DEPARTMENT OF THE ARMY
U.S. ARMY CRIMINAL INVESTIGATION COMMAND
Camp Cropper CID Office
20th/1149th Military Police Detachment (CID), 11th Military Police Battalion
(CID), Camp Cropper, Baghdad, Iraq APO AE 09342

02 Dec 2007

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL/SSI - 0044-2007-CID789-23673 - 5H6

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 23 AUG 2007, 1531 - 23 AUG 2007, 1531; 31ST COMBAT SUPPORT HOSPITAL, CAMP CROPPER, IRAQ, APO AE 09342, BAGHDAD, IRAQ

DATE/TIME REPORTED: 23 AUG 2007, 1538

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

SUBJECT:
1. NONE, ; [JUSTIFIABLE HOMICIDE (BATTLEFIELD CASUALTY)] (NFI)

VICTIM:
1. LATEEF, HATEM KRAREM (DECEASED); CIV; IRAQ; (DOB); (POB); MALE; OTHER; INTERNMENT SERIAL NUMBER (ISN) (b)(6), (b)(7)(C) THEATER INTERNMENT FACILITY (TIF) CAMP REMEMBRANCE II, CAMP CROPPER, (POB), APO AE 09342, IZ; XZ ; [JUSTIFIABLE HOMICIDE (BATTLEFIELD CASUALTY)]

INVESTIGATIVE SUMMARY:

This is an Operation Iraqi Freedom Investigation.

On 23 Aug 07, CPL [redacted] Patient Administration Division (PAD), 31st Combat Support Hospital (CSH), Camp Cropper, IZ APO AE 09342 (CCIZ), reported a detainee death at the hospital.

Investigation disclosed Mr. HATEM KRAREM LATEEF was admitted to the 31st Combat Support Hospital (CSH) with numerous battlefield injuries which he never recovered. Mr. LATEEF was found in his hospital bed unresponsive and pronounced dead at 1531, 23 Aug 07. An autopsy conducted by the Office of the Armed Forces Medical Examiner revealed Mr. HATEM KRAREM LATEEF's manner of death to be Homicide and his cause of death was complications of blast and blast fragmentation injuries. The results of this investigation were consistent with their findings.

STATUTES:

Article 118, UCMJ: Justifiable Homicide

EXHIBITS:

Attached:

1. Agent's Investigation Report (AIR) of SA [redacted] 24 Aug 07.

2. Detainee Management System Record 23 Aug 07, pertaining to Mr. HATEM.

3. Personal Data Report, 23 Aug 07, pertaining to Mr. HATEM.

4. Enemy Prisoner of War Screening Report, 23 Aug 07, pertaining to Mr. HATEM.

5. Photographic Packet (Death Scene).

6. CD containing original images associated with Exhibit 5 (USACRC, AFIP and file copies only).

7. Medical records, 24 Aug 07, pertaining to Mr. HATEM.

8. AIR of SA [redacted] 27 Aug 07.

9. CD containing original images associated with Exhibit 8 (USACRC and file copies only).

10. Autopsy Examination Report, 20 Nov 07.

11. Death Certificate, 27 Aug 07.

Not Attached:

None.

The originals of Exhibits 1, 5, 6, 8, and 9 are forwarded with the USACRC copy of this report. The originals of Exhibit 2, 3 and 4 are retained in the database of Task Force 134, Camp Victory, IZ. The original of Exhibit 7 is retained in the files of the Patient Administration Division, 31st CSH, CCIZ. The originals of Exhibits 10 and 11 are retained in the files of the Armed Forces Institute of Pathology, 1413 Research Blvd., Building 102, Rockville, MD.

STATUS: This is a Final Report. Commander's Report of Disciplinary or Administrative Action (DA Form 4833) is not required.

CID reports of investigation may be subject to a Quality Assurance Review by CID higher headquarters.

Report Prepared By:

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

Special Agent

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:
1 - Director, U.S. Army Crime Records Center, ATTN: CICR-CR, 6010 6th Street, Fort Belvoir, VA 22060 (Original)
1 - Director, Armed Forces Institute of Pathology, AFIP Annex - Bldg 102, 1413 Research Blvd, Rockvile, MD
1 - AOPS, 11TH MP BN (CID), Camp Victory, Baghdad, Iraq, APO AE 09342 (Email only)
1 - Commander, 11th MP BN (CID) (FWD), Camp Victory, Baghdad, Iraq, APO AE 09342
1 - Commander, 20th/1149th MP DET (CID), Camp Slayer, Baghdad, Iraq APO AE 09342 (Email only)
1 - Commander, 3D MP GRP (CID), USACIDC, Fort Gillem, GA 30297
1 - Commander, 525th MP BN, Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
1 - Garrison Commander, Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
1 - Operations Officer, 11th MP BN (CID), Camp Victory, Baghdad, Iraq APO AE 09342 (Email only)
1 - Provost Marshal, Victory Base Complex, Camp Victory, Baghdad, Iraq, APO AE 09342 (Email only)
1 - Office of the Staff Judge Advocate, Central Criminal Court of Iraq Liasion, ATTN: LT (b)(6), (b)(7)(C) TF 134, International Zone, Baghdad, iraq APO AE 09342 (Email only)
1 - Commander, Task Force 134, ATTN: Major General (b)(6), (b)(7)(C) Detainee Operations, Camp Victory, Baghdad, Iraq APO AE 09342 (Email only)
1 - File

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0044-07-CID789-23673

DETAILS

BASIS FOR INVESTIGATION: About 1538, 23 Aug 07, this office received notification of a detainee death from CPL (b)(6), (b)(7)(C) Patient Administration Division (PAD), 31st Combat Support Hospital (CSH), Camp Cropper, Iraq, APO AE 09342 (CCIZ).

About 1545, 23 Aug 07, SA (b)(6), (b)(7)(C) Camp Cropper CID Office, CCIZ, spoke with COL (Dr.) (b)(6), (b)(7)(C) Intensive Care Unit (ICU) attending Physician, 31st CSH, CCIZ, who stated Mr. HATEM Krarem Lateef, (b)(6), (b)(7)(C) had been in the ICU wing of the 31st CSH since his initial arrival on 4 Jul 07. Mr. HATEM arrived with shrapnel wounds to the chest, lacerated liver, kidney damage along with brain damage. Dr. (b)(6), (b)(7)(C) stated that about 10 days prior, Mr. HATEM's kidneys started failing and he was retaining fluid. Mr. HATEM died of kidney failure and no efforts were made to resuscitate him. He was pronounced deceased at 1531, 23 Aug 07.

About 1550, 23 Aug 07, SA (b)(6), (b)(7)(C) exposed digital photographs of Mr. HATEM using a Canon PowerShot SD900. (See Photograph Packet)

About 1615, 23 Aug 07, SA (b)(6), (b)(7)(C) obtained Mr. HATEM's movement history from the Detainee Management System (DMS). Mr. HATEM arrived at the 31st CSH at 0546, 4 Jul 07 and remained there until his death. (See DMS Record)

About 1620, 23 Aug 07, SA (b)(6), (b)(7)(C) obtained Mr. HATEM's Personal Data Report (PDR) and Enemy Prisoner of War Screening Report (EPWSR) from the Biometric Automated Toolset System (BATS). (See PDR and EPWSR)

About 1754, 23 Aug 07, SA (b)(6), (b)(7)(C) coordinated with SFC (b)(6), (b)(7)(C) S-4 NCOIC, 31st CSH, CCI, who stated he would transport the body to Mortuary Affairs at Sather Air Force Base (AFB), Victory Base Complex (VBC), Iraq, APO AE 09342 (SAFB).

About 1802, 23 Aug 07, SA (b)(6), (b)(7)(C) coordinated with Mortuary Affairs at Sather AFB to ensure Mr. HATEM was to be transferred to the United States for autopsy.

About 1430, 24 Aug 07, SA (b)(6), (b)(7)(C) obtained Mr. HATEM's capture paperwork from the Joint Intelligence Debriefing Center (JIDC). (See Capture Paperwork – Classified SECRET)

About 1600, 24 Aug 07, SA (b)(6), (b)(7)(C) reviewed the capture paperwork for Mr. HATEM. On 30 Jun 07 he engaged Coalition Forces (CF) and was wounded in the battle. Before CF were able to pick him up, he was taken away from the scene by Local Nationals (LN) in a non-tactical vehicle. LN later took him to a CF facility due to his injuries where he was immediately treated and eventually transported to the 31st CSH for further

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
(b)(6), (b)(7)(C), (b)(7)(F)	86th MP DET (CID) (FWD) CAMP CROPPER, IRAQ, APO AE 09342
SIG	DATE: 24 AUG 07 / EXHIBIT: 1

DETAILS

treatment. At the time of his initial treatment, he tested positive for recently being in possession of explosives. He was recommended not to be interned, but instead be released upon recovery.

About 1750, 24 Aug 07, SA [(b)(6), (b)(7)(C)] coordinated with SSG [(b)(6), (b)(7)(C)] NCOIC of the PAD, 31st CSH, CCI, to obtain Mr. HATEM's medical file. (See Medical File)///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
[(b)(6), (b)(7)(C), (b)(7)(F)]	86th MP DET (CID) (FWD) CAMP CROPPER, IRAQ, APO AE 09342
SIG	DATE: 24 Aug 07 / EXHIBIT: 1

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PHOTOGRAPH PACKET

NUMBER	DESCRIPTION OF PHOTOGRAPHS
1	Photograph depicting victim in hospital bed.
2	Photograph depicting close up victim's face.
3	Photograph depicting close up victim's chest.
4	Photograph depicting close up victim's mid section.
5	Photograph depicting close up victim's thighs.
6	Photograph depicting close up victim's feet.
7	Photograph depicting close victim's chest wounds.
8	Photograph depicting close up victim's stomach.
9	Photograph depicting close up of victim's lower stomach.
10	Photograph depicting victim's back.
11	Photograph depicting victims rectal area.
12	Photograph depicting victim's right ankle.
13	Photograph depicting victim's capture tag.
14	Photograph depicting victim's capture tag.
15	Photograph depicting body bag of victim at autopsy (DSC_0001).
16	Photograph depicting backside of victim at autopsy (DSC_0017).
17	Photograph depicting face of victim at autopsy (DSC_0024).
18	Photograph depicting right side of victim's head at autopsy (DSC_0025).
19	Photograph depicting left side of victim's head at autopsy (DSC_0026).

EXHIBIT 5

Exhibit 6

Page(s) 35

is duplicate of

Exhibit 5

Pages 16 thru 34

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Combined Photograph Compact Disc

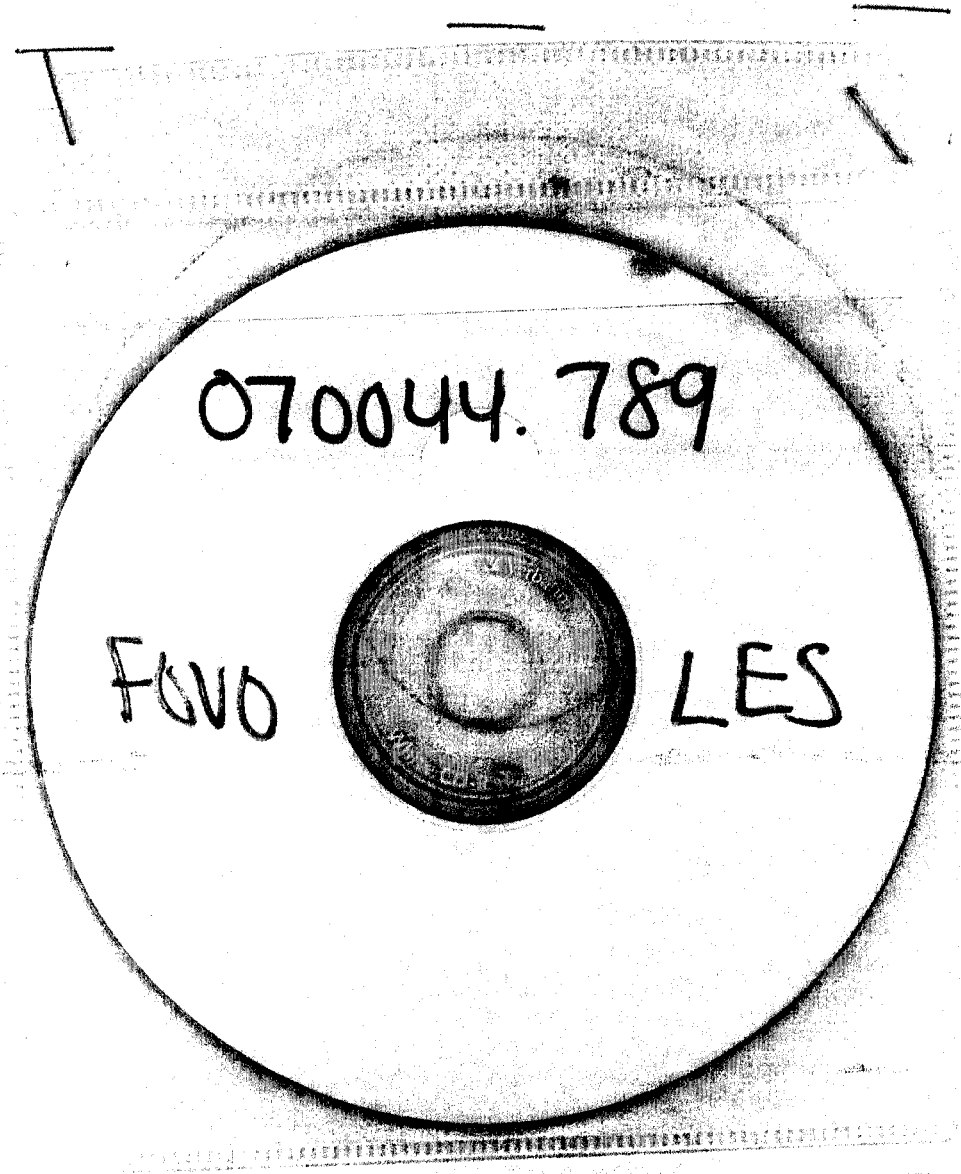

EXHIBIT 6

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
23Aug07 1340	Nurses Note: Pt has had several episodes of bradying down into 30's c BP 40's/20's for last several hours. (b)(6) is aware. Pt has ordered No BBs or ACEIs or ACEIs meds. Pt had one episode of Asystole lasting approx 20 seconds. (b)(6) No further Pt MAP is staying between 28-30. Pt sats maintain at 100 on vent will continue to monitor (b)(6)
23 Aug 07 1341	ICU Clinically deteriorating. HR ~ 30 c long pauses BP c MAP ~ 30. O2 sats 100% Pt appear confused & does not seem to be suffering. Pt is comatose & non-responsive to stim c ↓ BS. Plan c bradycardia and Distributed Widespread edema & anasarca. Pt is expectant & she will likely pass soon. Will Continue comfort measures (b)(6)

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

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

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

PROGRESS NOTES
Medical Record

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

EXHIBIT 7

ICU #9.

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~~LAW ENFORCEMENT SENSITIVE~~

(b)(6)

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
23 Aug 07 0725	Nurses Note: Assumed care of pt at 0645. Report recieved from (b)(6) (b)(6) will continue to monitor.

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

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

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

(b)(6)

PROGRESS NOTES
Medical Record

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

ICW #9

EXHIBIT 7

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~~LAW ENFORCEMENT SENSITIVE~~

ICU FLOW SHEET

Glasgow Coma Scale

Eyes Open:
- 4 - Spontaneously
- 3 – To speech
- 2 – To Pain
- 1 – None

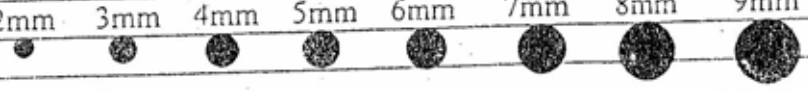
Verbal Response:
- 5 – Oriented
- 4 - Confused
- 3 – Inappropriate Words
- 2 – Incomprehensible Sounds
- 1 – None (Note – "T" = tube)

Motor Response:
- 6 – Obey Commands
- 5 – Localizes to pain
- 4 – Withdraws to Pain
- 3 – Flexion to pain
- 2 – Extension to pain
- 1 - None

Neuro Assessment Legend

Muscle Strength:
- 5 – Normal strength
- 4 – Moves against resistance
- 3 – Moves against gravity
- 2 – Moves not against gravity
- 1 – No movement

Pupil Scale



RESTRAINTS:	DAYS				NIGHTS			
0700 site	pulse	cap. ref.	edema	1900	Site	pulse	cap. ref.	ed
0900 site	pulse	cap. ref.	edema	2100	Site	pulse	cap. ref.	ed
1100 site	pulse	cap. ref.	edema	2300	Site	pulse	cap. ref.	ed
1300 site	pulse	cap. ref.	edema	0100	Site	pulse	cap. ref.	ed
1500 site	pulse	cap. ref.	edema	0300	Site	pulse	cap. ref.	ed
1700 site	pulse	cap. ref.	edema	0500	Site	pulse	cap.ref	ed

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESS NIG
TLC Lt subcl	01 AUG		(b)(6)		
A line Lt fem	31 JUL				

(b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 23 AUG 07

PATIENT'S INDENTIFICATION

(b)(6)

ICU #9

- ☐ HISTORY/PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT
- ☐ FLOWCHART
- ☐ OTHER

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EXHIBIT 7

(b)(6)

0044-07-CID789-23675

TIME	23	24	01	02	03	04	05	06
NIBP								
ABP (MAP)								
Pulse								
Respirations								
Temperature								
SaO2								
%O2								
O_2 Delivery								
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med								
Pt Position								
CVP								

24 Hour Totals	Yesterday	Today
INPUT		
OUTPUT		
DIFFERENCE		

Overall Fluid Status: +/-
(Running Total Fluid balance)

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV										
IVPB										
PO/ TF										
Other										
TOTAL										

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total										
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend	
Init=initials	P=Prone
JVD=Jugular Venous Distention	R= Right
L=Left	SaO2=Saturation of Arterial Oxygen
NIBP=Noninvasive Blood Pressure	~~POS=SUPINE~~
N=No	~~LAW ENFORCEMENT SENSITIVE~~
+2= strong +1=weak	PS=Pharmacologically Sedated

Name	Signature
(b)(6)	

EXHIBIT 7

TF 31 Medical, Baghdad, Iraq
Insulin Infusion Protocol (ICU Use Only)
(Updated July 2007)

Goal: Titrate blood glucose levels between 101 – 150 mg/dL

Initiation:

1) Initiate Insulin Infusion Protocol if 3 consecutive Blood Glucose levels >150 mg/dL or 1 Blood Glucose level >200 mg/dL

2) You MUST have a physician's order to initiate the infusion. All previous orders for insulin and oral hyperglycemic agents are discontinued.

3) Insulin Infusion Protocol and Flowsheet will be maintained in the patient's bedside record.

4) The Insulin Drip will be a standard concentration of 100 units Novolin R (Regular Insulin) in 100 ml NaCl to equal a **concentration of 1 unit/ml**. The insulin infusion bag should be changed every 24 hours and IV tubing changed every 72 hours. Ensure IV tubing and bag is labeled.

5) Insulin should be IV piggybacked into a maintenance carrier (NaCl) and always infused by pump.

Starting Insulin Infusion		
Blood Glucose	**IVP Insulin Bolus (Regular)**	**Initial Dose**
151-199 mg/dL	No bolus	* Start at 2 units/hr * If restarting drip – start at 1 unit/hr (no bolus)
200-250 mg/dL	Give 3 units Regular Insulin IVP	Start drip at 2 units/hr
251-300 mg/dL	Give 6 units Regular Insulin IVP	Start drip at 3 units/hr
301-350 mg/dL	Give 9 units Regular Insulin IVP	Start drip at 3 units/hr
> 350 mg/dL	Give 10 units Regular Insulin IVP	Start drip at 4 units/hr

EXHIBIT 7

Monitoring:

1) Check Glucose **every 1 hour** (either fingerstick or blood draw)

2) Titrate insulin drip according to table

3) If blood glucose remains within required goal for 3 consecutive hours, then glucose checks can be reduced to every 2 hours x 4; if blood glucose continues to remain within goal range, then glucose checks can be reduced to every 4 hours

4) Restart q1 hour glucose checks if any changes are required in the drip rate, or when glucose falls outside of goal range

Special Considerations:

1) If patient's enteral nutrition is interrupted for any reason, **decrease rate by ½,** and continue insulin drip per protocol.

2) If TPN is interrupted, start infusion of 10% Dextrose at same rate as TPN and continue insulin drip per protocol.

References:

Ku, S.Y., Sayre, C.A., Hirsch, I.B., & Kelly, J.L. (2005). New insulin infusion protocol improves blood glucose control in hospitalized patients without increasing hypoglycemia. *Joint Commission Journal on Quality and Patient Safety, 31*(3), 141-147.

Zimmerman, C.R., Mlynarek, M.E., Jordan, J.A., Rajda, C.A., & Horst, H.M. (2004). An insulin infusion protocol in critically ill cardiothoracic surgery patients. *The Annals of Pharmacotherapy, 38*, 1123-1129.

EXHIBIT 7

Insulin Infusion Titration Table

Glucose Level	Infusion Rate (1-5 units/hr)	Infusion Rate (6-10 units/hr)	Infusion Rate (11-16 units/hr)	Infusion Rate (>16 units/hr)
< 70	**STOP** infusion and give 1 Amp D50 IVP or if taking PO give 4 oz juice, and call MD. Recheck glucose in 30 min - 1 hour and continue to assess for hypoglycemia.			
71-100 mg/dL	* Discontinue infusion & recheck glucose in 1 hour.	* Decrease infusion by 50% and round up to the nearest whole number, recheck glucose in 1 hour.		
101-125 mg/dL	History of DM or steroids: no rate change All others: decrease rate by 2 units/hr		History of DM or steroids: no rate change All others: decrease infusion rate by 50% and round to nearest whole number	
126-150 mg/dL	History of DM or steroids: no rate change All others: decrease rate by 1 unit/hr		History of DM or steroids: no rate change All others: decrease infusion rate by 2 units/hr	
151-200 mg/dL	* Increase infusion by 1 unit/hr * NO IVP bolus	* Increase infusion by 2 units/hr * NO IVP bolus	* Increase infusion by 2 units/hr * NO IVP bolus	* Call MD for new order * NO IVP bolus
201-250 mg/dL	* Give 3 units Regular Insulin IVP * Increase infusion rate by 1 unit/hr	* Give 5 units Regular Insulin IVP * Increase infusion rate by 2 units/hr	* Give 5 units Regular Insulin IVP * Increase infusion rate by 2 unit/hr	* Call MD for new order
251-300 mg/dL	* Give 8 units Regular Insulin IVP * Increase infusion rate by 1 unit/hr	* Give 8 units Regular Insulin IVP * Increase infusion rate by 2 units/hr	* Give 8 units Regular Insulin IVP * Increase infusion rate by 2 units/hr	* Call MD for new order
301-350 mg/dL	* Give 10 units Regular Insulin IVP * Increase infusion rate by 1 unit/hr	* Give 10 units Regular Insulin IVP * Increase infusion rate by 2 units/hr	* Give 10 units Regular Insulin IVP * Increase infusion rate by 2 units/hr	* Call MD for new order
>350 mg/dL	* Give 10 units Regular Insulin IVP * Increase infusion rate by 2 units/hr	* Give 10 units Regular Insulin IVP * Increase infusion rate by 3 units/hr	* Give 10 units Regular Insulin IVP * Increase infusion rate by 3 units/hr	* Call MD for new order

EXHIBIT 7

TF 31 Medical – Insulin Infusion Flowsheet

Date/Time	Current Rate	Glucose Level	Rate Adjustment (+/-)	New Rate	Additional Interventions (Insulin Bolus/D50/Call MD, etc.)	Initial:
22AUG 1600	Ø	191	+1 UNIT	1 UNIT		(b)(6)
1700						

PR (b)(6)

DEPARTMENT/SERVICE/CLINIC ICU

DATE 22 AUG 07

PATIENT'S INDENTIFICATION

Hospital Number (b)(6)

ISN # (b)(6)

Originating Unit : ICW _____ Bed # _____

ICU _____ Bed # _____

- ☐ HISTORY/PHYSICAL
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ DIAGNOSTIC STUDIES

- ☐ FLOWCHART
- ☐ OTHER

EXHIBIT 7

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0044-07-CID789-23673

MEDIC__ RECORD - NURSING HISTORY AND A__SSMENT

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

1. Date (YYYYMMDD) and Time of Admission.	2. Admission Diagnosis.
20070701 @ 0200	S/P ex lap, small bowel repair Fragment wounds.

	YES	NO	Patient's own words when possible.
3. Tell me what you know about your illness/injury/hospitalization.			Pt. is unable to be interviewed at this time due to sedation from Propofol and Fentanyl gtts.
4. Do you have any other health problems?	☐	☐	
5. Have you been hospitalized before? If so, when and for what?	☐	☐	
6. What medications have you been taking? (to include prescription and over-the-counter drugs) For how long?	☐	☐	
7. Are you allergic to anything? If so, what? What reaction?	☐	☐	
8. Do you have any special needs that require assistance with daily activities? (e.g. diet, eating, bathing, elimination, ambulating, sleeping.) Prosthetics: dentures, reading glasses, contacts.	☐	☐	
9. What other concerns do you have?			
10. How can we be most helpful?			

11. Name of Local Contact/NOK.	12. Relationship.	13. Telephone Number.
N/A	N/A	N/A

14. Interviewer's Signature, Rank & Title.
(b)(6)

15. Informant/Relationship.
N/A

16. Patient Identification.
(b)(6)
ICU Bed #4

17. Personal Articles and Valuables. *(Indicate disposition of each item by initials.)* NONE

Item:	Bedside	Home	Treasurer	Other *(specify)*

EXHIBIT 1

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~~LAW ENFORCEMENT SENSITIVE~~

DA FORM 3888, FEB 2003 EDITION OF JUN 91 IS OBSOLETE. APD PE v1.00
Page 1 of 2

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: 22 Aug 07 TIME OF ORDER: 1755 HOURS

LIST TIME ORDER NOTED AND SIGN: (b)(6)

1. D/C Labs
2. D/C CXR
3. D/C ~~insulin~~ @ insulin drip / FS
4. Morphine 2-4 mg IV q 15 min, prn, pain, air hunger or suffering

(b)(6)

PATIENT IDENTIFICATION

24° chart ✓

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8/22/07 TIME OF ORDER: 1900 HOURS

(b)(6)

PATIENT IDENTIFICATION

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.

~~FOR OFFICIAL USE ONLY~~

~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 7

☆ U.S. GOVERNMENT PRINTING OFFICE: 2003-300-391

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 | TIME OF ORDER | LIST TIME ORDER NOTED AND SIGN

22 Aug 07 — 1344 HOURS

① Calcium chloride 10% Soln 1gm IV x 1 (b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

22 Aug 07 — 1545 HOURS

① Lasix 160 mg IV At 1700 hr (b)(6)

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

22 Aug 07 — 1651 HOURS

Magnesium sulfate 2 gm / 100 mL NS over two hrs. (b)(6)

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.: 24: chart ✓

22 Aug 07 — 1655 HOURS

① Hold Magnesium (Mg++ = 2.0) (b)(6)

(b)(6)

(b)(6)

DA FORM 1 APR 79 4256 — REPLACES EDITION OF 1 JAN 79, WHICH MAY BE USED. — FOR OFFICIAL USE ONLY — 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)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 Aug 07 TIME OF ORDER: 1804 HOURS

LIST TIME ORDER NOTED AND SIGN: (b)(6)

1. Do not ↑ dobutamine or Dopamine doses. (May decrease dose if Necessary)
2. If pt has hypotension, do Not change IVF doses or Med doses.
3. NO ACLS; NO BLS
4. Δ Ven-F702 = 4080

24 (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 Aug 07 TIME OF ORDER: 0715 HOURS

1. NaHCO3 1 Amp IV
2. Albumin 25% soln, 100 ml IV over 2 hrs
3. Lasix 200 mg IV x1

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 Aug 07 TIME OF ORDER: 1200 HOURS

1. ABG, BMP at 1300 hrs.

(b)(6)

Orders ver. for

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

EXHIBIT 7 47

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CLINICAL RECORD - DOCTOR'S ORDERS

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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.
ICU		9 24 chart

DATE OF ORDER: 20 Aug 07 TIME OF ORDER: 1225 HOURS

LIST TIME ORDER NOTED AND SIGN

① D/C All IVF boluses

X Meds

② Keep IVF At same rate

(b)(6)

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

DATE OF ORDER: ~~20~~ 21 Aug 07 TIME OF ORDER: 0908 HOURS

① Dobutamine 2 micrograms/kg/min IV ord increase dose to 5 micrograms/kg/min if tolerated by pulse & BP

~~② Wean dopamine to D/C~~

② IVF ⇒ NS to run At 100 cc/hr X 1 liter

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

DATE OF ORDER ↓ TIME OF ORDER ↓ HOURS

③ At Noon, Lasix 200 mg IV X 1.

④ Calcium chloride 10% Soln 1 gm Slow IV

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

DATE OF ORDER: 21 Aug 07 TIME OF ORDER: 1504 HOURS

① $NaHCO_3$ 1 Amp IV X 1

② ↓ IVF rate to 25 cc/hr

③ Titrate Dopamine to keep MAP >~~65~~ 70

④ Titrate Dobutamine to keep HR <100

⑤ Lasix 160 mg

(b)(6)

(b)(6)

(b)(6)

EXHIBIT 7

48

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: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 20 Aug 07 TIME OF ORDER: 0713 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)

1. Flush Foley
2. Kayexelate 30 gm per Dubhoff
3. $NaHCO_3$ 1 Amp IV
4. Albumin 25% soln, 100 mL IV over 2 hr
5. Lasix 200 mg IV x

(b)(6)

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF OR

6. Keep dopamine At 2 mcg/kg/min unless MAP > 115

(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER: 20 Aug 07 TIME OF ORDER: 1038 HOURS

1. BMP At 1400

(b)(6)

(10)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION

(b)(6)

DATE OF ORDER: 20 Aug 07 TIME OF ORDER: 1100 HOURS

1. Do not change dopamine dose
2. No ACLS Meds
3. No BLS or ACLS
4. Thanks

(b)(6)

(b)(6)

EXH

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)

Original ✓ 8/20/07

DA FORM 1 APR 79 4256

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: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 19 Aug 07 | TIME OF ORDER: 1057 HOURS | LIST TIME ORDER NOTED AND SIGN

(b)(6)

1. Albumin 25% solution infuse 100 cc over 4 hrs
2. Δ blood sugars to q2°

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 19 Aug 07 | TIME OF ORDER: 1914 HOURS

(b)(6)

1. ABG
2. BMP
3. At 2000 hrs, give 100 cc of 25% Albumin over 2hrs. At same time, start NS At 150 cc/hr for total of 500 cc, only.

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: ↓ | TIME OF ORDER: ↓ HOURS

(b)(6)

At 2100 hrs, Lasix 140 mg IV X1

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 19 Aug 07 | TIME OF ORDER: 2042 HOURS

(b)(6)

1. $NaHCO_3$ 1 Amp slow IV X1
2. Calcium 10% Soln, 1 gm slow IV

(b)(6)

(b)(6)

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: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 18 Aug 07 | TIME OF ORDER: 1350 HOURS | LIST TIME ORDER NOTED AND SIGN

① NaHCO₃ 1 Amp — 1400
IV x1

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 18 Aug 07 | TIME OF ORDER: 1651 HOURS

① Lasix 200 mg IV
② Albumin 25% 100 ml IV
③ NaHCO₃ 1 Amp IV
④ ~~ABG At~~ ①

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 18 Aug 07 | TIME OF ORDER: 1827 HOURS

① BMP @ 2000 hrs
If K+ > 5.3, ①
give 30 gm Kayexalate
per ~~tube~~ ①

(b)(6)

(b)(6)

(b)(6)

24° chart check completed

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 19 Aug 07 | TIME OF ORDER: 0739 HOURS

① Albumin 25%; 100cc IV
② Bolus with 500 cc NS
③ Lasix 200 mg IV
④ Calcium chloride 10% solution
1 gm slow IV
⑤ ~~Levofloxacin 250 mg IV x1~~
⑥ CXR

(b)(6)

(b)(6)

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LAW ENFORCEMENT SENSITIVE

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

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: ICU | ROOM NO. | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	17 Aug 07	1726 HOURS	
(1)	Lasix 200 mg IV x 1 now		
(2)	Fluconazole 200 mg per Dobhoff q AM		
		(b)(6)	
	(b)(6)		

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	
	18 Aug 07	0726 HOURS	
(1)	Albumin, 10%, 250 mL IV over 2 hrs		
(2)	After 1st hour of Albumin infusion, give Lasix 200 mg IV		
(3)	D/C Cipro		
(4)	Vancomycin 750 mg IV x 1		
(5)	Kayexelate 30 gm per dobhoff x 1		
			(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	
(1)	BMP at 1300 hrs with ABG	HOURS	
		(b)(6)	

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER	TIME OF ORDER
	HOURS

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 7

DA FORM 1 APR 79 4256 REPLACE EDITION OF 1 JAN 72 WHICH MAY BE USED

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)

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
16 Aug 07	1749 HOURS	(b)(6)
① Fluconazole 400 mg IV x1, Now		
② Lasix 240 mg IV x1		
③ BMP at ~~Mid~~ Midnight		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
16 Aug 07	HOURS	
① Δ Fluconazole to 400 mg per dobhoff (crushed) x1		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
16 Aug 07	1700 HOURS	
Hold Vitamin K.		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9 2°/docs- 16 Aug 0

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER	
17 Aug 07	0720 HOURS	(b)(6)
① Lasix 200 mg IV		
② Prior to lasix, give Mannitol 25 gm		
③ Fluconazole 200 mg per		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

~~FOR OFFICIAL USE ONLY~~
~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 1

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JAN 72 WHICH MAY BE USED.

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: ICU | ROOM NO.: 240 / done - 16 Aug 07 @ 0030 | BED NO.: 9

DATE OF ORDER: 15 Aug 07 | TIME OF ORDER: 1132 HOURS | LIST TIME ORDER NOTED AND SIGN

(b)(6)

(b)(6)

1. BMP at noon and 1800 hrs
2. ABG at noon
3. At 1400, give Albumin, 250 ml of 10-20 solution over 2 hrs. After Albumin complete, Lasix 240 mg

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 15 Aug 07 | TIME OF ORDER: 1953 HOURS

(b)(6)

(b)(6)

1. Lasix ~~300~~ 240 mg IV at Midnight
2. ↓ FiO_2 to 40%. (P)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 16 Aug 07 | TIME OF ORDER: 0812 HOURS

(b)(6)

(b)(6)

1. Calcium carbonate 500 mg crushed, per Dobhoff BID
2. Calcium chloride, 10% soln, 1 gm slow IV
3. Lasix 240 mg IV x 1 dose

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 16 Aug 07 | TIME OF ORDER: 0911 HOURS

(b)(6)

(b)(6)

1. Mannitol 25 gm IV

~~FOR OFFICIAL USE ONLY~~

~~LAW ENFORCEMENT SENSITIVE~~

EXHI

DA FORM 4250 1 APR 79 REPLACES EDITION OF 1 JAN 77, WHICH MAY BE USED.

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: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	14 Aug 07	1714 HOURS	(b)(6)
1	Hold PPN and lipids	(b)(6)	

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	
	14 Aug 07	1759 HOURS	(b)(6)
1	D/C Vancomycin		
2	Cipro ~~Sol~~ 400 mg IV qd, 1st dose this PM		
3	Mannitol 12.5 gm IV NO	(b)(6)	

24° chart ✓ 8/14/0 (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	
	14 Aug 07	1920 HOURS	(b)(6)
1	Vanc Δ = Fire = 508		
2	BMP at MN	(b)(6)	
3	Mannitol 12.5 gm IV with Lasix 80 mg IV At MN	(b)(6)	

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	
	15 Aug 07	0830 HOURS	(b)(6)
1	Albumin 250 ml of 5% solution to run in over 2hrs After 125 cc of Albumin infused, give Lasix 120 mg IV		
2	Hold tube feedings,	(b)(6)	(b)(6)

(b)(6) OFFICIAL USE ONLY ENFORCEMENT SENSITIVE

EXHIBIT 55

000055

DA FORM 4256 1 APR 79 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

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: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	14 Aug 07	0955		
1	D/C Lopressor			

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	HOURS
	14 Aug 07	1048	
1	↑ dopamine to 2 micrograms/kg/min		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	HOURS
	14 Aug 07	1404	
1	Renew PPN/ Lipids at prior rate and volume		
2	D/C Aminophylline		
3	Renew imipenem 500 mg IV q 6°		

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

	DATE OF ORDER	TIME OF ORDER	HOURS
	14 Aug 07	1640	
1	↑ Dopamine to 4 micrograms/ Kg/ MIN Titrate to keep MAP > 80		
2	D/C Aldactone		
3	Lasix ~~40 mg~~ @ 80 mg IV now		
4	Urine culture		

(b)(6)

(b)(6)

~~FOR OFFICIAL USE ONLY~~

~~LAW ENFORCEMENT SENSITIVE~~

DA FORM 4256 1 APR 79 REPLACES [illegible] 10-L-0126 ACLU CID ROI 7638

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)

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	13 Aug 07	1625 HOURS	
1.	RESTART ~~MVI~~ DDM.		
	V-(b)(6)		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER	
13Aug07	1750 HOURS	
hemoccult stool x1		
24 Hour 14 Aug 07 @ 04		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER		
13Aug07	2100 HOURS	
(1) Calcium chloride 10% soln 1gm slow IV.		
(2) Lasix 20mg IV x1 now		
(3) Δ IVF to TKO		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

Chart V 14 Aug 07 @ 0900 TC

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER	
14 Aug 07	0757 HOURS	
(1) Δ IVF to Sc/hr		
(2) Calcium chloride 10% Soln 1 gm slow IV		
(3) Lasix 40 mg IV x1		
(4) ↑ dopamine to 1 microgram/kg/min		
(5) ~~FOR STOOL LAB ONLY~~ Guaiac today		

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

~~LAW ENFORCEMENT SENSITIVE~~

EX 57

(b)(6)

DA FORM 1 APR 79 4256 REPLACES 10 (b)(6)

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)

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13 Aug 07	1320 HOURS	

(1) IL NS Bolus

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER
13 Aug 07	1518 HOURS

1. Renew PPN and Lipids at same volume & Rate

(b)(6)

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER
13 Aug 07	1525 HOURS

Lasix 20mg IV x 1 now please

(b)(6)

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER	TIME OF ORDER
13 Aug 07	1620 HOURS

(1) rev BMP @ 1900 hrs

(2) BMP @ 1900 hrs

(b)(6)

(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

(b)(6)

EXHIBIT 7

DA FORM 1 APR 79 4256 REPLACES EDITION OF [illegible] WHICH MAY BE USED.

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.
ICU		9

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13 Aug 07	0300 HOURS	

(1) ↑ IVF to NS 100 cc/hr
(2) Hold MVT for now
(3) Restart dopamine @ 2 ug/kg/min

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

DATE OF ORDER	TIME OF ORDER
13 Aug 07	0815

(1) Hold dopamine gtt

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

DATE OF ORDER	TIME OF ORDER
13 Aug 07	0840 HOURS

1. Recheck CMP, CBC @ noon
V.O

(b)(6)

PATIENT IDENTIFICATION

(b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

DATE OF ORDER	TIME OF ORDER
	HOURS

1. Restart Dopamine @ ~~2 ug~~ 1 mcg/kg/min to keep MAP above 70.

(b)(6)

(b)(6)

~~FOR OFFICIAL USE ONLY~~
~~LAW ENFORCEMENT SENSITIVE~~

59

DA 1 APR 79 4256 REPLACES EDITION OF JUN 67, WHICH MAY BE USED. 000059

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: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 12 Aug 07 TIME OF ORDER: 0741 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)

1. ↑ Aminophylline drip to 0.5 mg/kg/hr ⇒ 30 mg/hr
2. LASIX 20 mg IV x 1
3. BMP NOW (b)(6)

PATIENT IDENTIFICATION (b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 12 Aug 07 TIME OF ORDER: 1311 HOURS

(b)(6)

1. ↓ Aminophylline drip to 0.3 mg/kg/hr ⇒ 18 mg/hr
2. Calcium chloride 10% Soln 1 gm slow IV
3. Restart dopamine at 1 microgram/kg/min titrate to MAP ≥ 70 (b)(6)

PATIENT IDENTIFICATION (b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 12 Aug 07 TIME OF ORDER: 1355 HOURS

(b)(6)

1. D/C NGT
2. Dobhoff tube please for tube feeding (b)(6)

ORDERS VERIFIED 12 AUG 07

@ (b)(6)

PATIENT IDENTIFICATION (b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER: 12 Aug 07 TIME OF ORDER: 1500 HOURS

(b)(6)

Renew PPN and lipids at same volume and rate.

(b)(6)

(b)(6)

(b)(6)

EXHIBIT 1

60

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.
ICU		9

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	11 Aug 07	1609 HOURS	(b)(6)
1	Lasix 20 mg IV	(b)(6)	

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

	DATE OF ORDER	TIME OF ORDER	
	11 Aug 07	HOURS	(b)(6)
1	Clonidine 0.1 mg Per NGT x1	(b)(6)	
2	If no improvement in BP in 45 Min, enalapril 2.5 mg IV	(b)(6)	

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

	DATE OF ORDER	TIME OF ORDER	
	11 Aug 07	1936 HOUR	(b)(6)
1	BMP At 2200 hrs		
	KCl 40 meq IV over 4 hrs if Kt < 3.9		
2	Lasix 20 mg IV At 2100 hr		
3	If SBP > 160 or DBP > 100 or MAP > 110, enalapril 2.5 mg IV. May repeat		

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT	ROOM NO.	BED NO.
ICU		9

	DATE OF ORDER	TIME OF ORDER	
		HOURS	
	X T if No. A in BP over 30 Minutes. Max dose of enalapril over 6 hrs is 7.5 mg.	(b)(6)	
	~~EXPIRED~~ 12 Aug 07 @	(b)(6)	

EXHIBIT 7

61

DA FORM 4250 1 APR 79 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED. 000061

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: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 10 Aug 07 | TIME OF ORDER: 1820 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Rx Tylenol Per NGT x 1 now — (b)(6)

24° chart — (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: | TIME OF ORDER: HOURS

1 liter NS Bolus Aug 10 07 x 1

Wean dopamine — (b)(6)

Chart V's Aug 07 @ 1300 TR

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 11 Aug 07 | TIME OF ORDER: 1107 HOURS

(1) ↓ Aminophylline rate to 0.3 mg/kg/hr ⇒ 18 mg/hr (estimated weight = 60 kg)

(2) ~~Δ Aldactone to 25 mg per NGT BID~~ (R)

(2) Δ IVF rate to 25 cc/hr

(3) Δ Aldactone to 25 mg per NGT BID — (b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

DATE OF ORDER: | TIME OF ORDER: HOURS

(4) Calcium Chloride 10% solution 1 gm Slow IV

(5) Renew TPN/lipids at prior volume and rate — (b)(6)

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 7

62

DA FORM 4250 1 APR 79 — REPLACES EDITION OF JUN 72 WHICH MAY BE USED

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: 10 Aug 07 TIME OF ORDER: 0842 HOURS

LIST TIME ORDER NOTED AND SIGN: (b)(6)

1. ↓ IVF rate to TKO
2. KCL 40 meq IV over 4hrs
3. Calcium chloride 10% solution 1 gm slow IV

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Aug 07 TIME OF ORDER: 1857 HOURS

1. Renew PPN / Lipids at same volume & rate

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 Aug 07 TIME OF ORDER: 1625 HOURS

(b)(6)

1. Bolus with 500 cc NS, then ↑ ~~to~~ rate to 100 cc/hr
2. D/C Flagyl
3. Starting at 0700 hr tomorrow AM, Aminophylline ~~(6 mg/kg) ⇒ 360~~ (5 mg/kg) ⇒ 300 mg loading dose over 30 minutes, then

(b)(6)

PATIENT IDENTIFICATION: (b)(6)

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER ↓ TIME OF ORDER ↓ HOURS

0.5 mg/kg/hr ⇒ 30 mg/hr by continuous IV infusion (estimated weight is 60 kg)

(b)(6)

FOR CLINICAL USE ONLY

(b)(6)

24 hr chart ✓ 8/10/07

EXHIBIT 7

63

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED. 000063

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)

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND
8 Aug 07	1343 HOURS	

(1) Continue same PPN and lipids at same rate

(2) D/C Levofloxacin

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

24°chart ✓ 8 8

(b)(6)

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER | TIME OF ORDER

8 Aug 07 2140 HOURS

✓ 500cc NS Bolus

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

DATE OF ORDER | TIME OF ORDER

9 Aug 07 0171 HOURS

(1) Continue same PPN and lipids at same rate

(2) Transfuse 2u PRBC, each over 3-4 hrs. NS Premed

(3) Lasix 20 mg IV after 1st unit transfused

(4) Calcium chloride 10% soln, 1 gm slow IV

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

PATIENT IDENTIFICATION (b)(6)

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 7

64

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

000064

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)

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
7 Aug 07	1455 HOURS	
(1) Lasix 10mg IV x1		
(2) Restart Aldactone 25mg per NGT q.d starting in AM		

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER
7 Aug 07	1704 HOURS
(1) Magnesium Sulfate 2gm IV over 2 hrs	
(2) Lasix 20mg IV	

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

24° chart ✓ 8/7/07

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER
7 Aug 07	2200 HOURS
Lasix 20mg IVP x1 now	

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

Chart ✓ 8/8/07 @ 1200

PATIENT IDENTIFICATION: (b)(6)

DATE OF ORDER	TIME OF ORDER
8 Aug 07	0750 HOURS
(1) KCL 40 meq IV over 4 hrs	
(2) Calcium chloride 10% soln 1gm slow IV	

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 9

~~FOR OFFICIAL USE ONLY~~

~~LAW ENFORCEMENT SENSITIVE~~

24° chart ✓ 8/8/07

EXHIBIT 7

DA FORM 4250 1 APR 79 REPLACES EDITION OF 1 JUL 37, WHICH MAY BE USED

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: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
5 Aug 07	1517 HOURS	
1. continue same ppn and lipids at same rate		
V. (b)(6)		
24° chart √ done 8/5/07 (b)(6)		

PATIENT IDENTIFICATION
(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER	TIME OF ORDER	
6 Aug 07	1522 HOURS	(b)(6)
1. continue same ppn and lipids at same rate		
(b)(6)		

PATIENT IDENTIFICATION
(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 9

DATE OF ORDER	TIME OF ORDER	
7 Aug 07	1145 HOURS	
① Lopressor 12.5 mg per NGT BID		
② Hold for HR < 45, SBP < 100		(b)(6) (b)(6)

PATIENT IDENTIFICATION
(b)(6)

NURSING UNIT: ICU | ROOM NO. | BED NO.: 59

DATE OF ORDER	TIME OF ORDER	
1445	07 Aug 07 HOURS	
1. Continue same ppn and Lipids at same rate.		
(b)(6)		
24 chart √ (b)(6)		

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EXHIBIT 1

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

Basis for Investigation: About 0800, 24 Aug 07, this office received a Request for Assistance (RFA) from Camp Cropper CID Office, 86th Military Police Detachment (CID), 22nd Military Police Battalion (CID), Baghdad, Iraq APO AE 09342, to attend the autopsy of Mr. Hatem Krarem LATEEF, Detainee, Internment Settlement Number (ISN) [redacted] 31st Combat Support Hospital (CSH), Camp Cropper, Iraq APO AE 09342.

About 1100, 27 Aug 07, SA [redacted] attended the autopsy of Mr. LATEEF (ME # 07-1053), which was conducted by Dr. (CPT) [redacted] USA, Associate Medical Examiner, OAFME, AFIP, 1413 Research Blvd, Bldg 102, Rockville, MD 20850. The preliminary cause and manner of death was opined as pending. Photographers from AFIP exposed digital photographs of the autopsy and prepared a compact disc (CD) containing all images exposed. A copy of the CD containing all images was obtained. Fingerprints were obtained by the FBI. (See CD for details)

STATUS: The official results of the autopsy will be documented in the Final Autopsy Report, which will be provided upon completion. /// Last Entry ///

SA [redacted] APG Resident Agency (CID)
Sp[redacted] APG, MD 21005

Si[redacted] Date: 27 Aug 07 Exhibit: 8

CI[redacted] FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
301-319-0000

AUTOPSY EXAMINATION REPORT

Name: Lateef, Hatem K (b)(6)
ISN: (b)(6)
Date of Birth: (b)(6) 1985
Date of Death: (b)(6) 2007
Date/Time of Autopsy: 27 AUG 2007 @1100 hrs
Date of Report: 20 NOV 2007

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

Circumstances of Death: It is reported that this detainee was admitted to the 31st Combat Surgical Hospital on (b)(6) 2007 after receiving numerous battlefield injuries including shrapnel injuries, lacerations of the liver, kidney damage, and brain injury. He clinically suffered multiple complications including hemothorax, pneumothorax, bowel perforation, diabetic ketoacidosis, cardiac arrest (two times), congestive heart failure, anoxic brain injury, and peritonitis. Despite treatment, this detainee died 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 accompanying paperwork. Post-mortem dental charting, fingerprints and a specimen suitable for DNA comparison are obtained.

CAUSE OF DEATH: **Complications of blast and blast fragmentation injuries.**

MANNER OF DEATH: **Homicide.**

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EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished male clad in a hospital gown. The body exhibits generalized edema, weighs 156 pounds, is 69 inches in length, and appears compatible with the reported age of 21 years. The body is cold. Rigor has passed. Lividity is present and fixed on the posterior surface of the body, except in areas exposed to pressure. Skin slippage is identified on the extremities and face.

The head is normocephalic, and the scalp hair is short and black. The irides are brown. The corneae are cloudy. The conjunctivae are congested. The sclerae are white. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal skeleton and maxilla are palpably intact. The lips are without evident injury. The teeth are natural. Examination of the neck reveals no evidence of injury.

Injuries of the torso and extremities are described below. No evidence of injury of the ribs or the sternum is evident externally. The abdomen is protuberant. Healed surgical scars are noted on the abdomen. The external genitalia are those of an adult male. The anus is without note. The scrotum is swollen.

The fingernails are intact. Decubitus ulcers are identified on the lower back overlying the sacrum (6 x 2 inches), the buttock (1/4 inch), the back of the head (1 inch), the medial surface of the right thigh (4 x 4 inches), and the lateral surfaces of both heels (right - 2 x 1 inch, left - 1 1/2 x 3/4 inches).

CLOTHING AND PERSONAL EFFECTS

- None

MEDICAL INTERVENTION

- Nasogastric tube
- IV access (left subclavian; left groin)
- Laparotomy scar (10 inch vertical with a 1 inch area of granulation tissue on the superior, and a 1 1/2 inch area of granulation tissue on the inferior aspects)
- Foley catheter and attached urine bag
- EKG leads on the torso
- Multiple gauze dressings
- Sutures located in multiple loops of small and large bowel
- Tracheostomy
- A plastic bag is affixed to the left lower quadrant of the abdomen overlying a 1 inch stapled incision

RADIOGRAPHS

A complete set of postmortem radiographs is obtained.

EVIDENCE OF INJURY

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

HEAD/NECK:

On the left side of the face, lateral to the left eye, is a 1/4 inch scar. Radiographically there is a minute fragment of radiopaque foreign material (not recovered).

TORSO:

There is a 1 x 1 inch healing laceration on the right side of the chest, a 1/4 x 1/4 inch healing laceration of the center of the chest just left of the midline, and two healing lacerations of the left side of the chest lateral to the left nipple (1/2 x 1/2 inch and 1 1 /2 x 1 inch). Within the superior aspect of the above described laparotomy scar is a 1/4 x 1/4 inch healing laceration. On the right side of the abdomen are two 1/8 inch healing lacerations. On the left side of the abdomen are two healing lacerations that measure 1/2 and 1 1/2 inches in greatest dimension. On the right lower back is a 1/4 x 1/4 inch healing laceration. Multiple radiopaque foreign bodies are detected in the torso radiographically. However, due to their small size and limited evidentiary value these foreign bodies are not recovered. One thousand two hundred and fifty milliliters of serosanguineous fluid is identified in the right chest cavity, and 350 mL of serosanguineous fluid is identified in the left chest cavity. One liter of serosanguineous fluid is identified in the abdomen with mucous and frank pus present. There is a 250 mL of clotted blood identified in the left lower quadrant of the abdomen. Within the area of the clotted blood, there is a small amount of green stool. There is a 1 inch superficial laceration of the left lobe of the liver and a 1/2 inch superficial laceration of the spleen. Both of these wounds appear to be healing and are associated with old hemorrhage into the surrounding tissues. There are multiple defects of the small and large bowel that are sutured. The left scapula is fractured. Posterior cutdowns revealed hemorrhage into the soft tissues of the right buttock.

Exhibit 171

EXTREMITIES:

Right upper extremity - There is a 1 inch healing laceration of the posterior right arm. A cutdown of the forearm reveals hemorrhage into the anterior muscle group of the forearms.

Left upper extremity - There is a 1/2 inch healing laceration of the anterior forearm, and two 1/8 inch healing lacerations of the posterior forearm.

Right lower extremity - There is a 1/4 inch abrasion of the distal anterior thigh, and 3/4 x 1/4 inch healing laceration of the proximal right shin. There is a 1/4 inch healing laceration of the posterior right thigh, and four (4) 1/4 inch healing lacerations of the lateral right ankle.[1]

INTERNAL EXAMINATION

BODY CAVITIES:

The body is opened by the usual thoraco-abdominal incision and the chest plate is removed. The ribs, sternum, and vertebral bodies are visibly and palpably intact. Multiple adhesions are identified in both chest cavities and in the abdomen. All body organs are present in normal anatomical position. The subcutaneous fat layer of the abdominal wall is 1/8 inch thick.

HEAD AND CENTRAL NERVOUS SYSTEM

The scalp is reflected. The galeal and subgaleal soft tissues of the scalp are free of injury. There are no skull fractures. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. There is no epidural or subdural hemorrhage present. The leptomeninges are thin and delicate. The 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 1260-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. The spinal cord is unremarkable. The entire brain is soft, however, this finding is most prominent in the brainstem.

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. Incision and dissection of the posterior neck demonstrates no deep paracervical muscular injury and no cervical spine fractures.

[1] The healing lacerations that are described most likely represent superficial and deep penetrating blast fragmentation injuries.

CARDIOVASCULAR SYSTEM:

The 310-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 wide patency. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left ventricle, interventricular septum, and right ventricle are 1.2, 1.2, and 0.3 cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

RESPIRATORY SYSTEM:

The upper airway is clear of debris and foreign material: the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma is diffusely congested and edematous, exuding slight to moderate amounts of blood and frothy fluid; no focal lesions are noted. The cut surfaces are firm and red. The pulmonary arteries are normally developed, patent and without thrombus or embolus. The right lung weighs 880 grams; the left 690 grams.

HEPATOBILIARY SYSTEM:

See Evidence of Injury. The 1230-gram liver has a smooth capsule. The cut surface of the liver has a nutmeg appearance. No focal nontraumatic lesions are identified. The gallbladder contains 10 ml of green-brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi.

GASTROINTESTINAL SYSTEM:

See Evidence of Injury. The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 10 ml of brown fluid. The small and large bowels are described above. The pancreas has a normal pink-tan lobulated appearance and the ducts are clear.

GENITOURINARY SYSTEM:

The right kidney weighs 110 grams; the left 200 grams. The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying smooth, red-brown cortical surface. The cortex is dotted with numerous (less than 0.1 cm) abscesses. The calyces, pelves and ureters are unremarkable. White bladder mucosa overlies an intact bladder wall. The bladder is empty. The prostate gland and seminal vesicles are without note.

LYMPHORETICULAR SYSTEM:

See Evidence of Injury. The 320-gram spleen has a smooth, capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. Lymph nodes in the hilar, periaortic, and iliac regions are not enlarged.

ENDOCRINE SYSTEM:

The thyroid gland is symmetric and red-brown, without cystic or nodular change. The right and left adrenal glands are symmetric, with bright yellow cortices and red-brown medullae. No masses or areas of hemorrhage are identified.

MUSCULOSKELETAL SYSTEM:

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

ADDITIONAL PROCEDURES

1. Documentary photographs are taken by OAFME staff photographers.
2. Personal effects are released to the appropriate mortuary operations representatives.
3. Specimens retained for toxicology testing and/or DNA identification are: brain, heart, lung, kidney, liver, spleen, skeletal muscle, adipose tissue, blood, vitreous fluid, gastric contents, bile, and urine (from urine bag).
4. The dissected organs are forwarded with body.

MICROSCOPIC EXAMINATION

Lung (Slide 1) – There is extensive autolysis, congestion and edema. Intra-alveolar neutrophils are seen, consistent with an acute bronchopneumonia.

Spleen (Slide 1) – No significant pathological changes.

Kidney (Slide 2) – Numerous cortical abcesses are identified

Liver (Slide 3) – Necrosis is identified and confined to the peri-central hepatocytes. There is relative sparing of the peri-portal hepatocytes. These changes are consistent with centrolobular necrosis.

Brain (Slide 4) – There are changes consistent with anoxic brain injury and ischemia.

Heart (Slides 5, 6, 7) – Focal areas of granulomatous inflammation with calcifications are seen. There is focal sub-endocardial myocytolysis and necrosis. Special stains (periodic acid-Schiff, Gomori methenamine silver and Ziehl-Neelsen) are negative.

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Exhibit 10 74

FINAL AUTOPSY DIAGNOSES:

I. Blast and blast fragmentation injuries
   - A. Multiple superficial and deep penetrating blast fragmentation injuries
   - B. Multiple lacerations of the small and large bowel
   - C. Clotted blood and stool is identified in the left lower quadrant of the abdomen
   - D. Lacerations of the spleen
   - E. Lacerations of the liver

II. Other findings:
   - A. Anoxic brain injury
   - B. Acute bronchopneumonia
   - C. Acute pyelonephritis with abcess formation
   - D. Changes consistent with peritonitis
   - E. Centrolobular necrosis of the liver
   - F. Granulomatous myocarditis
   - G. Serosanguineous fluid is identified in both chest cavities and the abdomen
   - H. Multiple adhesions are identified in both chest cavities and the abdomen

III. Medical therapy: As described above

IV. Postmortem changes: As described above

V. Identifying marks: None

VI. Toxicology (AFIP):
   - A. VOLATILES: No ethanol is detected in the blood and vitreous fluid. Acetone is detected in the blood (11 mg/dL) and vitreous fluid (14 mg/dL). Trace amounts of 2-Propanol are detected in the blood and vitreous fluid.
   - B. DRUGS: No screened drugs of abuse or medications are detected in the blood.
   - C. CARBON MONOXIDE: The carboxyhemoglobin saturation in the blood was less than 1%.
   - D. CYANIDE: No cyanide is detected in the blood.

Exhibit 10 75

AUTOPSY REPORT (b)(6)
LATEEF, Hatem K ((b)(6))

OPINION

This 21-year-old male, Hatem K. Lateef, died of complications of blast and blast fragmentation injuries. The toxicology results can be explained by a clinical history of ketoacidosis (acetone in the blood and vitreous fluid) and post-mortem production (2-propanol in the blood and vitreous fluid). The manner of death is homicide.

(b)(6)

(b)(6) MEDICAL EXAMINER

Exhibit 76

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
LATEEF, HATEM KRAREM

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

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 8/23/2007 **Date Received:** 8/30/2007

CARBON MONOXIDE: The carboxyhemoglobin saturation in the blood was less than 1% as determined by spectrophotometry with a limit of quantitation of 1%. Carboxyhemoglobin saturations of 0-3% are expected for non-smokers and 3-10% for smokers. Saturations above 10% are considered elevated and are confirmed by gas chromatography.

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

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

	Acetone	Ethanol	2- Propanol
BLOOD	11	NF	Trace
VITREOUS FLUID	14	NF	Trace

NF = "None Found"
Trace = value greater than or equal to 1mg/dL, but less than 5 mg/dL

Exhibit 10 77

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

REPLY TO
ATTENTION OF

REPORT OF TOXICOLOGICAL EXAMINATION(CONTINUED (b)(6) LATEEF):

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

None were found.

(b)(6)

Exhibit 178

DIVISION OF FORENSIC TOXICOLOGY - TOXICOLOGICAL REQUEST FORM

TO:	FORWARD FINAL REPO
ARMED FORCES INSTITUTE OF PATHOLOGY ATTN: DIVISION OF FORENSIC TOXICOLOGY BUILDING 54 6825 16TH STREET, N.W. WASHINGTON, DC 20306-6000	(b)(6) Incident : OIF Remains/Case #: (b)(6) Recovery/TC #: Process Date: 27 Aug 07 ME #: (b)(6)

NAME OF PATIENT (Last, First, MI)	SOCIAL SECURITY #	AGE	SEX	RACE
(b)(6)	(b)(6)	21	MALE	

DATE OF INCIDENT/ ACCIDENT	TIME AND DATE OF DEATH	AUTOPSY #
(b)(6) 07	(b)(6) 07	

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

SPECIMEN/AMOUNT	SPECIMEN/AMOUNT	SPECIMEN/AMOUNT
1. BRAIN	5. SPLEEN	9. BILE
2. LUNG	6. KIDNEY	10. URINE
3. LIVER	7. ADIPOSE	11. GASTRIC CONTENTS
4. HEART	8. BLOOD	12. VITREOUS

INCIDENT/ACCIDENT DETAILS (*Include pertinent information regarding scene, site, autopsy, or investigation (i.e., What happened?)*)

Detainee DFT
Died from complications of
Blunt Trauma

DFT# (b)(6)

PRINTED NAME OF REQUESTER/ TITLE	SIGNATURE	DATE	PHONE # (DSN/COMM)
(b)(6)	(b)(6)	27 Aug 07	

CHAIN OF CUSTODY (CC)

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

(b)(6)	RECEIVED BY	DATE & TIME	PURPOSE OF TRANSFER
	SIGNATURE PRINTED NAME	27 Aug 07	To Toxy
	(b)(6)	AUG 2007 0943	Received From Courier
	SIGNATURE PRINTED NAME Secured Storage	AUG 2007 0943	TOXICOLOGY TESTING SECURED STORAGE
	SIGNATURE PRINTED NAME		
	SIGNATURE PRINTED NAME		

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Exhibit 179

CERTIFICATE OF DEATH (OVERSEAS)

Acte de décès (D'Outre-Mer)

NAME OF DECEASED (Last, First, Middle) Nom du défunté (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Social
Lateef, Hatem, Krarem		Civilian	(b)(6)
ORGANIZATION Organisation	NATION (e.g. United States) Pays	DATE OF BIRTH Date de naissance	SEX Sexe
	Iraq	(b)(6) 1985	[X] MALE [ ] FEMALE

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du défunté avec le sus
STREET ADDRESS Domicile 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 CONDITION DIRECTLY LEADING TO DEATH [1] Maladie ou condition directement responsable de la mort.	Complications of blast and blast fragmentation injuries	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		
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 [2]		

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

DATE OF DEATH (day, month, year) Date du décès (le jour, le mois, l'année)	PLACE OF DEATH Lieu de décès
(b)(6) 2007 15:31	Iraq

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

NAME OF MEDICAL OFFICER Nom du médecin militaire ou du médecin assermenté	TITLE OR DEGREE Titre ou diplôme
(b)(6)	(b)(6) Medical Examiner
GRADE Grade (b)(6)	INSTALLATION OR ADDRESS Installation ou adresse Dover AFB, Dover DE
(b)(Date 2007	(b)(6)

1 State Disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.
2 State conditions contributing to the death, but not related to the disease or condition causing death.
1 Indiquer la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc
2 Indiquer les conditions qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

DD FORM 1 APR 77 2064 REPLACES DA FORM 3505, 1 JAN 72 AND DA FORM 3565-R(PAS), 28 SEP 76, WHICH ARE OBSOLETE.

Exhibit 180