MEDICAL RECORD [redacted] **PROGRESS NOT**[redacted] 050-04-00259-80185

DATE	NOTES
	"Brief note"
2 May 2002	35 yo HVDC[?] c h/o myocardial infarction x 2, hypercholesterolemia and hyper- [redacted]
	tension presents for initial exam.
NKDA	PMHX
	① MI ? [illegible] (1996) He denies EST, Cath [illegible]
	MI " (1999) [illegible] CHF, LEF
	② Hypercholesterolemia ? of last # on Zocor 20 mg [illegible]
	③ Hypertension
	PSHX Hemorrhoid surg, 1975 **Meds** ① Atenolol 25 mg po qd
	FMHX Mother died of MI @ 45 yo ② ASA 81 mg po qd
	Social Smokes 1/4-1/2 PPD Now ③ SL NTG 0.4 PRN
	Exam ④ Zocor 20 mg po qd
	Appears well NAD — ROS ø c/p/SOB/Edema/PND/orthopnea
	171/92 93 20 97% — ø Vomit BS/Melena/hematochezia
	SKIN warm, dry ø infestation — ⊕ hemorrhoids
	ENT PERRLA EOMI
	Dry membranes — ABD obese ⊕ BS soft NTTP
	Canals clear TMS Pearly grey — Ext ⊖ Edema ⊖ Homans
	Neck ⊖ JVD — DP, PT 2/4
	Chest Thorax NTTP CTA B/L — (b)(6)-2
	Heart S1+S2, NL S2 ø m/r/g — CPT

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.

39 DP

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

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EXHIBIT 3

000[illegible]12

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Sept 03	Occult Blood Stool Test Negative [illegible]
[illegible] 03	55 y/o [illegible] HTN, [illegible] Currently asymptomatic [illegible]
	Appears [illegible] 130/[illegible] 84 12 98% sat
	[illegible] chest [illegible]
	[illegible]
	Lab [illegible] 4.3 [illegible] 19 [illegible] 4.8 26 [illegible]
	[illegible] 90 TBili 0.7
	[illegible] 12 TP 7.6 Chol 213
	AMT 43 [illegible] 22 T[illegible] 218
	[illegible] PSA 1.20
	A/ ASCVD (HTN, [illegible]) [illegible] 20%
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible]
	[illegible] chol < 130 [illegible] ATP III
	Plan [illegible] 40 mg [illegible] (b)(6)-2 [illegible]
	[illegible] 3 mo
	[illegible] 3 mo
	[illegible] PSA 3 mo
	[illegible]
	[illegible]

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EXHIBIT 3

STANDARD FORM 600 (REV 6-97) **BACK**

MEDCOM - 612

000.. 13

0050-04-C10259-80155

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7MAR04	1130pm (2330) Called to # 39 Rm For 96 Mal Stated Chest Pain (Burning)
	onset 1 hr PTA. Pt Assessed At bedside and Transported via
	Ambulatory to AND TMC. Once At TMC NIBP, SaO_2 and
	5 Lead ECG Initiated. on Monitor Appeared to be SR c̄
	ST Elevation in Lead II @ 2340 Pt Became unresponsive
	and Monitor Δ'd to Pulseless V-TACH. I Precordial Thump Administered
	s̄ Success, IV Initiated #18 (R) AC c̄ LR 1000cc ↑ KVO.
	100mg Lidocaine Administered As Ø Defib Immediately Available, OPA
	Airway Placed and Breathing Mask Utilized / CPR Started.
	@ 1145 1mg Epi Administered IV, and CPR Continued. Ø Pulse s̄
	CPR. 1mg Atropine Administered Via IV @ 1148. CPR Continued.
	Monitor showed V-Fib s̄ Pulses (+) Pulses c̄ CPR @ 1152
	Defib Arrived Pt Shocked @ 200, 300, 360. s̄ Return of
	Rythm or Pulses. 2nd Epi 1mg given Per IV. CPR Continued.
	Attempt At Digital Intubation c̄ 7.5 ET Tube s̄ Success.
	Mouth to Mouth Continued. 2nd 1mg Atropine Administered Via IV
	CPR Continued @ 1205 E-Med Medic Arrived. Attempted
	BVM Ventilation s̄ Success, Head repositioned and BVM Continued
	c̄ CPR. Care of Patient Transferred to E-Med Medics c̄ Full
	Report and Code Summary Documentation Pt left AND Facility
	Full Cardiac Arrest. in Care of E-Med Medics.

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY | STATUS | (b)(6)-2 | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | REGISTER NO. | WARD NO.

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USP LVN

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EXHIBIT 3

0050-04-CID259-80155

CSH28,HVD39 (b)(6)-4 M/55 ph#
BLOOD/SERUM [redacted] INE Req Loc: 28CSH [redacted] BIAB
Collected: 23 Sep 200301000 Received: 02 Oct [redacted] 031350
Accession: 031002 LSP 57335 HCP: MTF,OTHER

CHOLESTEROL	211 H	<certified>
TRIGLYCERIDE	218 H	<certified>
HIGH DENSITY LIPOPROTEIN	42	<certified>
LOW DENSITY LIPOPROTEIN CALC	127	<certified>
CHOLESTEROL/HDL	5.1	<certified>
PROSTATE SPECIFIC AG	1.20	<certified>

*** End of Report ***
****
CSH28 HVD39 (b)(6)-4 M/55 ph#

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USE ONLY

EXHIBIT 3

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EXHIBIT 3

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MEDICATION ADMINISTRATION RECORD

Name: (b)(6)-4 Unit: HUD Month: MAR, 04

Medication/Dose/Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ASA 325 mg Qam	X	X	X	X	X	X	X																								
Aricept 10 mg Qam	X	X	X	X	X	X	X																								
Zocor 20 mg Qpm				X	X	X	X																								
Protonix 40 mg Qam				X	X	X	X																								
Benadryl 25 mg Qpm				X	X	X	X																								

MEDCOM - 615

0050-04-C10259-80165

DETAINEE #: (b)(6)-4 **AGE:** 55	**ALLERGIES: NKDA**
MEDICATIONS: Atenolol 25 qd Aspirin qd Zocar 20 mg qd Colace 100 mg BID prn Benadryl 25 mg qhs prn SL NTG 0.4 mg prn x3 (chest pain)	**PROBLEM LIST:**
DIAGNOSTIC TESTS: GUIAC STOOL- Sept. 2003, negative PEAK FLOW- EKG- June 2003 PSA- OTHER-	**PMHX:** MI x2 hypercholesterolemia hypertension Hemmoriod surgery (1995) smoker hemmoriods
LABS: 142 | 106 | 11 4.3 | 26 | 1.5 CK 25 WBC 9.5 HCT 42 PLT 171 TSH 0.7	
HOSPITALIZATION SUMMARIES:	

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EXHIBIT 3

000017

0050-04-C10259-80155

PREVIOUS EDITION IS USABLE

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Code Note
3/8/04	Pt presents in cardiac arrest since 5 minutes
0045	~~s~~ midnight. Initial evaluation in the field
	reported by EMS to show ~~that~~ pt presented
PMHx	to aid medic c̄ CP and quickly deteriorated
	[redacted]
	Upon presentation to EMEDS full ACLS
	protocol was followed. CRNA placed a
	7.5 ETT at 21cm, placement was confirmed
	c̄ (B) bs. Telemetry confirmed asystole.
	Epinephrine in the usual dosage was
	given X 2 rounds while performing
	concurrent CPR. Despite all these
	efforts, pt remained in asystole
	s̄ any signs of life. Code was
	stopped at 0032. Pt's pupils
	were fixed & dilated, He had no response
	to any stimuli. He had no respiratory
	effort and no pulse. Time of death is
	0032.
	(b)(6)-2
	, MD
	Staff Emergency Physician

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT (b)(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	EMED

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.

Security Detainee #(b)(6)-4

112th MP Battalion

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

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EXHIBIT 3

Vuil. 18

MEDCOM - 617

0050 04-CID254-80155

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

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
(b)(6)-4			
ORGANIZATION Organisation	**NATION** *(e.g., United States)* Pays: IRAQ	**DATE OF BIRTH** Date de naissance	**SEX** Sexe: ☒ MALE Masculin ☐ FEMALE Féminin

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

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicile à (Rue)	**CITY OR TOWN AND STATE** *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]		Acute Myocardial infarction	
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Coronary artery Disease	
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]			

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
☒ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	Cardio pulmonary arrest
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident d'Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès

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

(b)(6)-2	ou du médicin sanitaire	TITLE OR DEGREE Titre ou diplôme: LtCoL D.O
GRADE Grade: LtCoL	INST (b)(3)-1 ... ou adresse: BIAP	(b)(6)-2
DATE Date: 08 Mar 2004	(b)(6)-2	LtCoL, USAF, MC, SFS (b)(6)-2 SHAW AFB, SC

[1] *State disease, injury or complication ... etc.*
[2] *State conditions contributing to the d... non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication ... qui a provoqué la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

EXHIBIT 4

DD FORM 1 APR 77 2064 REPLACES AF FORM 565, MAR 80, WHICH IS OBSOLETE.

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Unit 19

0050-04-CID259-80155

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

PRELIMINARY AUTOPSY EXAMINATION REPORT

Name: (b)(6)-4
SSAN:
Date of Birth: 6 DEC 1948
Date of Incident: 8 MAR 2004
Date of Autopsy: 10 MAR 2004
Date of Report: 11 MAR 2004

Autopsy No.: ME04-110
AFIP No.: Pending
Rank: EPOW
Place of Death: Baghdad, Iraq
Place of Autopsy: Baghdad International Airport

Circumstances of Death: Circumstances of Death: This 55-year-old male Enemy Prisoner of War had a history of ischemic heart disease. His past medical history includes hypertension, hypercholesterolemia, and possibly two previous myocardial infarctions. His medications included atenolol, Zocar, and aspirin, as well as sublingual nitroglycerin as needed. On the evening of 7 MAR 2004 he complained of chest pain and shortness of breath. He was brought to the medical clinic for evaluation where he became unresponsive. Resuscitation efforts, including Advanced Cardiac Life Support at a medical treatment facility, were unsuccessful.

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

Identification: Identification is obtained by paperwork accompanying the body, including a photograph with a matching prisoner number.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

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EXHIBIT 15

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

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0050-04-CI0259-80155

(b)(6)-4

ME04-110

PRELIMINARY AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease

A. History of ischemic heart disease
B. Cardiomegaly, marked (heart weight 620 grams)
C. Coronary atherosclerosis, focally severe
D. Diffuse myocardial scarring
E. Arterionephrosclerosis, mild

II. Marked Pulmonary Edema

III. Remote penetrating ballistic injury of the left buttock
A. Entrance: Inferior-medial aspect of left buttock (scar)
B. Wound Path: Skin, subcutaneous tissue, and muscle of left buttock, muscle of proximal left thigh
C. Recovered: Metallic foreign body encapsulated in fibrous tissue within muscle of proximal left thigh
D. Wound Direction: Left to right, back to front, and downward

IV. Fractures of the 5th and 6th ribs on the right, associated with hemorrhage into chest wall musculature and abrasions/thermal injury of the chest (resuscitation efforts)

V. Laceration of the nose and abrasion of the right index finger

VI. Toxicology Pending

(b)(6)-2 MD, FS, DMO
CDR, MC, USN
Chief Deputy Medical Examiner

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EXHIBIT 15