0206 05 CID 88 39288

NSN7540-00-634-4176 600-108

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATEMENT, TREATING ORGANIZATION (*Sign each entry*)
	Nutrition Risk Screening
20 Nov 05	
	S/O: Active Duty Contractor Detainee (circled) Civilian
	Ward: ICU Bed Number: 1
	Dx: Congestive Heart Failure
	Age: Gender: M Ht: 5'8" Wt: BMI:
	Diet: Regular
	Tolerating Diet: no problems to note.
	A/P:
	Nutrition Risk:
	Patient determined to be at low nutrition risk; will be re-screened in one week (circled)
	Patient determined to be at nutrition risk secondary to :
	Further intervention by RD needed within 48 hours
	(b)(6)

PATIENT'S IDENTIFICATION (Use this space for Mechanical

000501

RECORDS MAINTANED AT:			
PATIENT'S NAME (*Last, First, Middle Initial*) AVD, Unknown			SEX
RELATIONSHIP TO SPONSOR	STATUS		RANK/GRADE
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO. 600-00-0501		DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA/ICMR

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

ACLU DDII CID RVIS 40004

EXHIBIT 4

000188

344th Task Force
Ventilator Flow Sheet

Patient Info: Name:__________ Date:__________
Age:______ DOB:______ Vent Day #:______
Gender:______ Pt. ID:______ Vent Unit #:______

Date	11/26															
Time	830															
Mode	SIMV															
Set	12															
Spont.																
Total	12															
Set	600															
Spont.	589															
MV	7.															
FiO2	40%															
Peep	+5															
I/E	1:2															
Flow	34															
Sens.	-2															
PIP	22															
MAP	10															
Sats.	100															
PIP Alarm Hi/Lo	40 / 5															
PS	(b)(6)															
Initial																

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE		

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

344th Task Force
Ventilator Flow Sheet

Patient Info: Name:______________________ Date:__________
Age:__________ DOB:__________ Vent Day #:_____
Gender:______ Pt. ID:____________ Vent Unit #:_____

Date	26Nov																
Time	0600																
Mode	SIMV																
Set	12																
Spont.	12																
Total	24																
Set	600																
Spont.	800																
MV	12.1																
FiO2	.40																
Peep	+5																
I/E	2:1																
Flow	29																
Sens.	-2																
PIP	23																
MAP	11																
Sats.																	
PIP Alarm Hi/Lo	40 / 5																
PS	20																
Initials	(b)(6)																

ETT/Trach

Size	Position	Cuff

ABG

Date	Time	PH	PCO2	PO2	TCO2	BE		

Weaning Parameters

Time	Vt	Rate	RSBI	VC	NIF	MV

0206 05 ... 89 3928...

M   Icu #1

PCXR

(b)(6)

(b)(6)

27 Nov 05

Post intubation

27 Nov 2005   27 NOV

Opacification of RLL → increasing. RLL w/ Hilar c̄ associated pleural effusion. Congestive Δs still present bilaterally. Tubes & line stable

(b)(6)

A14F1

...01 2C 60020 0006
...UNKNOWN
...B M C DETAINEE

0206 05 CID 089 39288

PCXR ICU

(b)(6)

✓placement of ETT

11/24/03 26NOV03

1548hrs

ET tube 3cm above carina that continue to demonstrate CHF, ETT in stable position

(b)(6)

D0005C1 20 60020 0006 A14F1
MVD, UNKNOWN
1178 N C DETAINEE
CROPPER

0206 05 CID789 39288

CXR ICU #1

post-extubation
follow-up CHF
26NOV05 26NOV05

CHF appearance
c̄ interval stabilization
of patient
TLC in good position

(b)(6)

000001 20 60020 0006 A14F1
NVD, [illegible]
[illegible] DETAINEE
[illegible]

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LAW ENFORCEMENT SENSITIVE
CID ROIS 40019
EXHIBIT
000193
4

0206 05 CID 789 39288

0206 05 FCU #189 39288

CXR

(b)(6)

(b)(6)

CHF

NOV 25 2005 25 NOV 05

Compared to previous from 24 NOV 05.

No significant interval change - post-sternotomy s/p CHF

(b)(6)

A14F1

0000001 20 60020 0006
HVJ, UNKNOWN
DETAINEE

MED 05 [illegible] 39284

M ICU#1

PCXR

(b)(6)

(b)(6)

24 NOV 05

Chest Pain

24 NOV 2005 25NOV05

1:00.03 ITS

(B) Congestive H's consistent with CHF.

Tubes & lines stable

D416 hrs
AP film (B) Congestive H's not significantly changed

(b)(6)

(b)(6)

A14F1

DDOOS01 2C 60C2C 0006
HYO, UNKNOWN
[illegible] M O DETAINEE
CROPPER
[illegible]

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~~LAW ENFORCEMENT SENSITIVE~~
~~USE ONLY~~

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LAW ENFORCEMENT SENSITIVE

DII CID [illegible] 40011

EXHIBIT
4

0206 05 01 89 39288

NSN 7540-01-165-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR					

FILM NO.

PREGNANT: ☐ YES ☒ NO

REQUESTED BY (Print) (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR (b)(6)

DATE REQUESTED: 24NOV05

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

f/up CHF

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
24 NOV05	25 NOV05	

RADIOLOGIC REPORT

2146 Hrs

AP film - demonstrates
Diffuse congestive Δ's more
pronounced in lung Bases.
No Signi. ficantly Δ'd

(b)(6)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle, Medical Facility)

A14

0000501 20 60020 0008
HVD, UNKNOWN
B M O DETAINEE
CROPPER

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

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LAW ENFORCEMENT SENSITIVE

ACLU-DDII CID ROIS 40012

EXHIBIT 4

0206 05 CID 89 39288

NSN 7540-01-165-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

CXR

AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
			ICU #1	

FILM NO.

PREGNANT ☐ YES ☐ NO

(b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR

(b)(6)

DATE REQUESTED

23 NOV 05
1020 hrs

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

SOB / Dyspnea

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSACTION *(Month, day, year)*
23 NOV 05	24 NOV 05	

RADIOLOGIC REPORT

Cardiac silhouette mildly enlarged - diffusely ↑'d interstitial lung markings consistent c̄ CHF

(b)(6)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle, Medical Facility)*

A14F1

000501 20 60020 0006
NVO, UNKNOWN
30 M O DETAINEE
OPPER
NOV 05

ICU #1

LOCATION OF MEDI

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45.505

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EXHIBIT 4

0206 05 CID 89 39288

CX F

Pic #1

(b)(6)

(b)(6)

22 NOV 05

follow up CHF Pharmacy

22NOV05 22NOV05

Cardiac Silhouette to normal
to mildly enlarged although
vascularity remains similar
compared to some CHF

(b)(6)

A14F1

SCSBC1 20 60000 05C1
VD-UNKNOWN
ST M C C
MP CPOPIER

EXHIBIT
4

NSN 7540-01-165-7294

0206 05 CID; 89 39288

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED

P CXR

AGE | SEX | SSN (Sponsor) 0501 | WARD/CLINIC

REGISTER NO.

FILM NO.

RE (b)(6)

PREGNANT ☐ YES ☒ NO

TELEPHONE/PAGE NO.

(b)(6)

DATE REQUESTED 20NOV05

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

R/O PE Pneumonia ✓ ETT tube placement

DATE OF EXAMINATION *(Month, day, year)* 20 NOV 05

DATE OF REPORT *(Month, day, year)* 20 NOV 05

DATE OF TRANSACTION *(Month, day, year)*

RADIOLOGIC REPORT

Slightly more confluent appearance to (R) lung field. Tube & lines are stable

(b)(6)

PATIENTS IDENTIFICATION *(For typed or written entries give: Name - last, first, middle, Medical Facility)*

20050501 20 60000 05C1 A14F1
HVD-UNKNOWN
[illegible]

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 6-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

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FOR OFFICIAL USE ONLY

IT - Medical Records

DII CIDROIS 10015

EXHIBIT 4

ABBREVIATED MEDICAL RECORD

1. ADMISSION DATE *(YYYYMMDD)*

0206 05 CI 89 39288

2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW

Chest pain starting @ ~ 19:00 tonight, c̄ SOB.
- Has occurred multiple x in past, known vasculopath c̄ CAD
- ST↑ V1,V2 c̄ ST↓ V6, I (both old). ASA, Lovenox [illegible] given c̄ to transport here.

3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*

Arrives in extremis ⟶ ETI for severe CHF clinically
After ETI: T 99.6 HR 80 BP 70/30 — 130/70 SaO2 100% on PPV
Gen - color good
HENT ⊖ CAD ⊕ JVD
Chest - congestion diffusely
Cor - rrr
Abd - SSNT
Ext - ⊖ edema
Labs: Trop 3.9

4. IMPRESSION *(Enter admission note with plan on progress notes)*

1. CHF
2. AMI
3. Fever

5. ADMITTING OFFICER

a. SIGNATURE
(b)(6)

b. DATE SIGNED *(YYYYMMDD)*
2005·1120

6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*

7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGING OFFICER

a. NAME *(Last, First, Middle Initial)*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*

60000501

10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:

11. COPY PLACED IN OUTPATIENT RECORD *(X when done)* ☐

DD FORM 2770, APR 1998 (EG)

Designed using Perform Pro, WHS/DIOR, Apr 98

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0206 05 CID 39288

NSN 7540-01-165-7294 519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT
(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
PCXR		M		ICU #1	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print) (b)(6)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR (b)(6)

DATE REQUESTED 26 NOV 05

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings)

Post intubation - verification of ETT placement

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSACTION (Month, day, year)
26 NOV 05	26 NOV 05	

RADIOLOGIC REPORT

ET Tube 3cm above carina
(L) sided TLC in good position
(B) basilar pleural effusion
c̄ [illegible] seen.
Some Congestive Δ's seen as
well - Slightly progressed
compared to previous study

(b)(6)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle, Medical Facility)

3000001 20 60020 006
HVO, UNKNOWN
8 M O DETAINEE
CROPPER

LOCATION OF MEDICAL RECORD

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-B (Rev. 8-83)
Prescribed by GSA/ICMR FIRMR
(41 CFR) 201-45.505

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

ACLU DDII CID ROIS 40017

EXHIBIT 4

000201

0206 05 CID 789 39288

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER	TREATMENT FACILITY
RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 19 NOV 05 | TIME: 2239

TRANSPORTATION TO FACILITY: Trauma

SEX: M

AGE: 66

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: see list in chart

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN: ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES: ☐ YES ☐ NO

CHIEF COMPLAINT: Chest Pain / Resp distress

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME					
BP					
PULSE					
RESP					
TEMP					
WT					

LAB ORDERS

☐ CBC/DIFF	☐ ABG	☐ PT/PTT	☐ BHCG/URINE/BLOOD/QUANT		
☐ URINE C&S	☐ UA MSCC/CATH		☐ CHEM:		
☐ BLOOD C&S X					
☐					
☐					

X-RAY ORDERS

☐ CXR PA & LAT/PORTABLE	☐ C-SPINE		
☐ ACUTE ABDOMEN	☐ LS SPINE		
☐ SINUS	☐ HEAD CT		
☐ ANKLE R/L			
☐			

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Lasix 40mg IV @ 0130				
	Succ 200, Etomidate 20 IV @ 2257		(b)(6)		
	Propofol drip @ 30mcg/hr				
	Propofol 40mcg bolus				
	Metoprolol 5mg IV @ 2300				

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE: Bed 1 ICU

TIME OF RELEASE: 0140

REFERRED ▶	TO	WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); hospital or medical facility)*

HVD 006

600000501

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 6

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	NSN 7540-01-075-3786 TIME SEEN BY PROVIDER

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP 02	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT			U/A DIP			EKG INTERPRETATION	
PT			U/A MICRO				
APTT		BHCG / ETOH / GLU					

PROVIDER HISTORY/PHYSICAL

By report from sending institution: Pt c̄ 19:00 acute onset CP, relieved by nitro x3 8→5, known CAD/PVD/COPD/HTN, etc. ⊕ trop

Arrives here in severe CHF, stats ⊗ ..

Temp 99.6 Rx HR 148 BP 250/130,

- Gen - in extremis, SOB/diaphoresis
- Chest congested b/lat
- ⊘ pedal edema
- Cor - RRR - narrow complex

Rx - SSNT

- NTG x ~35 doses c̄ change c̄ mild ↓ in BP

→ ETT emergently

AW vs improved c̄ BP ↓ to 72/29 at lowest

90-100 syst currently

CXR c/w CHF, enzymes ⊕ for trop/MB → MI

EKG - ST depressions worsened since earlier today

A/P, Acute MI / CHF

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

(b)(6)

[DIAG]NOSIS

MI
HF

Fever

CODES

[PATIENT]'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID no (SSN or other); hospital or medical facility)

EMERGENCY CARE AND TREATMENT (Doctor)
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

For (b)(6)

0206 05 CI[illegible] 89 39288

TF 344 MED, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

SSN or ISN: [illegible] 20 6CC2C CCC6 (faint stamp) 14F
[illegible] UNKNOWN
LAST, FIRST, MI. [illegible] C DETAINEE
CROPPER

Physician: [illegible] Ward: ICU
Drawn by: (b)(6) Bed: 1
Gender (M) or F (circle) — M circled
(Stat) or Routine (circle) — Stat circled

Specimen
Date and time: 29 Nov 05 2210

Signs and Symptoms:

Reported by: (b)(6)
Date and Time: 11/29/05 @ 2300

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas Bld Gas w/ lytes Glu Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH		7.35-7.45
	PCO2		35-45 mmHg
	PO2		80-100 mmHg
	TCO2		18-33 mmol/L
	HCO3		22-26 mmol/L
	sO2		95-99%
	BEecf		(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	Hgb		12.0-18.0 g/dL
	Lactate		0.90-1.70 mmol/L

Urinalysis (circled)

X	TEST	RESULT	REF. RANGE
	Color	yellow	Straw/Yellow
	Clarity	clear	Clear
	Glucose	500	Negative
	Bilirubin	NEG	Negative
	Ketone	40	Negative
	SG	1.020	1.010-1.025
	Blood	TRACE	Negative
	pH	5.0	5.0-8.0
	Protein	30	Negative-Trace
	Urobili	1.0	0.1-1.0 Ehrlich U/dL
	Nitrite	NEG	Negative
	Leuko	NEG	Negative

Urine Microscopic

WBC		Epi	
RBC	0-5	Mucus	
Bacteria		Yeast	
Casts:		Spermatozoa	
Crystals:		Amorph Sed	
Other:			

Other lab request:

SSA - TRACE CLINITEST - 1/2%
Acetest - MOD

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan BMP Hepatic Pan Lipid Pan Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		M: 53-128 U/L F: 42-141 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		16-55 U/L
	Indirect bil (Bu)		0-1.1 mg/dL
	Dbil (Bc)		0-0.3 mg/dL
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	Cl		98-108 mmol/L
	TCO2		18-33 mmol/L
	Crea		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.4 mg/dL
	Tot. Protein		6.4-8.1 g/dL
	Na		128-145 mmol/L
	HDL Chol		40-75 mg/dL
	LDL Chol		50-129 mg/dL
	Triglycerides		60-149 mg/dL
	VLDL		<30 mg/dL
	Chol/HDL Ratio		≤ 5

Rapid Tests (SST or Red Top)

X	TEST	RESULT	REF. RANGE
	RPR		Negative
	HCG (or urine)		Negative

Rapid Tests

X	TEST	RESULT	REF. RANGE
	Strep A		Negative
	Drug Screen (urine)		Negative
	Chlamydia		Negative
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	OccBld		Negative
	Wet Mount		Negative
	KOH		Negative

Hematology / Purple Top

CBCN (no diff) CBC Malaria H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

X	TEST	RESULT	REF. RANGE
	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate / Purple Top

X	TEST	RESULT	REF. RANGE
	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top, Sodium Citrate)

X	TEST	RESULT	REF. RANGE
	PT		7.0-14.0 sec
	APTT		21.0-50.0 sec
	INR		0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel/Purple Top

X	TEST	RESULT	REF. RANGE
	Myoglobin		0-107 ng/mL
	CK-MB		0-4.3 ng/mL
	Troponin		0.0-0.4 ng/mL

Hemoglobin S (sickle)/Purple Top

X	TEST	RESULT	REF. RANGE
	Hemoglobin S		Negative

Rapid Tests (Green Top)

X	TEST	RESULT	REF. RANGE
	Mono		Negative
	H.pylori IgG		Negative

revised 31Aug05 mc

reviewed by: 4

0206 05 Cl, 04 39288

SSN or ISN:

LAST, FIRST, MI.

Physician:

Drawn by (b)(6)

Ward: ECC

Bed:

Gender M or F (circle)

Stat or Routine (circle)

TF 344 MED, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

Specimen Date and time: 29 Nov 05 1230

Signs and Symptoms:

Repo (b)(6)

Date and Time: 29 Nov

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-145 mmol/L
	K		3.3-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7,448 H	7.35-7.45
	PCO2	24,2 L	35-45 mmHg
	PO2	75 L	80-100 mmHg
	TCO2	23,	18-33 mmol/L
	HCO3	21,8 L	22-26 mmol/L
	sO2	96	95-99%
	BEecf	-2	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		37.0-52.0%
	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		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

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

Other lab request:

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
	ALP		M: 53-128 U/L F: 42-141 U/L
	ALT		10-47 U/L
	AMY		14-110 U/L
	AST		16-55 U/L
	Indirect bil (Bu)		0-1.1 mg/dL
	Dbil (Bc)		0-0.3 mg/dL
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	Cl		98-108 mmol/L
	TCO2		18-33 mmol/L
	Crea		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	Mg		1.6-2.3 mg/dL
	Phosphorus		2.2-4.4 mg/dL
	Tot. Protein		6.4-8.1 g/dL
	Na		128-145 mmol/L
	HDL Chol		40-75 mg/dL
	LDL Chol		50-129 mg/dL
	Triglycerides		60-149 mg/dL
	VLDL		<30 mg/dL
	Chol/HDL Ratio		≤ 5

Rapid Tests (SST or Red Top)

	RPR		Negative
	HCG (or urine)		Negative

Rapid Tests

	Strep A		Negative
	Drug Screen (urine)		Negative
	Chlamydia		Negative
	Flu A&B		Negative
	C. difficile (stool)		Negative
	O&P (stool)		No Ova / Parasite
	OccBld		Negative
	Wet Mount		Negative
	KOH		Negative

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
	RBC		4.2-6.1 x10(6)/uL
	Hgb		12.0-18.0 g/dL
	Hct		M: 42.0-52.0%
			F: 37-47%
	MCV		80.0-99.0 fl
	MCH		27.0-31.0 pg
	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

	RBC Abn Morph:	
	Plt Abn Morph:	
	WBC Abn Morph:	

Malaria / Purple Top

	Thin		No Plasmodium Seen
	Thick		No Plasmodium Seen

Sed Rate / Purple Top

	Sed Rate		1hr = 0-20 mm

Coagulation (Blue Top - Sodium citrate)

	PT		7.0-14.0 sec
	APTT		21.0-50.0 sec
	INR		0.5-1.5/therap 2-3
	D Dimer		Negative

Cardiac Panel/Purple Top

	Myoglobin		0-107 ng/mL
	CK-MB		0-4.3 ng/mL
	Troponin		0.0-0.4 ng/mL

Hemoglobin S (sickle)/Purple Top

	Hemoglobin S	Negative

Rapid Tests (Green Top)

	Mono		Negative
	H.pylori IgG		Negative

FOR OFFICIAL USE ONLY PRIVACY ACT DATA

EXHIBIT 000205

revised 31Aug05 mc

reviewed by: 4

SSN or ISN: [redacted] INEE
CROPPER
LAST, FIRST, MI: NOV 05

Physician (b)(6) Ward: ILU
Drawn by (b)(6) Bed: 1

Gender M or F (circle)
Stat or Routine (circle)

TF 344 MED, ABU
LABORATORY RESULTS FORM
(Subject to Privacy Act of 1974)

89 392 88

Specimen Date and time: 1800 29 Nov 05

Signs and Symptoms:

Reported by: (b)(6)

Date and Time: 11/29/05 1900

Chemistry (i-STAT) / Green Top / Syringe

Bld Gas | Bld Gas w/ lytes | Glu | Crea

X	TEST	RESULT	REF. RANGE
	Na		138-146 mmol/L
	K		3.5-4.9 mmol/L
	Cl		98-109 mmol/L
	pH	7.41	7.35-7.45
	PCO2	32.5 L	35-45 mmHg
	PO2	50 L C	80-105 mmHg
	TCO2	22 L	23-27 mmol/L
	HCO3	20.7 L	22-26 mmol/L
	sO2	86 L	95-98%
	BEecf	-4 L	(-2) - (+3)
	AGap		8-16 mmol/L
	iCa		1.12-1.32 mmol/L
	BUN		7-22 mg/dL
	Glu		73-118 mg/dL
	Creat		0.6-1.3 mg/dL
	Hct		38.0-51.0%
	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		0.1-1.0 Ehrlich U/dL
Nitrite		Negative
Leuko		Negative

Urine Microscopic

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

Other lab request:

Chemistry (Piccolo)/Green or red/tiger top

Comp Pan | BMP | Hepatic Pan | Lipid Pan | Renal Pan

X	TEST	RESULT	REF. RANGE
	ALB		3.3-5.5 g/dL
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	Indirect bil (Bu)		0-1.1 mg/dL
	Dbil (Bc)		0-0.3 mg/dL
	Tbil		0.2-1.6 mg/dL
	BUN		7-22 mg/dL
	Ca		8.0-10.3 mg/dL
	Chol		100-200 mg/dL
	CK		M: 39-380 U/L F: 30-190 U/L
	Cl		98-108 mmol/L
	TCO2		18-33 mmol/L
	Crea		0.6-1.2 mg/dL
	GGT		5-65 U/L
	Glu		73-118 mg/dL
	K		3.3-4.7 mmol/L
	Mg		1.6-2.3 mg/dL
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	Na		128-145 mmol/L
	HDL Chol		40-75 mg/dL
	LDL Chol		50-129 mg/dL
	Triglycerides		60-149 mg/dL
	VLDL		<30 mg/dL
	Chol/HDL Ratio		≤ 5

Panic values called & read back

Rapid Tests

RPR		Negative
HCG (or urine)		Negative

Rapid Tests

Strep A		Negative
Drug Screen (urine)		Negative
Chlamydia		Negative
Flu A&B		Negative
C. difficile (stool)		Negative
O&P (stool)		No Ova / Parasite
OccBld		Negative
Wet Mount		Negative
KOH		Negative

Hematology / Purple Top

CBCN (no diff) | CBC | Malaria | H/H

X	TEST	RESULT	REF. RANGE
	WBC		4.8-10.8 x10(3)/uL
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			F: 37-47%
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	MCHC		33.0-37.0 g/dL
	Plt		130-400 x10(3)/uL
	LY%		20.0-44.0%
	LY#		0.7-4.3 x10(3)/uL

Differential

Segs(50-70%)	Mono(4-10%)
Bands(1-10%)	Eos(0-4%)
Lymph(20-44%)	Baso(0-2%)
Atyp Ly	Immature cells

RBC Abn Morph:

Plt Abn Morph:

WBC Abn Morph:

Malaria / Purple Top

Thin		No Plasmodium Seen
Thick		No Plasmodium Seen

Sed Rate / Purple Top

Sed Rate		1hr = 0-20 mm

[illegible] / Purple Top

PT		7.0-14.0 sec
APTT		21.0-50.0 sec
INR		0.5-1.5/therap 2-3
D Dimer		Negative

Cardiac Panel/Purple Top

Myoglobin		0-107 ng/mL
CK-MB		0-4.3 ng/mL
Troponin		0.0-0.4 ng/mL

Hemoglobin S (sickle)/Purple Top

Hemoglobin S	Negative

Rapid Tests (Green Top)

Mono		Negative
H.pylori IgG		Negative

revised 31Aug05 mc

reviewed by:

EXHIBIT 4

EXHIBIT(S) 9, 10 & 11

Page(s) 000210 thru 000301
referred to:

CDR USAMEDCOM
ATTN: FOIA OFFICE, STOP 76
1216 STANLEY RD 2D FL
FT. SAM HOUSTON, TX 78234-5049

0206-05-CID789-39288

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 Armo	SOCIAL SECURITY NUMBER Numéro de l'Assurance Social
BTB Al-Zubaydi, Muhammed, Hamza		Civilian	US1Z200006OT
ORGANIZATION Organisation	NATION (e.g. United States) Pays: Iraq	DATE OF BIRTH Date de naissance: 28 July 1938	SEX Sexe: [X] MALE [ ] FEMALE

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

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

MEDICAL STATEMENT Déclaration médicale

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

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 causées 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 9 December 2005	AVIATION ACCIDENT? Accident d'Aviation [ ] YES Oui [X] NO Non

DATE OF DEATH (day, month, year) Date de décès (le jour, le mois, l'année): 2 December 2005

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 conclue que le décès est survenu à l'heure indiquée et à la suite des causes énumérées ci-dessus.

NAME OF MEDICAL OFFICER (b)(6)

TITLE Titre ou diplôme: Medical Examiner

GRADE Grade (b)(6)

INSTALLATION OR ADDRESS Installation ou adresse: Dover AFB, Dover DE

DATE Date: 9 Dec 2005

SIGNATURE (b)(6)

1 State disease, injury, or complication which caused death. Do not enter mode of dying, such as cardiac arrest, respiratory arrest, or ventricular fibrillation.
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, telle qu'un arrêt du cœur, etc.
2 Préciser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.

DD FORM 1 APR 77 2064 REPLACES DA FORM 3565, 1 JAN 72 AND DA FORM 3565-R(PAS), 28 SEP 75, WHICH ARE OBSOLETE.

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~~LAW ENFORCEMENT SENSITIVE~~

EXHIBIT 9

0206-05-CID789-39288

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

FINAL AUTOPSY EXAMINATION REPORT

Name: (BTB) AL-ZUBAYDI, Muhammed Hamza
ISN: US9IZ-200006
Date of Birth: (BTB) 28 JUL 1938
Date of Death: 02 DEC 2005
Date/Time of Autopsy: 09 DEC 2005 @ 1200
Date of Report: 23 JUN 2006

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

Circumstances of Death: This 67-year-old Iraqi civilian detainee was admitted to the hospital on 20 NOV 2005 with chest pain and in respiratory distress. He was by report in heart failure, and on 02 DEC 2005 suffered a cardiac arrest. Advanced Cardiac Life Support was provided to no avail.

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

Identification: Presumptive identification is established by comparison of antemortem records and identification bands. A complete postmortem fingerprint examination was conducted and can be used to establish positive identification should exemplars become available.

CAUSE OF DEATH: **HYPERTENSIVE ATHERSCLEROTIC CARDIOVASCULAR DISEASE**

MANNER OF DEATH: **NATURAL**

FINAL AUTOPSY DIAGNOSES

I. Hypertensive Atherosclerotic Cardiovascular Disease

A. Cardiomegaly (heart weight 560-grams; 358-grams to 438-grams expected for a body weight of 199-pounds) with biventricular dilated hypertrophy
B. Remote coronary artery bypass surgery with patent mammary artery graft to mid left anterior descending coronary artery
C. Severe aortic atherosclerosis with focally heavy calcification and ulceration
D. Severe coronary atherosclerosis with calcification, three vessel disease
E. Healed transmural infarction, posterior and septal left ventricle
F. Tricuspid regurgitation
G. Renal pitting and petechiae with arteriolosclerosis bilaterally

II. Other Natural Disease

A. Congestion of the lungs bilaterally (right lung weight 1040-grams, left lung weight 600-grams)
B. Bilateral pleural adhesions
C. Bilateral pleural effusions (right 400-milliliters, left 525-milliliters)
D. Microscopic evidence of pulmonary hypertension, including thickened pulmonary vasculature and interstitial fibrosis
E. Diffuse alveolar damage
F. Enlarged prostate gland with associated muscular hypertrophy of the bladder
G. Incidental nephrogenic rest
H. Passive central congestion of the liver with associated mild portal inflammation
I. Right adrenal myelolipoma
J. Smooth muscle tumor of uncertain malignant potential of the stomach

III. Other findings:

A. No internal or external evidence of recent trauma to head, trunk or extremities identified by complete autopsy and total body x-ray studies
B. No injuries of the neck identified (layer-by layer dissection of the neck performed)

IV. Early Changes of Decomposition

V. Evidence of Medical Therapy

A. Properly located endotracheal tube
B. Left nasogastric tube is in place
C. Triple-lumen balloon-tip catheter is in the left jugular vein
D. Right radial arterial line
E. Needle-stick marks are in the antecubital fosse bilaterally and in the right neck
F. Defibrillator abrasion is on the anterior right torso

IV. Toxicology

A. The blood and vitreous fluid are tested for ethanol and none is found

0206-05-CZ0789-39288

B. The blood is tested for carbon monoxide and the level is less than 1%
C. The blood is tested for cyanide and none is found
D. The blood is screened for drugs of abuse and none are found

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished appearing, 69 ½-inches, 199-pound obese white male whose appearance is consistent with the reported age of 67 years. Lividity is posterior and fixed. Rigor is equal in all extremities, and the temperature of the body is that of the refrigeration unit.

The scalp is covered with short gray hair, in a male-pattern baldness distribution. The irides are hazel, and the pupils are round and equal in diameter. There are no conjunctival petechiae. The external auditory canals are patent and clear. The ears are unremarkable. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. There is a 7 ½-inch midline sternotomy scar. The abdomen is flat. There is a 13-inch surgical scar in the left inguinal region. 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 distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing. Generalized edema and focal ecchymoses that are associated with medical therapy are present. Early changes of decomposition are present and evidenced by skin slippage on the lower back, posterior right arm and the scalp on the back of the head.

CLOTHING AND PERSONAL EFFECTS

The body is received nude, and no person effects accompany the remains.

MEDICAL INTERVENTION

G. There is a properly located endotracheal tube
H. A left nasogastric tube is in place
I. A triple-lumen balloon-tip catheter is in the left jugular vein
J. There is a right radial arterial line
K. Needle-stick marks are in the antecubital fosse bilaterally and in the right neck
L. A defibrillator abrasion is on the anterior right torso

RADIOGRAPHS

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

- No skeletal trauma is identified

- No metallic foreign bodies are identified

EVIDENCE OF INJURY

There is no evidence of recent trauma.

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 1,340-gram 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.

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

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. No excess fluid is in the pericardial or peritoneal cavities. The right pleural cavity contains 400-milliliters of serosanguinous fluid and the left pleural cavity contains 525-milliliters of serosanguinous fluid. There are pleural adhesions bilaterally. The pericardium is intact and is tightly adhered to the heart. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1,040 and 600-grams, respectively. The external surfaces are roughened and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. The lower lobe of the left lung is consolidated. No mass lesions are identified in either lung.

CARDIOVASCULAR SYSTEM:
The 730-gram heart is contained in an intact pericardial sac. There is evidence of remote cardiac surgery, and the heart is submitted for Cardiovascular Pathology consultation (Addendum 1).

The aorta gives rise to three intact and patent arch vessels. Severe atherosclerosis with heavy calcification and ulceration is present along the entire length of the aorta. Atherosclerosis is also present in the renal and mesenteric vessels.

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LIVER & BILIARY SYSTEM:
The 2,250-gram 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 210-gram spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is firm and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The left adrenal gland has a bright yellow cortices and grey medullae. The right adrenal gland is enlarged (2.0 x 2.0-centimeters), and is yellow and had yellow cut surfaces. No areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 220 and 220-grams, respectively. The external surfaces are intact and pitted with scattered petechiae bilaterally. The cut surfaces are red-tan and congested, with uniformly thin cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa that is focally hemorrhagic overlies an intact bladder wall. The bladder contains approximately 10-milliltiers of yellow urine. The prostate is enlarged in size, with nodular, 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 contains approximately 10-milliliters of tan fluid. The gastric wall is intact, and a 1.0 x 1.0 x 1.0-centimeter mass arises from the stomach wall. The duodenum, loops of small bowel and colon are unremarkable. The appendix is absent.

MICROSCOPIC EXAMINATION

Cardiovascular System: See the Cardiovascular Pathology consultation (Addendum 1) for complete details.

Respiratory System: Sections of the lung demonstrate evidence of pulmonary hypertension, including thickened pulmonary vasculature (mild to moderated medial hypertrophy) and interstitial fibrosis. Anthracotic pigment and hemosiderin are present in

0206-05-CZ0789-39288

Genitourinary System: There is marked arteriolosclerosis with focal glomerulosclerosis in both kidneys. An incidental nephrogenic rest is noted.

Hepatobiliary System: Passive central congestion of the liver and associated mild portal inflammation is present.

Endocrine System: Myelolipoma of the right adrenal.

Gastrointestinal System: Smooth muscle tumor of uncertain malignant potential of the stomach.

Spleen: Parenchymal congestion, otherwise unremarkable.

0206-05-CID 789-39288

ADDITIONAL PROCEDURES/REMARKS

- Documentary photographs are taken by AFMES photographers
- Specimens retained for toxicological testing and/or DNA identification are: vitreous fluid, heart blood, urine, gastric fluid, bile, spleen, liver, brain, lung, kidney, adipose tissue and psoas muscle
- The dissected organs are forwarded with the body and the body is sutured closed without embalming
- The following identifying body marks are present: Midline sternotomy incision (well-healed, 7 ½-inches), left lateral abdomen/groin incision (well-healed, 13-inches)

OPINION

This 67-year-old white male, (BTB) Muhammed Hamza Al-Zubaydi, died as a result of hypertensive atherosclerotic cardiovascular disease. Cardiomegaly, severe three-vessel coronary artery disease, a history of bypass-grafting surgery, aortic atherosclerosis and a healed transmural myocardial infarction are all components of this diagnosis. Also, microscopic sections of the kidneys show arteriolosclerosis in the kidneys that is a histological manifestation of systemic hypertension. Pulmonary interstitial fibrosis and the microscopic evidence of pulmonary hypertension are directly related. Incidental findings at autopsy of the right adrenal myelolipoma and smooth muscle tumor of the stomach did not contribute to the cause of death. Toxicological testing for ethanol, drugs of abuse, carbon monoxide and cyanide was negative. The manner of death is natural.

(b)(6)

(b)(6) Medical Examiner

(b)(6)

(b)(6) Medical Examiner

(b)(6) 11 Jul 06

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0206-05-CIO789-

ADDENDUM 1

Cardiovascular Pathology Consultation

FINAL DIAGNOSIS

DIAGNOSIS: ME (b)(6)

1. Severe coronary atherosclerosis with calcification, three vessel disease
2. Patent mammary artery graft to mid left anterior descending artery
3. Healed transmural infarction, posterior and septal left ventricle
4. Cardiomegaly with biventricular hypertrophy
5. Tricuspid regurgitation

History: 67 year old male Iraqi detainee admitted to hospital on 11/20/05 with chest pain and respiratory distress; subject developed heart failure and suffered a cardiac arrest on 12/02/05 and could not be resuscitated

Heart: 560 grams after removal of adherent pericardium and mediastinal soft tissues; diffuse fibrous pericardial adhesions; oversewn right atrial appendage; closed foramen ovale; dilated right atrium and right ventricle; left ventricular hypertrophy: left ventricular cavity diameter 35 mm, left ventricular free wall thickness 16 mm, ventricular septum thickness 18 mm, right ventricle thickness 6 mm; tricuspid regurgitation: thickened and redundant tricuspid valve leaflets, with dilated right atrium and right ventricle, and endocardial thickening under septal leaflet of valve; mild thickening of mitral valve leaflets along lines of closure; other valves unremarkable; endocardial thickening in left ventricular septum overlying healed transmural infarction that extends to anterior and posterior walls toward the apex; histologic sections show biventricular myocyte hypertrophy with subendocardial and perivascular interstitial fibrosis and patchy replacement fibrosis; transmural replacement fibrosis, posterior and septal left ventricle; basophilic degeneration of myocytes

Coronary arteries: Normal ostia; right dominance; severe calcific coronary atherosclerosis:

Left main coronary artery: 30% luminal narrowing with nodular calcification

Left anterior descending artery (LAD): 50% narrowing of proximal LAD and 90% narrowing of mid LAD by fibrocalcific plaque; mammary artery graft to mid LAD, patent anastomosis with mild intimal thickening and 30% luminal narrowing in run-off vessel; 80% narrowing of first diagonal artery by fibrocalcific plaque

Left circumflex artery (LCA): 60% narrowing of proximal LCA with nodular calcification and 70% narrowing of mid LCA by fibrocalcific plaque

Right coronary artery (RCA): 80% narrowing of proximal and distal RCA, and 75% narrowing of mid RCA by fibrocalcific plaque

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Staff Pathologist

Blocks made: 18 (5 heart, 13 coronary arteries)
Slides made: 31 (18 H&E, 13 Movat)

EXHIBIT
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0206-05-CID 89-39288

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
BTB AL-ZUBAYDI, MUHAMMED H.

SSAN: **Autopsy:** ME (b)(6)
Toxicology Accession #: (b)(6)
Date Report Generated: December 22, 2005

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS **REPORT OF TOXICOLOGICAL EXAMINATION**

Condition of Specimens: GOOD
Date of Incident: 12/2/2005 **Date Received:** 12/14/2005

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

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

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

DRUGS: The **HEART BLOOD** 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:

None were found.

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