0038-04-CID789-83988

CERTIFICATE OF DEATH

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

INTERN (b)(6)-4

FROM:

BAGHDAD CENTRAL DETENTION FACILITY

TO:

NAME (b)(6)-4 GRADE SERVICE NUMBER (b)(6)-4

NATIONALITY AND DATE

PLACE OF BIRTH DATE OF BIRTH

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

PLACE OF DEATH: BCDFH, ABU GHRAIB | DATE OF DEATH: 19 MAY 04 | CAUSE OF DEATH: Cardiac Arrest w/ fracture, [illegible]

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).*

Adm. to BCDFH 18 May with abd. pain/distention, dehydration, hypovolemia & DIC w/ internal bleeding and fracture. Xrays, analytic labs. Rehydrated x 18 hrs. Increased and fluids on 19 May [illegible] Resp. arrest while in Xray, resuscitated with Ambu bag ventilation. NC tube w/ positive. Cardiovasc arrest, CPR instituted immediately, ACLS protocol. Intubated, ventilated. No recovery of cardiac rhythm after 20 min. pronounced dead at 0915 hrs. by me.

DO NOT WRITE IN THIS SPACE
CERTIFIED A TRUE COPY

DATE 19 May 04

(b)(6)-2 [illegible], MC

SIGNATURE (b)(6)-2 COL, MC

SIGNATURE ADDRESS

SIGNATURE ADDRESS

DA FORM 2689-R, May 82 EDITION OF 1 JUL 63 IS OBSOLETE.

(b)(6)-1

LTC MI
COMMANDING, EX Cp

7

MEDCOM - 556

0038-04-CID714-83988

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL: BAGHDAD CENTRAL DETENTION FACILITY

Instructions - Medical Officer in attendance will:
Prepare, in one copy only, Items 1 through 10 and sign Item 11. Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.
Print or type entries.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

(b)(6)-4

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

2. TIME OF DEATH *(Hour-day-month-year)*: 0915 19MAY04

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

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

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

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Acute myocardial infarction, massive	1-2 hrs.
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) Severe coronary artery atherosclerotic disease	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. Morbidly obese, smoker/tobacco	2-3 days
	b. dehydration	2-3 days

9. DATE: 19 May 04

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER (b)(6)-2 MD CPT, MC

(b)(6)-2

SECTION B - ADMINISTRATIVE

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

SECTION C - RECORD OF AUTOPSY

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

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

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

USAPPC V2.00

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

8

Ex 3

EMERGENCY RESUSCITATION RECORD - PART I

For use of this form see MEDCOM Cir 40-5 0038-04-C10784-83488

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

1. DATE: 19 MAY 04

2. LOCATION OF RESUSCITATION EVENT
☐ MICU ☐ SICU ☐ CCU ☐ NICU ☒ ED ☐ PACU ☐ OR ☐ WARD: _____
☐ DIAGNOSTIC / PROCEDURE AREA: _____
☐ OUTPATIENT CLINIC: _____
☐ OTHER *(Specify)*: Pt brought to EMT from ICW area - 0800

3. WITNESSED ARREST?
☑ YES ☐ NO ☐ UNKNOWN

MONITORED AT ONSET?
☑ YES ☐ NO

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

☑ IV Access	☐	Time: :	
☐ Endotracheal Tube	☑	Time: 0805 :	#9 tube
☐ Mechanical Ventilation	☐	Time: :	
☐ Arterial Line	☐	Time: :	
☐ Central Venous Line	☐	Time: :	
☐ Pulmonary Artery Catheter	☐	Time: :	
☐ Nasogastric Tube	☑	Time: 0830	16 Fr French
☐ Pacing Device *(Specify type)*: _____	☐	Time: :	
☐ Implantable Defibrillator / Cardioverter	☐	Time: :	
☐ Other *(Specify)*: Foley	☑	Time: 0808	18 Fr foley to drainage

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

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

7. INITIAL CONDITION
CONSCIOUS ☑ Yes ☐ No
BREATHING ☑ Yes ☐ No
PULSE ☑ Yes ☐ No
Site: _____

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

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

CPR STOPPED AT: 0915

WHY: ☐ ROSC ☐ DNAR ☐ Considered futile ☑ Death

PATIENT DISPOSITION: Pt died in ER 0915

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

	HOUR	MIN
Collapse / Arrest Onset:	:	
CPR Started:	0835 :	
1st Defibrillation:	:	
Airway Achieved:	:	
1st Dose Epinephrine:	:	

Code Team Called: ☐ Yes ☐ No Time: :
Code Team Arrived: ☐ Yes ☐ No Time: :

10. GLASGOW COMA SCALE
(Post-resuscitation)
Circle appropriate scores, then total.

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

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

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

SCORE: 3

(b)(6)-4

AGE: _____
GENDER: _____
HEIGHT (in): _____
WEIGHT (lbs): _____

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

Ex 3

17 MAY 04

[illegible]ERGENCY RESUSCITATION RECORD - [illegible]ART 0034-04-C10785-83594

TIME (Hr/Min):	0800	0803	08[illegible]	0815	0825	08[illegible]5	0830	0850	0856	0900	0908	0910
VITALS												
BLOOD PRESSURE		82/43	83/37		93/41		120/49					
HEART RATE (* = CPR)	136	124	133		128	109	123	40				
RHYTHM	ST	ST						agonal			Ø	
PULSE PALPABLE (Y/N)	Y							CPR	CPR	CPR	CPR	CPR
DEFIBRILLATION (Joules: 200, 300, 360)												
CARDIOVERSION (Joules: 50, 100, 200, 300, 360)												
PACING PERFORMED (√)												
RESPIRATIONS Bagassist												
AIRWAY												
BAGGED w / 100% O2 (√)	Bag											
INTUBATED (√)									#9 ETT			
MASK (Specify type)		Face tent	NRB		PRB	NRB						
% OXYGEN	100%	100%										
O2 SATS		79%	84%		78%	83%						
P/G tube							16ga		(Foley) 18Fr			
MEDICATIONS												
EPINEPHRINE (1 mg - IV / ET tube)									IV 1amp	IV 1amp	IV 1amp	
ATROPINE (0.5 -1 mg - IV / ET tube)											IV 1amp	
LIDOCAINE (1-1.5 mg / kg - IV / ET tube)												
Bicarb										IV 1amp	IV 1amp	
Calcium Chloride										IV 1amp		
IV DRIPS												
LIDOCAINE (1 GM / 250cc - IV at 1 - 4 mg / min)												
DOPAMINE (400 mg / 250cc - IV at 1 - 20 mcg / kg / min)												
N/S 1000cc [illegible]				@125/hr								
N/S 1000cc [illegible]						bolus						
LABS												
POTASSIUM (K)												
GLUCOSE												
CALCIUM (Ca)												
MAGNESIUM (Mg)												
					Chem12							
					CBC							
ABGs												
PH												sent
pCO2												
pO2												
HCO3												

0915 [illegible]

(b)(6)-2

(b)(6)-2

(b)(6)-2

N (b)(6)-2

LTC A[illegible]

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Ex 3

~~ACLU-RDI 1047 p.4~~

DOD 003622

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5 0038-04-C10785-83498

SECTION I - PATIENT ASSESSMENT

DATE: 19 MAY 04 | PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY: 2

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia *(Specify)*: _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0600	0730													
BP ARTERIAL LINE															
BP CUFF	117/56														
TEMPERATURE	96.3														
PULSE	140														
RESPIRATORY RATE	36														
OXYGEN (L/%)															
PULSE OXIMETER	93%														
O2 METHOD	RA														

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:										
PAIN INTENSITY (10 / 5 / 0)										
MED ADMINISTERED (Y/N)										
RELIEF ACCEPTABLE (Y/N)										

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

(b)(6)-4

DIAGNOSIS: Acute Abd

DRG: _____ ADMISSION DATE: 19 MAY 04

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: ODC

ISOLATION REQUIRED *(Specify)*: _____

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5 0038-04-CIO789-83488

SECTION I - PATIENT ASSESSMENT

DATE: 15 May 04 | PATIENT ACUITY LEVEL : | POST-OP DAY: | HOSPITAL DAY: 1

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1315	1800	2130	2400												
BP ARTERIAL LINE																
BP CUFF	136/93	123/74	113/65	139/89												
TEMPERATURE	98	97.5	95.9	97.6												
PULSE	132	130	148	96												
RESPIRATORY RATE	28	18	40	40												
OXYGEN (L/%)																
PULSE OXIMETER	95%	95%	93%	93%												
O2 METHOD	RA	RA	RA	RA												

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1430	2045	2300							
PAIN INTENSITY (10 / 5 / 0)										
MED ADMINISTERED (Y/N)	Y	Y	Y							
RELIEF ACCEPTABLE (Y/N)		N								

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	1430	2000
*Skin breakdown prevention	W	RL
*Falls prevention protocol	W	RL
*Restraint protocol	W	RL
*Seizure precautions	NA	—
*Isolation precautions	NA	—

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

(b)(6)-4

Bed 11

DIAGNOSIS: Acute Abd.

DRG: _____ ADMISSION DATE: 15 May 04

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: ODS

ISOLATION REQUIRED (*Specify*): _____

38-04-C10789-83588

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

ECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief planation of abnormal findings will be noted in the appropriate column.

	TIME: 1430 INITIALS: NA	TIME: 2100 INITIALS: RL	TIME: 2200 INITIALS: RL
NEUROLOGICAL: Alert and oriented to ne place and name. Responds appropriately. ommunication is adequate to express needs. upils equal and reactive to light.	☑ (-)	☒	☐
. CARDIOVASCULAR: Pulse regular & rate ithin range for age. No dependent edema. ailbeds and mucous membranes pink. No calf enderness. *(See page 3 for extremity erfusion)*	☑ tachycardic equal - right 3/S2. extremity pulses -1+	☒ tachy cardic	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ equal - right chest expansion - feels quick slight -	☒	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ N/V - dark in color - abdomen tender distended -	☐ BOUTS OF EMESIS, DISTENDED - TENDER HYPOACTIVE BS x 3 QUAD ∅ BS RUQ ON AUSCULTATION	☐ NG TUBE (R) NARE CONT. SUCTION
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑ (-)	☐ SM AMTS URINE	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☑ (-)	☒	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☑ (-)	☒	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ + -	☐ C/O PAIN RUQ ABD	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☒	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1430 INITIALS: W	TIME: 2100 INITIALS: RL	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided: flushed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RAC / O.K.	IV Site #1: RAC / OR	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: ∠R D5 ½ @ 75 cc/hr	Comments:

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

E 3

0038-04-CID 795-83988

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: / TIME:	1430						
COLOR	P						
CAPILLARY REFILL	1						
TEMPERATURE	W						
EDEMA	0						
SENSATION	S						
MOTION	E						
PASSIVE FLEXION	C						
PERIPHERAL PULSE	2P						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1430	2000
ID band visible/legible	U	
Orient to environment prn	U	RL
Side rails (2/4) up	NA	—
Bed position low	✓	RL
Call light within reach	✓ NA	—

OTHER

Review & post lab results	NA	RL
Notify MD abnormal labs	✓	RL
Incontinent urine/stool	NA	—
Linen change prn	U	—
Turn/reposition q2h	NA	SELF
ROM q2h if immobile	✓	—
Antiembolic hose	✓ NA	—

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: NPO
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, (AMBULATE), BSC, (BRP), CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 1430 INITIALS: U	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
	(b)(6)-2	UT, ARL	D
	(b)(6)-2	SPC 91WM6	N

SECTION III - INTERVENTIONS & TEACHING (Cont) 0038-04-CID784-83488

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

18 May 04 @ 1430 - Pt transferred from EMT. He was seen at BAS c 2-3 day hx of abd pain. NV. Pt c/o abd pain presently. Abd distended. Q BS present upon auscultation. Abd tender to touch especially upper (R) quadrant. Pt having brown colored emesis. ~50cc. Will continue to monitor. —CPT [(b)(6)-2] [illegible]

1550 - Pt's enema given to pt. Will continue to monitor —CPT [(b)(6)-2] [illegible]

1700 - Pt results, last BM x 3 days ago. Nausea remains associated to BK several times. Tenderness to abd area esp RUQ remains. Abd remains distended. NPO remains —CPT [(b)(6)-2] [illegible]

1730 - Very small stool produced. Remains NPO. Constantly asking for H2O. —CPT [(b)(6)-2] [illegible]

19 MAY 04 0100 ASSESSMENT MEDCOM 689-R. PT HAD BM x2, VIA TRANSLATOR BM WAS MED AMT. ABD DISTENDED, HYPOACTIVE BS x 3 QUAD, Ø BS RUQ UPON AUSCULTATION. ABD TENDER TO RUQ. PT HAD BOUTS OF EMESIS, UPON CONSULTING DR. ODDI NG PLACED IN (R) NARE. PLACEMENT CHECKED C AIR BOLUS. PT GIVEN 25MG DEMEROL - 25MG PHENERGAN FOR EMESIS @ 2045. Ø RELIEF FROM PAIN NOTED. PT TO X-RAY @ 2200. DR. [(b)(6)-2] + DR [(b)(6)-2] IN. TO SEE PT, CBC - CHEM 12 DRAWN. PT CONTINUES TO COMPLAIN OF PAIN. WILL CONTINUE TO MONITOR. [(b)(6)-2] SPC 91W/M6

19 MAY 04 0100 Addendum LR BOLUS 1 LITER GIVEN PER DR [(b)(6)-2] [(b)(6)-2] SPC 91W/M6

Ex 3 15

OUTPUT 003F-04-C1078-83584

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL
1430	50cc	dark brown	50

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
1730	Brown		Sm amt	

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

Ex 3

(b)(6)-4

003F-04-CID789-83584

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1400 HOURS TO 0800 HOURS | TOTAL HOURS COVERED | DATE 18 May 04

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1400	Sips of H2O	~~1400~~ 7	7

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1400	1000	D5 LR @ 100cc/hr x 10			
1400	~~1000~~ 50	Tagamet IVPB	50	1430	

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

Ex 3 17

0038-04-C10715-83588

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
19 May 04	0740 HOURS	
1. O_2 per NC to maintain		
O_2 sats @ 90% or greater		
2. Ativan 1-2 mg IV per agitation		
q6h prn or		
3 Haldol 0.5 mg IV agitation q6h prn		
VO Col (b)(6)-2 / (b)(6)-2 LTCAN		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

Ex 3 18

0038-04-CID789-83988

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 May 04 TIME OF ORDER: 1300 HOURS

LIST TIME ORDER NOTED AND SIGN

① Admit to ICW.
② V.S. q 6h x 48hrs, then bid
③ Diet: NPO except for few sips of water for dry mouth prn
④ IV (Hep lock): D5/RL at 100 cc/h x 6 hrs, then 75 cc/h.
⑤ Activity: HOB elevated to 20-30°, pt. comfort

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT: ICW ROOM NO. BED NO.: 11

DATE OF ORDER TIME OF ORDER HOURS

⑥ call if pt. has more emesis
⑦ call if temp >101°F or syst BP < 95
⑧ labs: CBC, Lp-12 q AM x 2 days; send next urine for U/A; call results to me
⑨ strain all urine if possible.
⑩ record fluid I & O q shift.

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT: ICW ROOM NO. BED NO.: 11

DATE OF ORDER TIME OF ORDER HOURS

⑪ Demerol 25mg + phenergan 12.5mg I.M. q6h prn for pain.
⑫ [illegible] 300mg IVPB or slow I.V. push q8h
⑬ call me if any questions (b)(6)-2

Noted CPT [redacted] ANC 18 May 04 1530

PATIENT IDENTIFICATION (b)(6)-4

B6-2

NURSING UNIT: ICW ROOM NO. BED NO.: 11

DATE OF ORDER: 18 May 04 TIME OF ORDER: 1545 HOURS

① Fleets enema
V.O. Dr (b)(6)-2 (b)(6)-2 / CPT (b)(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

"USE BALL POINT PEN—PRESS FIRMLY ! NO CARBON PAPER REQUIRED"

Ex 3 10

0038-04-CID785-83981

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

DATE OF ORDER: 18 May 2004 — TIME OF ORDER: 2325 HOURS — LIST TIME ORDER NOTED AND SIGN

1. IVF Bolus - LR 1L over 1°
2. ↑ IVF to 150cc/h
3. Repeat CBC Diff, SMA-7, TBIL, DBIL - Done
4. Obstructive series/CXR in A.M 19 May 2004 0800

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER ______ HOURS

5. AM Labs @ 0800 19 May 2004
   1. Type & Cross
   2. CBC & Diff

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 18 MAY 04 — TIME OF ORDER: 2100 HOURS

VO: LT [illegible] / COL [illegible]

NG Tube to INT SUC

(b)(6)-2 [redacted]

NURSING UNIT: 24°C | ROOM NO. | BED NO.

[illegible] 0530 19 May

PATIENT IDENTIFICATION

DATE OF ORDER: 19 May 04 — TIME OF ORDER: 0713 HOURS

1. 1L LR
2. 0.9% NaCl for I.V. fluid at 125cc/hr
3. repeat chem-12 in ~1 hr

Thank you

(b)(6)-2 [redacted]

Noted [illegible] 0713

NURSING UNIT | ROOM NO. | BED NO.

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

Ex 3 20

Theater Trauma Registry Record

For use of this form, see AR 40-66; the proponent agency is OTSG 0038-04-CIDTR-83488

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

MTF DESIGNATION: BCDF (Number / Type) | (b)(6)-4 | CASUALTY SSN: (b)(6)-4

Arrive DTG: 1200 18 MAY 04 | Rank | Date of Birth JULY 1966 | Gender ☒ Male ☐ Female | Unit Ganci 4

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

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

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

Wound DTG:

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

N/A

PROTECTION: N/A.

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

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

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

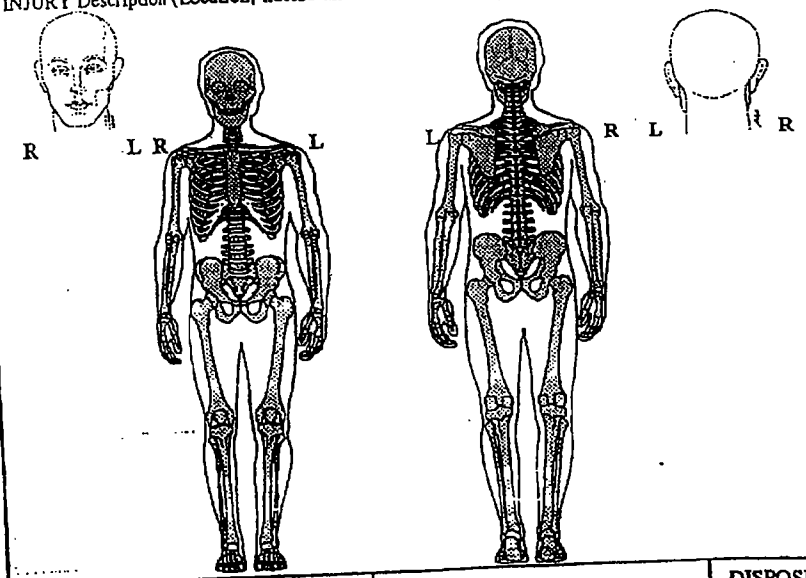
VITALS:

TIME	1208		
Pulse	127		
Temp	92.0		
B/P	112/59		
Resp	28		
SpO_2	99% RA		

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

N/A

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



TX & PROCEDURES:

SEDATED/ IMMOB	Y/N
INTUBATED	Y/N
CRIC	Y/N
NEEDLE DECOMP	Y/N
Chest Tube	L R air/blood
COLLOID	ml
CRYSTALLOID	LR/NS/HTS 2000 ml
TOURNIQUET	Time on
Collar / C-spine	Time off
HEMOSTATIC DEVICE	Y/N specify:
OXYGEN	Liters/min
RBC	Unit
FFP	Unit
CRYO	Unit
Plts	Pack
HBOC	U
Fresh Whole Bld	Uni

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

DISPOSITION: ADMIT EVACUATED to ICU
- ☐ RTD
- ☐ DECEASED
- ☐ URGENT
- ☐ URGENT SURGICAL
- ☐ ROUTINE
- ☐ MINIMAL

DTG: 18MAY04

PROVIDER: | SPECIALTY: | DATE:

MEDCOM Test Form 1381, OCT 2003

Ex 3

0038-04-CID785-83981

Theater Trauma Registry Record

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

Observations/Notes (Holding, En route, etc)

TIME	BP		PULSE	RESP	S-O	MENTAL Status	DRUG	DOSE	ROUTE	DTG
[illegible]	per		LT.	[redacted] (b)(6)-2		(A) V P U	Cimetidine	300mg	IVPB	[illegible] AM
1230						(A) V P U	Morphine	4mg	IVP	
1240						(A) V P U	Phenergan	12.5mg	IVP	
1300	139	90	130	28		(A) V P U				
						A V P U				
						A V P U				

NOTES: Seen by LT [redacted] (b)(6)-2 yesterday + today for low abd pain, nausea, vomiting and decreased urination x3 days [illegible] [redacted] (b)(6)-2 [illegible]). Given Cimetidine 300mg IV. H/S 1000cc #2 [illegible] in [illegible] LTC A[illegible] c/o abd pain. 1300 - Vomited small amt of coffee ground emesis. IV KVO maintained. Pt to be admitted to ICW via [illegible] [redacted] (b)(6)-2 LTC A[illegible] Pt alert & oriented; skin warm.

MEDICATIONS:	LABS:	XRAYS:	PMH:
Ø			Ø Allergies: NKDA.

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck:

Chest: See Progress Notes

Abdomen: [redacted] (b)(6)-2

Upper: [redacted] (b)(6)-2

Pelvis: CPT, MC, USAR

Lower:

Skin:

Cause of Death at ________

ANATOMIC:

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

PHYSIOLOGIC:

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

Ex 3 22

0038-04-CID785-83998

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 May 04	Death Note.
0920h	Pt. found to have O_2 sat'n in low 80's ⇒ O_2 started. Had resp. arrest while in X-ray ⇒ brought immediately to EMT. Bp = 83/40's initially. IV started in (R) ext. jugular (periph. IVs flat) ⇒ NS at 150 cc/h. Ambu-bag ventilation for ~5 min ⇒ pt. awake, RR = 45/min. Bp = 120/60. At this point, pt. agitated, splashing, moving all ext's. NG tube had been pulled by pt. in ICW → reinserted now on 3rd attempt. Following this, pt. had cardiorespiratory arrest, CPR initiated immediately, pt. intubated w/o difficulty c̄ 9.0 endo tube. ACLS protocol followed — pt. rec'd epi, atropine, $CaCl_2$, & $NaHCO_3$. Faint pulse c̄ ext. compressions never recovered any cardiac rhythm — remained agonal during CPR efforts, which were continued for 20 minutes. Despite flat periph. IVs, jugular IV distended. Highest O_2 sat'n noted was 86%. Labs revealed Na^+ 129, creat = 3.3, two spont. resp. & CPK = 3,416. With no return of cardiac rhythm for 20 min. of resuscitation, CPR was D/C'd & pt. pronounced dead by me at 0915 hrs.
	Presumed cause of death: acute MI, massive, unresponsive to resuscitative efforts.
	MAJ (b)(6)-2 [redacted] also present during resuscitation.
	(b)(6)-2 [redacted]
	coy MC

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

B 3 23

0038-04-CID7?? · 83584

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18 May 04 2330h	Pt seen by MAJ (b)(6)-2 [redacted] General Surgery: on abdominal exam, seems to have ↑ RUQ tenderness c̄ obvious diffuse tenderness & distention. Afebrile. Abd. U/S done (portable): difficult due to bowel gas, but prob. has mild GB dilatation s̄ obvious calculi (poss. "sludge" 2° to dehydration, c̄ acalculous cholecystitis?) WBC pending, U/A pending. Will continue to follow closely. (b)(6)-2 [redacted]
19 May 04 0710h	Afebrile, continues to have significant abd distention & is obviously moderately distressed because of this. AM labs: Na+ 113, but Cl- ↑ to 100. Will Δ IV fluid to NS & repeat labs in 1 hr. For repeat abd films this am. (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4 [redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

Ex 3   24

0038-04-CID789-83588

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Admission.
18 May 04	38 y/o male Iraqi Detainee brought to ER by 1LT (b)(6)-1 [redacted] CPA ē (b)(3)-1 [redacted]
1230 hrs	ē 2-3 days hx of progressive lower abdominal pain, now more
	acute & severe. ē N/V (reportedly had small coffee-ground emesis this AM
	— no d. [illegible]). BM this morning. States has had similar pain
	in past → took some medicine ē resolution of pain. Seen yesterday at
	sick call - labs OK x̄ for borderline creat = 1.3 & hemoconcentration
	ē H/H = 18.3/57.6 (nl RBC indices). Today pain ↑, dx suggests
	(R) ureteral stone and BUN/creat = 28/2.2 today; H/H = 18.4/56.6,
	130 | 95 | alb 2.8 amylase 97 AST/ALT = 35/20 (WNL) Ca 8.8
	4.5 | 21 | WBC 8,100 (was 3,100 yesterday)
	No prev. surgery. No known allergies. (L) arm fx many yrs ago.
	BP sometimes low. No hx of cardiac, pulm, hepatic, renal, thyroid p.
	Exam: asthenic young ♂ in mod. distress ē diffuse lower abd. pain; 5'5"
	Head/neck OK; no cervical lymphadenopathy, thyromegaly, JVD.
	Trachea midline.
	Chest symmetrical, good breath sounds throughout, T [illegible]
	Heart — RRR, tachycardic — 120/min, good periph. pulses pres.
	Abd — sl. distended, diffusely tender, lower > upper — not [illegible]
	quadrants; few bowel sounds; [illegible] Dx [illegible].
	abd. Xray: small [illegible] small bowel gas; air in (R) colon & distal
	sigmoid (redundant); large [illegible] stone in descending colon & proximal
	sigmoid.

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

(b)(6)-4 [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1 0

Ex 3 25

MEDCOM - 574

~~ACLU-RDI 1047 p.19~~

DOD 003637

0038 · 04. C110789 · 83487

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Impressions: ① Acute/subacute abd. pain, ? etiology. ② poss. ureteral stone, poss. obstruction poss. incipient pyonephritis ③ dehydration, mod. to mod.-severe, ↑ing BUN/creatinine & mild hypotension ④ leukocytosis, mild (incid. dec. count in ER), prob. secondary to fasting, poss. stress ulceration
	Recommendation/Plan: ① Admit to BCDFH tele for rehydration, observation, & repeat labwork ② IV fluids + Dilaudid + NPO status ③ NG tube if recurrent emesis + indication of actual pyonephritis + further abd. distention [redacted] MD COL, MC
18 May 04 2300h	↑ abd. pain for past 2 hrs. or so, ± recurrent emesis ⇒ NG tube for <100 cc NG drainage + signif. gastric air but no relief of pain — pt. moaning continuously now. Repeat x-ray shows multiple air-fluid levels in large & small bowel, ± some air in sigmoid, no evid. of free air. Exam: diffuse tenderness over lower quadrants, ± mild focal distention; no rebound tenderness, grimaces to no bowel sounds. Hypotensive to previously. Plan: ① repeat CBC now ② Surg. consult ± MSO [redacted] [redacted]

STANDARD FORM 509 (REV. [redacted] USAPA V1 0(

Ex 3

26

0038-04-CID 245. 83994

Task Force Alcatraz
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4 | SSN or ISN: (b)(6)-4 | Diagnosis: ACUTE ABDOMEN

Physician: (b)(6)-2 | Ward: ICW Bed: 11 | X STAT / Routine | Specimen Date and Time: 18 May 2330 | Reported by: (b)(6)-2 | Date and Time: 19 MAY 0020

Chemistry (i-STAT) / Green Top

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.08-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color	Yellow	Straw/Yellow
	Clarity	Cloudy	Clear
	Glucose	Neg	Negative
	Bilirubin	Neg	Negative
	Ketone	Neg	Negative
	SG	1.030	1.010-1.025
	Blood	Small	Negative
	pH	5.0	5.0-8.0
	Protein	100	Negative-Trace
	Urobili	0.2	Negative
	Nitrite	Neg	Negative
	Leuko	Neg	Negative

Urine Microscopic

	WBC	2-5	Epi None
	RBC	0-2	Mucus 1+
	Bacteria		Yeast
	Casts:	Hyaline	Spermatozoa Present
	Crystals:		Amorph Sed Present
	Other:		

Other lab request to be sent out:

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 MetLyte8 BMP Liver

X	TEST	RESULT	REF. RANGE
L	ALB	3.0	3.3-5.5 g/dL
H	ALP	94	53-128 U/L
	ALT	unreadable	10-47 U/L
	AMY	92	14-97 U/L
H	AST	49	11-38 U/L
	Tbil	0.7	0.2-1.6 mg/dL
	BUN	unreadable	7-22 mg/dL
	Ca	8.7	8.0-10.3 mg/dL
L	Chol	51	100-200 mg/dL
	CK		39-380 U/L
	Cl	100	98-108 mmol/L
	TCO2	21	18-33 mmol/L
H	Creat	2.1	0.6-1.2 mg/dL
L	GGT	<5	5-65 U/L
	Glu	85	73-118 mg/dL
	K	4.3	3.3-4.7 mmol/L
L	TProtein	5.7	6.4-8.1 g/dL
L	Na	113	128-145 mmol/L

[redacted]

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Presumptive Negative
	Legionella		Presumptive Negative
	Troponin I		< 0.5 ng/mL
	Myoglobin		< 80 ng/mL
	RSV		Negative

[redacted]

	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite
	Chlamydia		Presumptive Negative
	Strep A		Negative
	Leishmania		Presumptive Negative

[redacted]

X	TEST	RESULT	REF. RANGE
	WBC	9.6	4.8-10.8 x10(3)/uL
	RBC	5.99	4.2-6.1 x10(6)/uL
	Hgb	17.1	12.0-18.0 g/dL
	Hct	54.6	35.0-60.0%
	MCV	91.1	80.0-99.0 fl
	MCH	28.5	27.0-31.0 pg
L	MCHC	31.3	33.0-37.0 g/dL
	Plt	359	130-400 x10(3)/uL
L	LY%	7.9	15.0-50.0%
L	LY#	0.8	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	

Plt verify:		
Spun Crit		35-60%

Malaria Smear (purple)

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate (Purple top)

Sed Rate		1hr = 0-20 mm

Coagulation (waiting for analyzer)

[redacted]

Urine		Negative
Serum		Negative

Blood Bank/ Purple and Red Top

ABO/Rh		
T/C		

FORM 67th CSHLAB-1 08 Mar 2004

Ex 3 27

DOD F. 04-110 78-8559

Task Force A.
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI.

SSN (b)(6)-4

Diagnosis:

Physician:

Ward:

Bed: IW-Box

STAT

Routine

Specimen Date and Time: 18 MAY 04

Reported by: (b)(6)-2

Date and Time: 18 MAY 04 1045

Chemistry (i-STAT) / Green Top

6+ 7+ 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		128-145 mmol/L
	K		3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-90 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-28 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi	
RBC		Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			

Other lab request to be sent out:

Chemistry (Piccolo Analyzer) / Green Top

Chem 12 MetLyte8 (BMP) (Liver)

X	TEST	RESULT	REF. RANGE
	ALB	2.8	3.3-5.5 g/dL
	ALP	54	26-84 U/L
	ALT	20	10-47 U/L
	AMY	97	14-97 U/L
	AST	35	11-38 U/L
	Tbil	1.2	0.2-1.6 mg/dL
	BUN	28	7-22 mg/dL
	Ca	8.8	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		39-380 U/L
	CL	95	98-108 mmol/L
	TCO2	21	18-33 mmol/L
*	Creat	2.2	0.6-1.2 mg/dL
	GGT	25	5-65 U/L
	Glu	118	73-118 mg/dL
	K	4.5	3.3-4.7 mmol/L
	TProtein	5.7	6.4-8.1 g/dL
	Na	130	128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		Negative
HIV		Negative
Meningitis		Presumptive Negative
Legionella		Presumptive Negative
Troponin I		< 0.5 ng/mL
Myoglobin		< 80 ng/mL
RSV		Negative

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite
Chlamydia		Presumptive Negative
Strep A		Negative
Leishmania		Presumptive Negative

Hematology / Purple Top

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	8.1	4.8-10.8 x10(3)/uL
	RBC	6.28	4.2-6.1 x10(6)/uL
*	Hgb	18.4	12.0-18.0 g/dL
*	Hct	56.6	35.0-60.0%
	MCV	90.1	80.0-99.0 fl
	MCH	29.2	27.0-31.0 pg
	MCHC	32.4	33.0-37.0 g/dL
	Plt	315	130-400 x10(3)/uL
	LY%	10.7	15.0-50.0%
	LY#	0.9	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit: 35-60%

Malaria / Purple

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate: 1hr = 0-20 mm

Coagulation (waiting for analyzer)

HCG

Urine		Negative
Serum		Negative

Blood Bank/ Purple and Red Top

ABO/Rh

T/C

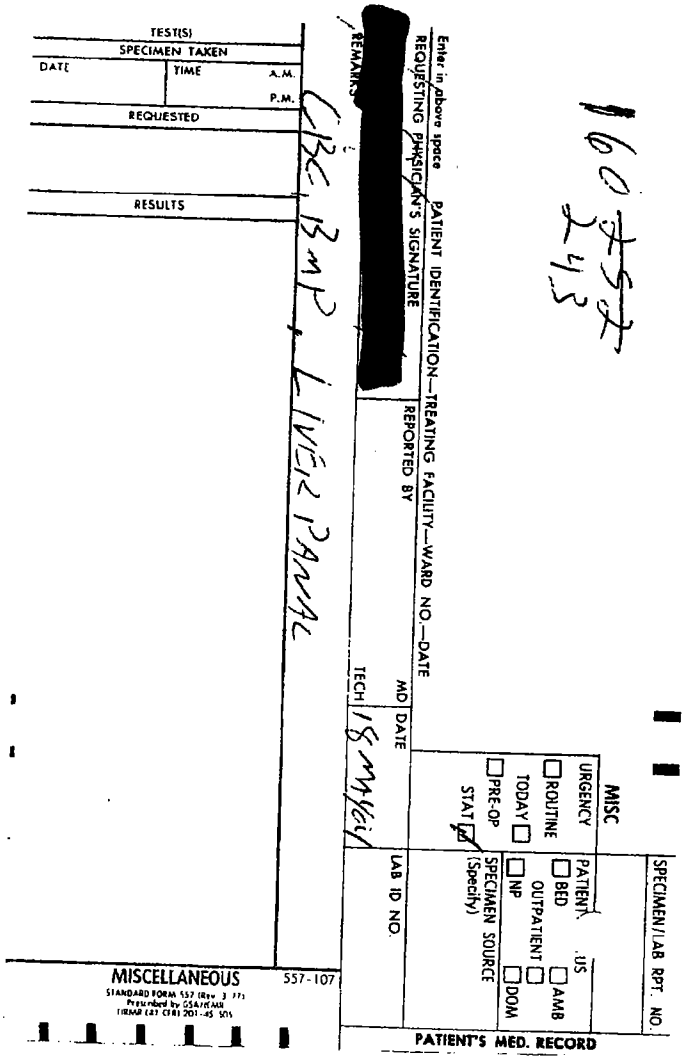
FORM 67th CSHLAB-1 08 Mar 2004

* Results confirmed

Ex 3 28

0038-04-CID381-83180

B6-2



160 ESS 243

(b)(6)-4

(b)(6)-2

Ex 3 29

0038-04-010785-83170

Task Force Alcatraz
Baghdad Central Detention Facility Hospital

LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

ST, FIRST, MI (b)(6)-4	SSN	DOB	RANK	UNIT
G4				

ysician: LT (b)(6)-2	Ward:	X STAT / Routine	Specimen Date and Time: 17 MAY 04 1500	Reported by: (b)(6)-4	Date and Time: 17 May 04 1530

Chemistry (i-STAT)

6+ 7+ 8+ Glu Crea

TEST	RESULT	REF. RANGE
Na		128-145 mmol/L
K		3.3-4.7 mmol/L
Cl		98-108 mmol/L
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-90 mmHg
TCO2		18-33 mmol/L
HCO3		22-26 mmol/L
sO2		95-99%
BEecf		(-2) - (+3)
AGap		8-16 mmol/L
iCa		0.11-1.23 mmol/L
BUN		7-22 mg/dL
Glu		73-118 mg/dL
Creat		0.6-1.2 mg/dL
Hct		35.0-60.0%
Hgb		12.0-18.0 g/dL
Lactate		0.90-1.70 mmol/L

Urinalysis

Color		Straw/Yellow
Clarity		Clear
Glucose		Negative
Bilirubin		Negative
Ketone		Negative
SG		1.010-1.025
Blood		Negative
pH		5.0-8.0
Protein		Negative-Trace
Urobili		Negative
Nitrite		Negative
Leuko		Negative

Urine Microscopic

WBC		Epi
RBC		Mucus
Bacteria		Yeast
Casts:		Spermatozoa
Crystals:		Amorph Sed
Other:		
Other:		

Chemistry (Piccolo Analyzer)

Chem 12 MetLyte8 (BMP) X (Liver)

X	TEST	RESULT	REF. RANGE
	ALB	4.0	3.3-5.5 g/dL
	ALP	79	53-128 U/L
	ALT	<5	10-47 U/L
	AMY	65	14-97 U/L
	AST	27	11-38 U/L
	Tbil	1.1	0.2-1.6 mg/dL
	BUN	15	7-22 mg/dL
	Ca	9.4	8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		39-380 U/L
	CL	100	98-108 mmol/L
	TCO2	20	18-33 mmol/L
H	Creat	1.3	0.6-1.2 mg/dL
L	GGT	<5	5-65 U/L
H	Glu	165	73-118 mg/dL
H	K	4.8	3.3-4.7 mmol/L
	TProtein	7.3	6.4-8.1 g/dL
	Na	130	128-145 mmol/L

Misc. Chemistry

Mono		Negative
RPR		
HIV		Negative
Meningitis		Presumptive Negative
Legionella		Presumptive Negative
Troponin I		< 0.5 ng/mL
Myoglobin		< 80 ng/mL
RSV		Negative

Microbiology

Source:		
FecLeuk		Negative
Gram Stain		
WetPrep		Negative
KOH		No Fungal Elements
OccBld		Negative
O&P		No Ova/Parasite
Chlamydia		Presumptive Negative
Strep A		Negative
Leishmania		Presumptive Negative

Hematology

CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC	3.1	4.8-10.8 x10(3)/uL
	RBC	6.23	4.2-6.1 x10(6)/uL
H	Hgb	18.3	12.0-18.0 g/dL
	Hct	55.6	35.0-60.0%
	MCV	89.3	80.0-99.0 fl
	MCH	29.4	27.0-31.0 pg
L	MCHC	32.9	33.0-37.0 g/dL
	Plt	377	130-400 x10(3)/uL
L	LY%	20.2	15.0-50.0%
L	LY#	0.6	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells

RBC Morph:

Plt verify:

Spun Crit 35-60%

Malaria (waiting for supplies)

Sed Rate

Sed Rate 1hr = 0-20 mm

Coagulation (waiting for analyzer)

HCG

Urine		Negative
Serum		Negative

Blood Bank

ABO/Rh

FORM 67th CSHLAB-1 08 Mar 2004

Ex 3

0038-04-CID785-83588

CERTIFICATE OF DEATH

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

INTERNMENT SERIAL NUMBER: (b)(6)-4 [redacted]

FROM:

BAGHDAD CENTRAL DETENTION FACILITY

TO:

NAME: (b)(6)-4 [redacted]

GRADE:

SERVICE NUMBER: (b)(6)-4 [redacted]

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	DATE OF DEATH	CAUSE OF DEATH
BCDFH, ABU GHRAIB	19 MAY 04	Acute myocardial infarction, massive

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).*

Adm. to BCDFH 18 May with abd. pain/distention, dehydration, symptoms of (R) ureteral stone and poss. gastroenteritis. Xrays: paralytic ileus. Rehydrated x 18 hrs. Increased abd. pain on 19 May. Resp. arrest while in Xray, resuscitated with Ambu bag ventilation. NG tube reportedly. Cardioresp. arrest; CPR instituted immediately, ACLS protocol. Intubated, ventilated. No recovery of cardiac rhythm after 20 min. Pronounced dead at 0915 hrs. by me.

DO NOT WRITE IN THIS SPACE

CERTIFIED A TRUE COPY

DATE: 19 May 04

(b)(6)-2 [redacted] COL, MC

SIGNATURE (b)(6)-2 [redacted] COL, MC

SIGNATURE ADDRESS

SIGNATURE ADDRESS

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

Ex 3 31

MEDCOM - 580

0038-09-CO745-83594

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 18	19	20	21	22
18 May 04	w	VS q 6° x 24°	06	/		/		
			12	/		/		
			18	W		/		
			24	RL		/		
18 May 04	w	VS q 8° x 24	06	/				
			14	/				
			22	/		/		
18 May 04	w	VS BID	08	/		/		
			20	/		/		
18 May 04	w	Diet NPO x for first Dose	07	W				
		for dry mouth prn	19	RL				
18 May 04	w	HOB 1 20-30° for pt Comfort	07	W				
			19	RL				
18 May 04	w	Call if pt has more emesis	07	W				
			19	RL				
18 May 04	w	Call if pt has T >101°F or	07	W				
		if BP <95	19	RL				
18 May 04	w	Strain all urine if	07	W				
		possible	19	RL				
18 May 04	w	Record fluid I+O q	07	W				
		shift	19	RL				
18 May 04	w	Call md if any questions	07	W				
			19	RL				

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

Ex 5

32

EX 3

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON MEDICATION)

Mo 05 Yr 04

Verify by Initialing: Order Date	Verify by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 May04	W	Admit to ICW	18 May 04			
18 May04	W	CBC + Chem 12 gam x2days	19 May 04	0600		
			20 May 04	0600		
18 May04	W	Next urine for UA - Call results to Dr. Addi	18 May 04	ASAP		
18 MAY	RL	Repeat CBC, Diff, SMA, TBIL, DBIL	18 MAY	NOW	2330	RL
18 MAY	RL	Obstructive Series & CXR in AM	19 MAY	0800		
18 MAY	RL	AM Labs Type in Cross, CBC c̄ Diff	19 MAY	0800		
18 MAY	RL	NG TUBE TO CONT SUC	18 MAY	NOW	2115	RL
19 May	WM	Repeat Chem 12 w/in 1hr	19 May	0830		

Order/Expir Date	Clerk/Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED

33

0051-04-CID185-83588

MEDCOM - 582

0038-04-CID789-83984

CLINICAL RECORD	**THERAPEUTIC DOCUMENTATION CARE PLAN** *(MEDICATIONS)* 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 ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21										
18May04	-w---	IV fluids D5/RL @ 100cc/hr	07	w													
	-----	x6°, then 75cc/hr	19														
18May04	-w---	Tagamet 300mg IVPB or	06	/	RL												
	-----	slow IV push q8°	14	ww													
	-----		22	RL													
	-----		/														
18MAY	RL---	↑ IVF to 150 cc/hr	07	/	D/C'd w McDermot												
	-----		19	RL	19May04 0730												
	-----		/														
19May	[illegible]---	0.9%NS @ 125cc/hr	07														
	-----		19														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

(b)(6)-4

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

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

Ex 3 34

MEDCOM - 583

EX 3

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 05 Yr. 04			
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18 May 04	(b)(6)-2	Fleets enema	18 May 04	ASAP	1050	(b)(6)-2
18 MAY	(b)(6)-2	IVF Bolus LR 1L over 1°	18 MAY	Now	2330	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED	
18 May 04	[illegible]	Demerol 25mg + Phenergan	D/T	[illegible] 2045
		12.5mg IM q 6° prn	D/R	25/25 IM
		Pain	I/E	RL

35

[illegible]

0038-04-CID789-83584

Task Force [illegible]traz
Baghdad Central Detention Facility Hospital

BORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

L(b)(6)-4	S(b)(6)-4	DOB	RANK / UNIT: EMT
Physicia(b)(6)-2: Pa	Ward: EMT	X STAT / Routine	Specimen Date and Time: 19 MAY 04 - 0815
Reported by(b)(6)-2	Date and Time:		

Chemistry (i-STAT) / Green Top
6+ (7+) 8+ Glu Crea

X	TEST	RESULT	REF. RANGE
	Na	132	128-145 mmol/L
	K	4.8	3.3-4.7 mmol/L
	Cl		98-108 mmol/L
	pH	7.131	7.35-7.45
	PCO2	67.1	35-45 mmHg
	PO2	19	80-90 mmHg
	TCO2	24	18-33 mmol/L
	HCO3	22	22-28 mmol/L
	sO2	17%	95-99%
	BEecf	-7	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa	1.27	0.11-1.23 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.2 mg/dL
	Hct		35.0-60.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis

	Color		Straw/Yellow
	Clarity		Clear
	Glucose		Negative
	Bilirubin		Negative
	Ketone		Negative
	SG		1.010-1.025
	Blood		Negative
	pH		5.0-8.0
	Protein		Negative-Trace
	Urobili		Negative
	Nitrite		Negative
	Leuko		Negative

Urine Microscopic

	WBC		Epi
	RBC		Mucus
	Bacteria		Yeast
	Casts:		Spermatozoa
	Crystals:		Amorph Sed
	Other:		
	Other:		

Chemistry (Piccolo Analyzer) / Green Top
Chem 12 (MetLyte8) BMP Liver

X	TEST	RESULT	REF. RANGE
	ALB	2.5	3.3-5.5 g/dL
	ALP	72	53-128 U/L
	ALT	18	10-47 U/L
	AMY	124	14-97 U/L
	AST	122	11-38 U/L
	Tbil	1.0	0.2-1.6 mg/dL
	BUN	42	7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
H	CK	3416	39-380 U/L
	CL	99	98-108 mmol/L
	TCO2	20	18-33 mmol/L
	Creat	3.3	0.6-1.2 mg/dL
	GGT	<5	5-65 U/L
	Glu	37	73-118 mg/dL
	K	4.4	3.3-4.7 mmol/L
	TProtein	4.8	6.4-8.1 g/dL
	Na	124	128-145 mmol/L

	Mono		Negative
	RPR		Negative
	HIV		Negative
	Meningitis		Presumptive Negative
	Legionella		Presumptive Negative
	Troponin I		< 0.5 ng/mL
	Myoglobin		< 80 ng/mL
	RSV		Negative
	Source:		
	FecLeuk		Negative
	Gram Stain		
	WetPrep		Negative
	KOH		No Fungal Elements
	OccBld		Negative
	O&P		No Ova/Parasite
	Chlamydia		Presumptive Negative
	Strep A		Negative
	Leishmania		Presumptive Negative

X	TEST	RESULT	REF. RANGE
H	WBC	11.6	4.8-10.8 x10(3)/uL
	RBC	5.08	4.2-6.1 x10(6)/uL
	Hgb	14.7	12.0-18.0 g/dL
	Hct	46.2	35.0-60.0%
	MCV	90.8	80.0-99.0 fl
	MCH	28.7	27.0-31.0 pg
L	MCHC	31.7	33.0-37.0 g/dL
	Plt	334	130-400 x10(3)/uL
L	LY%	6.4	15.0-50.0%
	LY#	0.7	0.7-4.3 x10(3)/uL

Differential

Segs	Mono
Bands	Eos
Lymph	Baso
Atyp Ly	Immature cells
RBC Morph:	

Plt verify:		
Spun Crit		35-60%

Malaria (waiting for supplies) / Purple

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

Coagulation (waiting for analyzer)

Urine		Negative
Serum		Negative

Blood Bank / Purple Top

ABO/Rh	
T/C	

FORM 67th CSHLAB-1 08 Mar 2004

Ex 3 36

0038-04-CID789-83988

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

PRELIMINARY AUTOPSY REPORT

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

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

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

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

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis of undetermined etiology

MANNER OF DEATH: Natural

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

EX 5 38

PRELIMINARY AUTOPSY DIAGNOSES:

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

II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)
III. Healing 3/8 inch abrasion of the right shin
IV. Tooth number 8 absent due to decay (used by family members as identification)
V. No significant trauma
VI. Toxicology and histology pending

(b)(6)-2

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

938.04-7FS-8398

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

AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
SSAN: NA
Date of Birth: Unknown
Date of Death: BTB 19 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 8 Jul 2004

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

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

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

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis

MANNER OF DEATH: Natural

43

Ex 8

FINAL AUTOPSY DIAGNOSES:

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

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

III. Chronic thyroiditis (microscopic)

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

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

VI. No significant trauma

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

43

Ex 8

EXTERNAL EXAMINATION

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

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

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

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

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

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

CLOTHING AND PERSONAL EFFECTS

The body is received nude at the time of autopsy.

MEDICAL INTERVENTION

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

RADIOGRAPHS

No radiopaque foreign objects or displaced fractures are identified.

EVIDENCE OF INJURY

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

INTERNAL EXAMINATION

HEAD:

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

44

Ex 8

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

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

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

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

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

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

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

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

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

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Ex 8

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

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

ADDITIONAL PROCEDURES

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

MICROSCOPIC EXAMINATION

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

TOXICOLOGY

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

OPINION

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

The manner of death is natural.

(b)(6)-2

(b)(6)-2 MD

MAJ, MC, USA
Deputy Medical Examiner

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Ex. 6

0038-04-789-85348

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

REPLY TO ATTENTION OF

AFIP-CME-T

TO:

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

PATIENT IDENTIFICATION

AFIP Accessions Number	Sequence
2929645	01

Name (b)(6)-4

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

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS REPORT OF TOXICOLOGICAL EXAMINATION

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

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

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

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

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

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

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

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

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Ex 8