MEMO FOR RECORD – EVIDENCE

(b)(6)4

On 04 Feb 2004, it was noticed by shift change that detainee #[redacted] was not moving. (exhibit G) After the medic summoned the physician on call, Dr. [redacted], the EPW was pronounced dead at 0730. (exhibit G) Prior to pronouncing the detainee, Dr. [redacted] had never seen, treated or been called to render advice on the patient. (exhibit D)

Prior to arrival at FOB Ironhorse, the detainee was processed at Brassfield Move FOB. (exhibit F) An intake physical done at that time by SPC [redacted] recorded that the patient had diabetes and anemia, as well as left kidney failure. The diabetes notation was crossed off without explanation. (exhibit F) Of particular importance, it was noted that the detainee was urinating only 1 oz. daily. (exhibit F)

(b)(6)2

The detainee was transported to Ironhorse on 5 Feb 2004. At the time of reception, the detainee was noted to be frail appearing, weak, and required assistance in dismounting the vehicle.(exhibit C) During the incarceration, the detainee had two episodes of fainting or near fainting, one resulting in injury requiring wound care. In addition, he was so weak that he required assistance in holding his head up for the photo ID. (exhibit C)

On the morning of 7 Feb 2004, the detainee was seen by the MP medic, SPC [redacted]. He stated that through an interpreter, the detainee reported painful urination. No action was taken by the medic. (exhibit E)

On the morning of 8 Feb 2004, SSG [redacted] and [redacted] were summoned to the detainee's area because he was not moving. SSG [redacted] check the detainee's pulse and also noted that he was cold. (exhibit B) The detainee was last seen alive during the evening coffee and soup administration. (exhibit A) Prior to the detainee's demise, the patient was not interrogated at FOB Ironhorse. (exhibit B)

FINDINGS:

1. The medic at FOB Ironhorse failed to recognize the seriousness of the detainee's condition, did not read the intake physical and failed to contact appropriate medical personnel for guidance and treatment.

2. The medic at FOB Brassfield MAY not have recognized the seriousness of the detainee's condition and may not have sought appropriate medical advice.

3. The medic at FOB Ironhorse appeared not to be aware of the detainee's medical conditions and it appears that the intake sheet was not available to the medic.

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4. Although in hindsight, officer personnel at the detention center were aware of the frail nature of the detainee, it appears that this was not communicated to the medic.

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