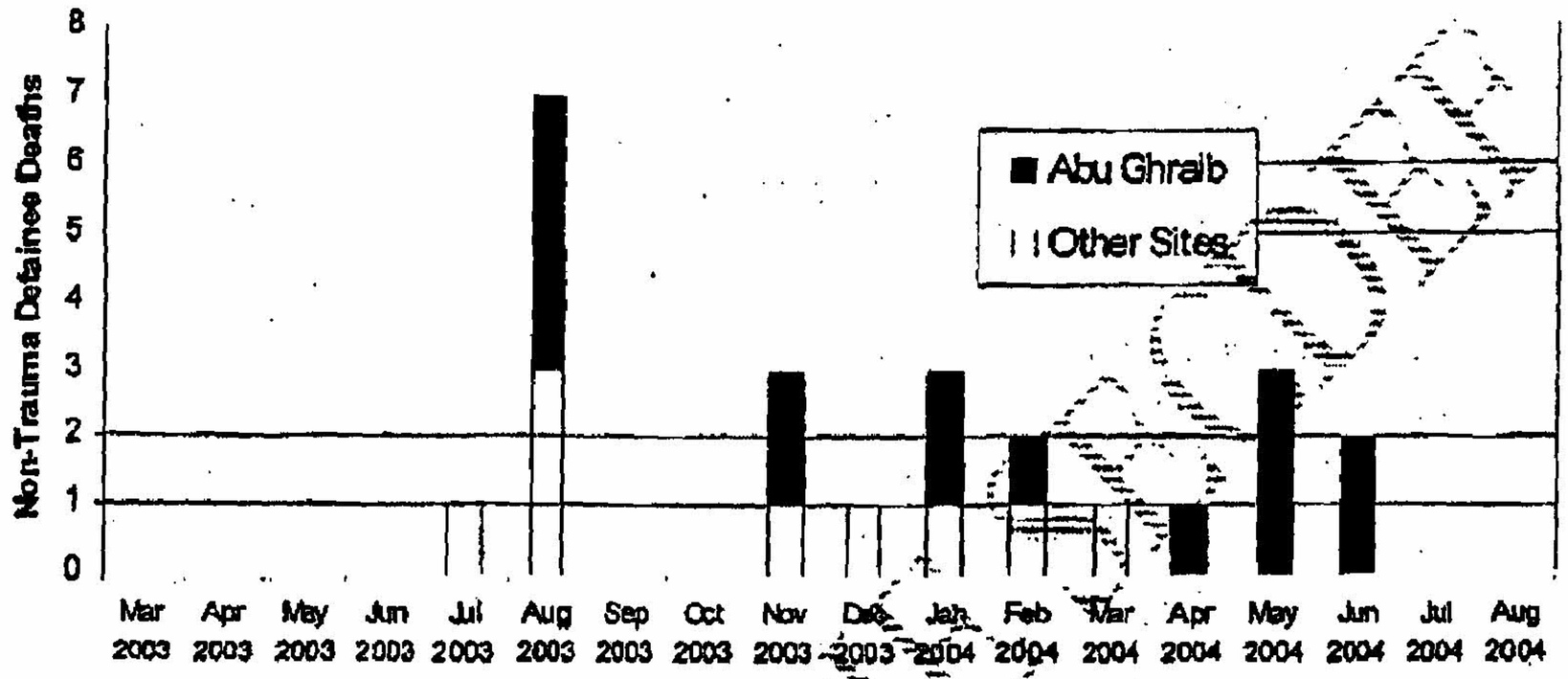

Non-Transit Detainee Deaths in Iraq, By Month (U)

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influenced non-trauma detainee deaths at other times. The seven "Non Trauma" detainee deaths occurring in Iraq in August 2003 are summarized below. In each of these seven cases, CID investigations of detainee death are now closed.

~~(FOUO)~~ 8/3/03 at Camp Cropper in Baghdad (Non-Trauma) - Data is incomplete. Detainee was observed by other detainees to be extremely ill before death. They ultimately brought him to the aid station, where medical life-saving measures were unsuccessful. Medical photos support a military physician's impression of no external injuries. No autopsy was performed.

~~(FOUO)~~ 8/7/03 at Diwania (Non-Trauma) - Detainee became short of breath and suffered low blood pressure during a transport by bus. He briefly improved after medics administered a fluid bolus, but later worsened and died. Autopsy by OAFME showed no evidence of trauma, although a precise cause of death could not be determined.

~~(FOUO)~~ 8/8/03 at Abu Ghraib in Baghdad (Non-Trauma) - Detainee with known diabetes had been on a hunger strike for two days. Other detainees saw him suffer chest pain and eventually collapse. Medics were summoned and they began cardiopulmonary resuscitation, which was not successful. Autopsy by OAFME cited atherosclerotic heart disease complicated by diabetes.

~~(FOUO)~~ 8/11/03 at Abu Ghraib in Baghdad (Non-Trauma) - Detainee had been treated for shortness of breath during medical in-processing, but he later refused to accept an inhaler. He was later found unconscious. Medics were summoned and began cardiopulmonary resuscitation, which was not successful. Autopsy by OAFME cited atherosclerotic heart disease.

~~(FOUO)~~ 8/13/03 at Abu Ghraib in Baghdad (Non-Trauma) - Detainee was found by other detainees to have no breathing or pulse. They carried him to prison gate area. Autopsy by OAFME found atherosclerotic heart disease. Investigative summary report mentions a suspicion the detainee suffered a heart attack due to the combined effects of extreme heat and self-induced dietary restriction. No mention is made of medical involvement except for the autopsy.

~~(FOUO)~~ 8/20/03 at Abu Ghraib in Baghdad (Non-Trauma) - Other detainees told guards of this detainee's apparent distress from illness. Medical staff arrived within ten minutes and found the detainee to have no pulse. They began cardiopulmonary resuscitation and advanced cardiac life support, without success. Autopsy by OAFME found atherosclerotic heart disease.

~~(FOUO)~~ 8/22/03 at Camp Sathe in Baghdad (Non-Trauma) - Detainee was found on the ground with shallow breathing, decreased perspiration, and a high temperature. Aggressive administration of intravenous fluids by medical personnel failed to prevent his rapid subsequent death. Autopsy by OAFME cited the death as heat-related.

~~(FOUO)~~ We do not know whether medical personnel reported concerns about climate impacts on detainee health in August 2003 or at other times. Sources outside our process suggest that at least some medical personnel did report concerns about detainee welfare during such hot periods. Overall circumstances would probably have led a number of medical personnel to have such concerns.

Conclusions (U)

(U) Medical doctrine of the U.S. Armed Forces is ultimately rooted in the Geneva Conventions of 1949, and applies the standard of humane medical care to all categories of detainees. This doctrine has been in place throughout operations in GTMO, Afghanistan and Iraq. In addition, we note that the Office of the Secretary of Defense is currently developing specific policies to address the issues raised below.

(U) The medical personnel that we interviewed appeared to understand, in general terms, their responsibility for providing humane medical care to detainees, but few had received training specifically relevant to detainee screening and medical treatment. In Afghanistan and Iraq, however, we found inconsistent field-level implementation of specific requirements, such as monthly medical inspections and weight recordings. One

obvious need is for a clear and concise training curriculum in a standardized format amenable to use in diverse settings.

(U) Two specific areas deserve further policy-level and legal review, as appropriate. Both touch on important ethical issues not specifically addressed by the Geneva Conventions of 1949. The first involves the roles and responsibilities of behavioral science personnel working in direct non-medical support of detainee interrogators to refine interrogation techniques. The status of medical personnel assigned to these non-medical duties deserves clarification, even though much of their work actually focused on encouraging less coercive interrogation techniques for most detainees. The second area deserving further policy-level review involves standards for detainee medical records and who should have access to them. We found substantial variation in field-level practices for maintaining and securing detainee medical records. In some situations, interrogators had easy access to detainee medical information, even though we separately found little interest by interrogators for that information and no instances where detainee medical information had been used coercively during interrogations. Although U.S. law provides no absolute confidentiality of medical information for any person, including detainees, DoD policy-level review is necessary in order to balance properly these reporting concerns. Meanwhile, a third important policy area, involving requirements for reporting detainee death, performing autopsies, and determining causes of death, was addressed by updated DoD policy guidance in June 2004, as previously discussed.

(U) While it is clear to us that medical personnel had frequent opportunities to observe the circumstances of detainee confinement, it was not possible for us to comprehensively assess when or whether medical personnel reported suspicions of detainee abuse. We were able, however, to obtain useful insights from a systematic review of investigative notes and autopsy results from detainee death cases. We found no cases of detainee death where we suspected direct involvement of medical personnel in detainee abuse. We did identify three individual cases of detainee death that warrant additional focused review of whether medical personnel may have attempted to misrepresent the circumstances of death. Specifically, in two similar cases from Bagram, Afghanistan, military physicians are said to have reported no evidence of trauma, when subsequent autopsies found severe soft tissue injuries to both legs. The third case involves a detainee death during interrogation at Abu Ghraib, in Baghdad, Iraq. Some reports suggest that medical personnel may have attempted to place an IV line after death to create a false appearance that life-saving efforts had been attempted. Finally, we identified several cases where medical personnel witnessed behavior or circumstances that should probably have led them to suspect detainee abuse. We do not know whether they reported those suspicions. In one instance from Iraq, military physicians documented concerns about possible detainee abuse in a Memorandum for the Record dated May 11, 2004 - six months after the detainee's death. Although

existing doctrine of the U.S. Armed Forces requires that all military personnel report suspicions of detainee abuse to their chain of command, our insights, taken together, suggest the need to clarify and reinforce the special responsibilities of medical personnel in preventing and reporting suspected detainee abuse. Further, ongoing CID investigations should address this additional aspect of detainee abuse or detainee death cases.

(U) We were reassured by the credible practices of the Office of the Armed Forces Medical Examiner (OAFME) in determining causes of detainee death, and in the unbiased summary reports from investigators of Army's Criminal Investigative Division (CID). In addition, OAFME and the Army Provost Martial General have collaborated progressively for some time to develop field guidance to ensure OAFME autopsies in cases of detainee death. We anticipate that those efforts will culminate in expanded and clarified medical doctrine regarding procedures in such cases. We have no additional recommendations with regard to detainee cause of death determinations.

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