutol)
2 D/C Imipenem.
3 D/C Vit B6

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) 07 TIME OF ORDER @ 0800 HOURS

1 Change IVF to D5 1/2 NS + 20 Meq KCl @ 100 cc/hr.
2 Vitals q 6 hours (b)(6) pulse ox.

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) 07 TIME OF ORDER @ 0440 HOURS

1 D/C milk of magnesia

(b)(6)

FOUO

24 ACLU DDII CID ROI 25515 7-2000

LAW ENFORCEMENT SENSITIVE

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

ACLU-RDI 5547 p.59

EXHIBIT b

000081

0026 07 C I D 57931 240 73

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)

(b)(6)

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) TIME OF ORDER 07 @ 0954 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) D/C IV Fluids
(2) Increase bottled water per dobhoff to 75cc Q 4 hours.
(3) Recheck Met 8 (AM labs ✓)
(4) Send For Met 8 Q AM instead of CMP or BMP until lab fixes equipment for BMP/CMP.

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6) TIME OF ORDER 07 @ 1500 HOURS

(1) Crush all medications and give via dobhoff with flushes of bottled water. May poke hole in colace + squeeze out gel. open prilosec capsules.
(2) D/C regular diet tray (pt eating at all + aspirating).
(3) Patient requests DO NOT Intubate in case of respiratory failure.
(4) Tylenol 500 mg Crush via dobhoff Q6° PRN pain

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

240 V K Chapman Mg Lam 07 2400

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

EXHIBIT 6

FOUO

0026 07 CID 579SF24073

LAW ENFORCEMENT SENSITIVE

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

DATE OF ORDER (b)(6) 07 TIME OF ORDER 0326 HOURS

LIST TIME ORDER NOTED AND SIGN

V.O. (b)(6) ✓ (b)(6)

(b)(6)

1) stat ABG ✓

2) ~~Twelve~~ lead EKG ✓
6 see below

3) Hold Tube feeding ✓

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

DATE OF ORDER (b)(6) 07 TIME OF ORDER 0423 HOURS

(b) (6)

1) CARDIAC ENZYMES NOW + @ 1000HRS 0600 30 JUN 07

2) P-CXR + LATERAL EKG.

3) 4 O_2 TO 15 LITERS/MINUTE

4) 4mg MORPHINE IV.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

DATE OF ORDER (b)(6) TIME OF ORDER 2000 HOURS

1) Restart tube feeds @ 60cc/hr

2) Hold for TF for 1 hour if emesis (Do not hold for coughing). + then restart.

3) Continue fluid via dobhoff as previously ordered

4) Chap Stick @ bedside

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

DATE OF ORDER (b)(6) TIME OF OR 1137 HOURS

1) Continuous Cardiac Monitor + pulse ox

(b)(6)

24° ✓

2400 (b)(6)

(b)(6)

ACLU DDII CID ROI 25517

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

LAW ENFORCEMENT SENSITIVE

EXHIBIT 6

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FOUO

CLINICAL RECORD - DOCTOR'S ORDERS

0026-07-CID 579724073

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

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

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

DATE OF ORDER (b)(6) 07 TIME OF ORDER 0400 HOURS

V.O. (b)(6) / (b)(6)

1) Give 250 cc NS Bolus now

2) add cardiac enzymes to blood draw

3) Do 12 lead EKG stat

(b)(6)

(b)(6)

(b)(6) 07er

LIST TIME ORDER NOTED AND SIGN

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

FOUO

ACLU DDII CID ROI 25518

EXHIBIT 6

LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5547 p.62

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

000084

FOUO

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

0026 07 CTU579 24073

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

(b)(6)

IFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — TIVE

ORDER DATE (Date)	CLERK / NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
				30	1	2	3	4	5	6	7	8	9					
(b)(6)	(b)(6)	Lovenox 30 mg SC BID	12	/	(b)(6)													
(b)(6)			22	(b)(6)														
(b)(6)		Colace 200 mg PO BID	10	/	(b)(6)													
			22	(b)(6)														
(b)(6)	(b)(6)	ASA 325 mg po QDay	10	/	(b)(6)													
		Prilosec 20 mg po QDay	10	/														
		Lisinopril 10 mg po Q Day (Hold for SBP<95)	10	/	@													
(b)(6)		Levofloxacin 750 mg IV Q Day	10	/	(b)(6)													
		Metoprolol 25mg po Q6H (Hold for SBP<95 or HR<60)	06	/	(b)(6)													
			12	/	(b)(6)													
			18	held														
			24	(b)(6)														
(b)(6)	(b)(6)	Imipenem (Primaxin) 500mg IV Q6H	06	/	(b)(6)													
			12	/	(b)(6)													
			18	(b)(6)	(b)(6)													
			24	/	(b)													
(b)(6)		O_2 NRB 15L/min	07	/	(b)(6)													
(b)(6)			19	(b)(6)														

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: R/O TB Possible Pneumonia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL CIRCLE MED TIMES

FOUO 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

23 24 01 02 03 04 05 06

ACLU DDII CID ROI 25519

LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5547 p.63

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED

USAPA V1.01

EXHIBIT 6

000085

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

(b)(6)

07

SENSITIVE

IFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION — DATE DISPENSED: 30	1	2	3	4	5	6	7	8	9
(Date Received)													
(b)(6)		Lovenox 30mg SQ BID	10	/	(b)(6)								
			22	T									
		Ceclor 200mg po BID	10	/	(b)(6)								
			22	(b)(6)									
		ASA 325mg po QDay	10	/	(b)(6)								
		Prilosec 20mg po QDay	10	/									
		Lisinopril 10mg po Q Day (Hold for SBP<95)	10	/	(b)(6)								
		Levofloxacin 750mg IV Q Day	10	/	(b)(6)								
		Metoprolol 25mg po Q6H (Hold for SBP<95 or HR<60)	06	/	(b)(6)								
			12	/	(b)(6)								
			18	(b)(6)									
			24	(b)(6)									
		Imipenem (Primaxin) 500mg IV Q6H	06	/	(b)(6)								
			12	/	(b)(6)								
			18	(b)(6)	(b)(6)								
			24	(b)(6)									
		O2 NRB 15L/min	07	/	(b)(6)								
			19	(b)(6)									

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: R/O TB Possible Pneumonia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

FOUO

ACLU DII CID ROI 25520

LAW ENFORCEMENT SENSITIVE

DA FORM 4678-1, FEB 79 EDITION OF DEC 77 WILL BE USED UNTIL EXHAUSTED

USAPA V1.01

Page 1 of 2

ACLU-RDI 5547 p.64

EXHIBIT 6

000086

AGENT'S INVESTIGATION REPORT

ROI NUMBER 0141-07-CID112

CID Regulation 195-1

Page 1 of 1 Page(s)

DETAILS:

BASIS FOR INVESTIGATION: On 8 Jul 07, this office was notified by SA (b)(6), (b)(7)(C) Investigative Operations, Operational Investigation, Office of the Armed Forces Medical Examiner (OAFME), Armed Forces Institute of Pathology (AFIP), 1413 Research Boulevard (Blvd), Building (Bldg) 102, Rockville, MD 20850, that the remains of Mr. Rafah Abdul Al Kader AMHED, Interment Serial Number (ISN) (b)(6), (b)(7)(C) (b)(6), (b)(7)(C) Theater Interment Facility (TIF), Hospital, Camp Bucca, APO AE 09375, IZ, were located at Dover Air Force Base, DE 19902 (DAFB), and the autopsy would be conducted on 9 Jul 07.

About 1030, 9 Jul 07, SA (b)(6), (b)(7)(C) attended the autopsy of Mr. AMHED (ME # 07-0863), which was conducted by Dr. (LCDR) (b)(6), (b)(7)(C) United Stated Navy (USN), Associate Medical Examiner, OAFME, AFIP, 1413 Research Blvd, Bldg 102, Rockville, MD 20850. Dr. (b)(6), (b)(7)(C) preliminary opine was that Mr. AHMED 's cause and manner of death will remain pending awaiting further investigation and results from toxicology. Dr. (b)(6), (b)(7)(C) indicated that Mr. AHMED may have suffered from cancer as indicated by growths on several areas and organs of the body and also may have suffered from a condition in the lungs. Further details will be reported in the final autopsy report. Photographers from AFIP exposed digital photographs of the autopsy and prepared a compact disc (CD) containing all images exposed. Fingerprints and a copy of the CD containing all images and were obtained. A preliminary autopsy report is no longer provided. (See Fingerprints and CD for details)

AGENT'S COMMENT: The official results of the autopsy will be documented in the Final Autopsy Report, which will be provided upon completion.///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER

SA (b)(6), (b)(7)(C), (b)(7)(F)

ORGANIZATION
Aberdeen Resident Agency (CID)
2201 Aberdeen Boulevard
APG, MD 21005

SIGNATURE (b)(6), (b)(7)(C)

DATE 9 JUL 07

EXHIBIT 7

CID Form 94

ROI 07-CID579-24073-5H

Exhibit(s): 8

Page(s): 000088 thru 000119

Referred to:

Commander
U.S. Army Medical Command
Attn: FOIA Office, Stop 76
1216 Stanley Road 2D FL
Fort Sam Houston, Texas 78234-5049

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

For Official Use Only-Law Enforcement Sensitive

ROI NUMBER
0026-07-CID579-24073

About 1600, 27 Aug 07, this office received the Final Autopsy Examination Report, report number: ME 07-0863, Certificate of Death, and the toxicology report from the Armed Forces Institute of Pathology (AFIP), Rockville, MD, pertaining to Detainee AMHED. The Final Autopsy Report and the Certificate of Death indicated the cause of death to be Metastatic Mucinous Adenocarcinoma and the manner of death to be by natural causes. (See Final Autopsy Report, Certificate of Death, and Toxicology Report for details)

//LAST ENTRY//

TYPED AGENT'S NAME AND SEQUENCE NUMBER

SA (b)(6), (b)(7)(C), (b)(7)(F)

(b)(6), (b)(7)(C)

ORGANIZATION
280th MP Detachment(CID), Camp Bucca, APO AE 09375

DATE
27 Aug 07

EXHIBIT
9

ROI 07-CID579-24073-5H

Exhibit(s): 10 thru 12

Page(s): 000121 thru 000129

Referred to:

Commander
U.S. Army Medical Command
Attn: FOIA Office, Stop 76
1216 Stanley Road 2D FL
Fort Sam Houston, Texas 78234-5049

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
(b)(6)

FINAL AUTOPSY REPORT

Name: Amhed, Rafah Abdul Al Kader
ISN Number: (b)(6)
Date of Birth: (b)(6) 1938
Date of Death: (b)(6) 2007
Date/Time of Autopsy: 09 July 2007@1000
Date of Report: 23 Aug 2007

Autopsy No.: (b)(6)
AFIP No.: (b)(6)
Rank: Detainee
Place of Death: Iraq
Place of Autopsy: Port Mortuary, Dover DE

Circumstances of Death: This 69 year old Iraqi detainee was admitted to the Theater Internment Hospital, Camp Bucca, on (b)(6) 2007 and was being treated for a reported tuberculosis infection. His condition deteriorated and he was transferred to the intensive care unit. He was pronounced dead on (b)(6) 2007.

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

Identification: Presumptive identification is established by review of all paperwork in the case file. Postmortem fingerprints and a specimen suitable for DNA analysis are obtained.

CAUSE OF DEATH: **Metastatic Mucinous Adenocarcinoma**

MANNER OF DEATH: **Natural**

AUTOPSY REPORT (b)(6)
AMHED, Rafah Abdul Al Kader

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished male. The body weighs 194 pounds, is 66 inches in length and appears compatible with the reported age of 69 years. The body is cold. Rigor is present to an equal degree in all extremities. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure.

The head is normocephalic, and the scalp hair is gray and one inch in length. Facial hair consists of moustache and beard. The irides are brown. The corneae are cloudy. The conjunctivae are unremarkable. The sclerae are white/yellow. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The ear lobes are not pierced. The nasal skeleton and maxilla are palpably intact. The lips are without evident injury. The teeth are natural and in fair condition. Examination of the neck reveals no evidence of injury. There is a 1 inch tan papule on the left cheek.

The chest is unremarkable. No evidence of injury of the ribs or the sternum is evident externally. The abdomen is soft and slightly protuberant. Healed surgical scars are not noted. The external genitalia are those of a normal adult male. There is a superficial decubitus ulcer on the mid-lower back, 2 ½ x 2 inches. The anus is without note.

The extremities show the presence of a few healed scars on the shin and a few contusions, but no evidence of fractures, lacerations or deformities. There is pitting edema of both legs and feet. The fingernails are intact. Tattoos are not noted.

CLOTHING AND PERSONAL EFFECTS

- No clothing or personal effects accompany the body.

MEDICAL INTERVENTION

- Triple lumen intravenous catheter on the right side of the neck
- Foley catheter with collection bag with brown urine in the bag
- EKG lead on the right side of the back
- Clear dressing on the mid-lower back
- Contusions on the abdomen and upper extremities associated with needle puncture sites

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates no fractures.

EVIDENCE OF INJURY

There is no evidence of recent significant injury.

INTERNAL EXAMINATION

BODY CAVITIES:

The ribs, sternum, and vertebral bodies are visibly and palpably intact. No adhesions are present in any of the body cavities. There is approximately 250 ml of serosanguinous fluid in each of the pleural cavities. All body organs are present in normal anatomical position. The subcutaneous fat layer of the abdominal wall is 1 inch thick.

HEAD AND CENTRAL NERVOUS SYSTEM:

The galeal and subgaleal soft tissues of the scalp are free of injury. There are no skull fractures. The dura mater and falx cerebri are intact. There is no epidural or subdural hemorrhage present. The leptomeninges are thin, delicate and slightly opaque. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels are intact. Clear cerebrospinal fluid surrounds the 1420-gram brain, which has unremarkable gyri and sulci. Coronal sections through the cerebral hemispheres reveal no lesions. Transverse sections through the brain stem and cerebellum are unremarkable. The atlanto-occipital joint is stable.

NECK:

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

CARDIOVASCULAR SYSTEM:

The 400-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 firm. The valve leaflets are thin and mobile. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

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 covered with purulent exudate bilaterally. There are multiple mass lesions palpable in all lobes of the lung. The pulmonary parenchyma is markedly congested and edematous, exuding moderate to large amounts of blood and frothy fluid. Sectioning reveals multiple non-caseating, tan-yellow mass lesions ranging in size from 0.6 cm to 5 x 3.75 cm. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 1040 grams; the left 790 grams.

AUTOPSY REPORT (b)(6)
AMHED, Rafah Abdul Al Kader

HEPATOBILIARY SYSTEM:

The 1450-gram liver has an intact smooth capsule covering tan-yellow, moderately congested parenchyma. There are numerous tan-yellow sub-capsular and deep mass lesions noted in the liver, ranging in size from 1.3 cm to 7.6 x 5 cm. 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.

GASTROINTESTINAL SYSTEM:

The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 300 ml of tan fluid. The lesser and greater curvatures of the distal stomach, the proximal duodenum, and the pancreas are firm and fibrotic, and are grossly involved by a tan-yellow mass lesion measuring 13 x 10 cm. The remainder of the small and large bowel is unremarkable. The appendix is present.

GENITOURINARY SYSTEM:

The right kidney weighs 120 grams; the left 120 grams. The renal capsules are smooth and thin, semi-transparent and stripped with ease from the underlying smooth, red-brown cortical surface. The cortex is sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves and ureters are unremarkable. The bladder contains a Foley catheter and there is approximately 50 ml of brown urine in the collection bag. The testes, prostate gland and seminal vesicles are without note.

LYMPHORETICULAR SYSTEM:

The 70-gram spleen has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. There are numerous enlarged, tan-yellow lymph nodes in the hilar, periaortic, iliac, and retroperitoneal regions, ranging in size from 5 x 2.5 cm to 15 x 8 cm.

ENDOCRINE SYSTEM:

The thyroid gland is enlarged and red-brown, with diffuse cystic change. There are no distinct mass lesions identified. The right and left adrenal glands are symmetric, with bright yellow cortices and red-brown medullae. No areas of hemorrhage are identified.

MUSCULOSKELETAL SYSTEM:

No significant abnormalities of muscle or bone are identified.

AUTOPSY REPORT (b)(6)
AMHED, Rafah Abdul Al Kader

ADDITIONAL PROCEDURES

1. Documentary photographs are taken by OAFME staff photographers.
2. Specimens retained for toxicology testing and/or DNA identification are: blood, urine, kidney, spleen, liver, brain, bile, gastric contents, adipose tissue, heart, lung, and psoas muscle.
3. The dissected organs are forwarded with body.
4. Incisions of the posterior torso and posterior upper and lower extremities demonstrate no evidence of injury.

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin, with preparation of (7) histology slides.

Slide Key:

1-2. Retroperitoneal lymph nodes
3-5. Pancreas, stomach, small bowel
6. Liver
7. Lung

Lung, liver, stomach, pancreas, small bowel, and retroperitoneal lymph nodes: Metastatic mucinous adenocarcinoma

EXHIBIT 10

AUTOPSY REPORT (b)(6)
AMHED, Rafah Abdul Al Kader

FINAL AUTOPSY DIAGNOSES:

I. Metastatic mucinous adenocarcinoma of the lungs, liver, stomach, pancreas, small bowel and numerous lymph nodes

II. Evidence of medical intervention: As listed above

III. Postmortem changes:
- **A. Rigor mortis is present to an equal degree in all extremities**
- **B. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure**

IV. No identifying marks or tattoos are identified

V. Toxicology (AFIP):
- **A. Volatiles: No ethanol is detected in the blood and urine**
- **B. Drugs: Morphine, metoprolol, metoclopramide, and promethazine are detected in the urine but not in the blood**

OPINION

This 69 year old male, Rafah Abdul Al Kader Amhed, died of metastatic mucinous adenocarcinoma. There were mass lesions identified in the lungs, liver, pancreas, stomach, and proximal small bowel, in addition to numerous enlarged lymph nodes. There was no evidence of tuberculosis. There was no evidence of recent significant trauma. Toxicological studies were positive for medications consistent with hospitalization. The manner of death is natural.

(b)(6) (b)(6)

MEDICAL EXAMINER

(b)(6)

(b)(6) 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 (b)(6) **Sequence** (b)(6)

Name
RAFAH, ABDUL AL KADER AMNHED

SSAN: **Autopsy:** (b)(6)
Toxicology Accession #: (b)(6)
Date Report Generated: July 18, 2007

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: **Date Received:** (b)(6) 2007

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

Positive Opiate: Morphine was detected in the urine by immunoassay and confirmed by gas chromatography/mass spectrometry. No morphine was detected in the blood at a limit of quantitation of 0.05 mg/L using gas chromatography/mass spectrometry.

Positive Metoprolol: Metoprolol was detected in the urine by gas chromatography and confirmed by gas chromatography/mass spectrometry. No metoprolol was detected in the blood at a limit of quantitation of 0.05 mg/L using gas chromatography/mass spectrometry.

Positive Metoclopramide: Metoclopramide was detected in the urine by gas chromatography and confirmed by gas chromatography/mass spectrometry. No metoclopramide was detected in the blood at a limit of quantitation of 0.05 mg/L using gas chromatography/mass spectrometry.

0026 07 CID579 24077

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

REPLY TO
ATTENTION OF

REPORT OF TOXICOLOGICAL EXAMINATION (CONT. (b)(6) RAFAH, ABDUL AL KADER AMNHED):

Positive Phenothiazine: Promethazine was detected in the urine by gas chromatography and confirmed by gas chromatography/mass spectrometry. No promethazine was detected in the blood at a limit of quantitation of 0.05 mg/L using gas chromatography/mass spectrometry.

(b)(6)

Office of the Armed Forces Medical Examiner

FOUO

LAW ENFORCEMENT SENSITIVE

EXHIBIT 11

FOUO

CERTIFICATE OF DEATH *(OVERSEAS)*

Acte de décès (D'Outre-Mer)

0026 07 CID579 24073

LAW ENFORCEMENT SENSITIVE

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 Social
Amhed, Rafah, Abdul Al Kader		Civilian	(b)(6)

ORGANIZATION Organisation	NATION *(e.g, United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe
Iraqi Detainee	Iraq		[X] MALE [ ] FEMALE

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décéde avec le sus
STREET ADDRESS Domicilé à (Rue)	CITY OR TOWN OR 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 CONDITON DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort.	Metastatic Mucinous Adenocarcinoma	Weeks
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 Condition morbide, s'il y a lieu. menant à la cause primaire		
OTHER SIGNIFICANT CONDITIONS [2] Autres conditions significatives		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée [X] YES Oui [ ] NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
X NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
ACCIDENT Mort accidentelle		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste (b)(6)	
HOMICIDE Homicide	SIGNATU (b)(6) DATE Date (b)(6) 2007	AVIATION ACCIDENT Accident á Avion [ ] YES Oui [X] NO Non

DATE OF DEATH *(day, month, year)* Date de décès (le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès
(b)(6) 2007 1014	Camp Bucca 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 dé funtet je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER Nom du médicin militaire ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplômé
(b)(6)	(b)(6) Medical Examiner

GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
(b)(6)	Dover AFB, Dover DE
DATE Date (b)(6) 2007	SIGNATUR (b)(6)

1 State disease, injury or complication which caused death, but not mode
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 dont elle est survenue, 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

FOUO

ACLU DDII CID ROI 25565

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

LAW ENFORCEMENT SE[illegible]

ACLU-RDI 5547 p.77

EXHIBIT 12

000129