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

30 Jun 2008

MEMORANDUM FOR: SEE DISTRIBUTION

SUBJECT: CID REPORT OF INVESTIGATION - FINAL/SSI - 0004-2008-CID789-53196 - 5H9A

DATES/TIMES/LOCATIONS OF OCCURRENCES:
1. 09 FEB 2008, 1845 - 09 FEB 2008, 1845; 31ST COMBAT SUPPORT HOSPITAL, CAMP CROPPER, BAGHDAD, IRAQ APO AE 09342

DATE/TIME REPORTED: 09 FEB 2008, 1848

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

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

VICTIM:
1. ANAD AL-JANABI, RASUL SAID (DECEASED); FRCIV; IRAQ; (DOB); (POB); MALE; OTHER; INTERNMENT SERIAL NUMBER (ISN) US b(6), b(7)(C) CAMP REMEBRANCE II, THEATER INTERNMENT FACILITY, CAMP CROPPER, BAGHDAD, IZ; XZ ; [DEATH BY NATURAL CAUSES]

INVESTIGATIVE SUMMARY:

This is an Operation Iraqi Freedom Investigation.

ACLU DDI CID ROI 29456

ACLU-RDI 5584 p.1

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This office was notified by the 31st Combat Support Hospital (CSH), Camp Cropper, Iraq APO AE 09342 (CCIZ), of the death of Mr ANAD while in the Intensive Care Unit (ICU), 31st CSH, CCIZ.

Investigation determined Mr ANAD was admitted to the 31st CSH on 6 Feb 08 for complications associated with pneumonia and congestive heart failure. On 9 Feb 08, Mr ANAD went into a state of cardiac arrest, which he did not recover and was subsequently pronounced dead. An autopsy conducted by the Office of the Armed Forces Medical Examiner (OAFME) revealed the cause of death was complications of idiopathic dilated cardiomyopathy and the manner of death was natural. The results of this investigation were consistent with their findings.

STATUTES:

N/A

EXHIBITS:

ATTACHED:

1. Agent's Investigation Report (AIR) of SA b(6), b(7)(C) 8 Mar 08.
2. Medical Records of Mr ANAD.
3. AIR of SA b(6), b(7)(C) 9 Feb 08.
4. Death Scene Sketch, 9 Feb 08.
5. Photographic Packet (Death Scene).
6. CD containing original images associated with Exhibit 5 (USACRC and file copies only).
7. AIR of SA b(6), b(7)(C) 14 Feb 08.
8. Photographic Packet (Autopsy).

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

10. AIR of SA [b(6), b(7)(C)] 24 Jun 08.

11. Final Autopsy Examination Report, OAFME, number ME08-0126, 2 Jun 08.

12. DD Form 2064, Certificate of Death (Overseas), 16 Jun 08.

The originals of Exhibits 1 and 3 - 10 are forwarded with the USACRC copy of this report. The original of Exhibit 2 is retained in the files of the 115th Combat Support Hospital, Camp Cropper, Baghdad, Iraq APO AE 09342. The originals of Exhibit 11 and 12 are retained in the files of the Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850.

NOT ATACHED:

None.

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.

ACLU DDI CID ROI 29458

ACLU-RDI 5584 p.3

Report Prepared By:

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

Special Agent

Report Approved By:

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

Special Agent in Charge

DISTRIBUTION:
Dir, USACRC, Ft Belvoir, VA
Commander, 20th/1149th MP DET (CID), Camp Slayer, Baghdad, Iraq APO AE 09342
Commander, 11th MP BN (CID) (FWD), Camp Victory, Baghdad, Iraq, APO AE 09342
Commander, 3D MP GRP (CID), USACIDC, Fort Gillem, GA 30297
Chief, DSCOPS, USACIDC, 6010 6th Street, Fort Belvoir, VA 22060
Director, Armed Forces of the Institute of Pathology, Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20852
FOB Commander, 1-161 Field Artillery, ATTN: LTC b(6), b(7)(C) Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
Commander, 744th MP BN, Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
Office of the Staff Judge Advocate, 300th Military Police Brigade, ATTN: MAJ b(6), b(7)(C) Camp Cropper, Baghdad, Iraq APO AE 09342 (Email only)
FILE

ACLU DDI CID ROI 29459

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0004-08-CID789-53196

PAGE 1 OF 1 PAGE

DETAILS

BASIS FOR INVESTIGATION: About 1848, 9 Feb 08, this office was notified by SPC b(6), b(7)(C) XXX-XX[b(6), b(7)(C)] Patient Administration Division (PAD), 31st Combat Support Hospital (CSH), Camp Cropper, IZ APO AE 09342 (CCIZ), of a undetermined death of a detainee identified as Mr. RASUL Said Anad Al-Janabi, Internment Serial Number (ISN) US[b(6), b(7)(C)] Camp Remembrance II (CRII), Theater Internment Facility (TIF), CCIZ, while he was treated for chest pains at the 31st CSH, CCIZ.

About 1905, 9 Feb 08, SA[(b)(6), (b)(7)(C), (b)(7)(F)] interviewed MAJ (Doctor) b(6), b(7)(C), Attending Physician, Intensive Care Unit (ICU), 31st CSH, CCIZ, who related Mr. RASUL Said Anad Al-Janabi, arrived to ICU on 6 Feb 08. MAJ[b(6), b(7)(C)] stated Mr RASUL Said Anad Al-Janabi did not have any apparent external trauma injuries. MAJ[b(6), b(7)(C)] stated Mr. RASUL was admitted to the 31st CSH approximately two weeks prior for feeling sick and not being able to sleep on his back. On 6 Feb 08, Mr. RASUL was again admitted to the 31st CSH for complaints of pneumonia and again unable to sleep on his back. MAJ[b(6), b(7)(C)] then stated an x-ray was taken of Mr. RASUL's chest which showed an enlarged heart. MAJ[b(6), b(7)(C)] also stated the symptoms he complained about were indicative of a congestive heart failure. MAJ[b(6), b(7)(C)] stated that there was little treatment available for Mr. RASUL and his condition steadily declined. On 8 Feb 08, Mr. RASUL went into cardiac arrest and was revived. MAJ[b(6), b(7)(C)] stated his condition at that time started spiraling downward. At 1839, 9 Feb 08, Mr. RASUL again went into cardiac arrest. All attempts to revive Mr. RASUL were unsuccessful. MAJ[b(6), b(7)(C)] pronounced Mr. RASUL at 1845, 9 Feb 08. MAJ[b(6), b(7)(C)] opined preliminary causes of death were congestive heart failure, renal failure and anoxic encephalophathy (brain death from lack of oxygen). MAJ[b(6), b(7)(C)] stated Mr. RASUL was given lasix, spironalactone, lopressor, captiopril, rocepehin and zithromax as medications during his treatment.

About 2004, 9 Feb 08, SA[b(6), b(7)(C)] released the remains of ISN:[b(6), b(7)(C)] to SFC b(6), b(7)(C) S-4, XXX-XX-[b(6), b(7)(C)] 31st CSH, CCIZ, for transportation to the Armed Forces Institute of Pathology (AFIP), Dover, MD, for autopsy.

About 1300, 8 Mar 08, SA[b(6), b(7)(C)] coordinated with SSG b(6), b(7)(C), XXX-XX-[b(6), b(7)(C)] PAD, 31st CSH, CCIZ, who provided all medical documentation concerning Mr. RASUL. ///LAST ENTRY///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION	
SA [(b)(6), (b)(7)(C), (b)(7)(F)] b(6), b(7)(C)	20th/1149th Military Police Detachment (CID) Camp Cropper, Baghdad, Iraq, APO AE 09342	
SIGNATURE	DATE	EXHIBIT
	8 Mar 08	1

ACLU DDI CID ROI 29460

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 Jan 14	
3 Jan 14	19 Yo F with 2 week Hx of dyspnea, pnd and facial edema discharged c idiopathic Dcm. EKG showed ↑ Chamber enlargement. Exam showed ↓ Heart Rate, Regular Rhythm, pedal edema and JVD. Treated c Lasix, Nitrates, Captopril and Lopressor. Due to possible renal dysfunction EKG also performed Rocephin and Zithromax. On day two Suffered a PEA/Asystole arrest. Recovered after 2 rounds of Epi and 2 rounds of Atropine. The following day he was noted to have anoxic encephalopathy and acute renal failure. He had a GCS of 3, fixed pupils that reacted to light, absent corneal reflex, absent gag reflex, intact cough reflex and a decrease eye reflex that flicked slightly. An ethics committee was convened and Agreed by the DCCS. The decision was not to make the patient NPO but to start debutamine to try and improve renal perfusion. As the ethical meeting ended the ICU Nurse ran in to

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

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

REGISTER NO.	WARD NO.

JSN 36207

600-09-4352 600-09-4352

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

ACLU DDI CID ROI 29462

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Exhibit 000062

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Say the patient had called Open. When I arrived at the bedside he was in a pulseless, idioventricular rhythm at a rate of 20/ minute. Blood pressure on arrival was palpable 5-7 mm Hg. Patient pronounced dead at 1845. No ACLS was performed per EMTS Committee recommendations. (b)(6)

ACLU DDI CID ROI 29463

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LAW ENFORCEMENT SENSITIVE

Exhibit 2

[redacted]-08-[redacted]ID789-53196

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

DISPOSITION OF BODY

RECEIPT OF BODY AT MORGUE

The body of b0[illegible]4752 2ir 312117 was receivec
(Name)

at _____ A.M. P.M. on _____
(Date)

_____
(Signature)

CERTIFICATE OF REMOVAL

The body of _____ was remove
(Name)

by _____
(Name and address of undertaker

at _____ A.M. P.M. on _____
(Date)

_____ _____
(Signature of person releasing body to undertaker) (Signature of representative of undertaker)

The following statement shall be completed only when specifically ordered.

PHYSICIAN'S STATEMENT REGARDING CONDITION OF REMAINS AS RELEASED *(Describe post-mortem, surface discolorations, abrasions, lesions, incisions, whether remains were embalmed, etc.)*

THIS BODY CONTAINS A MEDICAL IMPLANT WHICH MAY INCLUDE A BATTERY OR POWER CELL. ☐ YES ☐ NO

_____
(Signature of physician)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.
b0[illegible]4752 2ir 312117		

DISPOSITION OF BODY

Medical Record

ACLU DDI CID ROI 29464

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STANDARD FORM 523-A (REV. 12-93)
Prescribed by GSA/ICMR (41 CFR) 201-9.202-1

ACLU-RDI 5584 p.8

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Exhibit 2

0004-08-CID789-53196

HOSPITAL REPORT OF DEATH

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

NAME AND LOCATION OF HOSPITAL: TF 21 31 CSH Camp Cropf

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)*
ISN 31217
Loc 30 4252

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)*: 1845 09 02 08

3. MEDICAL EXAMINER/ CORONER'S CASE: [X] YES [ ] NO

4. RELIGION

5. CHAPLAIN NOTIFIED: [ ] YES [X] 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)*: Idiopathic Dilated Cardiomyopathy	3 days
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. Acute Renal Failure	3 days
	b. Anoxic Encephalopathy	3 days

9. DATE: 9 February 2008

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

(b)(6)

TYPE OF ACTION	HOUR	DAY			SIBLE 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 PREVIOUS EDITIONS WHICH WILL BE USED. USAPA V2.01

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ACLU-RDI 5584 p.9

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Exhibit 2

0004-08-CID789-53196

TAB

INTERNMENT SERIAL NUMBER

CERTIFICATE OF DEATH

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

FROM:

TO:

NAME (Last, first, MI)
60000 4352

GRADE
DET

SERVICE NUMBER
3121C7

NATIONALITY

POWER SERVED

PLACE OF CAPTURE/INTERNMENT AND DATE

PLACE OF BIRTH

DATE OF BIRTH

NAME, ADDRESS, AND RELATIONSHIP OF NEXT OF KIN

FIRST NAME OF FATHER

PLACE OF DEATH
IF 31 BCT JCV

DATE OF DEATH
9 February 2008

CAUSE OF DEATH
Dilated Cardiomyopathy

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).*

60 YO M Newly diagnosed with idiopathic dilated Cardiomyopathy had PEA (Asystolic arrest on day 2 of hospitalization. Subsequently suffered anoxic encephalopathy and acute renal failure that led to his death

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE
9 February 2008

SIGNATURE OF COMMANDING OFFICER
(b)(6)

WITNESSES

SIGNATURE
(b)(6)

ADDRESS

SIGNATURE

ADDRESS

ACLU DDI CID ROI 29466

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
29Feb08 1155	Nurses Note: Pt remains on Unit-Restraints continued. VSS. Support measures continued as per plan of care. Pt's mother at bedside. Pt's sister remains at bedside. Pt's IV fluids changed to D5 1/2 NS since 1000 FS was 64. (b)(6) current fluids, no other orders received. Will continue to monitor per MD orders. Next FSBG 1400. Lopressor / Captopril / PRN Valium DC'd per MD orders. Lorazepam ordered. No other A's from Am assessment. Continue to monitor per MD orders. Pt's family updated on Pt's condition.
29Feb08 1630	Nurses Note: Resp Rate trended to 450 pm. Dr (b)(6) notified. Propofol gtt restarted at 25mg/hr now. Pt's Resp Rate trended to 20's range. BP currently 90's/over 30's-40's. Pt had received a 500 cc bolus NS per Dr (b)(6) orders. UOP adequate. No other changes from Am assessment. GCS=3T. Unable to assess pupils at present time. Continue to monitor per MD orders. Pt's family updated by (b)(6)
1800	Pt BP 80's/70's, map in 60's noted. Dr (b)(6) notified. Fluid bolus ordered. Will continue to monitor pt.
1900	Pt BP 80's/30's, map 40's, MD informed, ordered (unclear) Levophed gtt to be titrated to keep MAP greater than 60. Pt's family updated by MD. Will continue to monitor pt.

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

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.

600-00-4352
Icu Bed 5

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.1

ACLU DDI CID ROI 29467
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Exhibit 2

0004-08-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

0004-08-ID789-5319

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
08Feb0715	Nurses Note: Assumed care of pt VSS c/o of back pain denies CP SOB pt oriented x3 NAD watches TV. Skin CDI. Resp even unlabored on RA. Sounds wet at lung fields generally CTA. Foley cath to gravity. Arrange pt had BM this AM according to night shift report. AM assessment completed and charted. Pt denies any needs at this time. Continue to monitor pt and provide safe ICU environment. (b)(6)
08Feb0820	Nurses Note: pt has an order to D/C to T.I.F. Foley D/C'd and awaiting pt to void prior to discharge. Continue to monitor (b)(6)
08Feb1240	Nurses Note: Still awaiting for pt to void. Pt resting in bed with eyes closed. VSS. Resp even and unlabored on RA. O2 sat 96% 96%. MD aware. No orders. D/C from earlier AM assessment. Cont. to monitor per MD orders and ICU guidelines. (b)(6)
08Feb1630	Nurses Note: Still no void as of this time. Discharge meds explained to pt. All questions answered regarding discharge. Foley D/C'd and explained. No orders D/C from AM assessment. Continue to monitor per MD orders and ICU guidelines. Pt d(b)(6) out foley cath of 450 cc, V.O. after 10 hours of no void. In and out cath and keep at overnight (b)(6)

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

600-00-4352
Icu Bed 5

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/19)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(
USAPA V1

ACLU DDI CID ROI 29469
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LAW ENFORCEMENT SENSITIVE

Exhibit 2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8Dec08	
900	Pt in chair at bedside. Pt A&O pt states he can't urinate. Report received assessment complete. See flow sheet for details. Will continue to monitor Pt. (b)(6)
1906	Pt in chair at bedside. Pt states epigastric pain. Pt states he is lightheaded and slumps down in chair. Pt is not on monitor. (b)(6) notified Pt placed on monitor Pt has stable vitals but is not responding ~~to pain~~ to stimuli. pupils are noted to be fixed @ 4mm. Dr (b)(6) notified and comes to bedside. Pt noted ~~to be~~ (b)(6) c to have agonal breathing. Pt given PP ventilation c BVM. Pt has HR in 50's. Pt quickly loses pulses. Cart moved to bedside AED attached to pt CPR began. A:c6 (b)(6) pushes epi, 1903 Lidocaine A09 Epi, A10 Atropine, 1911 Adenosine, A12 Atropine, 1920 CA. pt return to a ST ~~in the~~ 130. Pt is intubated c 7.5 ETT and placed on vent. Propofol gtt ~~started~~ started at 25 mcg/kg/min will continue to monitor Pt. (b)(6)
2400	NOT placed and pt to LWOS will continue to monitor Pt. (b)(6)
Feb09	Pt in bed LSS pt has ~~no distal~~ NSR @ 70 BPM (b)(6)
2400	Pt is on ventprofol for sedation will continue to monitor Pt. (b)(6)
Feb09	Nurse Note: Assumed care of pt. LSS currently. Pt on Ventilator Rate 15 TV-450 FIO2-40% Leg-5 PEEP-5 O2 sat 100% No Fluctuations with acute output. Propofol @ 15mcg/kg/min. NS @ 125 mL/hr. Pupils remain fixed & dilated on own eyes. No cough reflex noted. Skin pale, cool to touch. Pulses absent throughout. Chest rise symmetrical. Access established via 18g PIV in LAC. Plans to monitor for withdrawal of life support. (b)(6)

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ACLU-RDI 5584 p.14
Exhibit 000014

AUTHORIZED FOR LOCAL

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
4Feb08 1817	Nurses note. Pt admitted to ICC directly from OMC at 1730 Report received from Dr. (b)(6) Pt arrived c Ambulance personnel / Ambulatory. Pt had appearance of Rapid shallow breaths so placed on BLNRB mask. Pt Sao2 was 100 %. Before and after pt Resp rate slowed to 20 and appeared comfortable. Will continue to monitor. (b)(6)
05Feb08 1900	Pt received from (b)(6) in critical condition VSS, BP 101/41 AR-112 R-32 Sats 100% BLNRB during assessment pt hand some mild abd pain upper epigastric pain 1930-1945 Pt switched to bed 5 NRB taken off switched nasal cpap mask settings AB-level R-5 ~~F-12~~ F:02 50 P-10 and I-5 respirations and expanding prep will cont to monitor and provide excellent nsg (b)(6) effective care.
2100	foley and PCR done pt on blevel naso cpap mask tolerating well small air leak 100% in naso mask, nitro drip started BP - 110/39 - 104 HR (b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SP (IS

DEPARTMENT / 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

PROGRESS NOTES
Medical Record
STANDARD FORM 5
Prescribed by GSA/ICMR FPMR (41CFR)

600-00-4352
ISN-31217
Tech Bed 7

ACLU DDI CID ROI 29471
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LAW ENFORCEMENT SENSITIVE

Exhibit 2

0004- 8-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07 Aug 05	Continue upon [redacted] will report to MO in ED. Report given to [redacted] for review. [redacted] Written by Medical Assistant. Vitals: BP 110/68, P 68, R 18, T 98.4. Pt in NAD. Pt denies pain. Pt denies SI/HI. Pt denies AVH. Pt is A&O x 4. Pt is pleasant & cooperative. Pt denies any acute medical problems. Pt denies any recent illness. Pt denies any recent travel. Pt denies any recent exposure to infectious diseases. Pt denies any recent exposure to TB. Pt denies any recent exposure to HIV. Pt denies any recent exposure to STDs. Pt denies any recent exposure to hepatitis. Pt denies any recent exposure to tuberculosis. Pt denies any recent exposure to malaria. Pt denies any recent exposure to yellow fever. Pt denies any recent exposure to dengue fever. Pt denies any recent exposure to chikungunya. Pt denies any recent exposure to West Nile virus. Pt denies any recent exposure to Zika virus. Pt denies any recent exposure to Ebola virus. Pt denies any recent exposure to Marburg virus. Pt denies any recent exposure to Lassa fever. Pt denies any recent exposure to Rift Valley fever. Pt denies any recent exposure to Crimean-Congo hemorrhagic fever. Pt denies any recent exposure to Kyasanur Forest disease. Pt denies any recent exposure to Omsk hemorrhagic fever. Pt denies any recent exposure to Alkhurma

AUTHORIZED FOR LOCAL

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

D/C'd Pt sent from PACU to ICU for
closer respiratory surveillance
2/2 concerns for inhalation lung injury
Pt seen & examined c signs of
CVT & minimal edema. (+) Respiratory
distress RR 50's (+) accessory
muscle use. Given 5L NC x2
+ Sx's improved, lessened. Given IV
Lasix in ED. ABG 7.48/24/178.
@ 1900 Dark/tea urine output.
Acidosis → Bolus Mannitol,
Bolus Hypernatremia Depletion
as well c Possible mild CVA stroke
with image consistent c edema
c fluid restriction, Lasix, 2 hourly

11.1
134 | 10 26
4.8 | 21 | 0.3 | 121

ABTG
ASTG

(b)(6)

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR' (SSN or Ot

DEPART /SERVICE | HOSPITAL OR MEDICAL FACILITY: Cropper | 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 IC

PROGRESS NOTES
Medical Record

STANDARD FORM 9
Prescribed by GSA/ICMR FPMR (41CFR)

600-00-4352
ISN 312117
Icu Bed 7

ACLU DDI CID ROI 29473
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LAW ENFORCEMENT SENSITIVE

Exhibit 000017

Exhibit

0004-98-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7.Jul.01	Nutrition Info:
1515	Diagn: Endometriosis Pt c/o recurrent epigastric & pharyngeal pain. Pt has had multiple surgeries for endometriosis. Last surg was 1 yr ago. Pt has had multiple abdominal adhesions. Pt is currently on Lupron depot. Pt has had decreased appetite & wt loss over the past few months. Pt is 5'4" & 110 lbs. Pt's UBW is 120 lbs. Pt's BMI is 18.9 kg/m² (WNL). Pt's IBW is 110 lbs. Pt's %IBW is 100%. Pt's ABW is 110 lbs. Pt's %ABW is 100%. Pt's BMR is 1200 kcal/day. Pt's TDEE is 1500-1800 kcal/day. Pt's protein needs are 1.0-1.2 gm/kg/day. Pt's fluid needs are 1 cc/kcal. Pt's vitamin & mineral needs are WNL. Pt's lab values are WNL. Pt's medications are WNL. Pt's allergies are NKDA. Pt's social history is WNL. Pt's family history is WNL. Pt's review of systems is WNL. Pt's physical exam is WNL. Pt's assessment is WNL. Pt's plan is WNL.

(b)(6)

(b)(6)

ACLU DDI CID ROI 29474

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Exhibit

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2/16/8	HAP
0515	(S) 15 yo F in yard [illegible] 2 witnesses when
Patch	[illegible] developed dyspnea approx 6pm. 6 sx like
D	and diffx [illegible] pain. Went to ED where by
	[illegible] initially [illegible] CHF. Pt stopped
Noll	breathing CPR [illegible] Shimmer [illegible] (EMS) [illegible]
C	[illegible]. There is [illegible] patch-stained
	[illegible] Suggestive [illegible], but [illegible] is
All	[illegible] to [illegible] on [illegible]. Also has
of	bilat congestion and [illegible] AFX is [illegible]
	[illegible] Padded by Rudisill). [illegible] balloons
Sca	[illegible], [illegible] off and [illegible]. Not
P	negative [illegible] ters in [illegible] 17°. Redness with
	[illegible] this [illegible], [illegible] still not relieved.
Hy	Continues to [illegible] Dyspnea. Denies [illegible]
Pathfinder	weight [illegible], fatigue, [illegible] pain, [illegible] swelling
apst	[illegible]. Has [illegible] [illegible] [illegible] [illegible] that
	[illegible] and goes.
	OBS 20 108/60 96% RA Tho [illegible] S/o 3/3/2140
	Gen' A+O x3, NAD, Sitting upright
	Effort [illegible]
	Neck: 24 [illegible], [illegible] [illegible]

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.

PROGRESS NOTES
Medical Record

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USAPA V1

60000 4352

3/2117

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Exhibit 2

0004-08-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Cardiology consults, CVP ~7 cm Lungs CTA(B) CV: RRR, 4/6 SEM RUSB, no MRG, distant heart sounds Abd: soft, NT, ND, +BS, no HSM Ext: 2+ pulses, trace edema Skin: intact, no rashes Neuro: AOx3, no focal deficits PCXR Today: bilateral consolidation better EKG Today: NSR, LVH, LAE, RAE, poor R-wave progression 14.7 11/35 135 141/100 96/27 4.1 100 TSH(P) TI 40.5 x 5 ACT 98 AST 126 Tb: 1, 2, 3, Cefepime and CEFTAZ (Day #1 of 7) CHF exacerbation with R chamber enlargement Today is now compared to 10 months ago. Worsening R chamber enlargement. This is more c/w known pulmonary hypertension but still no CHF. W/ Heart MRS persistent RV hypertrophy and trace pericardial effusion. Additionally he is being for CHF exacerbation, c/ Congestive hepatopathy - Medicine staff, approved 25 beds, Lasix 20mg IV now TSH(P), c/ Transferred, Nephrology/HEM, ICU bed pending, Tylenol off, Nitrofurantoin, Cefepime, Nursing ED Discharge Medications, Continue Lexapro and Seroquel STAT

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(b)(6)

Exhibit 2

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
7Feb08 2000	Received one of pt PO meds w/ pt stating 'could I have a cup of cranberry juice?' Juice cup taken from pt room 1000. Pt denies any pain or discomfort @ this time will continue to monitor. (b)(6)
7Feb08 0830	Pt (b)(6) awoke & drank pt cup & juice. Pt placed on 2L NC & sats increased to 97%. Started screening pt from intercom cup showing vitals 113/31, 89, 24, 100%. Pt was given nitroglycerin 10mg/5 min & 5 min vital signs to monitor. (b)(6)
7Feb08 0900	pt received 2mg Lasix IV tolerating lowering of nitroglycerin & diff. pt remains on 2L NC. (b)(6) tolerating well 99% will continue to monitor. (b)(6)
7Feb08 0-0945	pt completely off nitroglycerin tolerated well. Last of VS 115/37, 85, 28, 99% will continue to monitor. Pt received all am meds @ 0830 and 0900. Pt (b)(6) dressing and urine is clear yellow
7Feb08 1200	pt has been resting comfortably. Denies any pain or discomfort VS remain stable will continue to monitor. (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
	Cropper	

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

600-00-4352

Icu #5

REGISTER NO.	WARD NO.
	ICU

PROGRESS NOTES
Medical Record
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Exhibit 2 000021

AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7FEB08 2100	c changes in cardiac assessment. pt had multiple leads down and is stable. Remains on 2L NC. pt got up for weight; removed O2. pt sats ↓ to 91% pt sat down and put back on 2L NC. Sats ↑ to 96%. pt now resting comfortably. Requested food, ordered changed pt food. will continue to monitor (b)(6)
7 FEB08 1900	Report received from (b)(6) pt in stable condition VSS pain assessment complete pt sats well 95-100% 2L NC BSBP I went by beside pt lying in bed, coughs frequently his pain from coughing will see (MD) CE to suggest Tessalon Perles. Also monitor cough / cough however is still unproductive will cont monitor and provide excellent and effective care (b)(6)
2130	MD (b)(6) order written for Tessalon perles given but pt cough somewhat minimized will monitor (b)(6)
2145	PT BP above 125 _ BP 134/58 98 given bpasser and cortrazine (b)(6)
2245	PT had massive BM liquid consistency brown/tan in color pt stated d/t tessalon Stomach/abdomen hurts (b)(6)

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ACLU-RDI 5584 p.22

Exhibit 000022

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

2/4/4 @ Fatigue & U/C Hemorrhoids
0811 @ Afebrile 4/5/31 SC 15 Weight stable
210 (472/238) - 236 Lbs.
Cont DAB 1060
Ambien 25MG
Cont: Cardiac Diet
D/C: Log of Symptoms 53 Sertraline
Add on: Soft Diet
Ext: Transfer to Edelweiss

VSRD HEMO HEMO
11 > 11 < 59 134/96/37
37 43/22/1.5 Temp

(A/P) @ STAT Evacuation - Physical Therapy and Occupational Therapy Consult
- Continue Compression, ACEs, Elevation
- Fluid Challenge Bolus
- 2 PRBC Ordered. Will Taper off 2nd unit
2nd PRBC Ordered. Will Recheck Hgb from 9.7 to 11.
- Maintain Course of Levaquin

(b)(6)

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: Cropper

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

600-00-4352

RE... ARD NO. IOU

PROGRESS NOTES
Medical Record

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USAPA V1...

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Exhibit 2

0004-08-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7/6/08	Saturation = 17 mg/dl
7/6/08	ferritin = 53.19
	- No evidence for iron Overload

(b)(6)

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USAPA V1.00

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ACLU DDI CID ROI 29480

ACLU-RDI 5584 p.24

Exhibit 000024

AEROSPACE MEDICINE
LOCOLOY REPORT

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

ICU Resuscitation Note

08 Feb 2008

Called to ICU at ≈ 1900 to see pt. who had deteriated on Ventilator and lost consciousness. PE at that time showed HR at 40-50 bpm, agonal Respiration. Pupils fixed and dilated, pt ~~[illegible]~~ unresponsive. Began Bag Respirations and HR ↓ FSBG 80 ~~[illegible]~~ and pt. became pulseless. Began CPR attached CARDIOVERSION pad.

19:06 epi 1911 Adenosine

19:08 Lidocaine. 1912 Atropine

19:09 Epi - HR 20 - palpable pulse 1920 ca

19:10 Atropine

Vent Setting 15/650/10/5 FiO_2 100%

PIP 25 ABG - pH 6.95 pO_2 162 pCO_2 42 HCO_3 9 98%

Attempted intubation x 2 - ~~time~~ after 6 oxygen on 100%, then intubated. Defibrillator underlid shock during code.

Pulse returned, HR 120 tachy.

Paralyzed & sedatives and Ventilations, then propofol drip began.

(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) | REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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ICU # 5

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Exhibit 2

0004-08-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

2/6/08 0955 (S) Cpt Unresponsive patient. Suddenly c/o pain, lost breath. Stopped talking. Immediately moved from chair to floor and started breathing. Immediately moved to stretcher. Transported to ICU. Upon arrival to ICU, patient was unresponsive. Required assistance of 3 medics to move patient to bed. Patient was placed on monitor. Initial BP was 90/palp. Started on 2L NC. Became hypotensive with BP 50/palp. Given 500ml bolus and infusion set at 125ml/hr. Continuous BP was up to 70/palp. Given 1L NS bolus. BP up to 90/palp. HR 117/38 31 Resp. SpO2 92%/2L NC. Pupils fixed and dilated. HEENT: Pupils fixed and very sluggish. After ~30 seconds constricted to ~5m. Slight movement in R pupil's eye reflex. Sluggish, almost absent corneal reflex. Absent cough reflex. Absent corneal reflexes. Neck: 7-8 cm CVP Lungs: Diffuse coarse BS and rhonchi

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY: Dropper | 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)

600-00-4352

REGISTER NO. | WARD NO. ICU

PROGRESS NOTES
Medical Record
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Exhibit 2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	CV dizzy, forgetful Alert, appr, soft, WD/WT EOT: PERRLA PE/ROS: WNL Cardiomegaly, Lungs pulmonary edema EKG: NSR/poor R wave progression, c/o CP/SOB, flipped Axis from CBD to RAD 12/15/53 (111 ACT 221 Trop I, 8 17) 10/39 (493 5'1" 16 2# 7.36/27/36/15/-10/999 A&P 1) Post-ictal 2) Elevated BUN is worsening 3) Anoxic brain injury - Sedate on minimal propofol and Fentanyl to assist brainstem reflexes 4) Hx-pneumothorax - This is going to be a tough medical decision during this admission and depending on his recovery. At this point his CT scan is unchanged from yesterday. D.C chest tube & see if CV and lung dysfunction improves. Antibiotics as per Chest surgery 5) Pulmonary - Bronchial toilet and aggressive pulmonary hygiene. Continue Zithromax and Rocephin. Will attempt extubation. Add diuresis only if kidney function improves

(b)(6)

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Exhibit
ACLU-RDI 5584 p.28
000028

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MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2/9/08 @ 1529	Although reported to have asystole arrest by the Nurse and Medics on duty last pm, the resuscitation note by the ED MD states differently. He states patient had a pulseless heart rate of 40-50. This is c/w bradycardic PEA. EKG not obtained. Sx ED don't know if CP, SOB, or identifiable. Arrogance by staffed MD bradycardic PEA and degenerated to asystole.

(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)* | REGISTER NO. | WARD NO.

2 of 2

Code 4352

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ACLU DDI CID ROI 29485

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/19
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USAPA V1

Exhibit 2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2/9/08 1337	Repeat CMP shows worsening fine renal function with GFR/creat of 61/2.4, 45 cc UOP in last 6 hours. Has been off pantoprazole x 2.50 and Neuro exam is unchanged, GCS 3T. Pupils 5mm(R) and constrict to 1mm, weak corneal reflex when suction fully inserted into ETT. No gag reflex to ETT manipulation. No cough reflex. MAPs are SC and stable. Despite normal MAPs he is likely volume depleted and has worsening pre-renal azotemia is post purge function that cannot perfuse his kidneys. Bolus 500 ml NS and re-assess Urine output. If he does not respond to fluid bolus, Desmopressin is the only option to perfuse his kidneys. This however could be considered heroic care, particularly in the setting of prolonged hypoxic injury / CPR. Ethics Committee Scheduled for tomorrow (b)(6)

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ACLU DDI CID ROI 29486

Exhibit 2 000030

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2/6/05 1547	Throughout the day pt has been ~~quiet~~ cooperative c VSS. Her cuff pressure has increased to 24. An Emergency session of the Ethics Committee was convened @ ~1525 to discuss further. Committee was advised by the DCCS (b)(6) The Committee felt his [illegible] failure was due to the combined effects of pump failure and fluid overload from the previous days care. Due to his poor prognosis and markedly abnormal neurological exam from all members were in favor to withdraw life support. We agreed to start withdrawing as this would be painless and could address his pump failure. Right as the meeting adjourned the ICU nurse [illegible] to tell us he had cardiac arrest. When I arrived he was in PEA & an idioventricular rate @ ~20/minute with an a-line MAP of 5-10 mmHg. Chest compressions started @ 1545 and the ventilator was turned off. DCCS PAO and CID notified. Aka, ACLS deferred per Ethics Committee Recs.

RELATIONSHIP TO SPONSOR | LAST | (b)(6) | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written ent... ID No or SSN; Sex; Date of Birth; Rank/Grade) | ...R NO. | WARD NO.

ICU 5

bed 08 435 2

PROGRESS NOTES
Medical Record
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ACLU-RDI 5584 p.31
Exhibit 000031

0004-08-CID789-53196

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

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

600 00 4352

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 5

DATE OF ORDER: 2/9/08 TIME OF ORDER: 0525 HOURS

LIST TIME ORDER NOTED AND SIGN

0 Advance Diet to Full

2 Taper off propofol gtt as long as pt is awake & follows commands. Switch to PO meds

3 Check ABG @ 1200 hrs.

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600 00 4352

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 5

DATE OF ORDER: 2/9/08 TIME OF ORDER: 0959 HOURS

1 Change IVF to D5 1/2 NS

(b)(6)

(b)(6)

09Feb08 @ 1010

PATIENT IDENTIFICATION

600 00 4352

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 5

DATE OF ORDER: 2/9/08 TIME OF ORDER: 1348 HOURS

500cc NS bolus

(b)(6)

(b)(6)

09Feb08 @ 1400

PATIENT IDENTIFICATION

600-00-4352

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 5

DATE OF ORDER: TIME OF ORDER: HOURS

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ACLU DDI CID ROI 29489

ACLU RDI 5584 p.33

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

600 00 4352

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
8 Feb 08	2327 HOURS	
NPO after midnight		
NPO solution		
NS @ 125 cc/h		
IVF's		
Chest PA/LAT/PORTABLE		AT 0230
Q shake 4 hours		
NGT-ILWS		
(b)(6)		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
8 Feb 08	2321 HOURS	
CBC/Chem/Mg in AM		
ABG 2 hrs in AM		
CXR (P) in AM		
EKG in AM		
Continue Enoxaparin 30 SQ q12		
1500 cc NSS		
(b)(6)		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
9 Feb 08	0300 HOURS	noted 0300 9 Feb 08
Propofol start 25 mcg/kg/min titrate to wean sedation		
(b)(6)		
(b)(6)		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
Orders ver. Ltd.		09 Feb 08 0900

DATE OF ORDER	TIME OF ORDER	
2 Feb 08	0821 HOURS	
Protonix 40 mg IV QD 1st now		
Lidocaine 30 mg SE BID 1st now		NOTED
Calcium gluconate 3 gm slow IV over 30 minutes		
Oxycodone IVP 2 mg q 2 hrs prn pain		
Ofloxacin 400 mg IV q 12 hrs		
(b)(6)		

(b)(6)

(b)(6)

(b)(6)

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(b)(6)

(b)(6)

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(b)(6)

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ACLU DDI C

ACLU-RDI 5584 p.34

DA FORM 1 APR 79 4250 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USE

Exhibit 2

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

600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
ICU		5

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
Feb 8/08	0035 HOURS	
Xpercept PO FC		CS Fdy 2 0035
24 hour ✓		

(b)(6)

PATIENT IDENTIFICATION

600 00 4352

NURSING UNIT	ROOM NO.	BED NO.
ICU		5

DATE OF ORDER	TIME OF ORDER	
2/8/08	0934 HOURS	
DC Foley		
DC to bsc with ambulation		ACCEPTED
Pt-mt Vitals		

(b)(6)

(b)(6)

DC'd 2/8/08 0935

PATIENT IDENTIFICATION

600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
ICU		5

DATE OF ORDER	TIME OF ORDER	
08 Feb 08	1700 HOURS	
1. IN + O-t Cath @ 2200 if no void.		
2. Keep it overnight if In-cath required.		ACCEPTED
V.O. Dr		

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600 00 4352

NURSING UNIT	ROOM NO.	BED NO.
ICU		5

DATE OF ORDER	TIME OF ORDER	
8 Feb 08	2000 HOURS	
1) CXR ✓		
2) Vent IT/600/10/5 40%		
3) CBC/Chem/ABG		noted
4		

(b)(6)

Chart done 8 Feb 08 1930 VSW

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 294

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CHART V0400AR-9 Feb 08

(b)(6)

ACLU-RDI 5584 p35

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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: 600-00-4352

NURSING UNIT: ICU | ROOM NO. | BED NO.: 5

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	2/7/08	0943		
1	1.5 Liter fluid restriction -			
2	QC daily CXR			
3	QC daily TSH -			
4	Lasix 20 mg IV now -			
5	Ferritin and TIBC and ferritin			
6	D2 to keep Sat > 95%			
7	HBV, HCV and HIV			
8	Ad lib			
9	BMP (Bun) Today			

(b)(6)

PATIENT IDENTIFICATION: 600-00-4352

NURSING UNIT: ICU | ROOM NO. | BED NO.: 5

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	2/7/08	1577		
10	Regular diet			

(b)(6)

PATIENT IDENTIFICATION: 600-00-4352

NURSING UNIT: ICU | ROOM NO. | BED NO.: 5

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	2045	Feb 7 08		
	Tessalon Perles 100mg x2 po Q8 hours PRN			

(b)(6)

(b)(6)

(b)(6)

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ACLU DDI ROI 29492

(b)(6)

ACLU-RDI 5584 p.36

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000056

Exhibit 2

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: 600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
ICU		5

DATE OF ORDER: Feb 6/08 TIME OF ORDER: 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

Nitro Drip start @ 20 mcg/min
titrate up every 5 min, 10 mcg/min
hold for for SBP < 100
Foley catheter

(b)(6)

(b)(6)

(b)(6)

PATIENT IDENTIFICATION: 600-00-4352

NURSING UNIT: ICU ROOM NO. BED NO.: 5

DATE OF ORDER: Feb 6/08 TIME OF ORDER: 2200 HOURS

2) Bipap 15/5 30% FiO_2

(b)(6)

PATIENT IDENTIFICATION: 600-00-4352

NURSING UNIT: ICU ROOM NO. BED NO.: 5

DATE OF ORDER: 2/7/08 TIME OF ORDER: 0500 HOURS

1) D/C Bipap
2) Captopril 12.5 mg po TID 1st new
3) Alternate 50 mg PO BID 1st new
4) Titrate NTG gtt to keep SBP < 125 mmHg
5) Lopressor 25 mg po BID 1st dose

(b)(6)

(b)(6)

PATIENT IDENTIFICATION: 600-00-4352

NURSING UNIT: ICU ROOM NO. BED NO.: 5

(b)(6)

PATIENT IDENTIFICATION: 600-00-4352

NURSING UNIT: ICU ROOM NO. BED NO.: 5

ACLU DDI CID ROI 29493
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LAW ENFORCEMENT

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

600-00-4352
Icu Bed 7

NURSING UNIT	ROOM NO.	BED NO.
Icu		75

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

Nitro inf. D/C XT

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
Icu		75

DATE OF ORDER 06 Feb 2008 TIME OF ORDER 18:56 HOURS

1) Lasix 20mg IV XT dose. 06Feb8
2) MSO4 2mg IV XT dose. noted

(b)(6)

6Feb08 @ 2300
24° Chart ok. completed

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
Icu		75

DATE OF ORDER 6 Feb 08 TIME 1528 HOU

Stop Reason Precaution
Sitting 215

6Feb08 @ 1930 noted

(b)(6)

PATIENT IDENTIFICATION

600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
Icu		75

(b)(6)

DATE OF ORDER 6 Feb 08 TIME OF ORDER 1930 HOURS

1) Saline-lock IV w/flush x 08 hrs 6Feb08 @ 1930 noted
C.V.O.

(b)(6)

(b)(6)

PATIENT IDENTIFICATION

600-00-4352

NURSING UNIT	ROOM NO.	BED NO.
Icu		75

(b)(6)

24° chart ok 8 Feb 08 CIC

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LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29494

ACLU-RDI 5584 p.38

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

600-00-4352

ISN 31217

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 6 Feb 08 | TIME OF ORDER: 1715 HOURS | LIST TIME ORDER NOTED AND SIGN

✓ EKG

✓ CXR PA & LAT

~~Blood Cx~~

✓ 2nd IV

✓ SLNX $\frac{1}{2}$

✓ Lasix 40mg IV

✓ ABG

(b)(6)

NOTED

(b)(6)

PATIENT IDENTIFICATION

ISN 31217

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 6 Feb 08 | TIME OF ORDER: 1715 HOURS

✓ Cardiac Enzymes Q6° X 3 sets.

✓ Consult Pulm Crit

Dr. Mercer

(b)(6)

6 Feb 08 @ 1745

PATIENT IDENTIFICATION

ISN 31217

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 6 Feb 08 | TIME OF ORDER: 1725 HOURS

1. SLNX $\frac{1}{2}$ NSW 2. D/C CXR ~~PA~~ Now

V.O.

(b)(6)

(b)(6)

NOTED

(b)(6)

PATIENT IDENTIFICATION

600-00-4352

ISN 31217

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 6 Feb 08 | TIME OF ORDER: 1815 HOURS

✓ 1) Iv. Fluids at 30 cc/hr.

✓ 2) NPO.

NOTED

(b)(6)

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LAW ENFORCEMENT SENSITIVE

(b)(6)

NURSING UNIT: ICU | ROOM NO.: | BED NO.: 7

6 Feb 08 @ 1815

24hr Chart ok. Completed

(b)(6)

ACLU DDI CID ROI 29495

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

ACLU-RDI 5584 p.39

Exhibit 2

EMERGENCY RESUSCITATION RECORD

For use of this form, see MEDCOM Circular 40-5

PART 1 - Complete this report immediately following the event. Place the original in the patient's record and provide a copy to the nursing supervisor/DIC.

1. DATE: 6 Feb 03

2. LOCATION OF RESUSCITATION: ☒ Ward: 22

☐ MICU ☐ SICU ☐ CCU ☐ NICU ☐ PICU ☐ ED ☐ PACU ☐ OR

☐ Diagnostic/Procedure Area:

☐ Outpatient Clinic:

☐ Other (Specify):

3. PATIENT STATISTICS:

Age: 16-MTC Gender: M

Height (in):

Weight (lbs): Weight (kg): 72 KG

4. INITIAL CONDITION:

CONSCIOUS? ☐ Yes ☒ No

BREATHING? ☐ Yes ☒ No

PULSE? ☒ Yes ☐ No Pulse Site: CAROTID

WITNESSED ARREST? ☒ Yes ☐ No ☐ Unknown

MONITORED AT ONSET? ☒ Yes ☐ No

5. INITIAL RHYTHM:

☐ Asystole ☐ Pulseless Electrical Activity ☒ Other: PR

☐ Bradycardia ☐ Ventricular Fibrillation

☒ Perfusing Rhythm ☐ Ventricular Tachycardia

RETURN OF SPONTANEOUS CIRCULATION (ROSC):

☒ Returned at: 1925 ☐ Never Achieved

☐ Unsustained ROSC: ☐ < 20 min ☒ > 20 min

TIME CPR STOPPED: 1925 1945 DUE TO: ☒ ROSC ☐ DNR ☐ Death

6. IMMEDIATE CAUSE OF ARREST/EVENT: *(Check One)*

☐ Hypotension/Hypovolemia

☐ Lethal Arrhythmias

☐ Metabolic

☐ Myocardial Infarction or Ischemia

☐ Respiratory Depression

☐ Trauma

☒ Unknown SUSPECT OPIOID OD

☐ Other:

7. RESUSCITATION ATTEMPTED:

☒ YES *(Check all that apply)*

☒ Airway Management ☐ Cardiac Message

☒ Chest Compressions ☐ Defibrillation

☐ NO *(Check one)*

☐ False Alarm/Arrest (BLS/ALS not needed)

☐ Do Not Resuscitate (DNR)

☐ Pronounced Dead Prior to Resuscitation

☐ Other:

8. EVENT TIMES: (The times below are required to calculate the American Heart Ass'n and European Resuscitation Council in-hospital chain of survival.)

Time *(Military)*

Collapse/Arrest Onset:	1901
CPR Started:	1902
1st Defibrillation:	N/A
Airway Achieved:	1902
1st Dose Epinephrine:	1906
Code Team Called: ☒ Yes ☐ No	
Code Team Arrived:	1902

9. INTERVENTIONS:

(CHECK THOSE IN PLACE AT START OF RESUSCITATION)	(b)(6)	THOSE INITIATED DURING RESUSCITATION, NOTE TIME)	COMMENTS
☒ IV Access Gauge: 20 Site: R HAND		☒ Time(s) /	
☒ Endotracheal Tube Size: 7.5		☐ Time(s) 1902 /	✓ placement w/ etco2 present
☒ Mechanical Ventilation		☒ Time(s) 1902 /	BVM / ETT & VENT @ 1925
☐ Arterial Line		☐ Time(s) /	
☐ Central Venous Line		☐ Time(s) /	
☐ Pulmonary Artery Catheter		☐ Time(s) /	
☐ Nasogastric Tube		☐ Time(s) /	
☐ Pacing Device *(Specify)*:		☐ Time(s) /	
☐ Implantable Defibrillator/Cardioverter		☐ Time(s) /	
☐ Other *(Specify)*:		☐ Time(s) /	

PATIENT DISPOSITION FOLLOWING RESUSCITATION:

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

600 004352

10. GLASGOW COMA SCALE: (Post-resuscitation)
Circle appropriate score for each parameter, then total score.

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

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

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

SCORE:

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LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5584 p.40

000040

Exhibit 2

EMERGENCY RESUSCITATION RECORD - PART 2

	TIME (Military):	1902	1906	1908	1909	1910	1911	1912	1920	1925	1927		
VITALS	BLOOD PRESSURE	[illegible]							124/47				
	HEART RATE	[illegible]							107				
	PULSE PALPABLE (Y/N)	N							Y				
	COMPRESSION (* = CPR)	Y							N				
	RHYTHM	ST							ST				
	DEFIBRILLATION (Joules: 200, 300, 360)	N/A							N/A				
	CARDIOVERSION (Joules: 50, 100, 200, 300, 360)	N/A							N/A				
	PACING PERFORMED (√)	N							N				
	RESPIRATIONS	R							20				
	TEMPERATURE	N/A							N/A				
AIRWAY	VALVE MASK w/100% O_2 (√)	✓	✓	✓	✓	✓	✓	✓	✓				
	INTUBATED (√)									✓			
	MASK (Specify)												
	% OXYGEN (O_2)									6L/Min			
	PULSE Ox / O_2 SATS	85	87	85	84	86	82	94	95	130			
MEDICATIONS	*Note dose and route.*												
	AMIODARONE												
	ATROPINE					✓		✓					
	DOPAMINE												
	EPINEPHRINE		✓		✓								
	LIDOCAINE			✓									
	PROCAINAMIDE												
	VASOPRESSIN												
LABS	POTASSIUM (K)										4.9		
	GLUCOSE										57		
	CALCIUM (Ca)										9.1		
	MAGNESIUM (Mg)										2.9		
ABGS	PH										6.95		
	pCO_2										72		
	pO_2										162		
	HCO_3										9		

COMMENTS: 1911 = Left Apical Pulse 1920 = Left Groin

PHYSICIAN *(Signature & Title)*

NURSE *(Signature & Title)*

(b)(6)

MEDCOM FORM 679-R (TEST) (MCHO) JUN 03

ACLU DDI CID ROI 29497

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LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5584 p.41

Exhibit 000041

ICU FLOW SHEET

Glasgow Coma Scale	Neuro Assessment Legend
Eyes Open:	
4 - Spontaneously	Muscle Strength:
3 – To speech	5 – Normal strength
2 – To Pain	4 – Moves against resistance
1 – None	3 – Moves against gravity
Verbal Response:	2 – Moves not against gravity
5 – Oriented	1 – No movement
4 - Confused	
3 – Inappropriate Words	
2 – Incomprehensible Sounds	
1 – None (Note – "T" = tube)	
Motor Response:	Pupil Scale
6 – Obey Commands	
5 – Localizes to pain	2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm
4 – Withdraws to Pain	
3 – Flexion to pain	
2 – Extension to pain	
1 - None	

RESTRAINTS:	DAYS		NIGHTS	
0700 site LLE	pulse +2 cap. ref. <3 edema +1	1900	Site LLE	pulse +1 cap. ref. <3 edema +1
0900 site LLE	pulse +2 cap. ref. <3 edema +1	2100	Site	pulse +1 cap. ref. <3 edema +1
1100 site LLE	pulse +2 cap. ref. <3 edema +1	2300	Site	pulse +1 cap. ref. <3 edema +1
1300 site LLE	pulse +2 cap. ref. <3 edema +1	0100	Site	pulse +1 cap. ref. <3 edema +1
1500 site LLE	pulse +2 cap. ref. <3 edema +1	0300	Site	pulse +1 cap. ref. <3 edema +1
1700 site RLE	pulse +2 cap. ref. <3 edema +1	0500	Site	pulse +1 cap. ref. <3 edema +1

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
18G Rt FA	06 Feb 08		COI-patent		—
20G Lt Bicep	06 Feb 08		COI-patent		patent
20G Ⓡ FA	9 Feb 08				patent
A-line Ⓡ Fem	9 Feb 08				patent

(b)(6)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 06 Feb 08

600-00-4352
ICU #5

ESV 312117

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

ACLU DDI CID ROI 29498
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LAW ENFORCEMENT SENSITIVE

Exhibit

BP (AP)																		
Pulse																		
Respirations																		
Temperature																		
SaO2																		
%O2																		
O2 Delivery																		
Mode																		
Rate																		
Tidal Vol.																		
Peep																		
PS																		
Pain Scale																		
Pain Med																		
Pt Position																		
CVP																		

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV																		
IVPB													250					250
Flush kit															10	10	10	30
NS keep vein open																	flush NS	
PO/ TF		240				240			480	1000	240							1240
Other																		
TOTAL									480									1240

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total	30/30	30/60	30/90	Emesis/90											25	25	25	75
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL									90									75

	TIME/INITIALS
Bath/Skin Care	2100
Oral Care	2100
Foley Care	2100
Trach Care EH	2100
Range of Motion	

(b)(6)

Cardiac Monitor	(Y) N	(Y) N	(Y) N
Bed position/Locked	Y (N)	Y (N)	Y (N)
Call bell in reach	Y (N)	Y (N)	Y (N)
Protective Device	(Y) N	(Y) N	(Y) N
High risk fall Precautions	(Y) N	(Y) N	Y (N)

ACLU DDI CID ROI 29499

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LAW ENFORCEMENT SENSITIVE

Exhibit _____

600-00-9352

	23/44	121/44	125/45	12/51	1/52	13/53	127/41	23/53
Pulse	81	91	91	90	76	76	75	74
Respirations	30	23	26	27	29	27	60	30
Temperature	97.3			97.1			97.3	
SaO2	100	100	100	100	100	100	100	100
%O2	40	40	40	40	40	40	40	40
O_2 Delivery	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
Rate	15	15	15	15	15	15	15	15
Tidal Vol.	450	450	450	450	450	450	450	450
Peep	5	5	5	5	5	5	5	5
PS	10	10	10	10	10	10	10	10
Pain Scale	-	-	-	-	-	-	-	-
Pain Med	-	-	-	-	-	-	-	-
Pt Position	B	B	B	B	B	L	L	B
CVP								

24 Hour Totals	Yesterday	Today
INPUT	+ 1472	4241.2
OUTPUT	- 2295	260
DIFFERENCE	- 823	3981.2

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

-2436 + 3981.3 = 1545.2

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV	125	125	125	125	125	125	125	125	1000	
IVPB										
NS Bolus	500	1000							1500	
Prop					5.3	5.3	5.3	5.3	21.2	
PO/ TF										
Other										
TOTAL									2521.3	

OUTPUT TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	0	5	5	20	15	25	20	5	95	
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL									95	

Legend

nit=initials
VD=Jugular Venous Distention
L=Left
NIBP=Noninvasive Blood Pressure
N=No
Y= Yes
-2= strong +1=weak
P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

Name	Signature	Init.
(b)(6)		

ACLU D

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LAW ENFORCEMENT SENSITIVE

Exhibit 2

NEUROLOGICAL

Level of consciousness, Glasgow		
Coma Scale (GCS), pupil size &		(b)(6)
response, motor & sensory function		
Muscle strength, pain, abnormal		
findings , spinal precautions		

CARDIOVASCULAR

Rhythm, Rate, Ectopy, PMI, Lead selected,		
Normal Heart Sounds (S1, S2),		(b)(
Abnormal Heart Sounds – (S3, S4,		
murmur, gallop, click, rub), color,		
skin temp, JVD, Capillary refill,		(b)(6)
Pulses (strength, bilaterally), turgor,		
moisture, edema, carotid bruits/thrills,		
CVP, abnormal findings, Central lines		
(Location, appearance, dressing, etc.)		

RESPIRATORY

Respiratory rate, rhythm, SaO2, oxygen		
delivery method, Ventilator settings,		
chest expansion, Accessory muscle use,		
lung sounds, cough, secretions/sputum		
(Color, amount, consistency) , ETT/Trach		
(size, placement, appearance), Chest		
Tubes (location, Suction/H20 seal, air		
leaks, drainage amount & color, dressing)		
Arterial line (appearance, location, etc.)		

GASTROINTESTINAL

Oral cavity appearance, dentition,		
Mucosal appearance, odor, Abdomen		
(contour, distention, tenderness, soft,		
Firm, guarding, bowel sounds), NG/OG/		
G-Tube (placement, verified, residuals),		
Tube feeds (type, rate), suction, stool/		
Emesis (color/consistency/amount),		
Colostomy (stoma location & appearance)		

GENITOURINARY

Mode of elimination (void, foley, urostomy),		
Foley size, bladder distention,		
Urine (color, amount, sediment)		

INTEGUMENTARY

General skin condition, dressings		
(locations, condition), wounds, lacerations,		(b)(6)
Incisions (staples or sutures, approximation		
of wound edges, drainage, signs of		
infection), drains (JP, hemovacs, etc.),		
Drainage (color, amount), protective aids,		
Decubitus ulcers, IV sites (location, fluid,		
rate, appearance, dressing), any additional		
Skin findings		

(b)(6)

(b)(6)

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
ACLU-RDI 5584 p.45
ACLU DDI CID ROI 29501

ICU FLOW SHEET

Glasgow Coma Scale	Neuro Assessment Legend
Eyes Open:	
4 - Spontaneously	Muscle Strength:
3 – To speech	5 – Normal strength
2 – To Pain	4 – Moves against resistance
1 – None	3 – Moves against gravity
Verbal Response:	2 – Moves not against gravity
5 – Oriented	1 – No movement
4 - Confused	
3 – Inappropriate Words	
2 – Incomprehensible Sounds	
1 – None (Note – "T" = tube)	
Motor Response:	Pupil Scale
6 – Obey Commands	
5 – Localizes to pain	2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm
4 – Withdraws to Pain	
3 – Flexion to pain	
2 – Extension to pain	
1 - None	

RESTRAINTS:	DAYS			NIGHTS	
0700 site [illegible]	pulse [illegible]	cap. ref [illegible] edema [illegible]	1900	Site LLE	pulse + cap. ref <3 edema +/-
0900 site LLE	pulse +	cap. ref <3 edema [illegible]	2100	Site LLE	pulse + cap. ref <3 edema +/-
1100 site LLE	pulse +	cap. ref <3 edema [illegible]	2300	Site LLE	pulse + cap. ref <3 edema +/-
1300 site LLE	pulse +	cap. ref <3 edema [illegible]	0100	Site LLE	pulse + cap. ref <3 edema +/-
1500 site LLE	pulse +	cap. ref <3 edema [illegible]	0300	Site LLE	pulse + cap. ref <3 edema +/-
1700 site LLE	pulse +	cap. ref <3 edema [illegible]	0500	Site LLE	pulse + cap. ref <3 edema +/-

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
18g RIJA	06 FEB		Patent		Patent
20g Lt bicep	06 FEB		Patent		Patent

PREPARED BY (signature & Title) (b)(6)

DEPARTMENT/SERVICE/CLINIC ICU

DATE 07 FEB 08

PATIENT'S INDENTIFICATION

600-004352

ICU #5

ISN 312117

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

ACLU DDI CID ROI 29502

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit _____

BP (MAP)																			
Pulse																			
Respirations																			
Temperature																			
SaO2																			
%O2																			
O_2 Delivery																			
Mode																			
Rate																			
Tidal Vol.																			
Peep																			
PS																			
Pain Scale																			
Pain Med																			
Pt Position																			
CVP																			

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV																		
IVPB													25		50			75
NSS	30	30	30	20					110									
PO/ TF				75				50	125				400		200			600
Other																		
TOTAL									197				425		50			

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total	100 / 100	200 / 300	200 / 500	300 / 800	325 / 1125	50 / 1200	100 / 1300	50 / 1350	1350	50 / 50	50 / 100	70 / 170	100 / 270	50 / 320	50 / 370	200 / 570	50 / 620	620
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

	TIME/INITIALS	
Bath/Skin Care	0400	(b)(6)
Oral Care	0400	
Foley Care	0400	
Trach Care		
Range of Motion	0400	(b)(6)

Cardiac Monitor	(Y) N	Y N	(Y) N
Bed position/~~Locked~~	(Y) N	Y N	(Y) N
Call bell in reach	Y N	Y N	Y N
Protective Device	Y (N)	Y N	Y (N)
[illegible]	Y (N)	Y N	Y (N)

ACLU DDI CID ROI 29503

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit _____

ABP (NAP)	107/43	102/44	103/50	87/38	115/53	110/44	121/50	112/53
Pulse	101	102	101	102	92	91	89	79
Respirations	28	24	24	28	24	18	20	24
Temperature	98.2	—	—	—	97.2	—	—	—
SaO2	96	95	95	89	97	96	95	100
%O2	24	28	28	28	28	21	21	21
O_2 Delivery	NC	NC	NC	CAT	NC	RA	RA	RA
Mode								
Rate								
Tidal Vol.								
Peep								
PS								
Pain Scale								
Pain Med	N	N	N	C	N	N	Y	N
Pt Position	S	S	C	S	S	S	S	S
CVP								

24 Hour Totals	Yesterday	Today
INPUT	363	670
OUTPUT	2140	2295
DIFFERENCE	-1613	-523

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

-1613 -2436

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV										
IVPB										
PO/ TF	100				250		100	(b)(6)		450
Other										
TOTAL										

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	100/100	100/200	60/260	(b)(6) (b)(6)	50/310	40/350	10/360	5/365	365	2295
NG output										
Emesis										
Stool										
Chest tube #1/ #2										
Jackson Pratt #1/ #2										
TOTAL										

Legend

nit=initials
VD=Jugular Venous Distention
L=Left
NIBP=Noninvasive Blood Pressure
N=No
Y= Yes
+2= strong +1=weak
P=Prone
R= Right
SaO2=Saturation of Arterial Oxygen
S= Supine
ABP= Arterial Blood Pressure
PS=Pharmacologically Sedated

Name	Signature	Init.
(b)(6)		

ACLU DDI CID ROI 29504
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 2

NEUROLOGICAL		
Level of consciousness, Glasgow		
Coma Scale (GCS), pupil size &		
response, motor & sensory function		
Muscle strength, pain, abnormal		
findings, spinal precautions		
CARDIOVASCULAR		
Rhythm, Rate, Ectopy, PMI, Lead selected,		
Normal Heart Sounds (S1, S2),		
Abnormal Heart Sounds – (S3, S4,		
murmur, gallop, click, rub), color,		
skin temp, JVD, Capillary refill,		
Pulses (strength, bilaterally), turgor,		
moisture, edema, carotid bruits/thrills,		
CVP, abnormal findings, Central lines		
(Location, appearance, dressing, etc.)		
RESPIRATORY		
Respiratory rate, rhythm, SaO2, oxygen		
delivery method, Ventilator settings,		
chest expansion, Accessory muscle use,		
lung sounds, cough, secretions/sputum		
(Color, amount, consistency), ETT/Trach		
(size, placement, appearance), Chest		
Tubes (location, Suction/H20 seal, air		
leaks, drainage amount & color, dressing)		
Arterial line (appearance, location, etc.)		
GASTROINTESTINAL		
Oral cavity appearance, dentition,		
Mucosal appearance, odor, Abdomen		
(contour, distention, tenderness, soft,		
Firm, guarding, bowel sounds), NG/OG/		
G-Tube (placement, verified, residuals),		
Tube feeds (type, rate), suction, stool/		
Emesis (color/consistency/amount),		
Colostomy (stoma location & appearance)		
GENITOURINARY		
Mode of elimination (void, foley, urostomy),		
Foley size, bladder distention,		
Urine (color, amount, sediment)		
INTEGUMENTARY		
General skin condition, dressings		
(locations, condition), wounds, lacerations,		
Incisions (staples or sutures, approximation		
of wound edges, drainage, signs of		
infection), drains (JP, hemovacs, etc.),		
Drainage (color, amount), protective aids,		
Decubitus ulcers, IV sites (location, fluid,		
rate, appearance, dressing), any additional		
Skin findings		

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

FOR OFFICIAL USE ONLY

ACLU DDI CID ROI 29505

Frequent Vital Signs Flowsheet –
TF 51 (Revised 1 May 2007)

SPECIAL INSTRUCTIONS

Date Time	Temperature (Route	Pulse	Respirations	Blood Pressure	SaO2	O2 Requirements	Additional Comments (i.e. urine, rate of infusion, volume infused, etc.)
0830		81	24	113/36	100%	FiO_2 36% Bipap	NE mcg/kg/min
0845		84	28	111/39	97%	2L NC	110mcg/min
0850		84	28	117/38	96%	2L NC	100 mcg/mL
0855		88	25	111/40	95%	2L NC	90mcg/mL
0900		88	28	110/40	99%	2L NC	80mcg/mL
0905		88	29	112/43	97%	2L NC	70mcg/mL
0910		89	30	109/42	96%	2L NC	60mcg/mL
0915		91	31	124/51	99%	2L NC	50mcg/mL
0920		92	27	122/51	98%	2L NC	52mcg/mL
0925		94	28	119/49	100%	2L NC	40mcg/mL
0930		89	28	116/45	100%	2L NC	30mcg/mL
0935		92	28	120/43	99%	2L NC	20mcg/mL
0940		85	28	115/39	99%	2L NC	10mcg/mL
0945		85	28	115/37	99%	2L NC	0mcg/mL
1000							

PREPARED BY: (signature & Title)
(b)(6)

DEPARTMENT/SERVICE/CLINIC
ICU

DATE
Feb 2025

PATIENT'S IDENTIFICATION

Hospital Number 600 00 4352

ISN #

Unit / ICW

☐ HISTORY/PHYSICAL
☐ OTHER EXAMINATION
☐ EVALUATION
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

☐ FLOWCHART
☐ OTHER

ACLU DDI CID ROI 29506
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
ACLU-RDI 5584 p.50

Exhibit 2

DATE:	DIAGNOSI								HOSPITAL DAY:								
Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
NIBP/ ABP (MAP)	103/58 (66)	117/62 (80)	120/71 (88)	120/72 (88)	129/75 (93)	134/73 (94)	119/75 (89)	120/78 (92)	115/ 103 (93)	130/58 (82)	152 (82)	109/57 (74)					
Pulse	74	74	80	81	64	85	105	103	117	114	110	100					
Respirations	31/15	31/15	31/15	33/15	34/15	33/15	30/15	34/15	34/15	40/15	15/15	36/15					
Temperature	/	97.6	/	/	/	97.6	/	/	/	100.2	/	/					
SaO2	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	95%	95%					
%O2	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%					
O_2 Delivery	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent					
Mode	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV	S.AV					
Rate	15	15	15	15	15	15	15	15	15	15	15	15					
Tidal Vol.	450	450	450	450	450	450	450	450	450	450	450	450					
Peep	5	5	5	5	5	5	5	5	5	5	5	5					
PS	10	10	10	10	10	10	10	10	10	10	10	10					
Pain Scale	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA	UTA					
Pain Med	/	/	/	/	/	/	/	/	/	/	/	/					
Pt Position	HOB ↑	HOB↑	LS↑	LS↑	RS↑	RS↑	HOB↑	HOB↑	LS↑	LS↑	HOB↑	HOB↑					
CVP	/	/	/	/	/	/	/	/	/	/	/	/					

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV	125	125	50	50	50	50	50	50	550	50	50	50	50					
IVPB										500								
Pepcid	5.3	5.3	5.3	3.2	off				19.1			9.4	9.4					
PO/ TF																		
Other																		
TOTAL									569.1									

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total	Ø / Ø	10 / 10	10 / 20	15 / 35	10 / 45	Ø / 45	Ø / 45	20 / 65	65	10 / 10	15 / 25	0 / 25	0 / 25	/	/	/	/	/
NG output								250	250									
Emesis																		
Stool																		
Chest tube #1/ #2	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Jackson Pratt #1/ #2	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
TOTAL									315									

	TIME/INITIALS					
Bath/Skin Care			Cardiac Monitor	Y N	Y N	Y N
Oral Care			Bed position/ Locked	Y N	Y N	Y N
Foley Care			Call bell in reach	Y N	Y N	Y N
Trach Care			Protective Device	Y N	Y N	Y N
Range of Motion			High risk for falls	Y N	Y N	Y N

ACLU DDI CID ROI 29507
ACLU-RDI 5584 p.51
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
000051
Exhibit 2

PATIENT

DATE:

TIME	23	24	01	02	03	04	05	06	07
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	4291.2	
OUTPUT	360	
DIFFERENCE	3931.2	

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

1545.2

(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	S=Supine
ABP= Arterial Blood Pressure	
Y= Yes	PS=Pharmacologically Sedated
+2= strong +1=weak	

Name	Signature	Init.
	(b)(6)	

ACLU DD FOIA RDI 29566
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
ACLU-RDI 5584 p.52
Exhibit 000052

SYSTEM	DAYS	NIGHTS
NEUROLOGICAL	TIME: 0730	TIME:
Level of consciousness, Glasgow	[illegible]
Coma Scale (GCS), pupil size &	[illegible]
response, motor & sensory function	[illegible]
Muscle strength, pain, abnormal	[illegible]
findings , spinal precautions	[illegible] GCS 6T.
CARDIOVASCULAR	[illegible]
Rhythm, Rate, Ectopy, PMI, Lead selected,	[illegible] SR-HR-81. Ectopy, none, [illegible]
Normal Heart Sounds (S1, S2),	S1, S2 [illegible]
Abnormal Heart Sounds – (S3, S4,	none. [illegible] none. Slushy
murmur, gallop, click, rub), color,	[illegible]
skin temp, JVD, Capillary refill,	[illegible]
Pulses (strength, bilaterally), turgor,	+1 peripheral Pulses, cool extremities
moisture, edema, carotid bruits/thrills,	Cool skin turgor. Moisture noted
CVP, abnormal findings, Central lines	+1 edema capacity in BLE. —
(Location, appearance, dressing, etc.)	
RESPIRATORY	
Respiratory rate, rhythm, SaO2, oxygen	Pt on vent: SIMV Rate 15 TV 450
delivery method, Ventilator settings,	FiO2-40% Peep-5 PS 10. O2 sat 98
chest expansion, Accessory muscle use,	100%. Equal chest expansion. [illegible]
lung sounds, cough, secretions/sputum	Accessory muscle use noted. Coarse
(Color, amount, consistency) , ETT/Trach	Breath sounds throughout, with
(size, placement, appearance), Chest	[illegible] rales throughout.
Tubes (location, Suction/H20 seal, air	8.0 ETT @ 23cm at teeth.
leaks, drainage amount & color, dressing)	Rt Femoral A-line - pressure
Arterial line (appearance, location, etc.)	[illegible] waveform/CDI
GASTROINTESTINAL	
Oral cavity appearance, dentition,	Oral Cavity pink moist. Dentition
Mucosal appearance, odor, Abdomen	intact. Abd soft, ND. [illegible]
(contour, distention, tenderness, soft,	BS x4 quads. Report of BM
Firm, guarding, bowel sounds), NG/OG/	last night. NG tube via [illegible]
G-Tube (placement, verified, residuals),	here to LWS, placement verified
Tube feeds (type, rate), suction, stool/	by x-ray [illegible]. NPO. Denies
Emesis (color/consistency/amount),	nausea at this time.
Colostomy (stoma location & appearance)	
GENITOURINARY	
Mode of elimination (void, foley, urostomy),	Foley to DSD. Yellow dark yellow
Foley size, bladder distention,	urine output. Bladder distention
Urine (color, amount, sediment)	or suprapubic noted. Palpated [illegible]
INTEGUMENTARY	low urine output.
General skin condition, dressings	Grossly intact & dry site.
(locations, condition), wounds, lacerations,	Please see wound/ostomy assmt.
Incisions (staples or sutures, approximation	Other braden scores noted
of wound edges, drainage, signs of	
infection), drains (JP, hemovacs, etc.),	
Drainage (color, amount), protective aids,	
Decubitus ulcers, IV sites (location, fluid,	
rate, appearance, dressing), any additional	
Skin [illegible]	
SIGNATURE	(b)(6)

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LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29509

Exhibit 2

ICU FLOW SHEET

Glasgow Coma Scale	Neuro Assessment Legend
Eyes Open:	
4 - Spontaneously	Muscle Strength:
3 – To speech	5 – Normal strength
2 – To Pain	4 – Moves against resistance
1 – None	3 – Moves against gravity
Verbal Response:	2 – Moves not against gravity
5 – Oriented	1 – No movement
4 - Confused	
3 – Inappropriate Words	
2 – Incomprehensible Sounds	
1 – None (Note – "T" = tube)	
Motor Response:	Pupil Scale
6 – Obey Commands	
5 – Localizes to pain	2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm
4 – Withdraws to Pain	
3 – Flexion to pain	
2 – Extension to pain	
1 - None	

RESTRAINTS:	DAYS		NIGHTS		
0700 site LLE	pulse +2 cap. ref. <3 edema +1	1900	Site	pulse	cap. ref. edema
0900 site LLE	pulse +2 cap. ref. <3 edema +1	2100	Site	pulse	cap. ref. edema
1100 site LLE	pulse +2 cap. ref. <3 edema +1	2300	Site	pulse	cap. ref. edema
1300 site LLE	pulse +2 cap. ref. <3 edema +1	0100	Site	pulse	cap. ref. edema
1500 site LLE	pulse +2 cap. ref. <3 edema +1	0300	Site	pulse	cap. ref. edema
1700 site LLE	pulse +2 cap. ref. <3 edema +1	0500	Site	pulse	cap.ref edema

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
20G (L) B.	06 Feb		CDI, p.l.+		
20G (R) FA	9 Feb		CDI. p.l.+		
A-line (R) Fem	9 Feb		Sup wrinkles + Hand Edema - Int. pt.		

PREPARED BY: (signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU	9 FEB 08

PATIENT'S INDENTIFICATION

600 90 4352
ICU #5

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

ACLU DDI CID ROI 29510
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
ACLU-RDI 5584 p.54

Exhibit 1

0004-08-CID789-53196

ICU FLOW SHEET

Glasgow Coma Scale	Neuro Assessment Legend
Eyes Open:	
4 - Spontaneously	Muscle Strength:
3 – To speech	5 – Normal strength
2 – To Pain	4 – Moves against resistance
1 – None	3 – Moves against gravity
Verbal Response:	2 – Moves not against gravity
5 – Oriented	1 – No movement
4 - Confused	
3 – Inappropriate Words	
2 – Incomprehensible Sounds	
1 – None (Note – "T" = tube)	
Motor Response:	**Pupil Scale**
6 – Obey Commands	
5 – Localizes to pain	2mm 3mm 4mm 5mm 6mm 7mm 8mm 9mm
4 – Withdraws to Pain	
3 – Flexion to pain	
2 – Extension to pain	
1 - None	

RESTRAINTS:	DAYS				NIGHTS			
0700 site	pulse	cap. ref.	edema	1900	Site LLE	pulse +2	cap. ref. <3	edema -
0900 site	pulse	cap. ref.	edema	2100	Site LLE	pulse +2	cap. ref. <3	edema -
1100 site	pulse	cap. ref.	edema	2300	Site LLE	pulse +2	cap. ref. <3	edema -
1300 site	pulse	cap. ref.	edema	0100	Site LLE	pulse +2	cap. ref. <3	edema -
1500 site	pulse	cap. ref.	edema	0300	Site LLE	pulse +2	cap. ref. <3	edema -
1700 site	pulse	cap. ref.	edema	0500	Site LLE	pulse +2	cap. ref. <3	edema -

VASCULAR ACCESS

DEVICE/SITE	START DATE	DSG CHANGE	ASSESSMENT DAYS	ASSESSMENT EVENINGS	ASSESSMENT NIGHTS
16g (R) FA	6Feb07		Patent	Patent	Patent
20g (L) bicep	6Feb07		Patent	Patent	Patent

PREPARED BY (Signature & Title)
(b)(6)

DEPARTMENT/SERVICE/CLINIC
ICU

DATE
06Feb08

PATIENT'S INDENTIFICATION

600-00-4352
ISN 312117
Icu Bed 7

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

ACLU DDI CID ROI 29511

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 000055

B/P (MAP)													91/50	104/41	85/46		
Pulse													119	115	110		
Respirations													20	32	36		
Temperature													99.1	-	100.1		
SaO2													100	100	100		
%O2													2 NC	4L	3 NC		
O_2 Delivery													RA	RA	RA		
Mode															CPAP		
Rate															5		
Tidal Vol.															-		
Peep															10-5		
PS															-		
Pain Scale													0	0	0		
Pain Med													Po	Po	Po		
Pt Position													Self	S	S		
CVP																	

INTAKE

Time	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
IV													0	0	0	0	0	
IVPB																		
Ativan													24	24	24	24	24	96
PO/ TF																		
Other																		
TOTAL																		

OUTPUT

TIME	07	08	09	10	11	12	13	14	Total 8 hr	15	16	17	18	19	20	21	22	Total 8 hr
Urine output/ Total													300/300	200/500	225/725	250/975	250/1225	1225
NG output																		
Emesis																		
Stool																		
Chest tube #1/ #2																		
Jackson Pratt #1/ #2																		
TOTAL																		

	TIME/INITIALS	
Bath/Skin Care		
Oral Care		
Foley Care		
Trach Care		
Range of Motion		

Cardiac Monitor	(Y) N	(Y) N	(Y) N
Bed position/Locked	(Y) N	(Y) N	Y N NA
Call bell in reach	Y N	Y (N)	Y N NA
Protective Device	(Y) N	(Y) N	(Y) N
High risk for falls	(Y) N	(Y) N	(Y) N

n/a

ACLU DDI CID ROI 29512
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 000056

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		363
OUTPUT		2140
DIFFERENCE		-1777

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

-1777

(INTAKE) TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
IV										
IVPB										
Nutr.	27	27	30	33	30	33	36	36	252	363
PO/ TF										
Other										
TOTAL										363

OUTPUT

TIME	23	24	01	02	03	04	05	06	Total 8 HRS	24 HOUR TOTAL
Urine output /Total	30 / 30	25 / 550	/	/	175 /	/	150 /	70 / 890	890	2140
NG output										
Emesis										
Stool										
Chest tube #1/ #2	/	/	/	/	/	/	/	/	/	
Jackson Pratt #1/ #2	/	/	/	/	/	/	/	/	/	
TOTAL										2140

Legend	
Init=initials	P=Prone
JVD=Jugular Venous Distention	R= Right
L=Left	SaO2=Saturation of Arterial Oxygen
NIBP=Noninvasive Blood Pressure	S= Supine
N=No	ABP= Arterial Blood Pressure
Y= Yes	PS=Pharmacologically Sedated
+2= strong +1=weak	

Name	Signature	Init.
(b)(6)		

ACLU D

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ACLU-RDI 5584 p.57

000057

Exhibit

Exhibit 2

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

SYSTEM	
NEUROLOGICAL	
Level of consciousness, Glasgow Coma Scale (GCS), pupil size & response, motor & sensory function, Muscle strength, pain, abnormal findings , spinal precautions	
CARDIOVASCULAR	
Rhythm, Rate, Ectopy, PMI, Lead selected, Normal Heart Sounds (S1, S2), Abnormal Heart Sounds – (S3, S4, murmur, gallop, click, rub), color, skin temp, JVD, Capillary refill, Pulses (strength, bilaterally), turgor, moisture, edema, carotid bruits/thrills, CVP, abnormal findings, Central lines (Location, appearance, dressing, etc.)	
RESPIRATORY	
Respiratory rate, rhythm, SaO2, oxygen delivery method, Ventilator settings, chest expansion, Accessory muscle use, lung sounds, cough, secretions/sputum (Color, amount, consistency) , ETT/Trach (size, placement, appearance), Chest Tubes (location, Suction/H20 seal, air leaks, drainage amount & color, dressing) Arterial line (appearance, location, etc.)	
GASTROINTESTINAL	
Oral cavity appearance, dentition, Mucosal appearance, odor, Abdomen (contour, distention, tenderness, soft, Firm, guarding, bowel sounds), NG/OG/ G-Tube (placement, verified, residuals), Tube feeds (type, rate), suction, stool/ Emesis (color/consistency/amount), Colostomy (stoma location & appearance)	
GENITOURINARY	
Mode of elimination (void, foley, urostomy), Foley size, bladder distention, Urine (color, amount, sediment)	
INTEGUMENTARY	
General skin condition, dressings (locations, condition), wounds, lacerations, Incisions (staples or sutures, approximation of wound edges, drainage, signs of infection), drains (JP, hemovacs, etc.), Drainage (color, amount), protective aids, Decubitus ulcers, IV sites (location, fluid, rate, appearance, dressing), any additional Skin findings	
SIGNATURE	

(b)(6)

ACLU DDI CID ROI 29514

0004-08-CID789-53196

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo Feb Yr 08

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 06 07 08 09 10
06Feb08	(b)(6)	Vital Signs ICU protocol	07	/ (b)(6)
			15	(b)(6)
			23	(b)(6)
			X	
06Feb08	(b)(6)	Activity: Bedrest c DRP	07	/
			15	(b)(6) DIC'd @ 0815 TFoCK
			23	(b)(6)
			X	
06Feb08	(b)(6)	Diet: Regular	07	/
			11	/ Dtd 06Feb08 (b)(6)
			17	(b)(6)
			X	
06Feb08	(b)(6)	Labs: CBC, BMP, TSH QAM	05	/ (b)(6) Reorder placed 1 Feb08
			X	TSH ordered (b)(6)
06Feb08	(b)(6)	X-Rays: CXR Q AM	05	/ (b)(6)
			X	
06Feb08	(b)(6)	EKG Q AM	05	/ (b)(6)
			X	
06Feb08	(b)(6)	Respiratory Isolation	07	/
			15	(b)(6) 1eFeb08 @1928 Stop Resp. Cultures/ (b)(6)
			23	
			X	
06Feb08	(b)(6)	Monitor 2 heplock IV's	07	/ (b)(6)
			15	(b)(6)
			23	(b)(6) /
			X	
			X	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Pneumonia, Cardiomegaly

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

600-00-4352

ISN 312117

IC4 Bed 7

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29515

DA FORM 4677, 1 OCT 1978 EDITION OF 1 DEC 77 MAY BE USED.

Exhibit 2

APD PE v1.00

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

0004-08-CID789-53196

Mo Feb Yr 08

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6 Feb 08	(b)(6)	Service: med Condition Stable	06 Feb 08	ASAP	1725	(b)(6)
6 Feb 08		EKG on arrival	06 Feb 08	ASAP	1735	
6 Feb 08		CXR (1) No J	06 Feb 08	ASAP	D/C'ed per (b)(6)	
6 Feb 08		ABG	06 Feb 08	ASAP	1815	
6 Feb 08		Cardiac Enzymes Q6' x 3 sets	06 Feb 08	#1 ASAP	1800	
	-----		06 Feb 08	#2 2400	~~2400~~ Q010	(b)(6)
	-----		07 Feb 08	#3 0600	~~0600~~ 0005	
6 Feb	(b)(6)	PCXR	06 Feb	ASAP	2130	(b)(6)
8 Feb 08		~~Foley~~ D/C Foley	08 Feb 08	ASAP	1000	
8 Feb 08		D/C to wean with meds after patient voids	08 Feb 08	After Void		
8 Feb 08		Int Dot Cath @ 2200 if no void	08 Feb 08	2200		
8 Feb 08		Keep pt overnight if Int Cath required	08 Feb 08	overnight.		
9 Feb		CXR P	09 Feb 08	2000	2000	(b)(6)
9 Feb		CBC/Chem/ABG	09 Feb 08	1600	2000	
9 Feb		✓ CBC/CMP/Mg in AM	9 Feb 08	0500	0500	
9 Feb		✓ ABG now & in AM	9 Feb	2330	2330	
	-----		9 Feb 08	0500	0500	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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ACLU DDI CID ROI 29516
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LAW ENFORCEMENT SENSITI

Exhibit 000060

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Feb Yr. 08

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 06	07	08	09	10
06Feb08	(b)(6)	NPO	07	✓	(b)(6)			
	- - - - - -		15	(b)(6)				
	- - - - - -		23					
	- - - - - -		X					
06Feb08	(b)(6)	Foley catheter	07	✓	(b)(6)			
	- - - - - -		15	✓				
	- - - - - -		23	(b)(6)				
	- - - - - -		X					
7Feb08	(b)(6)	1.5L Liter Restriction	07	x	(b)(6)			
	- - - - - -		15	x				
	- - - - - -		23	x	(b)(6)	✓		
	- - - - - -		x					
7Feb08	(b)(6)	Labs: CBC, BMP	05	x	x	(b)(6)		
	- - - - - -		x					
7Feb08	(b)(6)	O2 sats > 95%	07	x	(b)(6)			
	- - - - - -		15	x				
	- - - - - -		23	x				
	- - - - - -		x					
7Feb08	(b)(6)	Activity: ad lib	07	x	(b)(6)			
	- - - - - -		15	x				
	- - - - - -		23	x	(b)(6)	✓		
	- - - - - -		x					
7Feb08	(b)(6)	Diet: Regular	07	x	x	(b)(6)		
	- - - - - -		11	x	x			
	- - - - - -		17	x	(b)(6)			
	- - - - - -		23	✓				
	- - - - - -							

reboration 2 Feb 08 1004 (b)(6)

Ancef 09Feb08 (b)(6)

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Pneumonia, Cardiomegaly

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

600-00-4352

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29517

ACLU-RDI 5584 p.61

Exhibit

DA FORM 4677, 1 OCT 1978 EDITION OF 1 DEC 77 MAY BE USED. APD PE v1.00

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Feb Yr 2008

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
~~Feb~~	(b)(6)	~~Resix 2 mg IV q 1 PRN~~ per sheet	~~7 Feb~~	~~PRN~~ per sheet	~~1115~~	(b)(6)
Feb		Fentanyl, Fent, TIBC, IBV, HCV, HIV, BMP	7 Feb	11:00	8 Feb 08 1130	
Feb		CXR (P) in AM	8 Feb	0400	0400	
Feb		EKG in AM	8 Feb	0500	0500	
8		CARDIAC ENZYMES Q6° x 3	8	2200	2200	
	-----		9	0400	0400	
	-----		9	1000	1000	
Feb 08	(b)(6)	Advance NGT 6-8 cm	08 Feb 08	ASAP	0830	
Feb 08		Check BMP @ 1200 hrs	08 Feb 08	1200	1210	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
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ACLU DDI CID ROI 29518
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITI
Exhibit 2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. ___ Yr. ___

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 05	09	10	11
8 Feb	(b)(6)	I:O's	07	/	(b)(6)		
	- - - - - -		15	/			
	- - - - - -		23	(b)(6)			
	- - - - - -		X				
8 Feb	(b)(6)	V D-Sticks q4hours	02	X	(b)(6)		
	- - - - - -		06	X			
	- - - - - -		10	X			
	- - - - - -		14	X			
	- - - - - -		18	X	/		
	- - - - - -		22	57	(b)(6)		
	- - - - - -		X				
8 Feb	(b)(6)	NGT-ILWS	07	/	(b)(6)		
	- - - - - -		15	/			
	- - - - - -		23	(b)(6)			
	- - - - - -		X				
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0004-08-CID789-53196

THERAPEUTIC DOCUMENTATION CARE PLAN

(NON-MEDICATION)

Mo _____ *Yr* _____

Verify by Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED
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ACLU DDI CID ROI 29520
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENS. /E

Exhibit 2

Medical Record
Education Report

CLINICAL RECORD | THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see DA PAM 40-3; the proponent agency is OTSG.

NAME (LAST, FIRST, MIDDLE INITIAL) (PATIENT IDENTIFICATION AND ACCESSION NUMBER)

(b)(6)

WARD/BUILDING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 5 7 10
8 Feb	(b)(6)	Vent 15/650/10/5 40%	07	/
			15	/ (b)(
			23	(b) (6)
			X	
8 Feb	(b)(6)	NG @ 125 cc/hr	07	/
			15	/ Held 09 Feb 05 (b)(6)
			23	(b) (6)
			X	
8 Feb	(b)(6)	Vent R15 TV 450	07	/ (b) (6)
		PS 10 PEEP 5 FIO2 40%	15	/
			23	(b) (6)
			X	
9 Feb	(b)(6)	PROFAR: START 2 SPRAYS/NG	07	/ (b) (6)
		A2c, TREATS TO LIGHT	15	/
		SEDATION - KEEP LT ETOH	23	/
		ETC PRN 2 MOD. HEAVY SEDATION	X	
09 Feb 05	(b)(6)	Protonix 40mg IV ~~PO~~	10	/ (b) (6)
		QD. 1st Now	X	
			X	
09 Feb 05	(b)(6)	Lovenox 30mg SQ BID-	10	/ (b) (6)
		1st Now	22	/
			X	
09 Feb 05	(b)(6)	Decrease IVF to 50 ml/hr	07	(b)(6)
		BAK (N) Δ IVF to DSW	15	
			23	/
			X	

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Cardiomegaly, Pneumonia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO

PATIENT IDENTIFICATION:

600-00 4352

ICU #5

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					
N	23	24	01	02	03	04	05	06					

ACLU DDI CID ROI 29521

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DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

Exhibit 2

PAGE 1 OF 2

0004-08-CID789-53196

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo: Feb Yr 06

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8	(b)(6)	Hold all existing medication orders	8 Feb	now	now	(b)(6)
8		1500ml NS Bolus	8 Feb	now	now	
8		Help Sedation	8 Feb	2230	2230	
8		Calcium Gluconate 3gms 4hrly IV over 30mins	08Feb	ASAP	0700	
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
- - -	- - - - -		
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FORM 4572, 1 FEB 79

USAPA V1.01

ACLU DDI CID ROI 29522

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

Exhibit 000066

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION (CASE PLAN, MEDICATIONS)

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 06 07 08 09 10
06Feb08	(b)(6)	Saline Lock w/ flush Q8	01	/
		hrs	15	(b)(6)
			23	Aid 06Feb08 (b)(6)
			X	
06Feb08	(b)(6)	Ceftriaxone 2gm IV	20	(b)(6) /
		Q24°	X	
			X	
06Feb08	(b)(6)	Azithromycin 500mg	18	(b)(6)
		IV Q 24hrs	X	
			X	
06Feb08	(b)(6)	Concentrate all drugs	07	/ (b)(6)
		Please	15	(b)(6)
			23	(b)(6)
			X	
06Feb08	(b)(6)	IV Fluids at 30cc/hr	07	
			15	(b) (6) D/C'd
			23	
			X	
6Feb08	(b)(6)	Saline-lock IV w/flush	07	/ (b)(6)
		Q8hrs	15	(b)(6)
			23	(b)(6) /
			X	
6Feb08	(b)(6)	BiPaP 12\5	07	/ (b) (6)
		4 Feb 08 2112PR	15	(b) (6) D/C 7Feb08 (b)(6)
		BiPaP 12/5 2112 Feb 2	23	/
	(b)(6)		X	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Pneumonia, Cardiomegaly

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

600-00-4352
ISN 31217
ICU Bed 5

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

E	15	16	17	18	19	20	21	22						
N	23	24	01	02	03	04	05	06						

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

ACLU DDI CID ROI 29523
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LAW ENFORCEMENT SENSITIVE

Exhibit 2

rify by
tialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

0094-08 CID789-53196

Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)	SLN x 1 Now	06FEB08	ASAP	1715	(b)(6)
	SLN x 1 Now	06FEB08	Now	1732	
	Lasix 40mg IV Now	06FEB08	Now	1725	
	Nitropaste 2" x 1	06FEB08	now	1913	
	Lasix 20mg IV x 1 dose	06Feb08	Now	1930	
	MSO4 2mg IV x 1 dose	06Feb08	now	1927	
	Lasix 20mg IV x 1 Now	06Feb	Now	1915	
	Phenergan 12.5	06Feb	0035	0045	
	Socio NS bolus	07FEB08	1400	1402	

Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
(b)(6)	Tylenol 650mg PO	
	Q4hrs PRN Pain	
	Ens, Heitic, Ac	
	Not given in ED	
	4hrs S.S. Bowel	
	/	
(b)(6)	Benadryl 25mg PO	25mg 2x 2x
	IV Q2hrs PRN	
	Itch or Insomnia	
	/	
(b)(6)	Tylenol 650mg PO	2x 2x
	Q2 PRN Cough	

SMC 6075, 1 FEB '05

CONTINUED ON PAGE 2 OF 3

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LAW ENFORCEMENT SENSITIVE

ACLU DDI CID ROI 29524

0004-08-CID789-53196

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

For use of this form, see DA PAM [illegible]; the proponent agency is [illegible]

Wt 12 yr 8x

VERIFY BEFORE FILLING

INITIAL PROPER COLUMN WHEN EACH ADMINISTERED

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	DATE DISPENSED →	6	7	8	9	10	11
06 Feb 08	(b)(6)	nitro drip start @ 3cc/hour	07	/					
		titrate up every 5 min, 10 mcg/kg/	15	/					
		hold for SBP <100	23						
	(b)(6)		X						
7 Feb 08		Captopril 12.5mg PO TID 1st dose now	06						
			14	X					
			22	X					
			X						
7 Feb 08	(b)(6)	digoxin 125mcg PO BID 1st dose now	10						
			22	X					
			X						
7 Feb 08	(b)(6)	Lidocaine 50mg PO QD 1st dose now	10						
			X						
7 Feb 08	(b)(6)	Japer gtt ATC, titrate to keep SBP < 125mmHg	01	X					
			13	X					
			23	/					
			X						
7 Feb 08	(b)(6)	O2 to keep SaO2 > 95%.	07	X					
			15	X					
			23	X					
			X						
06 Feb 08	(b)(6)	Zosyn 3.375 grams IV Q6° - 1st dose now	06	/	/	/			
			12	/	/	/			
			18	/	/				
			24	/	/				
			X						

Discontinued @ 0841

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Pneumonia, Cardiomegaly

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

602-00-4352

TSN 31317

160 #5

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE
ACLU DDI CID ROI 29525

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.C PAGE 1 OF 2

ACLU-RDI 5584 p.69
000069
Exhibit 2

0004-08-CID789-53196

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo _____ Yr _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
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	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED															
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4 FORM 4676, 1 FEB 79

ACLU DDI CID ROI 29526
FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIV

Exhibit 000070

MEDICAL RECORD - SUPPLEMENTAL DOCUMENT

For [redacted] form, see AR 40-66; the proponent agency is the Office of the Surgeon General

REPORT TITLE: PROVIDER ORDERS

OTSG APPROVED (Date)

DATE: 06Feb08 TIME: 1645

SERVICE: (X) MED ( ) SURG ( ) ORTHO ( ) POD

DIAGNOSIS: Pneumonia, Cardiomegaly

CONDITION: (X) STABLE ( ) CRITICAL ( ) GUARDED

Vital Signs ( ) ICW Protocol (X) ICU Protocol

Allergies: (X) NKDA

Activity: Bedrest c BRP

Weight Bearing Status: _____

Diet: ( ) NPO (X) Regular ( ) Soft ( ) Clear Liquid ( ) Diabetic ( ) NPO after midnight for surgery DOS: _____

Dressing Change: ( ) POD # _____ ( ) Daily ( ) BID ( ) PRN ( ) Dakins ( ) Wet-Dry ( ) Xeroform-Dry

Continuous Wound Vac to _____ ( ) 75 mmHg ( ) 125 mmHg ( ) 150 mmHg

Drains: ( ) NGT to LWS ( ) Chest Tube to _____ ( ) Hemovac ( ) JP ( ) Foley ( ) Record output q 8hrs

Labs: (X) CBC ( ) CRP ( ) ESR ( ) Coags ( ) ABG ( ) CMP (X) BMP (X) Other TSH
( ) NOW ( ) in AM (X) q AM ( ) q AM x 3 days

X-Rays: CXR q AM

MEDICATIONS

(X) Saline Lock w/flush q 8 hrs ( ) NS ( ) LR @ _____ ml/hr ( ) D5 1/2 NS + 20mEq KCL @ _____ ml/hr

( ) Other IV Fluid: _____

( ) Lovenox 30 mg SQ BID ( ) Lovenox - Weight Based _____ mg SQ BID ( ) Hold PM dose the night before surgery

( ) Zosyn 3.375 grams IV q 6 hours

( ) Unasyn 3 grams IV q 6 hours

( ) Ancef 1 gram IV q 8 hours

( ) Ancef 1 gram IV x 1 on chart for OR

( ) Vancomycin 1 gm IV q 12 hours

( ) Levofloxacin 500 mg q day ( ) PO ( ) IV

( ) Cefoxilin ( ) 1 gram IV q 6 hours ( ) 2 gm IV q 8 hours

( ) MS Contin _____ mg PO q 12 hours

( ) Zantac ( ) 150 mg PO BID ( ) 50 mg IV q 8 hours

( ) Colace ( ) 100 mg PO BID ( ) 200 mg PO BID

( ) Dulcolax 10 mg ( ) PO ( ) Supp PR ( ) q AM ( ) BID ( ) Other: _____

PRN MEDICATIONS

( ) Percocet 1-2 tablets PO q 6 hours PRN pain

( ) Morphine 2-8 mg IV q 1 hour PRN severe pain or while NPO

(X) Tylenol 650 mg (X) PO ( ) Supp PR q 4 hours PRN for pain, fever, headache, do NOT give it within 4 hrs of Percocet

( ) Motrin ( ) 400 mg ( ) 800 mg PO q 8 hours PRN for pain, fever, headache

(X) Benadryl (X) 25 mg ( ) 50 mg ( ) 25 - 50 mg PO / IV / IM ( ) q 4 hours (X) q 8 hours PRN itch or insomnia

( ) Reglan 10 mg IV / PO q 6 hours PRN nausea

( ) Zofran 4 mg IV q 6 hours PRN nausea

ADDITIONAL ORDERS

( ) Sign and Witness Consent

(X) EKG on arrival and qam

(X) Ceftriaxone 2gm IV q24°

(X) Azithromycin 500mg IV q24hrs

(X) Respiratory Isolation

(b)(6)

(b)(6)

PREPARED BY (Signature & Title)
31st Combat Support Hospital

DEPARTMENT/SER
DCCS

20080115

PATIENT'S IDENTIFICATION (For typed or written entries give: Name (Last, First, Middle), Grade, Date, Hospital or Medical Facility)

PSUEDO ISN 606-00-4352 ISN 312117

LOCATION: ( ) ICU ( ) ICW BED # _____ AGE _____

( ) HISTORY / PHYSICAL ( ) FLOW CHART
( ) OTHER EXAMINATION (X) OTHER (specify) Provider Orders
( ) DIAGNOSTIC STUDIES
( ) TREATMENT

DD FORM 4700 FEB 2007 PREVIOUS EDITION IS OBSOLETE 31 CSH OP 08-01 15 Jan 08

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT SENSITIVE

000071

Exhibit 2

ACLU DDI CID ROI 29527

ACLU-RDI 5584 p.71

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0004-08-CID789-53196

DETAILS

DEATH SCENE EXAMINATION: About 1902, 9 Feb 08, SA [redacted] and SA [redacted] this office, conducted a death scene examination of Bed #5, 31st Combat Support Hospital (CSH), Camp Cropper, Iraq APO AE 09342 (CCIZ).

Characteristics of Death Scene: The 31st CSH was a single story, aluminum type construction, grey in color building used as a hospital. The main entrance to the 31st CSH was gained through a double door entrance located on the Northwest wall of the building. Upon entrance into the CSH there are several rooms located on both sides of the hallways. Mr. Rasul Said ANAD AL-JANABI, US [redacted] was located in the Intensive Care Unit (ICU) of the 31st CSH. The ICU was located in the Eastern most corridor of the hospital, the last set of doors on the southern wall. The entrance to the ICU was two double doors which opened into the main ICU area. The floor of the ICU was white in color, linoleum type construction which covered the entire floor, from wall to wall. The walls of the ICU were white in color, aluminum type construction. The walls appeared to be flat and level and ran from floor to ceiling. The ceiling of the ICU was white in color, aluminum type construction, there was several fluorescent lights which appeared to be centered on the ceiling and ran north to south. The lights were on during the time of the examination. The ceiling appeared to be level and ran from wall to wall. Upon entering there were two doors on the north wall which opened to a storage room and a latrine. After the storage room the ICU opened and there were five beds located along the north wall, three of which were occupied. The beds numbered two through six. Opposite the storage room, the south wall turned at a 90 degree angle and a small inlet held a sink and a refrigerator, after which continued on to another room which held supplies for the ICU. After the room was a large nurse's station which sat flush with the south wall. After the nurse's station, were two beds which were numbered eight and nine. Mr. ANAD AL-JANABI was located in bed five which was located in the Northeast portion of the room along the Northern wall. Bed five was positioned the northeast corner of the room. The head of the bed was facing the north wall with the Eastern side of the bed along the East wall. At the opposite ends of the room from the main E/E was another opening to another storage room and a break room. Centered in front of the opening to the second storage room sat a guards desk, with two chairs.

Conditions of the Scene: Mr. ANAD AL-JANABI's remains were positioned on the bed lying face up with his head facing the Northern wall. Mr. ANAD AL-JANABI was approximately 5'9" tall, 160lbs, tanned skin tone, and clean shaven; he appeared to have black hair with flecks of gray and brown eyes. Mr. ANAD AL-JANABI appeared to be of a thin stature and was approximately 18 years old. Upon arrival at scene, Mr. ANAD AL-JANABI was attached to several black, red and green in color wires which ran from Mr. ANAD AL-JANABI's chest, arms, left leg, and index finger on his right hand. The wires were attached to his chest by small adhesive electrodes. There was one bag of what was described as saline solution and contained injected medication. The bag was attached to his arms by tubes which were then attached to needles, placed into his arms. There was also a foley catheter in place in Mr. ANAD AL-JANABI's genitals. The bed below Mr. ANAD AL-JANABI's remains were several pairs of detainee issue sandals. Mr. ANAD AL-JANABI's eyes were partially opened with a breathing tube in his open mouth. Mr. ANAD

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA [redacted]	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE [redacted]	DATE 9 Feb 08 / EXHIBIT Z

ACLU DDI CID ROI 29528

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0004-08-CID789-53196

DETAILS

AL-JANABI's back and lower extremities were purplish in color, apparently from the blood pooling since his death which showed signs of livor mortis. Mr. ANAD AL-JANABI's joints appeared to have rigor mortis and algor mortis in his small joints. Mr. ANAD AL-JANABI's body temperature at time of examination was approximately 94 degrees.

Environmental Conditions: At the time of the examination it was dark outside. The temperature outside was 62 degrees and clear skies while the temperature inside the ICU was 68 degrees. There were no odors out of the ordinary near the remains during the time of the examination.

Factors Pertinent to Entrance/Exit (E/E): The main entrance and exit point to the ICU could be gained from the southern most wall in the ICU. There was a set of double doors which could be accessed by pushing in either direction. There were no other E/E points in the room. All other doors led to alternate room.

Scene Documentation: The scene was documented by SA b(6), b(7)(C) utilizing a Nikon Coolpix 5900 digital camera. A death scene sketch was prepared by SA b(6), b(7)(C)

Search for Latent Impressions: There was no search for latent impressions due to the entire staff and patients of the 31st CSH had unfettered access to the scene.

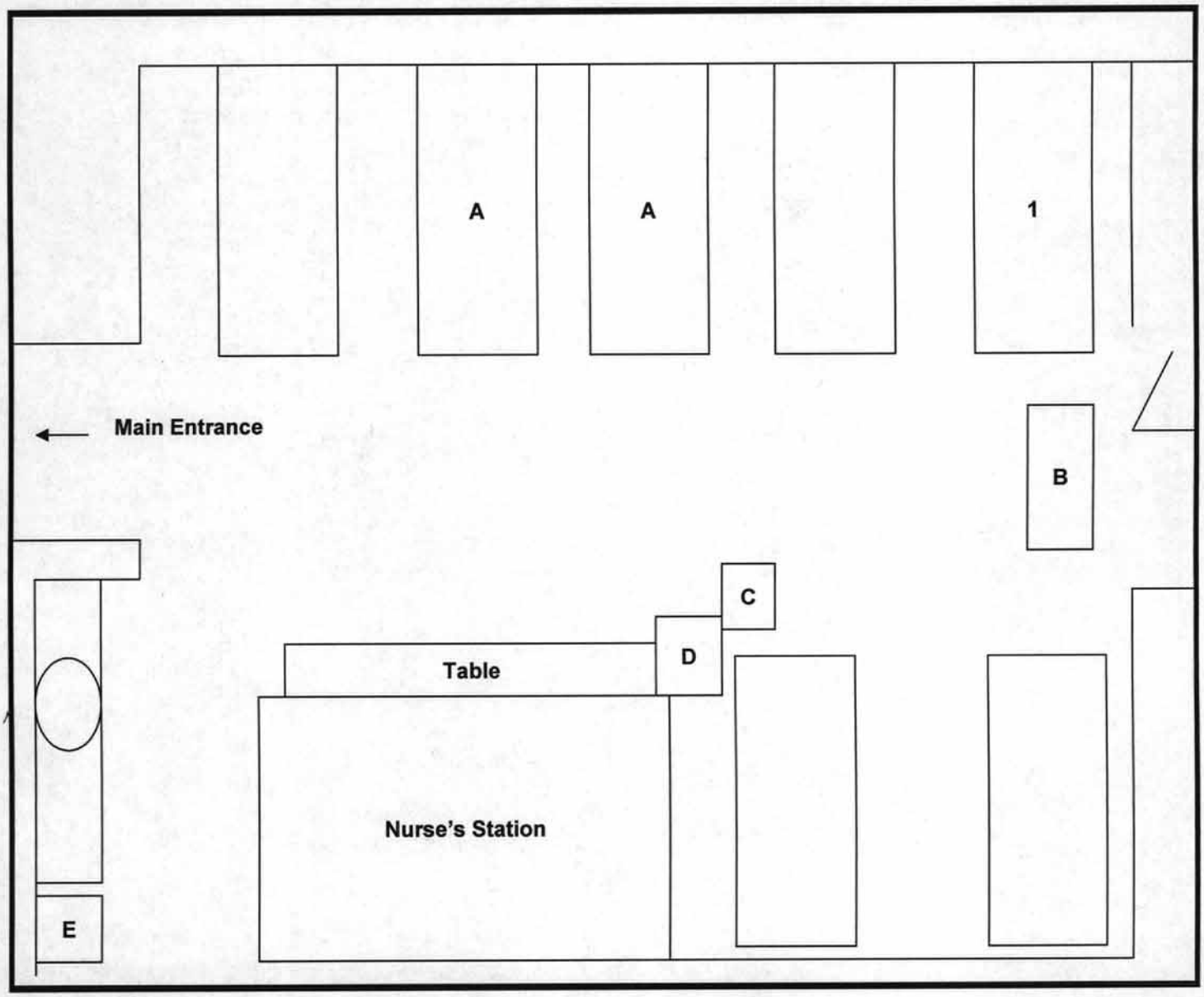
Collection of Evidence: A collection of evidence was not performed due to the fact that the remains were located at the ICU for several days prior to his demise and all clothing had been disposed of by hospital staff.

Search Beyond the Scene: A search beyond the scene was not conducted due to the victim was in the care and custody of the 31st CSH staff and no signs of foul play were observed. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	Camp Cropper CID Office, 1149th/20th MP DET (CID) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE b(6), b(7)(C)	DATE 8 FEB 08 / EXHIBIT Z

ACLU DDI CID ROI 29529

ROUGH SKETCH DEPICTING SCENE



LEGEND

1 – Location of Mr. RASUL

A – Occupied Bed

B – Guards Desk

C – Crash Cart

D – Cart with medical supplies

E - Refrigerator

N

Not To Scale

TITLE BLOCK
Case: 0004-08-CID789-
OFFENSE: Undetermined Death
SCENE PORTRAYED: ICU, 31st CSH
LOCATION: Camp Cropper, IZ APO AE 09342
VICTIM:ISN: US[redacted]
TIME & DATE BEGAN: 1905, 9 Feb 08
SKETCHED BY: SA [redacted]
VERIFIED BY: SA[redacted]

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EXHIBIT 4

ACLU DDI CID ROI 29530

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER 0004-08-CID789-53194
0037-08-CID112

DETAILS

BASIS FOR INVESTIGATION: On 11 FEB 08, this office received a Request for Assistance (RFA) from Special Agent b(6), b(7)(C), Office of Armed Forces Medical Examiner (OFAME), Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd., Bldg 102, Rockville, MD 20850. The request required this office to attend the autopsy of Mr. Anad AL-JANABI, Internment Serial Number (ISN) b(6), b(7)(C) Camp Remembrance II, Theater Internment Facility, Camp Cropper, IZ APO AE 09342 Baghdad, who was admitted to 31st CSH on 6 FEB 08 for chest pain and possible pneumonia. He was pronounced dead at 1845 on 9 FEB 08 by Dr. (MAJ) b(6), b(7)(C) Emergency Medicine Physician, 31st CSH, CCIZ.

About 0900, 14 FEB 08, SA b(6), b(7)(C) Fort Meade CID Office, Fort Meade, MD, attended the autopsy of Mr. AL-JANABI (ME#08-0126), which was performed by Dr. b(6), b(7)(C) United States Army, Office of the Armed Forces Medical Examiner (OAFME), Armed Forces Institute of Pathology (AFIP), 1413 Research Blvd., Bldg 102, Rockville, MD, 20850. The preliminary cause and manner of death were not opined. Photographers from AFIP exposed all 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. (See CD and Fingerprints 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//

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA (b)(6), (b)(7)(C), (b)(7)(F)	Aberdeen Proving Ground Resident Agency (CID) Aberdeen Proving Ground, MD 21005
b(6), b(7)(C)	DATE: 14 FEB 08 / EXHIBIT: 7

ACLU DDI CID ROI 29561

1 FEB 77

ACLU-RDI 5584 p.75

AGENT'S INVESTIGATION REPORT

CID Regulation 195-1

ROI NUMBER
0004-07-CID789-53196

PAGE 1 OF 1 PAGE

DETAILS

About 2027, 23 Jun 08, SA [b(6), b(7)(C)] received the Autopsy Examination Report, number ME07-1342, Armed forces Institute of Pathology, Office of the Armed Forces Medical Examiner, 1413 Research Boulevard, Building 102, Rockville, MD 20850. The report listed the cause of death concerning Mr ANAD was complications of idiopathic dilated cardiomyopathy and the manner of death was reported as natural. ///Last Entry///

TYPED AGENT'S NAME AND SEQUENCE NUMBER	ORGANIZATION
SA [(b)(6), (b)(7)(C), (b)(7)(F)]	20th/1149th Military Police Detachment (CID)(FWD) Camp Cropper, Baghdad, Iraq APO AE 09342
SIGNATURE	DATE: 24 Jun 08 / EXHIBIT: 18

ACLU DDI CID ROI 29613

ACLU-RDI 5584 p.76

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

AUTOPSY EXAMINATION REPORT

Name: Anad Al-Janabi, Rasul Said
ISN: 312117
Date of Birth: Estimated 18-19 year old
Date of Death: 09 FEB 2008
Date/Time of Autopsy: 14 FEB 2008/0930
Date of Report: 02 JUN 2008

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

Circumstances of Death: This adult male detainee at Camp Cropper Iraq was estimated to be 18 to 19-years old. Review of available medical records indicate that Mr. Anad Al-Janabi had recently been given a diagnosis of Idiopathic Dilated Cardiomyopathy and had a 2 week history of dyspnea, orthopnea, paroxysmal nocturnal dyspnea, and pedal edema. He was admitted to the 31st Combat Support Hospital on 06 February 2008 where on his second day of hospitalization he suffered from a cardiac arrest and was noted to have anoxic encephalopathy and acute renal failure. His condition continued to decline until his demise on 09 February 2008.

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

Identification: Presumptive identification by accompanying reports, identification tags and documentation. A postmortem dental examination, postmortem fingerprint examination, and a postmortem DNA sample are taken for profile purposes should exemplars becomes available for positive identification.

CAUSE OF DEATH: Complications of Idiopathic Dilated Cardiomyopathy

MANNER OF DEATH: Natural

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ACLU DDI CID ROI 29615

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished appearing, young adult male, whose appearance is consistent with the reported estimated age of 18 to 19-years. The body is received unclad with hands and feet secured with gauze for transport. Multiple medical devices are in place and will be described below in "Evidence of Medical Intervention". The remains are 72-inches in length, and weigh 150-pounds. Lividity is present and fixed on the posterior surface of the body except in areas exposed to pressure. Rigor has resolved to an equal degree in all extremities. The temperature of the body is that of the refrigeration unit.

The head is normocephalic, and the scalp is covered with straight black hair with grey streaks measuring up to 1-inch, in a normal distribution. Facial hair consists of sparse black hair on the chin and upper lip. The irides are brown. The corneae are hazy. The conjunctivae are pale. The pupils are round and equal in diameter. The sclerae are white and without petechial hemorrhage. The external auditory canals, external nares, and oral cavity are free of foreign material and abnormal secretions. The ears are unremarkable. The nares are patent and the lips are atraumatic. The nasal skeleton and maxillae are palpably intact. The teeth appear natural and in fair condition. The neck is straight, and the trachea is midline and mobile. There is a 1 ¼ x 3/16-inch healing superficial abrasion on the left side of the posterior neck. Examination of the head and neck reveals no evidence of recent trauma.

The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult circumcised male. The testes are descended and free of masses. Pubic hair is present in a normal male distribution. The buttocks and anus are unremarkable. There is a healing ½ x 1/8-inch superficial abrasion overlying the left posterior superior iliac spine. No evidence of recent trauma is noted on the torso.

The upper and lower extremities are symmetric and without clubbing or edema. The fingernails are intact and the nailbeds cyanotic.

Identifying marks include a single ¼ x ¼-inch hypopigmented scar on the anterior right leg.

CLOTHING AND PERSONAL EFFECTS

No personal effects accompany the body at the time of autopsy:

MEDICAL INTERVENTION

- Oro-tracheal intubation
- 2 x 2-inch gauze taped to the right anterior arm
- Double lumen intravenous catheter with occlusive dressing, "08 FEB 08 RN"
- Multiple (2) venipuncture marks on the dorsum of the right hand with surrounding 2 ½ x ¾-inch contusion

ACLU DDI CID ROI 29616

AUTOPSY REPORT (b)(6)
ANAD AL-JANABI, Rasul Said

- Intravenous catheter in the right inguinal crease, "08 FEB 08 MH"
- 2 x 2-inch gauze and surgical tape covering a venipuncture mark in the left inguinal crease
- Double lumen intravenous catheter and occlusive dressing/surgical tape on the anterior left arm with surrounding 3 x 2-inch contusion, "TOS"
- A self-adhesive ECG electrode on the right hip
- Residual adhesive marks on the both anterior shoulders, both lower quadrants of the abdomen, and immediately inferior to the left nipple

RADIOGRAPHS

A complete set of postmortem radiographs is obtained and demonstrates the following:

- Widened mediastinum
- Diffuse, scattered pulmonary infiltrates

EVIDENCE OF INJURY

There is no evidence of recent trauma.

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. No adhesions are present in the pleural, pericardial, or peritoneal cavities. There are bilateral pleural effusions of straw colored fluid (right-100-milliliters, left-150-milliliters). Ascites is present with 350-milliliters of straw colored fluid in the peritoneal cavity. No abnormal collections of fluid are noted in the pericardial sac. All body organs are present in their normal anatomic positions. There is no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

The subcutaneous fat layer of the abdominal wall is ¼-inches 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 is intact, as is the dura mater beneath it. There are no epidural or subdural hemorrhages present. The leptomeninges are thin and delicate. Clear cerebrospinal fluid surrounds the 1460-gram brain. The cerebral hemispheres are symmetrical with unremarkable gyri and sulci. The structures at the base of the brain, including cranial nerves and blood vessels, are intact and unremarkable.

Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. The atlanto-occipital joint is stable.

ACLU DDI CID ROI 29617

AUTOPSY REPORT (b)(6)
ANAD AL-JANABI, Rasul Said

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. A separate layer-wise dissection of the anterior neck reveals no evidence of trauma.

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 dark red, dense, congested and edematous, exuding copious amounts of blood and frothy fluid. Thick red mucous is noted in both mainstem bronchi. There is focal hemoaspiration in the left lower lobe and the right middle and lower lobes of the lungs. No mass lesions or discrete areas of consolidation are present. The right and left lungs weigh 1030 and 1080-grams, respectively.

CARDIOVASCULAR SYSTEM:
The pericardial surfaces are smooth and glistening. The 620-gram heart is contained in an intact pericardial sac free of significant fluid or adhesions. The heart is globoid and flabby. The epicardial surface is smooth, with minimal fat investment. The coronary arteries arise normally, follow the usual distribution in a right dominant pattern, are widely patent, and without evidence of thrombosis or significant atherosclerosis. The myocardium is homogenous, red-brown, soft and unremarkable; the atrial and ventricular septae are intact. The walls of the left and right ventricles are 0.9 and 0.3-centimeters thick, respectively. All chambers are dilated (ventricles greater then atriae). The valve leaflets are thin and mobile. The tricuspid, pulmonary, mitral, and atrial valves measure 14, 7, 13, and 6-centimeters, respectively. The mean valve circumferences for adult males (20-60 years) are 11.4, 6.6, 9.6, and 6.7, comparatively. The aorta and its major branches arise normally, follow the usual course and are free of significant atherosclerosis or other abnormalities. The venae cavae and its major tributaries return to the heart in the usual distribution and are free of thrombi. The renal and mesenteric vessels are unremarkable.

HEPATOBILIARY SYSTEM:
The hepatic capsule is smooth, glistening and intact, covering heavily congested parenchyma with a nutmeg appearance when sectioned. No mass lesions or other abnormalities are noted. The gallbladder contains 40-milliliters of green-brown mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent and without evidence of calculi. The liver weighs 1670-grams.

ACLU DDI CID ROI 29618

AUTOPSY REPORT (b)(6)
ANAD AL-JANABI, Rasul Said

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa coated with a thick white mucous. The gastric wall is intact and the lumen of the stomach is empty. The gastric mucosa is arranged in the usual rugal folds. The duodenum, loops of small bowel and colon are unremarkable. The appendix is present.

GENITOURINARY SYSTEM:
The kidneys each weigh 180-grams. The renal capsules are smooth and thin, semi-transparent and strip with ease from the underlying granular, red-brown cortical surface. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves and calyces are unremarkable. The ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. There is focal mucosal hemorrhage in the posterior bladder wall. The bladder contains approximately 3-milliliters of cloudy yellow urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

LYMPHORETICULAR SYSTEM:
The 190-gram spleen has a smooth, intact capsule covering maroon, dense parenchyma; the lymphoid follicles are unremarkable. Lymph nodes in the hilar, periaortic, and iliac regions are not enlarged.

ENDOCRINE SYSTEM:
The pituitary gland is unremarkable. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The pancreas is firm and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are noted. The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

MUSCULOSKELETAL SYSTEM:
Muscle development appears normal. No non-traumatic bone or joint abnormalities are noted. Incision and dissection of the skin and muscles of the back, buttocks and extremities demonstrates no evidence of recent or remote injury.

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ACLU-RDI 5584 p.81

Exhibit 11

AUTOPSY REPORT (b)(6)
ANAD AL-JANABI, Rasul Said

ADDITIONAL PROCEDURES

1. Documentary photographs are taken by OAFME staff photographers.
2. Specimens retained for toxicology testing and/or DNA identification are: Blood, vitreous fluid, urine, bile, heart, spleen, liver, lung, kidney, brain, adipose tissue, and skeletal muscle
3. Full body radiographs are obtained and demonstrate the above findings.
4. Selected portions of organs are retained in formalin.
5. The heart is fixed in formalin and retained for further examination.
6. The remaining dissected organs are forwarded with the body.
7. Personal effects are released to the mortuary affairs representatives.

MICROSCOPIC EXAMINATION

Cassette log:

1. Left kidney, spleen
2. Right kidney, liver
3. Right middle and lower lobes of the lung
4. Right upper and left lower lobes of the lung
5. Left upper lobe of the lung, left ventricle of the heart
6. Ventricular septum and right ventricle of the heart
7. Brain
8. Brain
9. Brain

A. Kidney (slides #1-2): Focal tubular necrosis and cast formation, unremarkable glomeruli
B. Spleen (slide #1): Perivascular fibrosis (focal) and vascular congestion
C. Liver (slide #2): Perivenular dilation of sinusoids and hepatocyte necrosis, no acute or chronic inflammation identified
D. Lungs (slides #3-5): Early changes of decomposition, focal pigmented macrophages, and focal pulmonary hemorrhage
E. Heart (slides #5-6): Multifocal ventricular fibrosis and myocyte hypertrophy.
F. Brain (slides #7-9): No significant pathologic diagnosis

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AUTOPSY REPORT (b)(6)
ANAD AL-JANABI, Rasul Said

FINAL AUTOPSY DIAGNOSES:

I. Cardiovascular
   A. Cardiomegaly (620-grams)
   B. Dilation of all chambers of the heart with increased circumference of the tricuspid and mitral valves
   C. Microscopic evidence of focal myocyte hypertrophy and interstitial fibrosis
   D. No evidence of significant atherosclerotic cardiovascular disease

II. Additional autopsy findings
   A. Ascites (350-milliliters) and bilateral pleural effusions (right 100-milliliters and left 150-milliliters)
   B. Bilateral pulmonary congestion and edema (right 1030-grams, left 1080-grams)
   C. Vascular congestion of liver with centrilobular hemorrhagic necrosis
   D. Focal hemoaspiration and pigment laden macrophages
   E. Focal renal tubular necrosis and cast formation
   F. No evidence of recent or remote blunt force or penetrating trauma

III. Post-mortem changes
   A. Lividity is fixed on the posterior surface of the body except in areas exposed to pressure
   B. Rigor is resolved to an equal degree in all extremities

IV. Toxicology results
   A. Volatiles: The blood and vitreous fluid were examined for the presence of ethanol at a cutoff of 20 mg/dl. No ethanol was detected.
   B. 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 drug was detected:
      1. Positive Antihistamine: Diphenhydramine was detected in the liver by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood contained 0.66 mg/L of diphenhydramine as quantitated by gas chromatography/mass spectrometry.
   C. 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.
   D. Cyanide: No cyanide is detected in the blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

ACLU DDI CID ROI 29621

ACLU-RDI 5584 p.83

Exhibit 11

AUTOPSY REPORT (b)(6)
ANAD AL-JANABI, Rasul Said

OPINION

This 18 to 19-year-old adult male detainee at Camp Cropper Iraq, BTB Rasul Said Anad Al-Janabi, died as the result of complications of a recently diagnosed Idiopathic Dilated Cardiomyopathy. Autopsy findings are consistent with the clinical diagnosis of idiopathic dilated cardiomyopathy of unknown etiology and congestive heart failure. There is no gross or microscopic evidence of pre-existing diseases of the heart valves, lungs, coronary arteries, or acute or chronic infections of the heart. There is no gross or x-ray evidence of recent blunt or penetrating trauma. Postmortem analysis of the body fluids and tissues for ethanol and screened illicit drugs of abuse are negative. The presence of diphenhydramine in the blood is consistent with the report of medical intervention. The elevated level of diphenhydramine is attributed to post-mortem redistribution and does not contribute to the cause or manner of death.

The manner of death is natural.

(b)(6)

(b)(6)

06 Jun 08

(b)(6) Medical Examiner

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ACLU DDI CID ROI 29622

Exhibit 11

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
ANAD AL-JANABI, RASUL SAID

SSAN: **Autopsy:** ME (b)(6)
Toxicology Accession #: (b)(6)
Date Report Generated: February 28, 2008

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 2/9/2008 **Date Received:** 2/20/2008

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.

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

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

DRUGS: The **LIVER** was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, chloroquine, mefloquine, 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 Antihistamine: Diphenhydramine was detected in the liver by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood contained 0.66 mg/L of diphenhydramine as quantitated by gas chromatography/mass spectrometry.

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Exhibit 11

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

REPLY TO
ATTENTION OF

REPORT OF TOXICOLOGICAL EXAMINATION (CONT - (b)(6) ANAD AL-JANABI, RASUL SAID:

(b)(6)

Office of the Armed Forces Medical Examiner

ACLU DDI CID ROI 29624
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Exhibit 11 000165

0004 08-CID789-53196

DIVISION OF FORENSIC TOXICOLOGY - TOXICOLOGICAL REQUISITION

TO:

ARMED FORCES INSTITUTE OF PATHOLOGY
ATTN: DIVISION OF FORENSIC TOXICOLOGY
BUILDING 54
6825 16TH STREET, N.W.
WASHINGTON, DC 20306-6000

FORWARD FINAL R

Dover AFB Port Mortuary
(b)(6)
Incident : CIF
Remains/Case #: D08-0158
Recovery/TC #:
Process Date: 14 Feb 08 ME #: (b)(6)

NAME OF PATIENT (Last, First, MI)	SOCIAL SECURITY #	AGE	SEX	RACE
BTB Anad Al-Janabi, Kasul Said	ISN 31217		M	

DATE OF INCIDENT/ ACCIDENT	TIME AND DATE OF DEATH	AUTOPSY #
	09FEB08	(b)(6)

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

SPECIMEN/AMOUNT	SPECIMEN/AMOUNT	SPECIMEN/AMOUNT
1. Blood	5. Bile	9. Kidney
2. Vitreous Blood	6. Spleen	10. Brain
3. Gastric Contents	7. Liver	11. Adipose
4. Urine	8. Lung	12. Eyes / Heart

(b)(6)

INCIDENT/ACCIDENT DETAILS (Include pertinent information regarding crush site/autopsy/pertinent pathology):

Detainee,

DFT#
08-0768

PRINTED NAME OF REQUESTER/TITLE	SIGNATURE	DATE	(b)(6)
(b)(6)		14FEB08	(b)(6)

CHAIN OF CUSTODY (CC)

Each individual who gains custody of specimens must complete information following and the specimens remain sealed until

RELEASED BY	RECEIVED BY	DATE/TIME	PURPOSE OF CHANGE
(b)(6)			
HAND CARRIE	(b)(6)	FEB 20 2008 @ 0820	Received From Courier
(b)(6)	Secured Storage	FEB 20 2008 @ 0820	TOXICOLOGY TESTING SECURED STORAGE

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Exhibit 11

0004-[redacted]-CID789-53196

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Social
Anad Al-Janabi, Rasul, Said		Civilian	CID 789-531965H9B
ORGANIZATION Organisation	NATION *(e.g, United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe [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 Negroide		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 décédé 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. [1]	Complications of Idiopathic Dilated Cardiomyopathy	
ANTECEDENT CAUSES — MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire		
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 [2]		

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	SIGNATURE Signature (b)(6) / DATE Date 14 February 2008 / AVIATION ACCIDENT Accident à 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
9 February 2008 18:45	Camp Cropper, Baghdad Iraq

I HAVE VIEWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE
J'ai examiné les restes mortels du dè 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)

GRADE Grade	INSTALLATION OR ADDRESS Installation ou adresse
(b)(6)	Dover AFB, Dover DE
DATE Date 6/16/2008	SIGNATURE Signature (b)(6)

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

REPLACES DA FORM 3565, 1 JAN 70 AND DA FORM 3565-R(PAS), 26 SEP 75, WHICH ARE OBSOLETE.

DD FORM 1 APR 77 2064

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Exhibit 12

0004-08-CID789-53196

(REMOVE, REVERSE AND RE-INSERT CARBONS BEFORE COMPLETING THIS SIDE)

DISPOSITON OF REMAINS

NAME OF MORTICIAN PREPARING REMAINS	GRADE	LICENSE NUMBER AND STATE	OTHER

INSTALLATION OR ADDRESS	DATE	SIGNATURE
436 SVC/SVD 116 26th Street, Dover AFB DE 19902		

NAME OF CEMETERY OR CREMATORY	LOCATION OF CEMETERY OR CREMATORY

TYPE OF DISPOSTION	DATE OF DISPOSTION

REGISTRATION OF VITAL STATISTICS

REGISTRY *(Town and Country)*	DATE REGISTERED	FILE NUMBER	
		STATE	OTHER

NAME OF FUNERAL DIRECTOR	ADDRESS

SIGNATURE OF AUTHORIZED INDIVIDUAL

DD FORM 2064, APR 1977 (BACK) *USAPA V1.00*

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Exhibit 12