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(U) AR 15-6 INVESTIGATION

(U) REPORT ON THE FACTS AND CIRCUMSTANCES SURROUNDING

(U) THE 8 SEPTEMBER 2012 DEATH OF DETAINEE

(U) ADNAN FARHAN ABD LATIF

(U) (ISN US9YM-000156DP)

(U) AT JOINT TASK FORCE-GUANTANAMO (JTF-GTMO)

~~(U//FOUO)~~ (b)(6),(b)(7)(C)

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(U) LEGAL ADVISOR

(U) 8 NOVEMBER 2012

CLASSIFICATION DERIVED FROM JTF-GTMO SECURITY CLASSIFICATION GUIDE DATED 5 FEBRUARY 2009

Classified By: (b)(6),(b)(7)(C) **Investigating Officer**
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(U) Executive Summary

1. (~~S~~) This Army Regulation 15-6 Report provides the facts, findings, and recommendations of the United States Southern Command (USSOUTHCOM) investigation into the facts and circumstances surrounding the death of detainee Adnan Farhan Abd Al Latif (ISN156). ISN156, a 31-year old citizen of Yemen, had been a detainee at Joint Task Force–Guantanamo (JTF-GTMO), Naval Station Guantanamo Bay, Cuba since January 2002. ISN156 died 8 September 2012 in his cell at Camp V at JTF-GTMO. This Report makes fifteen findings and offers seventeen recommendations. (b)(1),Sec. 1.4(c)

2. (~~U//FOUO~~) The Armed Forces Medical Examiner (AFME) determined the cause of death of ISN156 to be suicide by overdose of paliperidone (Invega). ISN156 had 24 capsules of Invega, an anti-psychotic drug, in his stomach at the time of death. The toxicology examination revealed the presence of paliperidone (Invega), codeine (Tylenol #3), oxycodone (Percocet), quetiapine (Seroquel), mirtazpine (Remeron), and citalopram (Celexa), morphine (by-product of Tylenol #3), oxymorphone (active ingredient in Percocet), and lorazepam (Ativan) were present in the system of ISN156 at the time of his death. ISN156 also had acute pneumonia.

3. (~~U//FOUO~~) ISN156 had an extensive history of disciplinary and self-harm attempts while detained at JTF-GTMO. Because of his unique issues, guards and medical personnel frequently treated ISN156 differently than other detainees. Many guards and medical personnel indicated that ISN156 was an exceptionally challenging detainee.

4. (~~U//FOUO~~) Guards and medical personnel repeatedly violate various Joint Detention Group (JDG) and Joint Medical Group (JMG) Standard Operating Procedures (SOPs). In some cases, the guards and medical personnel are unfamiliar with the SOPs. In other cases, the guards and medical personnel are familiar with the requirements but for various reasons, fail to follow them.

5. (~~U//FOUO~~) In the case of ISN156, the JDG guard force failed to follow the JDG Line of Sight SOP and the JDG Med Pass SOP, and failed to take remedial measures after ISN156 appeared to be sleeping an unusual length of time. Likewise, the JMG personnel violated the JMG Med Pass SOP.

6. (~~U//FOUO~~) ISN156 hoarded medications and ingested them shortly before he was found unresponsive in his cell. Several factors contributed to the ability of ISN156 to hoard medications. These factors include inconsistent JDG and JMG SOPs with respect to Med Pass, confusion on the part of the guards, corpsmen, leadership (camp, JDG, and JMG) regarding what the SOPs require, and in many cases, failure to comply with Med Pass SOP requirements.

7. (~~U//FOUO~~) JMG training procedures and record keeping were also flawed. This contributed to the Med Pass violations and to confusion of JMG personnel. The JMG commander and JMG senior leadership, including the Senior Nurse Executive, appear largely removed from several

aspects of what is going on at the tactical level at the Behavioral Health Unit / Detainee Hospital (BHU/DH) and the camps.

8. ~~(U//FOUO)~~ Other SOP violations impact the operations of the camps. Generally, the JDG and JMG leadership do not communicate effectively to ensure that their respective detainee operations practices and policies are consistent and synchronized. These commanders must improve communications between their respective units. The JDG and JMG should synchronize their SOPs, train the guard force and medical personnel, and supervise execution of the SOPs.

9. ~~(U//FOUO)~~ JTF-GTMO should establish, with USSOUTHCOM oversight, a rigorous inspection program designed to detect tactical level deficiencies in detainee operations at JTF-GTMO across a broad spectrum of operations, to include medical, legal, intelligence, and security.

10. ~~(U//FOUO)~~ Many of the recommendations in this investigation have been made in previous investigations. Because it appears that JTF-GTMO has not implemented some of the required changes, the JTF-GTMO Commander should provide a detailed implementation plan and timeline with respect to any recommendations connected with this investigation.

(U) List of References and Enclosures

(U) REFERENCES

1. (U) AR 15-6, Procedures for Investigating Officers and Boards of Officers, 2 October 2006

2. (U) Uniform Code of Military Justice

3. (U) AR 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees and other Detainees, 1 October 1997

4. (U) Geneva Convention Relative to the Treatment of Prisoners of War of August 12, 1949 (Geneva Convention III), 12 August 1949

5. (U) DoD Directive 2310.01E, The Department of Defense Detainee Program, 5 September 2006

6. (U) DoD Directive 2310.08E, Medical Program Support for Detainee Operations, USD(P), 6 June 2006

7. (U) AR 3-19.40, Internment / Resettlement Operations, September 2007

8. (U) Army Regulation 15-6 Investigation Guide for Informal Investigations, USSOUTHCOM, May 2010

9. ~~(S//NF)~~ JTF-GTMO Security Classification Guide, 5 February 2009

10. ~~(S//NF)~~ Report on the Facts and Circumstances Surrounding the Death of Detainee Haji Naseem (AKA Anayatullah) (ISN-10028) at Joint Task Force-Guantanamo (JTF-GTMO) on 18 May 2011 (31 July 2011)

11. ~~(S//NF)~~ Report on the Fact and Circumstances Surrounding the Death of Detainee Awal Gul (ISN-782) at Joint Task Force-Guantanamo (JTF-GTMO) on 1 February 2011 (10 March 2011)

ENCLOSURES

I. ~~(U//FOUO)~~ USSOUTHCOM Memorandum of Appointment appointing (b)(6),(b)(7)(C) (b)(6),(b)(7)(C) as Investigating Officer (10 September 2012)

II. ~~(U//FOUO)~~ Email approving appointment (b)(6),(b)(7)(C), (b)(6),(b)(7)(C), and (b)(6),(b)(7)(C) to investigation (15 October 2012)

III. (U) Email approving extension of time through 29 October 2012 (17 October 2012)

IV. ~~(U//FOUO)~~ Email approving request to appoint (b)(6),(b)(7)(C) to investigation (17 October 2012)

V. (U) DA Form 1574 (29 October 2012)

VI. (U) Exhibit List

(U) FACTS

I. (U) Life of ISN156 at JTF-GTMO

A. (U) Personal Background

1. (~~S~~) Adnan Farhan Abd Al Latif (ISN US9YM-000156DP) ("ISN156") was detained at Joint Task Force – Guantanamo (JTF-GTMO) since his arrival on [redacted] January 2002. At the time of his death on 8 September 2012, he was approximately 31 years old.[1] ISN156 was a citizen of Yemen, born in Aluday, Yemen. His native language was Arabic and during his over ten years of detention at JTF-GTMO, ISN156 learned some English. (Exhibit 51) (b)(1),Sec. 1.4(c)

2. (~~U//FOUO~~) ISN156 had an extensive family in Yemen, including a 10-year old son. ISN156 frequently wrote letters to his family, including his grandmother, father, mother, brother, cousin, son and nephew. In 2012, ISN156 sent twenty-two outgoing letters to family members, fourteen of which were to his brother, Muhammad Farhan.[2] Coincidentally, it appears that ISN156's mother also died on 8 September 2012.[3] (Exhibit 59)

B. (~~U//FOUO~~) Communications with Family and Attorneys

3. (~~U//FOUO~~) From 2010 to 2012, ISN156 made 14 video phone calls (VPCs) or telephone calls to his family in Yemen. ISN156 made three calls in 2010, seven calls in 2011, and four calls in 2012. In 2012, ISN156 made calls on 1 February (1-hour VPC), 9 March (1-hour regular call), 21 May (1-hour call[4]), and 11 July (1-hour VPC). (Exhibits 36, 60)[5]

4. (~~U//FOUO~~) ISN156 also frequently communicated with his attorneys regarding his *habeas corpus* proceedings. According to an entry in the Detainee Information Management System

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[1] (~~U//FOUO~~) The precise date of birth of ISN156 is unknown. J2 [redacted] (b)(7)(E) reports indicate a birth date of 1 January 1981, but a recent press release quoting ISN156's lawyer state that his passport and other records indicate that he was 35 or 36 years old. (Exhibit 86)

[2] (~~S//NF~~) [redacted] (b)(1),Sec. 1.4(c)

[3] (~~S~~) [redacted] (b)(1),Sec. 1.4(c)

[4] (~~S//NF~~) [redacted] (b)(1),(b)(3):10 USC 130b,(b)(6),(b)(7)(C),Sec. 1.4(c) (Exhibit 36)

[5] (~~S//NF~~) [redacted] (b)(1),Sec. 1.4(c)

Classified By: [redacted] (b)(6),(b)(7)(C) USA, Investigating Officer
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Declassify On: 10 years after completion of detention operations

(DIMS),[6] around 1430[7] on 7 September 2012 (the day before ISN156 was pronounced dead), ISN156 insisted that a letter be mailed to his attorney.[8] The same DIMS entry also reflects that ISN156 stated that "to die is better than to live" but ISN156 would not specify what he meant by the statement.[9] (Exhibit 63)

5. ~~(U//FOUO)~~ In 2012, ISN156 was to have a total of six scheduled telephone calls or meetings with his attorneys. On 14 June, ISN156 had a call with his attorneys, David Remes and Brian Foster. On 21 May, ISN156 met with his attorneys David Remes and David Kudzin, and on 24 August, ISN156 met with attorney David Remes. The remaining visits with his attorneys were canceled (21 March and 9 May, canceled by attorney; 28 August, canceled due to Hurricane Isaac; 18 September, canceled following ISN156 death). (Exhibit 61)

C. ~~(U//FOUO)~~ Capture

6. ~~(S//NF)~~ (b)(1),(b)(5),Sec. 1.4(c)

(Exhibit 51)

7. ~~(U//FOUO)~~ ISN156 disputed these claims, and asserted that he had left Yemen in August 2001 on what ultimately turned out to be a fruitless quest to receive medical treatment for head

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[6] ~~(U//FOUO)~~ DIMS is the primary tool used to track day-to-day information about detainees, and is made up of electronic entries regarding each detainee.

[7] (U) All times in the report are in local (GTMO) time.

[8] ~~(U//FOUO)~~ The Office of the Staff Judge Advocate (OSJA) for United States Southern Command (USSOUTHCOM) and Joint Task Force – Guantanamo (JTF-GTMO) have asked Naval Criminal Investigative Services (NCIS) and the Department of Defense Office of General Counsel (OGC) whether the letter is covered by the attorney-client privilege. As such, the Investigative Team was not able to obtain a copy of the letter.

[9] ~~(U//FOUO)~~ As discussed later in this report, ISN156 frequently made passive statements about death and dying during his over ten years of detention at GTMO. Although the DIMS report indicates that this conversation took place through (b)(3):10 USC §130b,(b)(6),(b)(7)(C) the DOMEX Cell Block Weekly Schedule reflects that the interpreter on duty that day was [redacted]. On 5 October 2012, an individual from DOMEX clarified in a telephone call with the Investigative Team that the same interpreter alternated using the cell block names of (b)(3):10 USC §130b,(b)(6),(b)(7)(C) Interpreters are sometimes referred to as "linguists" in the sworn statements. On 23 October 2012, during a telephone conversation with the (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated he did not recall the specific conversation. (b)(3):10 USC §130b,(b)(6),(b)(7)(C)

[10] (U) A federal district court judge found the government's report to be unreliable and granted ISN156's petition for a writ of *habeas corpus* on the basis of the confession's unreliability and other factors. The district court's decision was subsequently reversed and remanded. (Exhibit 131)

injuries he suffered in a 1994 car accident.[11] ISN156 claimed that he traveled to Pakistan and then Afghanistan to meet up with a Yemeni who he had met at a charitable organization in Yemen. ISN156 claimed that after waiting in vain for several weeks for the individual, ISN156 then attempted to return to Yemen on his own, fleeing United States-supported forces he had been told were advancing from northern Afghanistan. Pakistani police seized ISN156 near the border of Afghanistan and Pakistan in late 2001, and transferred him to U.S. custody in December 2001. With respect to his alleged confession, ISN156 claimed that his interrogators misunderstood what he asserted, and that their summary bore no relation to what he actually had stated. (Exhibit 131)

8. ~~(S)~~ ISN156 arrived at the detention facilities at Naval Station (NAVSTA) Guantanamo Bay, Cuba (GTMO) on [redacted] January 2002. He was initially housed at Camp X-Ray until Camp Delta opened in June 2002. During his over ten years of detention at JTF-GTMO, ISN156 moved from camp to camp at least 67 times. ISN156 was housed in Camps I, II, III, V, VI, and the Behavioral Health Unit (BHU) and the Detainee Hospital (DH).[12] A breakdown of the last three years is of external camp movements is as follows: 2012 – 12 moves; 2011 – three moves; 2010 – eight moves.[13] (Exhibits 51, 66, 67, 68)

(b)(1),Sec 1.4(c)

D. ~~(U//FOUO)~~ Diagnoses

9. ~~(U//FOUO)~~ Guantanamo Bay Joint Medical Group (JMG) doctors[14] diagnosed ISN156 with Bipolar Disorder and Borderline Personality Disorder with antisocial traits. His most recent episode was characterized as manic with psychotic features, possibly affected by Traumatic Brain Injury (TBI), a cognitive disorder, or personality changes secondary to TBI.[15] Over the course of his detention at JTF-GTMO, ISN156 was an occasional hunger striker. (Exhibits 24, 28)

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[11] ~~(U//FOUO)~~ [redacted] indicated that ISN156 was almost completely blind in his left eye, and the JTF-GTMO optometrist indicated that blindness was consistent with a traumatic injury. [redacted] had recently consulted with the JMG Commander, [redacted] to determine whether the JMG could work with Jordan (where the hospital was that ISN156 claimed treated his head injury) to obtain records of treatment of ISN156 related to the car accident. [redacted] indicated that although the JMG would normally not request such records, she pursued the matter with [redacted] because she felt the records might assist her in treating ISN156. ISN156 died before [redacted] was able to obtain the records. (Exhibit 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b,(b)(6)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[12] ~~(U//FOUO)~~ Camps I, II, III, and IV are no longer used to house detainees.

[13] ~~(U//FOUO)~~ The details surrounding many of these specific moves, including the reasons the moves were made, are set forth later in the report.

[14] ~~(U//FOUO)~~ For security reasons, this report refers to JMG medical personnel and interpreters by their block names. Certain billets at JTF-GTMO, including medical personnel and interpreters, operate under "block names" for force protection. (Exhibits 114, 115)

[15] ~~(U//FOUO)~~ A TBI may lead to brain damage to the frontal lobes (the part of the brain that controls personality), making the individual impulsive and aggressive. A cognitive disorder usually implies problems with basic thinking, memory, and intellectual development (mental retardation or dementia, for example), thereby explaining some of the individual's behavior. The diagnoses of ISN156 evolved over the course of his detention at JTF-GTMO. (Exhibits 24, 128)

10. ~~(U//FOUO)~~ Bipolar Disorder is considered an "Axis I" mood disorder, where the individual's moods swing either high or low. According to the diagnosis, in the case of ISN156, the most recent swing was to the "high" mood (mania) to the point that he lost some touch with reality (psychotic features). (Exhibits 24, 128)

11. ~~(U//FOUO)~~ Borderline Personality Disorder (Borderline PD) is a considered an "Axis II" personality disorder. Axis II disorders are generally characterized by mismatches between the personality (basic way that an individual relates to the world) and society. As such, Axis II disorders are long-lasting and difficult to change. Individuals with Borderline PD generally are unstable in how they view themselves and in their relationships with others. They tend to view people very concretely (all good or all bad) but frequently and impulsively change their assessment (the previously all good person is all bad suddenly, and the previously all bad person is suddenly all good). They are impulsive, like to generate crises, and frequently harm themselves, classically by cutting to "feel something." Individuals with Borderline PD are unstable in their relationships and try to manipulate people into divided groups, or set groups and individuals against each other.[16] (Exhibit 128)

12. ~~(U//FOUO)~~ Antisocial Personality Disorder (Antisocial PD) is another "Axis II" personality disorder. Individuals with Antisocial PD generally show a "pervasive disregard for the rights of others." They tend to be impulsive, aggressive, and reckless. As such, they tend to engage in conduct that society disapproves of, such as promiscuity and criminality. (Exhibit 128)

13. ~~(U//FOUO)~~ In layman's terms, all of these diagnoses translate into an individual that would be unstable in mood, personality and relationships." The diagnoses also mean that the individual would be "very difficult to work or live with" and would be "prone to impulsivity and to harm self or others," generally living life from one crisis to another. (Exhibit 128)

14. ~~(U//FOUO)~~ The Healthcare Ethics Committee at the Naval Medical Center, Portsmouth, Virginia (Healthcare Ethics Committee), assessed the condition of ISN156 as treatable with anti-psychotic medications but not reversible. The Healthcare Ethics Committee also noted ISN156's chronic Impulse Control Disorder, and stated that all of these conditions were associated in ISN156 with acts of self-harm and violent behavior. The Healthcare Ethics Committee noted that due to ISN156's Borderline PD and possible cognitive effects from TBI, ISN156's thought process was often illogical, and he engaged in near daily debates and negotiations with JMG medical staff regarding compliance with oral medications. When not compliant with oral medications, ISN156's condition became "critical and emergent" as evidenced by harmful actions directed at himself and others. (Exhibit 96)

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[16] ~~(U//FOUO)~~ Individuals with Borderline PD were often sexually abused at a young age. Borderline PD is more frequently seen in women than men. (Exhibit 128)

15. ~~(U//FOUO)~~ On 6 August 2012, the JMG Deputy Commander (b)(3):10 USC §130b,(b)(6),(b)(7)(C) asked the Healthcare Ethics Committee for assistance in determining whether it would be ethical to involuntarily administer depot level anti-psychotic medication (monthly doses) to ISN156. At the time, ISN156 was refusing to take his daily administered doses of anti-psychotic medications, which was resulting in behavior harmful to him and others.[17] (Exhibits 24, 96)

16. ~~(U//FOUO)~~ On 31 August 2012, a subcommittee concluded that there existed an ethical basis for the depot level anti-psychotic medication.[18] (Exhibits 24, 96)

17. ~~(U//FOUO)~~ ISN156 had standing weekly appointments (separate appointments, on different days) with the JMG psychiatrist (b)(3):10 USC §130b, (b)(6),(b)(7)(C) and the JMG psychologist (b)(3):10 USC §130b, (b)(6),(b)(7)(C) The appointments lasted approximately 30-45 minutes each. (Exhibits 24, 37)

18. ~~(U//FOUO)~~ The physician for Camps V and VI (b)(3):10 USC §130b, (b)(6),(b)(7)(C) was the primary care provider for ISN156. During ISN156's frequent stays at the BHU/DH, however, (b)(3):10 USC §130b (b)(6),(b)(7)(C) acted as the attending physician to ISN156, with (b)(3):10 USC §130b,(b)(6),(b)(7)(C) available for consult as needed. Over the course of his detention at JTF-GTMO, ISN156 had also been seen by specialists, including a gastroenterologist and an optometrist, routinely brought in to see detainees.[19] (Exhibit 27)

E. ~~(U//FOUO)~~ History of Disciplinary Events and Self-Harm

19. ~~(U//FOUO)~~ ISN156 had a long history of disciplinary and self-harm events while detained at various camps in JTF-GTMO. Those events spanned his over 10 years of detention at JTF-GTMO, with a significant spike in late 2008. Disciplinary events spanning from 2002 to 2012 included, but are not limited to, assaults on the guard force, inappropriate use of bodily fluids, failures to comply, possession of contraband, cross block talking, and writing on cell walls. (Exhibits 51, 52)

20. ~~(U//FOUO)~~ ISN156 self-harm events began in 2003 with two head-banging incidents, followed by three separate wrist-cutting events in 2006, and a spike in 2008 of nineteen self-

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[17] ~~(U//FOUO)~~ The specific behavior by ISN156 is detailed later in the report, and includes ISN156 throwing rocks at a guard tower and guards, (b)(7)(E),(b)(7)(F) and splashing a nurse and guards.

[18] ~~(U//FOUO)~~ The subcommittee was established specifically for the Navy Medicine East ethics concerns and those at JTF-GTMO. The delay between the initial question and the decision by the committee is explained by the fact that the committee asked (b)(3):10 USC §130b, (b)(6),(b)(7)(C) to gather additional data, and the committee chair was on leave at one point. During deliberations, the committee consulted (b)(3):10 USC §130b, (b)(6),(b)(7)(C) the JMG Behavioral Health Services (BHS) OIC and psychiatrist for ISN156. (Exhibit 96)

[19] ~~(U//FOUO)~~ The case of ISN156 was so complex that (b)(3):10 USC §130b, (b)(6),(b)(7)(C) had scheduled a forensic psychiatrist consult. A forensic psychiatrist has expertise with assaultive behavior and regularly works with correctional populations. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that the consult was scheduled for 6-13 October 2012. (Exhibit 24)

harm attempts, involving choking, ingestion of inedible items, hanging, head-banging, and cutting.[20] (Exhibit 51)

21. ~~(U//FOUO)~~ ISN156 frequently made passive statements to (b)(3):10 USC §130b,(b)(6),(b)(7)(C) asking to die, such as "I wish I could die here" and "you could find meds that would kill me." ISN156 would also ask (b)(3):10 USC §130b,(b)(6),(b)(7)(C) to prescribe a "suicide pill" to him so that he could die. [redacted] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that she advised ISN156 that there was no such thing, and reminded him that she was there to help him.[21] (Exhibits 24, 37)

22. ~~(U//FOUO)~~ Analysts noted that while at JTF-GTMO, ISN156 frequently wrote dark poems with suicidal themes, and wrote long letters to Joint Detention Group (JDG) leadership with quality of life complaints. ISN156 watched virtually unlimited television,[22] and periodically moved from communal to single-cell environments to "take a break from the pressures of communal living." Analysts noted that triggers for ISN156 included perceived slights, noise during prayer call, pressures from communal living, and not being allowed to watch enough television. (Exhibit 51)

23. ~~(U//FOUO)~~ Guards noted specific instances of misconduct and aberrant behavior by ISN156 over the course of his detention. One guard noted that ISN156 "had always done weird stuff" and noted that ISN156 frequently (b)(6) (b)(6) ISN156 would also put a sheet around his neck like a cape, run up the wall, and do a backflip off the wall. (Exhibits 6, 14, 29)

24. ~~(U//FOUO)~~ The Camp V Officer in Charge (OIC) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) recounted incidents where ISN156 would (b)(6) She indicated that several guards placed written complaints about the (b)(6) in the complaint box in the Camp V break room. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that she raised the issue with the former battalion commander of the 525th Military Police Battalion at the time. However, no disciplinary action was taken against ISN156 because "he was a special case." According to (b)(3):10 USC §130b, (b)(6),(b)(7)(C), the SOPs were "definitely not consistently followed" with respect to ISN156. (Exhibit 16)

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[20] ~~(U//FOUO)~~ One such instance occurred at Camp V or VI in 2008. An interpreter recalled ISN156 approaching him and saying something like "here, I could eat these pills if I wanted to kill myself" and showing him a fist-full of four or five pills. The interpreter indicated that the guard confiscated the pills from ISN156. The interpreter indicated that he had heard of other instances of detainees (including ISN156) hoarding pills, but the 2008 instance was the only time the interpreter had actually seen a detainee produce the pills. (Exhibit 2)

[21] ~~(U//FOUO)~~ ISN156 appeared to engage fairly well as a patient with [redacted] whereas ISN156 had a more tumultuous relationship with [redacted] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that he often saw ISN156's sense of humor, with ISN156 joking that all he would need to get out of GTMO was a boat and an island, and that he would not even need to go back to Yemen. (Exhibits 24, 37) (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[22] ~~(U//FOUO)~~ As discussed later in the report, ISN156 had (b)(7)(E) (b)(7)(E) allowed him to watch unlimited television. (Exhibit 48-B)

25. ~~(U//FOUO)~~ One guard indicated that he understood the policy requiring line of sight duty to be rotated every [(b)(7)(E)] stemmed from behavior by ISN156 – specifically, that ISN156 would [(b)(6)] and do all sorts of crazy things" and that "they did not want guards to have to watch that for more than [(b)(7)(E)] at a time." Another guard noted that it was "horrible" to have to be on line of sight duty for ISN156 because of these types of actions, many of which ISN156 would do right near the cell window. (Exhibits 6, 14)

26. ~~(U//FOUO)~~ [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] also noted that the "ease by which ISN156 transferred between camps" confused her. She felt that the moves caused stress on the guard force and ISN156. She noted that at one point, other detainees were using ISN156 as a messenger to pass information between blocks and between camps. [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] indicated that she raised the matter with [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] and [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] and did not understand "why ISN156 was not a permanent resident at the BHU." (Exhibit 16)

27. ~~(U//FOUO)~~ Several individuals complained about what they perceived as special treatment for ISN156, noting things such as his unlimited television and recreation time. Some guards expressed that they were concerned about interacting with ISN156 because he was "special" and they were "afraid of getting into trouble." (Exhibits 6, 12, 16, 17, 35)

F. (U) Behavioral Incidents: June 2012

28. ~~(U//FOUO)~~ Multiple sources at JTF-GTMO indicated that ISN156's most recent downward spiral of behavior began in June 2012.[23] It appears that on 14 June 2012, ISN156 learned during a phone call with his attorney (David Remes) of the Supreme Court's denial of review of his *habeas* petition. [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] indicated that after the phone call, ISN156 "came back furious and really started saying crazy stuff." (Exhibits 16, 24, 37, 61)

29. ~~(U//FOUO)~~ After the call with his lawyer, ISN156 was voluntarily admitted to the BHU for approximately one and a half weeks. [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] recalled ISN156 talking about his 10-year old son in Yemen and his hopes to see him again, which she took as a good sign as it demonstrated a future orientation. During this same time, however, [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] also reported that ISN156 engaged in lots of talk regarding death, which for ISN156 was fairly common behavior. (Exhibits 24, 68)

30. ~~(U//FOUO)~~ It appears that during this stay at the BHU, ISN156 began to discuss stopping his hunger strike, indicating that routine foods were making him nauseous and that he had no

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[23] ~~(U//FOUO)~~ [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] referenced July 2012 as the date of the Supreme Court decision and the start of ISN156's downward spiral. She may have been mistaken as the date of the decision denying ISN156's petition for a writ of *certiorari* was 11 June 2012, and the date that ISN156 had the phone call with his attorneys was 14 June 2012. (Exhibit 16)

appetite.[24] (b)(3):10 USC §130b,(b)(6),(b)(7)(C) consulted (b)(3):10 USC §130b,(b)(6),(b)(7)(C) the primary care provider for ISN156, to assist with a gastrointestinal (GI) evaluation.[25] With the encouragement of (b)(3):10 USC §130b, (b)(6),(b)(7)(C) ISN156 began eating solid foods. ISN156 also began to express interest in moving to Camp VI, which (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6) supported because she believed it would provide ISN156 opportunities for socialization.[26] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) saw no issue with moving ISN156 to Camp VI, as he had been at Camp V only because he was an enteral feeder, not because he was there on disciplinary status. (Exhibit 24)

31. ~~(U//FOUO)~~ While at the BHU, ISN156 started requesting to receive his medications in the recreation yard. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) reported that she told ISN156 that the current Standard Operating Procedure (SOP) (b)(7)(E)[27] (Exhibit 24)

32. ~~(U//FOUO)~~ On 25 June 2012, ISN156 was discharged from the BHU to Camp V. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) reported that while at Camp V, (b)(7)(E) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that she felt that ISN156 was attempting to manipulate the system. She noted, for example, that if ISN156 knew his medications pass was scheduled for 0500, he would request to go to the recreation yard at 0445. Nonetheless, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) understood that the guards told ISN156 that he (b)(7)(E)[28] (Exhibits 24, 68)

33. ~~(U//FOUO)~~ When (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) met with ISN156 for his normal post-discharge visit, ISN156 told her that he had learned that she was the one who "personally changed the SOP" and (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) explained to ISN156 that this was not true, and that the policy was long-standing. ISN156 dismissed (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) from the appointment, essentially, as he stated, "firing" her.[29] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) continued to see

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[24] ~~(U//FOUO)~~ The report reflects the dates indicated in the DIMS Detainee Movements Report. Because individual recollections vary, the actual sworn statements sometimes reflect dates distinct from the dates in the DIMS Detainee Movements Report. In her sworn statement (b)(3):10 USC §130b, (b)(6),(b)(7)(C) for example, recalled that ISN156 was admitted to the BHU on 14 June 2012 (consistent with the DIMS Detainee Movements Report) and again approximately a week or two later. That subsequent BHU stay, however, is not reflected in the DIMS Detainee Movements Report. Relying on the veracity of the DIMS Detainee Movements Report rather than the recollection of one individual, the Investigative Team concluded that there was only one BHU stay for ISN156 in June 2012. (Exhibits 24, 68)

[25] ~~(U//FOUO)~~ As noted above, because ISN156 was at the BHU, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) would have been the attending physician for ISN156, with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) available for consult. (Exhibit 27)

[26] ~~(U//FOUO)~~ Camp VI is communal. Detainees at Camp VI live in communal blocks, as opposed to single cells.

[27] ~~(U//FOUO)~~ As discussed later in the report, the (b)(7)(E) (b)(7)(E) (Exhibit 50)

[28] ~~(U//FOUO)~~ As discussed later in the report, not all guards, nurses, and corpsmen understood or were complying with the JMG Medication Administration Policy. The medical records are inconsistent with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) statement. The medical records for ISN156 indicate that (b)(3):10 USC §130b, (b)(6),(b)(7)(C) was authorizing corpsmen to (b)(7)(E) (b)(7)(E) the audiovisual (TV) room around this same time. (Exhibits 9, 21, 34, 35,98)

[29] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that it was not unusual for a patient like ISN156 to dismiss those persons attempting to help him. (Exhibit 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) ISN156 for mental health issues, and [redacted] remained involved for ISN156's GI issues. (Exhibit 24)

34. ~~(U//FOUO)~~ On 5 July 2012, in anticipation of the start of Ramadan, ISN156 moved from Camp V to Camp VI as part of the "Ramadan gift."[30] At the time, ISN156 was housed in a single cell at Camp V [(b)(7)(E)] [(b)(7)(E)].[31] At Camp VI, ISN156 was housed in a communal block with approximately [(b)(7)(E)] other detainees. (Exhibits 24, 68)

35. ~~(U//FOUO)~~ Approximately ten days after arriving at Camp VI, ISN156 began expressing to the JMG psychologist [(b)(3):10 USC §130b,(b)(6)] that he was feeling "overwhelmed" by Camp VI.[32] Around this time, ISN156 stopped taking his medications and began fasting for Ramadan. The JMG psychiatrist [(b)(3):10 USC §130b,(b)(6)] told ISN156 that he was not required to fast because he was sick,[33] and she indicated that JMG professionals were concerned about the effect of fasting on his mental state. (Exhibits 24, 37)

G. (U) Behavioral Incidents: July 2012

36. ~~(U//FOUO)~~ Beginning on 25 July 2012, there were multiple incidents involving ISN156. Major events, highlighted below, include: a rock-throwing incident; [(b)(7)(E),(b)(7)(F)] [(b)(7)(E),(b)(7)(F)] a splashing incident with urine and feces; and a [(b)(7)(E),(b)(7)(F)] (Exhibit 51)

37. ~~(U//FOUO)~~ On 25 July 2012 around 0800, while in the Recreation Yard [(b)(7)(E)] of Camp VI, ISN156 and another detainee [(b)(6),(b)(7)(C)] told the watch commander (WC) that they wanted to speak to him via an Arabic interpreter. The WC told them that they first needed to speak to the Block Non-Commissioned Officer (BNCO), followed by the Assistant Watch Commander (AWC). ISN156 started yelling insults as the WC walked away to continue his inventory.

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[30] ~~(U//FOUO)~~ The JDG Commander grants certain "gifts" (to include absolving detainees from discipline time or moving detainees from camp to camp) as part of Ramadan. Ramadan began 20 July 2012. The DIMS Detainee Movements Report is confusing in that it reflects ISN156 moving from Camp VI to Camp V on 18 July 2012, and back again from Camp V to Camp VI on the same day. (Exhibits 24, 68, 107)

[31] ~~(U//FOUO)~~ There are several reasons, to include medical and disciplinary, that a detainee might be housed at Camp V. (Exhibit 16)

[32] ~~(U//FOUO)~~ [(b)(3):10 USC §130b,(b)(6)] indicated that the "somewhat chaotic" nature of communal living was overwhelming ISN156. (Exhibit 37)

[33] (U) Islam excuses certain individuals, including children, the elderly, the mentally disabled, pregnant women, and travelers, from fasting. (Exhibit 106)

ISN156 then began throwing rocks at the Recreation Yard (b)(7)(E) Tower, damaging the tower spotlight.[34] (Exhibits 53, 58, 100)

38. ~~(U//FOUO)~~ At this point, having heard the radio traffic about the rock-throwing, the WC returned to the recreation yard. As the WC returned, ISN156 began throwing rocks at the WC, hitting him in the left elbow with a rock. ISN156 then walked across the recreation yard and began throwing rocks at the Super Recreation Yard Tower, striking one of the tower windows and a tower guard in the head with a rock. ISN156 also hit a guard standing near the guard tower in the hand with a rock.[35] (Exhibits 53, 58)

39. ~~(U//FOUO)~~ (b)(6),(b)(7)(C) approached ISN156 and tried to calm him down. ISN156 continued throwing rocks, only stopping when the OIC and the Camp VI Response Team approached the Super Recreation Yard. At approximately 0825 hours, the Response Team restrained ISN156 and led him out of the Super Recreation Yard.[36] (Exhibits 53, 58)

40. ~~(U//FOUO)~~ As a result of the rock-throwing incident, ISN156 was given a verbal warning.[37]

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) ---- met with ISN156 at Camp VI after the incident, reminding him that he needed to take his medications and not fasting. (Exhibits 24, 53, 58)

41. ~~(U//FOUO)~~ Later that day, 25 July 2012, ISN156 was transferred to the BHU on line of sight.[38] At the time, ISN156 was on three psychiatric medications: Celexa (anti-depressant); Remeron (anti-depressant); and Zyprexa (anti-psychotic to help control impulsivity). (Exhibits 24, 68)

42. ~~(U//FOUO)~~ At approximately 1740 25 July 2012, while in the BHU Recreation Yard 1, ISN156 (b)(7)(E),(b)(7)(F)[39] ISN156 was able to

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[34] ~~(U//FOUO)~~ There are no photographs reflecting the damage to the tower or tower spotlight from the time of the incident. The Investigative Team requested that photographs be taken as part of the investigation into the death of ISN156.

[35] ~~(U//FOUO)~~ In a telephone conversation with the Investigative team on 24 October 2012, the JDG Joint Operations Center (JOC) OIC (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that medical personnel assessed the guards and released them, as the guards suffered no real physical injuries.

[36] ~~(S)~~ (b)(1),(b)(3):10 USC §130b,(b)(6),Sec. 1.4(c) (Exhibits 12, 37)

[37] ~~(U//FOUO)~~ According to the discipline matrix, the discipline for Damage to Government Property is (b)(7)(E) and for Failure to Follow Camp Rules, (b)(7)(E) The Camp VI OIC recommended a verbal warning and the JDG Commander (COL Bogdan) approved the recommendation on 27 July 2012. (Exhibit 41)

[38] ~~(U//FOUO)~~ As discussed later in the report, line of sight can be direct (person), electronic (camera), or both. (Exhibit 45)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) [39] ~~(U//FOUO)~~ ---- indicated that ISN156 had told the guards that the (b)(7)(E),(b)(7)(F) The Investigative Team requested that photographs be taken as part of the investigation into the death of ISN156. (Exhibits 37, 101)

(b)(7)(E),(b)(7)(F)

(Exhibits 17, 57, 101)

43. ~~(U//FOUO)~~ As a result of the (b)(7)(E),(b)(7)(F) ISN156 was given (b)(7)(E) (b)(7)(E), consistent with the Discipline Matrix for "Altering Cell or Modification of Government Property."[41] (Exhibits 24, 57)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

44. ~~(U//FOUO)~~ Also on 25 July 2012, [redacted] started ISN156 on Remeron, an anti-depressant with side effects of stimulating appetite and causing drowsiness, which [redacted] and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) deemed helpful as ISN156 was trying to eat solid foods and frequently complained of insomnia. (Exhibit 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

45. ~~(U//FOUO)~~ On the night of 31 July 2012, ISN156 was agitated about recent events and was in his cell at the BHU.[42] At one point, ISN156 began jumping around in the cell, from the bed to the sink to the table to the toilet. (b)(3):10 USC §130b, (b)(6),(b)(7)(C), the nurse on duty at the BHU that night, observed ISN156 and asked him to stop what she explained was "very unsafe" behavior. ISN156 would stop once (b)(3):10 USC §130b, (b)(6),(b)(7)(C) spoke to him, but as soon as she left the tier, ISN156 would start jumping again. At one point, ISN156 did fall, but not seriously. (Exhibits 24, 35)

46. ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) was fairly certain that ISN156 had not taken his medications, to include Zyprexa (used to control impulsivity) that day. After the jumping had gone on for some time and because she was very concerned for the safety of ISN156, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) called [redacted] (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

at home to inform her of the situation. [redacted] indicated that she would come in, and suggested that they consider giving the Zyprexa to ISN156 as an injection to prevent an accident that could aggravate ISN156's TBI.[43] (Exhibits 24, 35)

47. ~~(U//FOUO)~~ While (b)(3):10 USC §130b, (b)(6),(b)(7)(C) was discussing the situation with [redacted], ISN156 agreed (b)(3):10 USC §130b, (b)(6),(b)(7)(C) to calm down and indicated that he wanted to go to the Audio-Visual (AV) room.[44] The guards moved ISN156 to the AV room and he agreed to take the injection of Zyprexa. ISN156 then

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[40] ~~(U//FOUO)~~ The issue of passing food at the recreation areas is linked to the issue of detainees feeding the wildlife at GTMO, as detainees at Camp V, Camp VI, the BHU, and the DH encounter wildlife while in the recreation yards. The JDG Wildlife and Pest Control SOP, and instances of the SOP not being enforced, are included later in the report. (b)(7)(E),(b)(7)(F)

(Exhibits 5, 17, 18, 31, 35, 109)

[41] ~~(U//FOUO)~~ The BHU/DH OIC recommended (b)(7)(E) and COL Bogdan approved the recommendation on 26 July 2012. Discipline time is not necessarily served immediately. (Exhibit 57)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[42] [redacted] indicated that ISN156 was upset because he felt that his meals were not arriving on time and that medical staff was not paying sufficient attention to him. (Exhibit 35)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[43] (U) [redacted] explained that once a patient has had one TBI, a second TBI can be more damaging. (Exhibit 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[44] ~~(U//FOUO)~~ As discussed later in the report, ISN156, unlike other detainees, received unlimited television time. [redacted] indicated that television helped to distract ISN156 and "re-focus on other things." (Exhibits 37, 48-B)

refused to sit in the restraint chair, however, and indicated that he would only receive the injection if he could give it to himself. At that point, [redacted] walked in to the AV room. According to [redacted], ISN156 was doing "OK" up until that point, but upon seeing [redacted] ISN156 got very angry with [redacted] for "waking up the doctor." (Exhibits 24, 35)

48. ~~(U//FOUO)~~ [redacted] discussed the unsafe behavior with ISN156 and told him that he would take the medication one way or another, either by injection or by mouth. ISN156 refused both. At that point, [redacted] indicated that she would leave and deal with the situation in the morning. The jumping continued through the night, with [redacted] calling [redacted] to update her periodically. [redacted] told [redacted] to continue monitoring ISN156 closely on line of sight. In the middle of the night, ISN156 went into the recreation yard, and in fact never went to sleep in his cell.[45] (Exhibit 35)

49. ~~(U//FOUO)~~ The next morning, on 1 August 2012 at approximately 0555 hours, ISN156 asked to see [redacted] in BHU Recreation Yard 2, where [redacted] was standing guard on ISN156.[46] The NCOIC for the BHU/DH [redacted] escorted [redacted] down the tier. When they arrived at the Recreation Yard 2, ISN156 was holding a large white Styrofoam cup with a lid in his right hand. Stating something like "I have something for you," ISN156 removed the lid and made three motions with the cup – first throwing the contents of the cup at [redacted] then at [redacted] and then at [redacted] (Exhibits 17, 35)

50. ~~(U//FOUO)~~ The contents were a brown substance with a "pungent smell" and consistency of feces. [redacted] was splashed with the substance on her face, hair, uniform, and boots, and [redacted] and [redacted] on their faces, uniforms and boots. [redacted] informed ISN156 that he would be written up for splashing the staff with feces. (Exhibits 17, 35, 56, 102)[47]

51. ~~(U//FOUO)~~ Although [redacted] stated that it was "still not clear" to her how ISN156 was able to get a cup of feces and urine out to the recreation yard, the [redacted] (b)(7)(E) [redacted] indicated that in [redacted] (b)(7)(E) [redacted] ISN156 took a sheet outside with him to the recreation yard. [redacted] indicated that out of concern that ISN156 would be able to use the sheet to make a noose, she raised the

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[43] ~~(U//FOUO)~~ [redacted] understood that ISN156 had unlimited recreation time, but the [redacted] (b)(7)(E),(b)(7)(F) does not reflect such a provision. (Exhibit 48-B)

[46] ~~(U//FOUO)~~ As noted above, there are no photographs reflecting [redacted] (b)(7)(E),(b)(7)(F) [redacted] The Investigative Team requested that photographs be taken as part of the investigation into the death of ISN156.

[47] ~~(U//FOUO)~~ [redacted] (b)(7)(E),(b)(7)(F) [redacted] (Exhibits 101, 102)

issue with [redacted] indicated that [redacted] dismissed her concerns, stating that if ISN156 tried to make a noose, the guards would stop him. (Exhibits 24, 35, 48-B)

52. ~~(U//FOUO)~~ [redacted] explained that frequently, ISN156 would wrap the sheet over his back and appear to kneel and pray, all the while shielding himself with the sheet. [redacted] explained that sometimes ISN156 would rock under the sheet as though he was meditating. [redacted] stated that she saw ISN156 doing this the morning she and the guards were splashed. [redacted] stated that in retrospect, she believed that ISN156 was in fact defecating and urinating in the cup, which he later used to splash her and the guards. Similarly, [redacted] explained that it was possible for a detainee to walk with a cup of feces and urine, covered, from his cell to the recreation yard. [redacted] also said that it was possible for a detainee to defecate and urinate in a cup in the recreation yard by wrapping himself inside the ISOMATs and shielding himself. (Exhibits 17, 35)

53. ~~(U//FOUO)~~ As a result of the splashing incident, ISN156 received [redacted] consistent with the Discipline Matrix for "Major Assault of Staff or Another Detainee."[48] (Exhibit 56)

H. (U) Behavioral Incidents: August 2012

54. ~~(U//FOUO)~~ Later that same day, uncomfortable with the handling of the jumping incident the night before, [redacted] met with the Senior Medical Officer ([redacted]) and discussed issues regarding guard safety, clarifying that anyone (guard or medical) could call a [redacted]. [redacted] is used to indicate a detainee is committing self-harm in a particular location. (Exhibits 24, 47)

55. ~~(U//FOUO)~~ On 2 August 2012 at approximately 0610 hours, while in BHU Recreation Yard 2, ISN156 told the NCOIC of the BHU/DH ([redacted]), that he wanted to speak to [redacted] and the OIC of the BHU/DH ([redacted]), along with an interpreter. ISN156 told [redacted] that if they did not arrive in the next fifteen minutes, there would be "big problems." ISN156 then started to [redacted][49] (Exhibits 11, 17, 102)

56. ~~(U//FOUO)~~ At that point, [redacted] called for extra personnel to come over from the DH, and instructed them to use interpersonal communication (IPC) skills to try to de-escalate the situation. [redacted] also called the Joint Operations Center (JOC) to advise them of the

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[48] ~~(U//FOUO)~~ The BHU/DH OIC recommended [redacted] and COL Bogdan approved the recommendation.

[49] ~~(U//FOUO)~~ [redacted]

situation, and requested the Quick Reaction Force (QRF). Approximately four to five minutes later, the JOC dispatched the (b)(7)(E) to the BHU. (Exhibits 11, 17)

57. ~~(U//FOUO)~~ During this entire time, the guards continued to talk to ISN156, who eventually (b)(7)(E),(b)(7)(F) By then, according to (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) Also during this time, ISN156 continued threatening the guards with statements such as "you have five more minutes!" in broken English. (Exhibits 11, 17)

58. ~~(U//FOUO)~~ Sometime after 0700, the QRF arrived at the back gate. Upon seeing the QRF, ISN156 got more agitated, threatening that "if those people come in here, there are going to be big problems." ISN156 then stated that he did not have an issue with the guard force and that he just wanted to speak to (b)(3):10 USC §130b,(b)(6),(b)(7)(C) ISN156 stated that if he could talk to (b)(3):10 USC §130b,(b)(6),(b)(7)(C) he would go peaceably back to his cell. (Exhibits 11, 17)

59. ~~(U//FOUO)~~ By that time, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and an interpreter had arrived. (b)(3):10 USC §130b,(b)(6) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) a BHU/DH guard, escorted (b)(3):10 USC §130b,(b)(6) onto the tier, and told her that ISN156 wanted to talk to her. When (b)(3):10 USC §130b,(b)(6),(b)(7)(C) came onto the tier and (b)(7)(E),(b)(7)(F) she stated that she would not go out to talk to ISN156. When she turned around and started walking down the tier and away from ISN156, ISN156 (b)(7)(E),(b)(7)(F) and "just exploded." As ISN156 lunged, the guards closed their shields together, thereby shielding (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) continued walking off the tier. (Exhibits 11, 17, 104)

60. ~~(U//FOUO)~~ At that point, the QRF entered the BHU through the main entrance and approached the recreation yards down the tier.[50] ISN156 had (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) and was swinging wildly, throwing himself at one of the guards (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) ISN156 was able to (b)(7)(E),(b)(7)(F) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) neck, near the base of his head. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) tried to subdue ISN156, but ISN156 attempted to (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) as well. ISN156 hit (b)(3):10 USC §130b,(b)(6),(b)(7)(C) combat patch, but did not penetrate the uniform.[51] ISN156 then (b)(7)(E),(b)(7)(F) and started swinging a metal chair. During this time, a guard (b)(3):10 USC §130b,(b)(6),(b)(7)(C) was spraying ISN156 with Oleoresin Capsicum (OC) spray. ISN156 was able to reach for a mag light in the (b)(7)(E) and throw the light at (b)(3):10 USC §130b,(b)(6),(b)(7)(C). (Exhibits 11, 17)

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[50] ~~(U//FOUO)~~ The QRF initially tried to enter the recreation area (a small, enclosed area that is adjacent to the actual recreation yards) through the exterior gate but could not, as ISN156 (b)(7)(E),(b)(7)(F) (b)(7)(F) barricade himself in. The recollections of (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and (b)(3):10 USC §130b,(b)(6) differed regarding when precisely the QRF arrived down the tier; (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that the QRF was present during the time that ISN156 was lashing out, whereas (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that the QRF did not arrive until after ISN156 had finished lashing out. (Exhibits 11, 17)

[51] ~~(U//FOUO)~~ In a telephone conversation with the Investigative Team on 24 October 2012, the JDG JOC OIC (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that medical personnel assessed the guards and released them, as the guards suffered no real physical injuries.

61. ~~(U//FOUO)~~ ISN156 then (b)(7)(E),(b)(7)(F) and into BHU Recreation Yard 2. The (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(7)(E) then restrained ISN156.[52] Nurse ---- entered BHU Recreation Yard 2 and administered three injections of emergency medications to ISN156, and irrigated ISN156's eye because he had been sprayed by OC spray.[53] ISN156 appeared completely compliant at this point. The (b)(7)(E) then moved ISN156 back to his cell, where he slept for 12 to 14 hours. ISN156 was continued on line of sight observation and psych techs checked on ISN156 frequently throughout the day, common practice after administration of emergency medications.[54] (Exhibits 11, 17, 24)

62. ~~(U//FOUO)~~ As a result of the (b)(7)(E),(b)(7)(F) ISN156 received (b)(7)(E) (b)(7)(E) for "Aggravated Assault on Staff" and (b)(7)(E) for "Major Damage to Property."[55] (Exhibits 54, 55)

63. ~~(U//FOUO)~~ Following the (b)(7)(E),(b)(7)(F), the JDG ordered an After Action Review (AAR). The AAR contained several recommendations, including (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) ensuring that the Cultural Advisor be brought on scene as soon as possible, reinforcing proper use of brevity codes and their meanings (specifically, that at the BHU, the guard force have a lower threshold on calling a (b)(7)(E) because of the heightened risk of self-harm by BHU patients), and enforcing adherence to SOPs. Specifically, "any deviations or changes to the SOP must be included in pass down notes and incorporated during SOP updates." (Exhibit 83)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) 64. ~~(U//FOUO)~~ ---- indicated that her concern was "not so much with the medical response but the guard response." She expressed serious concerns about her ability to conduct medical operations given that it did not appear to her that the guard force had "sufficient ability to control / prevent incidents like this." (b)(3):10 USC §130b,(b)(6),(b)(7)(C) felt that the JDG senior leadership was very supportive of the medical staff during the AAR, and the senior leadership instructed the guard force that

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[52] ~~(U//FOUO)~~ In order for the (b)(7)(E) to enter, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) used (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) (Exhibit 17)

[53] ~~(U//FOUO)~~ Although (b)(3):10 USC §130b (b)(6),(b)(7)(C) referred to the nurse administering four injections, ---- referred to three injections, which was consistent with BHU/DH practice. (Exhibit 24) (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[54] ~~(U//FOUO)~~ The JMG Commander indicated that he did not believe the incident was reported to USSOUTHCOM as the incident was considered a "standard [Force Cell Extraction] FCE." (Exhibit 5)

[55] ~~(U//FOUO)~~ The Discipline Matrix for Aggravated Assault on Staff recommended (b)(7)(E) but the OIC of the BHU/DH recommended (b)(7)(E) for the "Aggravated Assault on Staff" in conjunction with (b)(7)(E) the "Major Damage to Property", consistent with the (b)(7)(E) COL Bogdan approved the recommendations on 3 August 2012. The JDG SOP specified a (b)(7)(E) discipline time for certain offenses, including "Major Assault of Staff" to be served at Camp V, (b)(7)(E) Although not included in his statement, the Camp V AOIC (b)(3):10 USC §130b, (b)(6),(b)(7)(C) ---- indicated during the interview that Camp V Echo Block was closed in late August 2012. (Exhibit 41)

they were authorized to act in a crisis to protect other detainees and staff, without waiting for approval from the JOC. (Exhibit 24)[56]

I. ~~(U//FOUO)~~ August–September 2012

65. ~~(S)~~ After the incident, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) called back to Portsmouth, Virginia to speak with the Psychiatry Specialty Leader for the Navy ((b)(6)). (b)(3):10 USC §130b,(b)(6),(b)(7)(C) discussed with her the possibility of using a depot anti-psychotic medication (a once per month injection, rather than a daily, oral medication) to assist with managing ISN156's impulsivity. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) recalled that (b)(6) supported the depot injection idea. (Exhibit 24)

66. ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6),(b)(7)(C) discussed the issue with ISN156, and he initially agreed to the depot injection. ISN156 also began taking his medications again. On 2 August 2012, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) ordered several months of Invega (anti-psychotic) oral medications, as well as the depot injection.[57] (Exhibits 24, 95)

67. ~~(U//FOUO)~~ Around this time, Ramadan was coming to a close and ISN156 was the only patient left at the BHU. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that ISN156 was having fewer outbursts and incidents, and overall was doing well. ISN156 often complained that loneliness led to his "bad thoughts" and that he did not want to be alone at the BHU. On 9 August 2012, ISN156 was transferred from the BHU to the DH, for increased socialization with other detainees. (Exhibits 24, 68)

68. ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that ISN156 did extremely well at the DH, and was getting a lot of support from other detainees at that point. One day, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that ISN156 seemed "extraordinarily happy" in the recreation yard, singing, dancing and kicking a soccer ball. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) noted that because ISN156 had been diagnosed with bipolar disorder, she talked to him regarding scaling back the Celexa medication, as the risk with anti-depressants is they can make a bipolar patient manic. (Exhibit 24)

69. ~~(U//FOUO)~~ On 21 August 2012, ISN156 started the oral Invega, an anti-psychotic medication. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) intended to increase the Invega and titrate ISN156 off the Zyprexa, his earlier prescribed anti-psychotic medication. (Exhibits 24, 99)

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[56] ~~(U//FOUO)~~ The interpretation of (b)(3):10 USC §130b,(b)(6),(b)(7)(C) differs from that of (b)(3):10 USC §130b, (b)(6),(b)(7)(C) with respect to the incident and the AAR on several points. According to (b)(3):10 USC §130b,(b)(6) what triggered the incident was (b)(3):10 USC §130b, (b)(6),(b)(7)(C) turning her back on ISN156. (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) also indicated that he was instructed to use the minimal amount of force necessary, and that in the past, his guards had been able to de-escalate situations simply by talking to the detainee. (Exhibit 17)

[57] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) explained that normally, before being administered a depot injection, a patient would do an oral trial of medications. According to the date of the invoice and the Healthcare Ethics Committee Memorandum, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) ordered the oral and injectable Invega before the Joint Medical Group Deputy Commander ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) approached the committee regarding the ethics of administering the medication against ISN156's will. (Exhibit 24, 95, 96)

70. ~~(U//FOUO)~~ ISN156 was moved twice in the next week for operational reasons. On 23 August 2012, ISN156 was moved to Camp V (b)(7)(E)[58] On 26 August 2012, ISN156 was moved back from Camp V to the DH, Ward 2, Bed 4 (b)(7)(E) .[59] When (b)(3):10 USC §130b,(b)(6),(b)(7)(C) met with ISN156 (b)(7)(E) , ISN156 informed her that she was a "horrible doctor" and that he felt the medication was not helping him.[60] ISN156 shared a love letter with (b)(3):10 USC §130b,(b)(6),(b)(7)(C) that he had written for one of the guards. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that she informed ISN156 that he knew that kind of relationship was not appropriate and that she would not deliver the letter to the guard. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) also noted that during this period, ISN156 was drafting many dark poems.[61] (Exhibits 24, 68, 105)

71. ~~(U//FOUO)~~ On 31 August 2012, the Medical Ethics Review Committee determined there existed an ethical basis for the JMG to administer the depot level anti-psychotic medication (Invega) to ISN156. (Exhibit 96)

72. ~~(U//FOUO)~~ The days went on fairly unremarkably, and on 5 September 2012, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that ISN156 seemed "much improved" on his daily oral medications, and appeared to be suffering no side effects from the oral Invega. The plan was to transition ISN156 to the depot injection. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that ISN156 said that he had written a letter to his lawyer asking whether he thought that ISN156 should take the injection.[62] (Exhibit 24)

J. ~~(U//FOUO)~~ Events of 6 September 2012

73. ~~(U//FOUO)~~ On 6 September 2012, the Senior Medical Officer (SMO) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) talked to COL Bogdan, the JDG Commander, about moving ISN156 back to Camp V Delta (communal) block.[63] They agreed that ISN156 would move on 10 or 11 September 2012. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) discussed the matter with ISN156, who seemed happy about the plan and even asked which detainees were at Camp V Delta. (Exhibit 24)

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[58] ~~(U//FOUO)~~ (b)(7)(E)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) [57] ~~(U//FOUO)~~ [redacted] indicated that she advocated leaving ISN156 at Camp V, but was told that all detainees would be returned to their (b)(7)(E) . (Exhibit 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) [60] ~~(U//FOUO)~~ [redacted] did not indicate what medication she understood ISN156 was referencing. (Exhibit 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) [61] ~~(U//FOUO)~~ [redacted] indicated that ISN156 had been drafting poetry in one form or another since his arrival at JTF-GTMO in 2002. (Exhibit 24)

[62] ~~(U//FOUO)~~ From the dates in DIMS, it appears that this may have been the letter ISN156 attempted to send to his attorney on 7 September 2012. Because NCIS and OGC have not yet determined whether the letter is covered by the attorney-client privilege, as discussed above, the Investigative Team has not reviewed it. (Exhibit 63)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C) [63] ~~(U//FOUO)~~ [redacted] had talked to ISN156 earlier about leaving the DH. Both (b)(3):10 USC §130b,(b)(6),(b)(7)(C) were concerned that Camp VI, which is entirely communal, would be too much stimulation for ISN156. ISN156 reluctantly agreed, and appeared open to the idea of moving to Camp V Delta (communal) block. (Exhibit 24)

74. ~~(U//FOUO)~~ Later that same day, on 6 September 2012, however, ISN156 began spontaneously yelling and kicking, and threw his portable urinal, thereby splashing a guard.[64] Another detainee, (b)(6) attempted to intervene and asked (b)(3):10 USC §130b,(b)(6),(b)(7)(C) not to request discipline for ISN156's infraction. (b)(6) offered to talk to ISN156 about not splashing. ISN156 took his night dose of Remeron (anti-depressant) that night. (Exhibits 24, 28)

75. ~~(U//FOUO)~~ About 2200 that night, ISN156 was demanding his urinal back, and sprayed several guards with urine from flip-top water bottles. He threatened that if he did not get his urinal back, he would keep splashing. ISN156 also defecated on a paper towel and threatened to throw feces unless he was able to speak to a linguist. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that she viewed this as a "guard management issue" and not a medical issue. ISN156 finally quieted down around 0400, the morning of 7 September 2012. (Exhibit 24)

K. ~~(U//FOUO)~~ Events of 7 September 2012

76. ~~(U//FOUO)~~ That morning, ISN156 refused his morning dose of Invega.[65] Also that morning, ISN156 handed a note to the Watch Commander, telling him to give the note to the JDG Commander COL Bogdan. In the note, ISN156 claimed that (b)(3):10 USC §130b,(b)(6),(b)(7)(C) was "rushing him towards death" and that she was the "cause of the problems in the detainee hospital."[66] (Exhibit 63)

77. ~~(U//FOUO)~~ Sometime around 1100 or 1130, the Psychiatric Mental Health Nurse [redacted] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) met with ISN156 to talk with him regarding why he had not taken his morning dose of Invega. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) again offered ISN156 the Invega capsules, and this time, he accepted them. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that she watched ISN156 take the capsules, put them in his mouth, drink water, and swallow them.[67] (Exhibit 28)

78. ~~(U//FOUO)~~ Later that morning, on 7 September 2012, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) asked the Senior Medical Officer ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) whether there was a medical or psychiatric reason that ISN156 could not serve his discipline time. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated to (b)(3):10 USC §130b, (b)(6),(b)(7)(C) that she viewed ISN156's recent behavior as willful, and that there was no medical or psychiatric reason that ISN156 could not serve his discipline time. COL Bogdan indicated that based on that, he

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[64] ~~(U//FOUO)~~ It was not clear to [redacted] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) whether ISN156 intended to splash the guard, or whether he just meant to throw his portable urinal. (Exhibit 24)

[65] ~~(U//FOUO)~~ The morning dose for ISN156 was 9 mg, which was in two capsules – one 6 mg and one 3 mg. (Exhibit 28)

[66] ~~(U//FOUO)~~ The Investigative Team did not see the actual note but rather relied on a summary reflected in the DIMS Report for 7 September 2012. (Exhibit 63)

[67] ~~(U//FOUO)~~ As discussed further in the report, there are specific SOPs governing medication administration. (Exhibits 46, 50)

decided to send ISN156 to Camp V for discipline.[68] The plan was to transfer ISN156 around 1500. However, based on ISN156's erratic behavior the previous day, medical personnel and guards were concerned about telling ISN156 about his pending transfer. They therefore decided to wait until just before 1500 to notify ISN156 of the transfer. Medical personnel and guards kept the movement team off the tier so as not to alert other detainees of ISN156's pending transfer. (Exhibits 5, 28)

79. ~~(U//FOUO)~~ Around 1345 – 1430 that same day, [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] was still trying to convince ISN156 to take the depot injection of Invega. Around 1605, [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] the Watch Commander ([(b)(3):10 USC §130b,(b)(6),(b)(7)(C)]) and an interpreter approached ISN156 and told him he would be transferring to Camp V. At first, ISN156 appeared calm, and [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] told ISN156 that [(b)(6),(b)(7)(C)] had agreed to accompany ISN156 to Camp V.[69] According to [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] that is when ISN156 became more agitated, saying that it was prayer time, and that he would go after prayer. (Exhibit 28)

80. ~~(U//FOUO)~~ After prayer call around 1623, ISN156 became increasingly agitated and repeatedly asked for another 30 minutes to pack his things. The guards and the medical team told ISN156 that he would not receive additional time and that he needed to pack his things and be ready to move. At that point, ISN156 began ripping the magazine photos from his wall and threw a shoe and remote control out of the cell bean hole. Throughout all of this, [(b)(6),(b)(7)(C)] was trying to calm ISN156. (Exhibit 28)

81. ~~(U//FOUO)~~ ISN156 and [(b)(6),(b)(7)(C)] wanted to know what specific tier they were going to at Camp V. Camp V control indicated to [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] that they did not have that information, but that ISN156 and [(b)(6),(b)(7)(C)] would be kept together.[70] (Exhibit 28)

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[68] ~~(U//FOUO)~~ Several of the cells at Camp V are designed for single cell detention, distinct from the communal cells on Camp V Delta (communal) block, where it was originally envisioned ISN156 would be transferred. The single cells are used to house detainees on discipline who meet certain criteria of the detainee disciplinary matrix. (Exhibit 41)

[69] ~~(U//FOUO)~~ [(b)(6),(b)(7)(C)] had been accompanying ISN156 through the camps in recent moves. He was considered a close friend of ISN156 and one of the few people who could calm him. (Exhibit 24)

[70] ~~(U//FOUO)~~ Camp V houses several categories of detainees on its five blocks. One block is for communal, compliant detainees. Another block contains convicted detainees, and another block is used for single cell detention for those detainees in a disciplinary status. There was considerable discussion regarding where ISN156 would be housed at Camp V. [redacted] indicated, for example, that ISN156 had "a lot of bad memories" of Alpha Block – events that occurred during earlier rotations including splashing, self-harm, and Forced Cell Extractions (FCEs). Accordingly, [redacted] recommended against housing [(b)(6),(b)(7)(C)] in Alpha Block. However, because there were issues involving another detainee in Camp V ([(b)(6),(b)(7)(C)], who in the past had encouraged detainees to commit suicide) on Charlie Block, [redacted] discussed the matter with [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)]. They agreed to allow the guard force to determine the best location for ISN156. The guards placed ISN156 on Camp V Alpha Block, with [redacted] diagonally across from him. [(b)(6),(b)(7)(C)] was directly across from ISN156. Because of the way the cell doors and glass are positioned, both [(b)(6),(b)(7)(C)] and [(b)(6),(b)(7)(C)] could see into parts of ISN156's cell. (Exhibits 15, 37, 123)

82. ~~(U//FOUO)~~ Around 1650, ISN156 looked at [redacted] and said something along the lines of "when I die, it will be on you" and "you know that you have killed me sending me [to Camp V]." [redacted] interpreted these as very passive threats, but asked ISN156 if he had a specific plan. [redacted] intervened at that point, and indicated to [redacted] that he would "handle" the matter. (Exhibit 28)

83. ~~(U//FOUO)~~ ISN156 spent a few more minutes gathering his things, and the movement team then took ISN156 in the transport van to Camp V. Approximately five minutes later, a separate movement team followed with [redacted] (Exhibit 28)

84. ~~(U//FOUO)~~ That afternoon, [redacted] talked with the Officer-in-Charge (OIC) of Camp V, [redacted] recommended that ISN156 be put on line of sight, and she and [redacted] determined that ISN156 [redacted][71] (Exhibit 24)

85. ~~(U//FOUO)~~ [redacted] recalled that earlier in the day, around 1400, a [redacted] analyst from the [redacted] arrived with a Force Protection Report indicating that [redacted] was saying that ISN156 was suicidal and was going to kill himself. [redacted] recalled asking the analyst whether he knew what method ISN156 intended to use to kill himself. The analyst indicated that he did not know, and followed up the exchange with an email.[72] (Exhibits 16, 123)

86. ~~(S)~~ The JTF-GTMO Cultural Advisor ([redacted]) also received the same Force Protection Report, in a high priority email at 1430 on 7 September 2012.[73] [redacted] forwarded the email to COL Bogdan, [redacted] (the Deputy JDG Commander), and others in a high priority email, adding that "pushing 156 to the corner never works to our advantage." COL Bogdan indicated he was not aware of the email until sometime the following day, Saturday.[74] (Exhibits 5, 12A)

87. ~~(U//FOUO)~~ Upon arriving at Camp V, ISN156 was placed in cell A105 (cell 105 on Alpha Block lower) with [redacted] in A107, diagonal from him. By 1800, ISN156 had flooded his cell

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[71] ~~(U//FOUO)~~ [redacted] recalled that [redacted] asked whether because of resource issues, electronic line of sight observation of ISN156 would be sufficient. [redacted] recalled telling [redacted] that she recommended ISN156 be placed on direct (physical) line of sight. The recollection of [redacted] differs from that of [redacted] with respect to line of sight. [redacted] recalled being very concerned about having ISN156 back at Camp V, and ordering that ISN156 be on direct and electronic line of sight. (Exhibits 16, 24)

[72] It was in response to this information that [redacted] recalled ordering ISN156 on direct and electronic sight. (Exhibit 16)

[73] ~~(S)~~ [redacted] (Exhibit 12-A)

[74] ~~(U//FOUO)~~ COL Bogdan indicated that his decision to send ISN156 to Camp V on discipline would have stood even if he had seen the email on Friday, as he knew ISN156 to make melodramatic statements. (Exhibit 5)

and was banging on his cell door, generally "causing a racket" on the tier. Based on ISN156's behavior at the BHU, he had a splashbox on his cell at Camp V.[75] (Exhibits 20, 103, 123)

88. (~~U//FOUO~~) The AOIC at Camp V ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) talked to ISN156 and tried to convince him to settle down.[76] ISN156 gave (b)(3):10 USC §130b,(b)(6),(b)(7)(C) a speech about respect, saying that he did not like to be pressured. ISN156 also said something like "I am a sick man and because of that, I am not afraid to die." (b)(3):10 USC §130b,(b)(6),(b)(7)(C) recalled that ISN156 insisted that his personal belongings be returned to him. (Exhibit 20)

89. (~~U//FOUO~~) Understanding that ISN156 was "banging and yelling" because he wanted his belongings, the block non-commissioned officer (BNCO), (b)(3):10 USC §130b,(b)(6),(b)(7)(C), searched them. After removing the items that ISN156 was not allowed because he was on discipline, including extra towels and T-shirts, the guards gave ISN156 his belongings, including a foam pillow and linens.[77] ISN156 indicated that he did not want his mattress. (Exhibit 19)

90. (~~U//FOUO~~) At the time, there were (b)(7)(E) guards ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) posted on direct (b)(7)(E) line of sight for ISN156 for the night shift on Alpha Block (Lower).[78] At the start of their shift, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) agreed to rotate line of sight duty (b)(7)(E) and that if either guard "got sleepy" he would ask the other guard to take over. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) informed (b)(3):10 USC §130b,(b)(6),(b)(7)(C) of their intent.[79] (Exhibits 1, 6, 19)

91. (~~U//FOUO~~) Around 1830, at the request of ISN156, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) gave ISN156 cereal, apple juice, and milk. Around 1920, ISN156 "mash[ed] up the cereal" using the milk and apple juice, jumped from the sink and smeared his (b)(7)(E) with the food mixture. (Exhibit 1)

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[75] (~~U//FOUO~~) Only certain cells at Camp V have splashboxes, which are employed to minimize the risk that a detainee is able to "splash" guards with feces, urine, or other materials.

[76] (~~U//FOUO~~) ISN156 told (b)(3):10 USC §130b,(b)(6),(b)(7)(C) that it would be a sign of respect to talk to him without the splashbox. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) reluctantly agreed. (Exhibit 20)

[77] (~~U~~) Detainees in a disciplinary status are given only basic issue items; comfort items are removed pending the completion of their disciplinary time. (Exhibit 41)

[78] (~~C~~) (b)(1),Sec. 1.4(a),Sec. 1.4(c)

[79] (~~U//FOUO~~) As discussed later in the report, there are specific SOPs that govern line of sight procedures. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that he knew that the SOP required guards to rotate out every (b)(7)(E) but that he and PFC (b)(3):10 USC §130b,(b)(6),(b)(7)(C) decided to rotate out (b)(7)(E). For his part, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that he knew that the SOP required guards to rotate out every (b)(7)(E)." Although (b)(3):10 USC §130b,(b)(6),(b)(7)(C) all recall that (b)(3):10 USC §130b,(b)(6),(b)(7)(C) were rotating line of sight approximately (b)(7)(E), (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated he received permission from (b)(3):10 USC §130b,(b)(6),(b)(7)(C) to stay off the tier for "at most (b)(7)(E)" to complete administrative duties, including filling out counseling statements. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that at one point, he pulled line of sight duty on ISN156 for approximately (b)(7)(E) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that 7 September 2012 was the first time he had ever been in charge of or done line of sight. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that he allowed (b)(3):10 USC §130b,(b)(6),(b)(7)(C) to rotate every (b)(7)(E) because he thought it would be "easier on the Soldiers" to have (b)(7)(E) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that the day after ISN156 died, 9 September 2012, he was told that the SOP says that guards are supposed to rotate out every (b)(7)(E). The AOIC on duty the night of 7 September 2012 ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) indicated that "guards usually rotate every (b)(7)(E) when pulling line of sight duty" and stated that he did not think the SOP required anything specific about rotation times. (Exhibits 1, 1-A, 6, 6-A, 19, 19-A, 20, 45)

92. (~~U//FOUO~~) Around 2200, ISN156 was still jumping around, now with a towel tied around his neck that he was using as a cape and smearing honey on his face. At some point, the night corpsman, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) came to deliver ISN156 his prescribed medications. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) recalled (b)(3):10 USC §130b,(b)(6),(b)(7)(C) leaving the medications in the splashbox, but did not recall ISN156 taking the medications that night.[80] (Exhibits 6, 9-A)

L. (~~U//FOUO~~) Events of 8 September 2012

93. (~~U//FOUO~~) Sometime shortly before midnight, ISN156 finally appeared to go to sleep.[81] (b)(3):10 USC §130b,(b)(6),(b)(7)(C) did not recall seeing ISN156 "lift his head or move all night" but did recall seeing ISN156 breathing. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that in his experience, it was "odd" that ISN156 would have slept that long, as he was usually a very active sleeper. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that he had "never seen [ISN156] sleep that much," pointing out that ISN156 usually slept for only a few hours at a time, and even then, continued to move all over his cell in his sleep. (Exhibits 1, 6, 6-A)

94. (~~U//FOUO~~) At 0455 the morning of 8 September 2012, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) was on line of sight during the call to prayer. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) recalled banging on the door at that point, along with HN (b)(3):10 USC §130b,(b)(6),(b)(7)(C) who had come back with another round of medications, to wake up ISN156. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that other detainees were calling ISN156's name to wake him up for prayer, as they were angry that ISN156 was missing prayer call.[82] At some point, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) mentioned to (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) that ISN156 had been sleeping for "quite a while." (Exhibits 1, 6)

95. (~~U//FOUO~~) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated they did not see ISN156 ingest any pills. They also indicated that they did not leave their duty, and did not look away from ISN156 for more than two to five seconds while they were on line of sight duty. (Exhibits 1-A, 6-A)

96. (~~U//FOUO~~) Around 0600 8 September 2012, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) took over line of sight duty on ISN156 from (b)(3):10 USC §130b,(b)(6),(b)(7)(C). (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that

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[80] (~~U//FOUO~~) As discussed later in the report, there is a JMG SOP governing medication administration. As explained by several guards and corpsmen, when a detainee was asleep and had a splashbox on his cell, (b)(7)(E) (b)(7)(E) When the detainee awoke, the guard was to alert the corpsman. (b)(3):10 USC §130b,(b)(6),(b)(7)(C),(b)(7)(E),(b)(7)(F) (Exhibits 1-A, 6, 9, 10, 23, 25-A, 50)

[81] (~~U//FOUO~~) Although he was authorized two hours at the recreation yard per day while on discipline, ISN156 did not go to the recreation yard that night. (Exhibit 20)

[82] (~~U//FOUO~~) Although the calendar dictates the specific prayer time, detainees at JTF-GTMO detention facilities customarily initiate the call to prayer on their own.

when the shift changed over at (b)(7)(E) ISN156 was still asleep, "vigorously snoring." (b)(3):10 USC §130b, (b)(6),(b)(7)(C) took over from (b)(3):10 USC §130b, (b)(6),(b)(7)(C) as the NCOIC for Alpha Block (Lower). (b)(3):10 USC §130b, (b)(6),(b)(7)(C) recalled the Watch Commander, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) briefing at guard mount that ISN156 had come back to Camp V during the night and that the guards needed to "all stay on [their] toes."[83] (Exhibits 1, 8, 25-A)

97. (~~U//FOUO~~) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) was on his first day of guard duty when he showed up for the morning shift on 8 September 2012. He had just recently arrived at JTF-GTMO on 7 August 2012, and had been settling in after completing his pre-service training on 30 August 2012. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that he never received any instruction concerning line of sight rotation times the morning of 8 September 2012.[84] (Exhibits 10, 10-A)

98. (~~U//FOUO~~) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) took the (b)(7)(E) of line of sight duty on ISN156, from approximately (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that he was told that he and (b)(3):10 USC §130b, (b)(6),(b)(7)(C) would rotate (b)(7)(E) line of sight. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) the BNCO, was aware that (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) were going to rotate line of sight duty (b)(7)(E)[85] (Exhibits 10, 25, 25-A)

99. (~~U//FOUO~~) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) noted that when he took over line of sight duty at (b)(7)(E), he saw two small paper cups, one filled with a cream, in ISN156's splashbox. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) noted that at the time, ISN156 appeared to be asleep on his back, rolling from side to side, "dreaming and mumbling."[86] (Exhibit 8)

100. (~~U//FOUO~~) Around (b)(7)(E), (b)(3):10 USC §130b, (b)(6),(b)(7)(C) took over, and indicated that ISN156 still appeared to be sleeping and mumbling, as though he was dreaming. The two cups were still in the

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[83] (~~U//FOUO~~) At guard mount, the Watch Commander briefs the incoming shift regarding significant detainee updates from the previous night. Guard mount takes place outside the camp, in formation, approximately one-half hour before the shift change. (Exhibit 8)

[84] (~~U//FOUO~~) Pre-service training records do not reflect a specific block of instruction for line of sight. (See JDG POD / BLOCK GUARD Job Qualification Requirement for (b)(3):10 USC §130b, (b)(6),(b)(7)(C) 31 August 2012.) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated, however, that at the training, (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) stated that he was not told anything about line of sight rotation times at the pre-service training (b)(3):10 USC §130b, (b)(6),(b)(7)(C) stated that at the training, parts of the SOPs were read to the guards, but the guards never saw actual copies of the SOPs. As discussed later in the report, there are specific SOPs that govern requirements for line of sight duty, including rotation times. (Exhibits 10, 45)

[85] (~~U//FOUO~~) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that he knew that the SOP required guards to rotate line of sight duty every (b)(7)(E) minutes, but that he generally allowed Soldiers on duty to decide how long they wanted to rotate line of sight. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C),(b)(7)(E) indicated that the day after ISN156 died, 9 September 2012, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) put out information at guard mount that line of sight would be rotated every -- minutes from then on. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that although he knew the SOP required guards to rotate line of sight every -- minutes, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) told him to switch out with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) whenever they needed to. (Exhibits 8, 25)

[86] (~~U//FOUO~~) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) could not recall at what time he last saw ISN156 breathe, but recalled that it was right before he switched duty with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (Exhibit 8)

splashbox. [redacted] understood that if ISN156 awoke, he was to alert [redacted], the corpsman. (Exhibit 10)

101. ~~(U//FOUO)~~ Around 0800, [redacted] arrived for the morning med pass for ISN156, but ISN156 appeared to be asleep all morning. [redacted] brought a suppository and Colace that helps with bowel movements. At that time, [redacted] noted that there were two pill cups – one with a cream and one with a pill – already in the splashbox.[87] [redacted] did not leave the 0800 medications for ISN156 in the splashbox, as there were already other medications there. [redacted] indicated that as a matter of practice, he never leaves medications in a detainee's splashbox. (Exhibits 10, 23)

102. ~~(U//FOUO)~~ ISN156 did not wake up for his recreation time scheduled for 1000-1200. The Watch Commander, [redacted] recalled that the last time he saw ISN156 alive was around 1100. At that time, he checked on ISN156 to see whether he wanted to go to recreation, but because ISN156 appeared to be asleep, he did not disturb ISN156.[88] (Exhibit 15, 25-A)

103. ~~(U//FOUO)~~ ISN156 did not wake up for the noon prayer call.[89] [redacted] recalled checking on ISN156 around 1245, and indicated that ISN156 was "definitely still breathing at that point." [redacted] recalled mentioning to the guard on line of sight (he did not remember whether it was [redacted] at the time) that the breathing of ISN156 looked "rapid or labored." (Exhibits 10, 23)

104. [redacted] indicated they did not see ISN156 ingest any pills. They also indicated they never left their duty, and did not look away from ISN156 for more than 30 to 60 seconds while they were on line of sight duty. [redacted] stated, however, that he was not looking at ISN156's breathing pattern and was focused on verifying that ISN156 was not trying to hurt himself. (Exhibits 8-A, 10-A, 23-A, 25-A)

105. ~~(U//FOUO)~~ Around 1400, [redacted] was on line of sight duty, preparing for [redacted] to take over. [redacted] indicated that he had not seen ISN156 snore or mumble for a while, and therefore called over [redacted] who was doing a tier check at the time. [redacted] tapped on the glass of ISN156's cell, and when ISN156 did not respond, [redacted] called [redacted] over to the cell. [redacted] recalled that [redacted] believed ISN156 was still

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[87] ~~(U//FOUO)~~ [redacted] stated that the cups may have been stacked two high, for a total of four pill cups, but he was not certain. Photographs taken following the incident indicate a total of four pill cups in the splashbox. (Exhibits 23, 129)

[88] ~~(U//FOUO)~~ [redacted] indicated that guards frequently discuss whether to wake a detainee for recreation time. [redacted] explained that because ISN156 was so unpredictable, he decided to allow ISN156 to continue to sleep, and planned to give him recreation time later. (Exhibit 15)

[89] ~~(U//FOUO)~~ There are no DIMS entries during this period of time. As discussed later in the report, there is a specific SOP that governs entry of information into DIMS during line of sight duty. (Exhibit 45, 56)

breathing at that point, because ISN156's blanket had moved. To be sure, however, they called (b)(3):10 USC §130b, (b)(6),(b)(7)(C), who arrived at Camp V 20 to 30 seconds later. (Exhibits 8, 10)

106. ~~(U//FOUO)~~ At the same time, the Watch Commander, (b)(3):10 USC §130b, (b)(6),(b)(7)(C), was on the tier talking to another detainee. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) called (b)(3):10 USC §130b, (b)(6),(b)(7)(C) over. Around 1400, (b)(3):10 USC §130b,(b)(6),(b)(7)(C), (b)(3):10 USC §130b,(b)(6),(b)(7)(C) knocked on the glass of ISN156's cell, and when he did not receive a response, called a Code Yellow.[90] (Exhibits 10, 15)

107. ~~(U//FOUO)~~ Several Camp V guards, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) ("the guard team") responded to the Code Yellow.[91] Once members of the guard team donned their protective gear,[92] they stacked up on the cell door of ISN156 and waited for the other NCOs to arrive. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) called for the door to be opened, central control released the cell door lock, and (b)(3):10 USC §130b, (b)(6),(b)(7)(C) pushed the door open, with the guard team rushing in. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that when the guard team entered, ISN156 was lying on his right side with his head on a foam pillow, a blanket covering him, and his right arm extended. (Exhibit 3)

108. ~~(U//FOUO)~~ As (b)(3):10 USC §130b, (b)(6),(b)(7)(C) secured ISN156's head, she saw "chunky vomit" and when she turned ISN156's head to the side, she stated that a large quantity of "yellowish bloody goo" drained out of ISN156's mouth.[93] By this time, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) had secured ISN156's hands with restraints as a safety precaution. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) the corpsman, arrived, took ISN156's pulse, and indicated that there was no pulse.[94] (b)(3):10 USC §130b,(b)(6),(b)(7)(C) told the Watch Commander he thought ISN156 was dead and to call the nurse.[95] (Exhibits 3, 23)

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[90] ~~(U//FOUO)~~ A Code Yellow is used to indicate a potentially life-threatening medical condition requiring an immediate response. The Camp V OIC (b)(3):10 USC §130b,(b)(6),(b)(7)(C), indicated that she receives approximately five to seven Code Yellows per week. As discussed later in the report, there is a JDG SOP governing brevity codes. (Exhibits 16, 47)

[91] ~~(U//FOUO)~~ ---- was (b)(7)(E) (the equivalent of the Assistant Watch Commander (AWC)) at Camp V that day. (b)(3):10 USC §130b,(b)(6) was assigned to Delta Block, (b)(3):10 USC §130b,(b)(6) was already on Alpha Block (Lower) as the NCOIC, and (b)(3):10 USC §130b, (b)(6),(b)(7)(C) was assigned as the Recreation Yard 1 NCO. (Exhibits 3, 25, 26, 34)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[92] ~~(U//FOUO)~~ The protective gear included a neck protector, face shield, and gloves. (Exhibit 3)

[93] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) description is similar to that of (b)(3):10 USC §130b, (b)(6),(b)(7)(C) who inidicated that when they rolled ISN156, a large amount of "red fluid and water" (enough to fill a 750 ml bottle of water) flowed out. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) recalled similarly, noting that he saw vomit on ISN156's right arm when he entered the cell. (Exhibits 25, 34)

[94] ~~(U//FOUO)~~ An After Action Report (AAR) determined that although a Code Yellow was appropriately called by the guard force initially, the situation should have been upgraded to a (b)(7)(E) immediately upon verification that ISN156 had no pulse or respirations. A (b)(7)(E) would have "appropriately precipitated the recall of emergency medical support and triggered notification of the duty provider for potential [Advanced Cardiac Life Support] ACLS response." (Exhibit 85)

[95] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) recalled that when he arrived in the cell, ISN156 was still warm ("not cold yet") and had a "yellow, sweaty look." When he bent down to see if he could hear breaths or see chest movement, ---- noted that he saw and smelled vomit, which looked to him like mashed up cornflakes and milk. (Exhibit 23)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

109. ~~(U//FOUO)~~ Using the keys she had on her belt as (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) removed the restraints on ISN156 to begin chest compressions, and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) began rescue breaths.[96] With (b)(3):10 USC §130b, (b)(6),(b)(7)(C) performing rescue breaths, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) continued with the chest compressions, alternating approximately every four minutes. (Exhibits 3, 23, 26)

110. ~~(U//FOUO)~~ A few minutes later, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) arrived from Camp VI and took over rescue breaths from (b)(3):10 USC §130b,(b)(6),(b)(7)(C), in order for (b)(3):10 USC §130b,(b)(6),(b)(7)(C) to get the crash cart. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) upgraded the situation to a (b)(7)(E) as ISN156 was in cardiac arrest. (b)(3):10 USC §130b,(b)(6), (b)(7)(C) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) paused the chest compressions for (b)(3):10 USC §130b, (b)(6),(b)(7)(C) to attach the defibrillator pads to ISN156. Upon a reading of "shock not advised," (b)(3):10 USC §130b,(b)(6),(b)(7)(C) continued alternating chest compressions for approximately 18 to 20 minutes. (Exhibits 3, 23, 33)

111. ~~(U//FOUO)~~ Other guards passed a backboard into the cell, and the guard team secured ISN156 to the backboard, carried him out, and loaded him into the ambulance. By this time, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) another nurse from Camp VI, had arrived. She got into the back of the ambulance, performing chest compressions on ISN156. Also in the ambulance were (b)(3):10 USC §130b,(b)(6) (b)(3):10 USC §130b,(b)(6), (b)(7)(C) (driving)[97], (b)(3):10 USC §130b, (b)(6),(b)(7)(C), and (b)(7)(E) Camp V guards. The ambulance left the Sally Port of Camp V around 1426, and arrived at the BHU/DH a few minutes later. (Exhibits 3, 13, 23, 29, 30)

112. ~~(U//FOUO)~~ Once at the DH, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) got out of the ambulance to prepare a bed for ISN156. At the same time, a nurse at the BHU/DH (b)(3):10 USC §130b,(b)(6),(b)(7)(C) assessed ISN156 in the ambulance and instructed (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (a corpsman at the DH) to proceed directly to the NAVSTA Hospital.[98] (Exhibits 22, 32)

113. ~~(U//FOUO)~~ The ambulance, at that point containing ISN156, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) the two Camp V guards and with (b)(3):10 USC §130b,(b)(6),(b)(7)(C) driving, left the DH for the NAVSTA Hospital. En route, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) continued chest compressions, with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) maintaining an airway, performing rescue breaths, and suctioning. Upon arrival at the NAVSTA Hospital, a doctor and corpsman came out and rushed ISN156 into the Emergency Room. There, medical staff

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[96] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) used a pocket mask and breathed into the nozzle – which contains a one-way valve to protect the individual providing the breaths from any contamination from the patient – to start the rescue breaths. (Exhibit 23)

[97] ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6),(b)(7)(C) are both certified as Emergency Vehicle Operators (EVOs). (Exhibit 23)

[98] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) explained that the NAVSTA Hospital is (b)(7)(E) Explaining that there are usually no medical doctors at the BHU/DH on the weekends, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated he would have proceeded differently had it been a weekday, as there would have been more medical staff present. In the AAR, the JMG recommended that in all cases involving codes from Camp V, VI, and Echo, where ACLS is not available on site, the patient "should have [Basic Life Support] BLS initiated immediately and then be evacuated to the Naval Hospital for ACLS response." (Exhibits 32, 85)

administered epinephrine and intravenous drugs, and continued life-saving measures. They declared ISN156 dead at 1448.[99] (Exhibits 13, 23, 30)

114. ~~(U//FOUO)~~ The guards understood their mission was to remain with the body of ISN156 at all times. At some point around 1543, NCIS, the FBI, and Combat Camera arrived to examine the body and take photographs. ISN156 was moved to the X-Ray room around 1725. The guards escorted the body via ambulance to the morgue. (Exhibit 29)

115. ~~(U//FOUO)~~ The next day, 9 September 2012, a team including a medical examiner, pathologist, and a Muslim Chaplain arrived at GTMO. The Muslim Chaplain's role was to care for the remains of ISN156 and prepare them in accordance with the Muslim faith. The Muslim Chaplain noted that the handling of the body was in accordance with the requirements of Islam. (Exhibit 127)

M. (U) Timeline

116. ~~(U//FOUO)~~ Table 1 reflects key events in the timeline leading up to the death of ISN156, beginning with his transfer from the DH to Camp V on 7 September 2012. The information for Table 1 was compiled from several witness statements, DIMS reports, and medical records for ISN156.

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[99] ~~(U//FOUO)~~ (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that there was no response, no pulse, and no respirations from ISN156 from the time (b)(3):10 USC §130b,(b)(6),(b)(7)(C) entered the cell to the time they arrived at the NAVSTA Hospital. (Exhibit 23)

(U) Table 1 – Timeline.

~~(U//FOUO)~~

Approximate Time	Events
7 Sep 2012	
1727	ISN156 starts move from Detainee Hospital BED4-DH to Camp V
1738	ISN156 arrives Camp V Cell 5A105
1739-1800	ISN156 floods cell
1800	ISN156 begins banging on cell door, causing a racket on Alpha (Lower) Block
1925	ISN156 eats dinner – rice, beef, shrimp, soup, and apple juice
2006	ISN156 speaks with AOIC about respect issues; conversation ends with AOIC explaining that it would take compliance and respect to remove the splashbox
2018	ISN156 begins altering cell and covering (b)(7)(E) with a food substance
2230-2359	ISN156 appears to fall asleep
8 Sep 2012	
0400	Corpsman ( ) leaves medications in ISN156 cell splashbox – ISN156 appears to be asleep
0600	Shift change from night to day shift; ISN156 appears to remain asleep, misses prayer and breakfast
0800	Corpsman ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) tries to administer medications to ISN156 but ISN156 appears to be asleep; medications from ( ) still in splashbox
1030	Watch Commander ( ) comes for ISN156 to go to recreation, but ISN156 appears to be asleep
1200	ISN156 appears to remain asleep
1405	( ) indicates ISN156 breathing had become abnormal, and attempts to gain ISN156's attention; ISN156 unresponsive
1405	Watch Commander ( ) calls Code Yellow
1406	Team of (b)(7)(E) guards enters cell, followed by (b)(3):10 USC §130b, (b)(6),(b)(7)(C) ; team secures ISN156; (b)(3):10 USC §130b, (b)(6),(b)(7)(C) assesses ISN156 and calls for nurse; (b)(3):10 USC §130b,(b)(6),(b)(7)(C) begin performing chest compressions with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) providing rescue breaths
1411	Registered Nurse ( ) arrives and determines further assistance is needed
1412	Registered Nurse ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) is called
1416	(b)(3):10 USC §130b, (b)(6),(b)(7)(C) arrives and assesses ISN156; determines an ambulance is required
1417	Ambulance is dispatched
1417	ISN156 is secured to backboard
1419	Ambulance arrives
1420	ISN156 is loaded into ambulance and taken to BHU/DH
1422	Ambulance arrives at BHU
1424	(b)(3):10 USC §130b, (b)(6),(b)(7)(C) determines to send ambulance to NAVSTA Hospital
(b)(7)(E)	Ambulance departs for NAVSTA Hospital; (b)(3):10 USC §130b, (b)(6),(b)(7)(C) performing basic CPR
	Ambulance arrives NAVSTA Hospital and ISN156 taken into emergency room; emergency room doctors take over
1448	ISN156 is pronounced dead
1740	ISN156 body is transported to morgue

II. (U) Listing of ISN156's Recent Prescribed Medications

A. (U) Prescribed, As-Needed Medications

117. ~~(U//FOUO)~~ Table 2 reflects prescribed PRN[100] medications for ISN156 beginning in 2010 through his death on 8 September 2012.[101]

~~(U//FOUO)~~ Table 2 – PRN Medications for ISN156 (September 2010 – September 2012).

~~(U//FOUO)~~

Prescribed Start Date	Name of Medication	Dosage
9 Sep 2010	Tucks pads	1 pad, once a day, at night
9 Sep 2010	Sea Soft nasal spray	2 sprays each nostril, twice a day, as needed (for dry nasal passages)
9 Sep 2010	Hydrocortisone suppository	Per rectum, four times per day, as needed (for hemorrhoids)
28 Sep 2010	Proctosol – HC 25%	Apply to rectal area, twice a day, as needed (for external hemorrhoids)
21 Dec 2010	Hibiclens wash	As needed (for legs)
20 Feb 2011	Surfak	240 mg, by mouth, once a day, at night
18 May 2011	Seroquel	50-100 mg, by mouth, three times per day, as needed (for anxiety or agitation)
23 Dec 2011	Clotrimazole cream 1%	Apply to affected area, twice a day, as needed (for rash) (should use for 1-2 weeks, if not effective, request provider appointment)
23 Dec 2011	Hydrocortisone cream 1%	Apply to affected area, twice a day, as needed (for itching) (not to exceed four doses per week without doctor's review)
23 Dec 2011	Eucerin Cream	30 ml, apply to affected area, twice a day, as needed (for dry skin) (not to exceed four doses per week without doctor's review)
23 Dec 2011	Claritin	10 mg, by mouth, once a day, as needed (rhinorrhea, sneezing, watery eyes) (not to exceed four doses per week without doctor's review)

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[100] ~~(U//FOUO)~~ "PRN" indicates "as needed" medications and items, and are different from the scheduled, prescribed medications reflected in Table 4. Some medications and items on the PRN Medications Records are "over the counter" items (such as ice, tape, or Tucks pads), but some require a prescription (such as Haldol, Percocet, and Tylenol with Codeine). In either case, a detainee could request PRN medications from a corpsman or nurse on an as needed basis, and so long as the medication and request was consistent with what was reflected in the PRN Medications Records for the detainee, the corpsman or nurse was authorized to dispense it. Accordingly, a detainee would not necessarily be taking all the PRN medications at one time. The PRN Medications Records also contain a column where the corpsman or nurse indicates when a detainee took a particular PRN medication (see Table 3, below). The information in Table 2 was compiled from PRN Medications Records for ISN156. (Exhibits 50, 97)

[101] ~~(U//FOUO)~~ A reference of medical / pharmacological abbreviations and their meanings is included as Exhibit 117.

Prescribed Start Date	Name of Medication	Dosage
23 Dec 2011	Cepacol	1 lozenge, in mouth, every six hours, as needed (for sore throat) (not to exceed six doses per week without doctor's review)
23 Dec 2011	Pepto-bismol	2 tabs, by mouth, four times per day, as needed (for minor abdominal distress) (not to exceed four doses per week without doctor's review)
23 Dec 2011	Tylenol	650 mg, by mouth, every four hours (minor aches and pain, headache) (not to exceed two doses per day without doctor's order)
23 Dec 2011	Mylanta	15-30 ml, by mouth, every six hours, as needed (for heartburn or indigestion) (not to exceed four doses per week without doctor's order)
23 Dec 2011	Milk of Magnesia (laxative)	30 ml with 8 oz of water, by mouth, twice a day, as needed (for heartburn or indigestion) (not to exceed four doses per week without doctor's order)
23 Dec 2011	Zantac	150 mg, by mouth, twice a day, as needed (for heartburn or indigestion) (not to exceed four doses per week without doctor's review)
23 Dec 2011	Robitussin	10 ml, by mouth, four times per day, as needed (for cough) (not to exceed four doses per week without doctor's review)
23 Dec 2011	Ensure	1-3 cans, three times per day, as needed (not to exceed four doses per week without doctor's review)
23 Dec 2011	Ice	Apply to affected area for 15 minutes, four times per day, as needed (minor injury)
29 Dec 2011	Zofran	4 mg, by mouth, every six hours, as needed, for five months (for nausea)
29 Dec 2011	Tape	Buddy tape right second digit to right big toe, for four weeks (for stability due to injury)
23 Jan 2012[102]	Percocet	1 tab, by mouth, every six hours, as needed (for severe back pain)
25 Jan 2012	Flonase	2 sprays each nostril, twice a night (prior to enteral feeds)
14 Feb 2012	Naprosyn	500 mg, by mouth, twice a day, as needed, for for four weeks (for pain)
14 Mar 2012	Atarax	50 mg, by mouth, once a day, for ninety days (for itch)
25 Apr 2012	Motrin	400 mg, by mouth, every six hours, for thirty days (for pain)

[102] ~~(U//FOUO)~~ There is also a later start date for Percocet, 30 August 2012, for the same dosage but for "pain" as opposed to "severe back pain." (Exhibit 97)

Prescribed Start Date	Name of Medication	Dosage
14 Jun 2012[103]	Benadryl[104]	25 mg, intramuscular, every eight hours, as needed (WITH Haldol) (NOTIFY [redacted] PRIOR TO ADMISTERING)[105]
14 Jun 2012	Ativan	2 mg, per oral or intramuscular, every four hours, as needed (for acute anxiety) (NOTIFY [redacted] PRIOR TO ADMINISTERING)
14 Jun 2012	Haldol	10 mg, intramuscular, every eight hours, as needed (for agitation, WITH Benadryl) (NOTIFY [redacted] PRIOR TO ADMINISTERING)
19 Jun 2012	Triamcinolone	Orabase dental paste, at night, up to three times per day, during day
19 Jun 2012	Vaseline	Offer Vaseline / petroleum jelly, three times per day, as needed (for dry lips)
1 Jul 2012	Lactose-free milk	25 oz., by mouth, once a day, as needed
25 Jul 2012	Selenium shampoo	30cc, apply to hair, two times per week, as needed
25 Jul 2012[106]	Benadryl	25 mg intramuscular injection (to be given with Haldol per medical officer)
25 Jul 2012	Ativan	2 mg, by mouth or intramuscular injection, every four hours, as needed (agitation)
26 Jul 2012	Haldol	10 mg intramuscular injection daily, as needed (for agitation) (to be given with Benadryl per medical officer)
29 Aug 2012	Artificial tears	1 drop, left eye, four times per day, as needed
29 Aug 2012	Erythromyclin ophthalmic ointment	1/4 inch strip inside lower eye lid, left eye, each night
31 Aug 2012	Tylenol with codeine	1 tab, by mouth, once a day, as needed (for pain)
7 Sep 2012	Tylenol #3	1 tab, by mouth, once a day, as needed (for pain)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

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[103] ~~(U//FOUO)~~ As noted above, 14 June 2012 is the date that ISN156 had a telephone call with his attorney following the Supreme Court decision on 11 June 2012 denying his petition for a writ of *certiorari* in his *habeas corpus* proceedings. The Camp V OIC [redacted] indicated that ISN156 came back furious and saying "crazy stuff" after the call. The phone call with his lawyer is cited as the beginning of the most recent downward spiral of ISN156. (Exhibit 16)

(b)(3):10 USC §130b,(b)(6),(b)(7)(C)

[104] ~~(U//FOUO)~~ A series of three injections, Benadryl (to counteract the effect of itching caused by the Ativan and Haldol), Ativan, and Haldol are considered "emergency medications." (Exhibit 97)

[105] ~~(U//FOUO)~~ The all caps appear in the original PRN Medications Records. (Exhibit 97)

[106] ~~(U//FOUO)~~ 25 July 2012 is the date of the "rock-throwing incident" detailed above, when ISN156 threw rocks at Camp VI guards and recreation tower. ISN156 was transferred to the BHU as a result of the incident. Later that same day, 25 July 2012, ISN156 [redacted] (Exhibits 53, 54, 57, 58)

(b)(7)(E),(b)(7)(F)

(b)(7)(E),(b)(7)(F)

118. ~~(U//FOUO)~~ Table 3 reflects the "High-Risk DEA Classified Drugs" that were on ISN156's PRN medications chart, and that he requested and took in 2012.[107]

~~(U//FOUO)~~ Table 3 – High-Risk DEA Classified Drugs for ISN156 (2012).

~~(U//FOUO)~~

Date and Time of Administration[108]	Drug	Quantity
25 Jan 2012 2000	Percocet	1 tab
26 Jan 2012 1300	Percocet	1 tab
26 Jan 2012 2235	Percocet	1 tab
28 Jan 2012 1930	Percocet	1 tab
30 Jan 2012 2004	Percocet	1 tab
3 Feb 2012 0330	Percocet	1 tab
23 Jul 2012 0001	Percocet	1 tab
28 Aug 2012 0130	Percocet	1 tab
28 Aug 2012 0530	Percocet	1 tab
28 Aug 2012 1445	Percocet	1 tab
28 Aug 2012 2045	Percocet	1 tab
29 Aug 2012 2030	Percocet	1 tab
29 Aug 2012 2040	Percocet	1 tab
29 Aug 2012 2045	Percocet	1 tab
31 Aug 2012 0508	Percocet	1 tab
31 Aug 2012 1445	Percocet	1 tab
31 Aug 2012 0015	Tylenol with codeine	1 tab
2 Sep 2012 1003	Tylenol with codeine	1 tab
3 Sep 2012 0505	Tylenol with codeine	1 tab
4 Sep 2012 0205	Tylenol with codeine	1 tab
5 Sep 2012 0630	Tylenol with codeine	1 tab
7 Sep 2012 0120	Tylenol with codeine	1 tab
2 Aug 2012 0705	Ativan	1 tab
4 Aug 2012 0155	Ativan	1 tab
25 Aug 2012 2200	Ativan	1 tab
26 Aug 2012 0500	Ativan	1 tab
27 Aug 2012 0500	Ativan	1 tab
6 Sep 2012 1500	Ativan	1 tab
2 Aug 2012[109]	Haldol	10 mg, by injection

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[107] ~~(U//FOUO)~~ According to the SOP, Percocet, Tylenol with Codeine, and Ativan were drugs that were (b)(7)(E) (b)(7)(E) and Haldol and Seroquel (b)(7)(E) As discussed later in the report, not all nurses and (b)(7)(E) Although the Investigative Team analyzed all medications on the PRN Medications Records for ISN156, for the purposes of the report, a table reflecting only the most medically significant medications, specifically, narcotics, is included. The information for Table 3 is compiled from the PRN Medications Records for ISN156. (Exhibits 50, 97)

[108] ~~(U//FOUO)~~ "Administration" is used as opposed to "Ingestion." Based on interviews with nurses and corpsmen regarding current practice within the camps, the PRN Medications Reports indicate when the medication is provided to the detainee, not necessarily when he ingests it.

Date and Time of Administration[108]	Drug	Quantity
26 Jan 2012 2220	Seroquel	100 mg
28 Jan 2012 0000	Seroquel	100 mg
28 Jan 2012 1930	Seroquel	100 mg
30 Jan 2012 2100	Seroquel	100 mg
1 Feb 2012 2000	Seroquel	100 mg
3 Feb 2012 2100	Seroquel	100 mg
5 Feb 2012 2030	Seroquel	100 mg
7 Feb 2012 2010	Seroquel	100 mg
9 Feb 2012 0100	Seroquel	100 mg
10 Feb 2012 2100	Seroquel	100 mg
11 Feb 2012 2000	Seroquel	100 mg
14 Feb 2012 0000	Seroquel	100 mg
15 Feb 2012 2000	Seroquel	100 mg
16 Feb 2012 2030	Seroquel	100 mg
17 Feb 2012 2100	Seroquel	100 mg
19 Feb 2012 0000	Seroquel	100 mg
20 Feb 2012 2000	Seroquel	100 mg
23 Feb 2012 2015	Seroquel	100 mg
24 Feb 2012 2315	Seroquel	100 mg
25 Feb 2012 2322	Seroquel	100 mg
26 Feb 2012 2200	Seroquel	100 mg
27 Feb 2012 1909	Seroquel	100 mg
3 Mar 2012 2100	Seroquel	100 mg
4 Mar 2012 2230	Seroquel	100 mg
7 Mar 2012 2056	Seroquel	100 mg
11 Mar 2012 2315	Seroquel	100 mg
XX Mar 2012 0015[110]	Seroquel	100 mg
14 Mar 2012 0015	Seroquel	100 mg
2 Apr 2012 2200	Seroquel	100 mg
3 Apr 2012 2000	Seroquel	100 mg
13 Apr 2012 0000	Seroquel	100 mg
14 Apr 2012 0000	Seroquel	100 mg
18 Apr 2012 0000	Seroquel	100 mg
18 Apr 2012 2050	Seroquel	100 mg
19 Apr 2012 2213	Seroquel	100 mg

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[109] ~~(U//FOUO)~~ 2 August 2012 [(b)(7)(E),(b)(7)(F)] From the entries on the Medication Administration Record (MAR), it appears that the Haldol was given via injection. This is consistent with sworn statements indicating that a nurse administered emergency medications to ISN156 following the incident. (Exhibits 11, 17, 99)

[110] ~~(U//FOUO)~~ Like virtually all entries on the PRN Medications Reports, the date is very difficult to read, and is in fact illegible, but appears to fall between 11 and 14 March 2012 and 14 Mar 12. As discussed later in the report, because of the way the PRN Medications Reports are structured, it is extremely difficult to reconstruct a chronology of when a particular medication was taken. These tables reflect the Investigative Team's effort to do so. (Exhibit 97)

Date and Time of Administration[108]	Drug	Quantity
23 Apr 2012 0000	Seroquel	100 mg
4 May 2012 2300	Seroquel	100 mg
7 May 2012 2109	Seroquel	100 mg
10 May 2012 2213	Seroquel	100 mg
15 Jun 2012 0015	Seroquel	100 mg
16 Jun 2012 0020	Seroquel	100 mg
17 Jun 2012 0021	Seroquel	100 mg
17 Jun 2012 2300	Seroquel	100 mg
19 Jun 2012 0020	Seroquel	100 mg
20 Jun 2012 0205	Seroquel	100 mg
22 Jun 2012 0145	Seroquel	100 mg
22 Jun 2012 2405[111]	Seroquel	100 mg
16 Jul 2012 0000	Seroquel	100 mg
18 Jul 2012 2200	Seroquel	100 mg
26 Jul 2012 2010	Seroquel	100 mg
30 Jul 2012 2020	Seroquel	100 mg
3 Aug 2012 0155	Seroquel	100 mg
13 Aug 2012 0155	Seroquel	100 mg
25 Aug 2012 2105	Seroquel	100 mg
27 Aug 2012 0005	Seroquel	100 mg
28 Aug 2012 0550	Seroquel	100 mg
30 Aug 2012 2345	Seroquel	100 mg
31 Aug 2012 0508	Seroquel	100 mg
1 Sep 2012 0820	Seroquel	100 mg
2 Sep 2012 0530	Seroquel	100 mg
3 Sep 2012 0000	Seroquel	100 mg
3 Sep 2012 2115	Seroquel	100 mg
4 Sep 2012 0945	Seroquel	100 mg
4 Sep 2012 2240	Seroquel	100 mg
5 Sep 2012 0940	Seroquel	100 mg

[111] ~~(U//FOUO)~~ The small size of the boxes on the PRN Medications Reports sometimes makes it difficult to discern whether a date is for "Jan" or "Jun", or "Mar" or "May", for example. (Exhibit 97)

B. (U) Prescribed, Scheduled Medications

119. ~~(U//FOUO)~~ Table 4 reflects prescribed, scheduled medications for ISN156 that he was prescribed at the time of his death on 8 September 2012.[112]

~~(U//FOUO)~~ Table 4 – Prescribed, Scheduled Medications for ISN156 (5 -8 September 2012).[113]

~~(U//FOUO)~~

Prescribed Start Date	Date and Time of Administration[114]	Drug	Dosage
14 Jun 2012	5 Sep 2012 0430 5 Sep 2012 2200 6 Sep 2012 0430 6 Sep 2012 2200 7 Sep 2012 2200 8 Sep 2012 0430	Zantac	1 tab, by mouth, twice a day
14 Jun 2012	5 Sep 2012 0430 5 Sep 2012 2200 6 Sep 2012 0430 6 Sep 2012 2200 7 Sep 2012 2200 8 Sep 2012 0430	Lidex Cream	Apply to lesions, twice a day
14 Jun 22012	NONE[115]	Benzoyl Peroxide Solution 10 %	Use in shower daily
14 Jun 2012	6 Sep 2012 2200	Salicylic Acid Wash	Apply to legs, twice a day
14 Jun 2012	5 Sep 2012 2100 6 Sep 2012 2100 7 Sep 2012 2100	Calcium and Vitamin D	1 tab, by mouth, every day
14 Jun 2012	7 Sep 2012 2100	Glucosamine /	1 tab, by mouth, every day

[112] ~~(U//FOUO)~~ As noted above, prescribed, scheduled medications are distinct from PRN medications. The scheduled medications are offered to the detainee at particular times each day based on the doctor's order. (Exhibit 99)

[113] ~~(U//FOUO)~~ The information for Table 4 is compiled from the Medications Administration Records for ISN156. (Exhibit 99)

[114] ~~(U//FOUO)~~ Because none of the scheduled medications appeared on the "High-Risk DEA Classified Drugs" list (see Table 3), Table 4 only reflects the dates and times of administration going back three days from ISN156's death on 8 September 2012. As with the PRN Medications Records, "administration" is used as opposed to "ingestion". Based on testimony from guards and corpsmen, ISN156 did not take any medications after 2200 hours 7 September 2012, as he appeared asleep the entire time. It appears the Medication Administration Record for 7 and 8 September 2012 is improperly completed as it indicates that ISN156 accepted medications during that time, which is inconsistent with the statements and photographs. Based on the fact that there were medications in pill cups in the splashbox of ISN156 at the time of his death, it is possible that the MAR is reflecting when the medications were *offered* to the detainee (i.e., were left in his splashbox), not when ISN156 *accepted* them. Those medications after 2200 7 September 2012 are included in Table 4 because they were discovered in his splashbox following his death. (Exhibits 1, 6, 8, 9, 10, 23, 99, 129)

[115] ~~(U//FOUO)~~ ISN156 refused certain scheduled drugs from 5 to 8 September 2012. In such cases, Table 4, Column 2 reflects "NONE."

Prescribed Start Date	Date and Time of Administration[114]	Drug	Dosage
		chondroitin	
19 Jun 2012	5 Sep 2012 0800 5 Sep 2012 2100 6 Sep 2012 0800 6 Sep 2012 2100 7 Sep 2012 2100 8 Sep 2012 0800	Colace	100 mg, by mouth, twice a day
19 Jun 2012	5 Sep 2012 0800 5 Sep 2012 2100 6 Sep 2012 0800 6 Sep 2012 2100 7 Sep 2012 2100 8 Sep 2012 0800	Hydrocortisone suppository	Insert by rectum, twice a day
19 Jun 2012	5 Sep 2012 0430 5 Sep 2012 2200 6 Sep 2012 0430 6 Sep 2012 2200 7 Sep 2012 2200 8 Sep 2012 2200[116]	Hydrocortisone 2.5% Rectal Cream	
19 Jun 2012	5 Sep 2012 2100	Triamcinolone in Oralbase Dental Paste	Each night (over lower lip)
25 Jul 2012	5 Sep 2012 2200 6 Sep 2012 2200 7 Sep 2012 2200	Remeron[117]	15 mg, by mouth, each night, for three months
27 Jul 2012	6 Sep 2012 [no time]	Throat lozenges	Offer every 4 hours, while awake, for sore throat
22 Aug 2012	5 Sep 2012 0430 6 Sep 2012 0430 7 Sep 2012 0430 8 Sep 2012 0430	Invega	9 mg,[118] by mouth, every morning

[116] ~~(U//FOUO)~~ It appears that the corpsman initialed in the wrong box as ISN156 was no longer in his cell by 2200 8 September 2012.

[117] ~~(U//FOUO)~~ Remeron and Invega were the only two scheduled, psychiatric medications that ISN156 was taking at the time of his death on 8 September 2012. (Exhibit 24)

(b)(3):10 USC §130b
(b)(6),(b)(7)(C)

[118] ~~(U//FOUO)~~ [redacted] indicated that starting 22 August 2012, the Invega dose was made up of two capsules – a one 3 mg capsule and one 6 mg capsule. (Exhibit 24)

C. (U) Administration of Invega

120. (~~U//FOUO~~) Table 5 reflects the administration times and dates of Invega for ISN156, which prescribed start date was 21 August 2012. (Exhibit 99)

(~~U//FOUO~~) Table 5 – Invega (21 August 2012 – 8 September 2012).[119]

(~~U//FOUO~~)

Prescribed Start Date	Date and Time of Administration	Drug	Dosage	Number of Total Capsules in Dosage
21 Aug 2012[120]	21 Aug 2012 0430	Invega	6 mg	1
22 Aug 2012	22 Aug 2012 0430	Invega	6 mg	1
	23 Aug 2012 0430	Invega	9 mg	2
	24 Aug 2012 0430	Invega	9 mg	2
	25 Aug 2012 0430	Invega	9 mg	2
	26 Aug 2012 0430	Invega	9 mg	2
	27 Aug 2012 0430	Invega	9 mg	2
	28 Aug 2012 0430	Invega	9 mg	2
	29 Aug 2012 0430	Invega	9 mg	2
	30 Aug 2012 0430	Invega	9 mg	2
	31 Aug 2012 0430	Invega	9 mg	2
	1 Sep 2012 0430	Invega	9 mg	2
	2 Sep 2012 0430	Invega	9 mg	2
	3 Sep 2012 0430	Invega	9 mg	2
	4 Sep 2012 0430	Invega	9 mg	2
	5 Sep 2012 0430	Invega	9 mg	2
	6 Sep 2012 0430	Invega	9 mg	2
	7 Sep 2012 0430[121]	Invega	9 mg	2
	8 Sep 2012 0430[122]	Invega	9 mg	2

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[119] (~~U//FOUO~~) The information for Table 5 is compiled from the Medication Administration Records for ISN156. (Exhibit 99)

[120] (~~U//FOUO~~) There are two prescribed start dates reflected for Invega. On 21 August 2012 [redacted] ordered ISN156 on a dose of 6 mg. On 22 August 2012, [redacted] changed the Invega dose to 9 mg. (Exhibit 99) (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[121] (~~U//FOUO~~) The Medication Administration Record indicates that [redacted] administered the daily Invega dose to ISN156 at 0430 on 7 September 2012. That time is inconsistent with the information provided by [redacted] in her statement, in which she indicated that ISN156 initially refused his dose of Invega that morning, but that she was able to convince him around 1100 or 1130 to take them. [redacted] indicated that she watched ISN156 take the capsules, put them in his mouth, drink water, and swallow them. (Exhibit 28) (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[122] (~~U//FOUO~~) The Medication Administration Record indicates that on 8 September 2012, [redacted] administered 9 mg of Invega to ISN156. It appears that ISN156 did not ingest the dose, as NCIS photos of the cell and splashbox indicate two capsules of Invega (3 mg and 6 mg) in a pill cup in the splashbox. NCIS arrived at the scene and took the photographs at that time. (Exhibits 99, 129) (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

III. (U) Cause of Death of ISN156:

121. ~~(U//FOUO)~~ The Armed Forces Medical Examiner (AFME) determined the cause of death of ISN156 to be suicide by paliperidone toxicity.[123] The AFME noted that resuscitative efforts were initiated at the scene and that ISN156 was transported to the hospital, where he was pronounced deceased. The AFME review of medical records showed a history of multiple psychiatric disorders, suicidal ideation with previous attempts, intentional harm to others and reported traumatic brain injury. The autopsy examination showed a fracture of a rib, compatible with resuscitative efforts. An examination of the lungs showed acute bilateral pneumonia. (Exhibits 130, 131)

122. ~~(U//FOUO)~~ The toxicology examination revealed the presence of paliperidone (Invega), codeine (Tylenol #3), oxycodone (Percocet), quetiapine (Seroquel), mirtazpine (Remeron), and citalopram (Celexa) in the blood of ISN156. Morphine (by-product of Tylenol #3), oxymorphone (active ingredient in Percocet), and lorazepam (Ativan) were present in the urine without detectable blood levels. (Exhibit 131)

123. ~~(U//FOUO)~~ The AFME was not able to determine a precise time of death for ISN156, nor was he able to pinpoint a precise time that ISN156 ingested the 24 capsules of Invega, found in the stomach at the time of death. (Exhibit 131)

124. ~~(U//FOUO)~~ The AFME concluded that ISN156 died of paliperidone toxicity resulting from an overdose. The AFME determined that it is uncertain to what extent the acute pneumonia contributed to the death of ISN156. The AFME indicated that "no evidence was identified to suggest that [ISN156's] actions were other than purposeful and self-inflicted." (Exhibits 130, 131)

IV. (U) Joint Task Force Guantanamo (JTF-GTMO)

125. ~~(U//FOUO)~~ The commander of Joint Task Force – Guantanamo (JTF-GTMO) is Rear Admiral John W. Smith. The deputy commander of JTF-GTMO is Brigadier General James Lettko. The chief-of-staff is Captain William Docherty. The mission statement for JTF-GTMO

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[123] Paliperidone is the pharmacological name for the brand name drug Invega. The certificate of death is in the name of "Ad-Rahman, Allal A." The name that is attached to ISN156 at JTF-GTMO is "Adnan Farhan Abd Al Latif." The AFME indicated that the Federal Bureau of Investigation (FBI) determined that the fingerprints on the person of ISN156 matched an individual known as "Ad-Rahman, Allal A." An internet search reveals several names very similar to Ad-Rahman as aliases for Adnan Farhan Abd Al Latif. (Exhibit 130)

is 1) safe, humane, legal, and transparent care and custody of detainees; 2) intelligence collection; and 3) commissions support. (Exhibit 69)[124]

V. (U) Joint Detention Group (JDG)

A. (U) Leadership and Command Structure

126. ~~(U//FOUO)~~ The commander of the JDG is COL John Bogdan. COL Bogdan arrived at JTF-GTMO 29 May 2012, and took command on 7 June 2012. The JDG and the Joint Medical Group (JMG) fall under the command and control of JTF-GTMO.[125] (Exhibits 5, 69, 108)

127. ~~(U//FOUO)~~ The JDG is composed of a Headquarters element (HQ) and the Joint Operations Center (JOC). The 525th Military Police Battalion (525th MP BN) and the Navy Expeditionary Guard Battalion (NEGB) both fall under the HQ. (Exhibit 69)

128. ~~(U//FOUO)~~ The 525th MP BN is ADCON to United States Army South (ARSOUTH), and TACON to JDG. (Exhibit 4)

129. ~~(U//FOUO)~~ The commander of the 189th Military Police Company (189th MP CO) is [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)]. [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] is also the Camp V OIC. The 189th MP CO is an active duty unit and provides the guard force for Camp V and Camp Echo. She arrived at JTF-GTMO December 2011, took over Camp V on 15 February 2012, and took command of the 189th MP CO on 23 March 2012. She is currently the most senior OIC of the camps at GTMO. (Exhibit 16)

130. ~~(U//FOUO)~~ The 193rd MP CO is an active duty unit, and provides the guard force for Camp V and Camp Echo. (Exhibit 4)

131. ~~(U//FOUO)~~ The commander of the 314th Military Police Company (314th MP CO) is [(b)(3):10 USC §130b,(b)(6)] [(b)(3):10 USC §130b,(b)(6),(b)(7)(C)] The 314th MP CO is a reserve unit out of Southern California. The 314th MP CO provides the guard force for the BHU, DH, Camp Iguana, and Camp VI. [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] is also the OIC of the BHU, DH, and Camp Iguana. [(b)(3):10 USC §130b, (b)(6),(b)(7)(C)] arrived at JTF-GTMO 14 December 2011. At the time of the report, the 314th MP CO had redeployed. (Exhibit 18)

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[124] ~~(U//FOUO)~~ CAPT Docherty provided the slides to the Investigative Team on 11 September 2012. The slides themselves are undated. One slide titled "Detention Conditions: *Safe*" lists as a bullet "Troops adhere to SOPs." Adherence, and the lack thereof, to SOPs is discussed at length below in this report. (Exhibit 69)

[125] JDG Procedure #2, Command and Control establishes the procedures for Command and Control of the JDG. Paragraph 2-4c, establishes a "Field-Grade-in-the-Wire" Program to provide leadership presence in the camps nightly. [(b)(5)] (Exhibit 108)

132. ~~(U//FOUO)~~ The 348th MP CO is a reserve unit out of Iowa, and provides the guard force for Camp VI. (Exhibit 4)

133. ~~(U//FOUO)~~ The 755th MP CO is a National Guard unit out of Puerto Rico, and provides external security, including manning the traffic control points and sally ports for the camps, and serving as the Quick Reaction Force (QRF). (Exhibit 4)

134. ~~(U//FOUO)~~ Together, the 189th MP CO, the 193rd MP CO, the 314th MP CO, the 348th MP CO, and the 755th MP CO fall under the command and control of the 525th MP BN and provide the guard force for camps and external security. The rotation dates for the units are detailed in Exhibit A to Exhibit 4. (Exhibits 4, 69)

B. (U) Camp V, Detainee Hospital, Behavioral Health Unit

135. ~~(C)~~ Camp V houses compliant and non-compliant detainees in single cells and communal blocks, as well as a prisoner population in single cells.[126]

(b)(1),(b)(3):10 USC 130b,(b)(6),(b)(7)(C)

(Exhibit 16)

136. ~~(C)~~ The BHU/DH houses mentally and physically ill detainees, as well as long-term hunger strikers, in single cells.

(b)(1),(b)(3):10 USC 130b,(b)(6),(b)(7)(C)

[128]

C. (U) Training

137. ~~(U//FOUO)~~ Ultimately, the JDG is responsible for training camp guards. The 525th MP BN, specifically, the S3 section, conducts the actual training over 12 days, with the final two days being on-the-job training (OJT). (Exhibits 4, 70)

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[126] ~~(U//FOUO)~~ Because ISN156 was housed at Camp V at the time of his death and was transferred from the DH the day before, only the guard structures for Camp V and the BHU/DH are set forth in the report.

[127] ~~(U//FOUO)~~ Alpha (Upper) is empty. (Exhibit 16)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[128] ~~(U//FOUO)~~ Although not included in his statement, [redacted] provided the information during a telephone call with the Investigative Team on 12 October 2012.

138. ~~(U//FOUO)~~ At the end of the 12 days, the guards must pass a Job Qualification Requirement (JQR). The JQR is divided into three sections. The 100 Section, Fundamentals, covers SOPs, guard mount messages, and night orders, and is designed to enable Soldiers to understand the guard post / work station duties. Fundamentals covers such items as block cleanliness, rules for the use of force, and detainee discipline levels.[129] (Exhibits 4, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81)

139. ~~(U//FOUO)~~ The 200 Section, Basic Knowledge, is designed to acquaint Soldiers with the systems they will be required to operate at the guard post / work station. Basic Knowledge includes sections on proper restraint procedures, medication administration, medical emergency codes, detainee search policy, and detainee feeding policy and procedures. (Exhibits 4, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81)

140. ~~(U//FOUO)~~ The 300 Section, Guard Posts, is made up of tasks Soldiers are required to satisfactorily perform to pass the final JQR. Guard Posts includes sections on how to properly conduct a cell search and open feed tray slots.[130] (Exhibits 4, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81)

141. ~~(U//FOUO)~~ Training for the BHU/ DHU BNCOs and DIMS operators is divided into four sections. The 100 section, Prerequisites, is similar to the 100 section for the JDG Pod / Block Guard JQRs, and cover SOPs and other directives necessary to understand the watch station. (Exhibits 4, 82, 83)

142. ~~(U//FOUO)~~ The 200 Section, Camp Specific Knowledge, includes sections on weight refusal and hunger striker protocols, detainee restraint levels, and priority of force. (Exhibits 4, 81, 82)

143. ~~(U//FOUO)~~ The 300 Section, Introduction to Watch Standing is made up of tasks Soldiers must satisfactorily perform to pass the final JQR. (Exhibits 4, 82, 83)[131]

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[129] ~~(U//FOUO)~~ While the front page and other parts of the training packets slightly vary between the JDG Pod / Block Guard, the NCO, and the WC/AWC JQRs, the substance of the training is very similar. The training of [redacted] (b)(3):10 USC §130b. (b)(6),(b)(7)(C) appears to have been conducted by the NEGB on 2 August 2012 for duty at Camp Iguana. Again, although the front page and other parts of the training packets slightly vary, the substance of the training is virtually identical to the training for other camps. (b)(3):10 USC §130b (b)(6),(b)(7)(C)

[130] ~~(U//FOUO)~~ Training on line of sight duty is not listed in any of the three sections. Also not listed is any training by the JMG to provide an overview of the JMG operations and expectations of the guards with respect to JMG operations in the camps. This item addressed in the Recommendations of the report.

[131] ~~(U//FOUO)~~ The training for the JDG Camp Guard Force and the JDG BHU/DH Guard Force is very similar except that the JDG BHU/DH Guard Force JQR includes two sections covering systems (Sections 200 and 300 – one general and one specific to the BHU/DH) whereas the JDG Camp Guard Force JQR includes only one section (Section 200).

144. ~~(U//FOUO)~~ The 400 Section, Watches, which is similar to the 300 Section of the JDG Camp Guard Force JQRs, is the validation section where the Soldier must complete the tasks required to pass the final JQR. (Exhibits 4, 82, 83)

D. (U) JDG Standard Operating Procedures (SOPs)

145. ~~(U//FOUO)~~ There are a total of 90 JDG SOPs governing a wide range of detainee operations, from Standard Operating Procedures Changes, Detainee Movement Operations, Wildlife and Pest Control, Restraint Devices, External Security, and Medication Pass Procedures, to Detainee Death.[132] (Exhibit 39)

1. (U) JDG Procedure #27: General Guidelines for Camp Operations

146. ~~(U//FOUO)~~ JDG Procedure #27 addresses General Guidelines for Camp Operations. The SOP notes that "fair, firm, and impartial enforcement of rules and regulations facilitates the control of detainees." The SOP also notes that "[c]ustody and control measures maintain good order and discipline and protect the welfare of all camp personnel and detainees alike." Specifically, security requires all personnel to "continually maintain an effective working knowledge of rules, regulations, and special orders; maintain constant vigilance throughout their daily duties; review/evaluate procedures."[133] (Exhibit 40)

147. ~~(U//FOUO)~~ Several guards and medical personnel indicated a lack of familiarity with specific provisions of various SOPs. (Exhibits 9, 10, 14, 18, 20, 24, 28)

148. ~~(U//FOUO)~~ Other guards and medical personnel indicated that although they were familiar with specific provisions of the SOP and what the SOP required, they did not always follow the SOPs. Indeed, guards indicated that enforcement of the SOPs is one of the biggest challenges they face at JTF-GTMO.[134] (Exhibits 1, 6, 8, 18, 25)

149. ~~(U//FOUO)~~ The Camp V OIC ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) noted that (b)(7)(E) inconsistent application of SOPs to ISN156 caused "stress on the guard force" and also ISN156. ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) indicated that she was frustrated that "consistency" was the "watchword" and yet,

[132] ~~(U//FOUO)~~ Although the current SOP Version List goes to 95, three of the SOPs are archived and two are not used, for a total of 90. The JDG SOPs and Procedures that the Investigative Team received were signed by the previous JDG Commander. However, the current JDG Commander indicated that one of his significant projects since taking command has been to "update and synchronize the SOPs, to ensure that they are reflecting current practice." Although some are entitled "JDG SOPs" and some are entitled "JDG Procedures" they are the same type of document – a Standard Operating Procedure. (Exhibits 5, 39)

[133] ~~(U//FOUO)~~ Specific examples of guards following, and in many cases not following, the SOPs are laid out later in the report, following the specific corresponding SOP, rather than here in the "General Guidelines" section.

[134] ~~(U//FOUO)~~ One guard noted that when the 314th MP Company took over, Sailors from the Navy unit they replaced would say "this is what the SOP says" and then would say "but this is how we do it." He indicated that detainees would observe the right seat / left seat handover and would state things like "be sure to tell the 314th how to do it the right way." (Exhibit 17)

in her opinion, "there is not a consistent application of the SOPs." (b)(3):10 USC §130b, (b)(6),(b)(7)(C) cited several other examples of inconsistent application of the SOPs.[135] (Exhibit 16)

2. ~~(U//FOUO)~~ JDG SOP #53: Sally Port Operations

150. ~~(U//FOUO)~~ JDG SOP#53 addresses Sally Port Operations. (b)(7)(E) (Exhibit 44)

151. ~~(U//FOUO)~~ On the day ISN156 was found unresponsive in his cell at Camp V, several witnesses stated the ambulance arrived to Camp V "very quickly," within minutes of having been called.[136] The guards and medical personnel indicated they were not aware of any issues with the Sally Port when the ambulance left Camp V for the BHU/DH. Furthermore, guards and medical personnel indicated they arrived promptly at the BHU/DH, entering through (b)(7)(E) (b)(7)(E) The guards and medical personnel indicated they left the BHU/DH expeditiously, and arrived at the NAVSTA Hospital (b)(7)(E) [137] (Exhibits 10, 15, 23, 25, 29, 30, 34)

152. ~~(U//FOUO)~~ Having been identified by the Camp V Watch Commander (b)(7)(E) Camp V guards accompanied ISN156 from the time the ambulance departed Camp V, arrived at the BHU/DH, departed the BHU/DH, and arrived at the NAVSTA Hospital, through the time the body of ISN156 was transferred to the morgue. (Exhibits 13, 15, 29)

3. ~~(U//FOUO)~~ JDG Procedure #22: Wildlife and Pest Control

153. ~~(U//FOUO)~~ JDG Procedure #22 addresses Wildlife and Pest Control. The Chief, Joint Task Force (JTF) Preventive Medicine shall ensure that inspectors are trained and proficient in conducting an environmental inspection, and shall ensure that inspections are scheduled and completed. Commanders and subordinates shall ensure that camp leadership and guard force personnel are trained and "are aware of their responsibilities with respect to wildlife and pest control." (Exhibit 109)

154. ~~(U//FOUO)~~ The SOP notes that iguanas "can and will become aggressive once they have been domesticated through feeding by humans." Accordingly, guards are instructed to not attempt to "feed, capture, or harm an iguana." "At no time will a detainee be allowed to feed an iguana." Similarly, noting that banana rats will bite if fed by guards or detainees, "at no time

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[135] ~~(U//FOUO)~~ Those examples are addressed in turn throughout the report.
[136] ~~(U//FOUO)~~ There is an unmanned ambulance permanently stationed outside Camp V / VI. (Exhibit 15)
[137] ~~(U//FOUO)~~ Immediately after the incident, several of the medical personnel created timelines of the events surrounding ISN156's death. Copies of those hand-written timelines are attached as exhibits to the witness statements. (Exhibits 13, 30, 22, 32, 33)

will a banana rat be fed."[138] If a banana rat is found in a camp, the SOP directs the individual to contact NAVSTA security for removal. Finally, because of the number of human diseases that pigeons carry, "[d]etainees that feed and give water to the birds should be discouraged from doing so. At no time should a detainee touch or pet these birds." (Exhibit 109)

155. ~~(U//FOUO)~~ On numerous occasions, the Investigative Team observed stray cats, iguanas, and pigeons lined up at the BHU/DH recreation yards.

156. ~~(U//FOUO)~~ Several guards and medical personnel spoke of detainees regularly feeding wildlife. A nurse at the BHU/DH ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)), for example, noted that one of the things that stuck out in her mind about ISN156 was that he was allowed to leave food out for the iguanas at the BHU/DH recreation yards. She noted that stray cats, iguanas, and banana rats sometimes line up outside of the recreation yards, waiting for food. She also noted that one detainee, (b)(6),(b)(7)(C) has pigeons regularly come and sit on his shoulder.[139] (Exhibit 35)

157. ~~(U//FOUO)~~ The OIC for the BHU/DH and Camp Iguana (b)(3):10 USC §130b,(b)(6), (b)(7)(C) indicated he understood that although generally not allowed, certain detainees were allowed to interact with the wildlife. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that (b)(6),(b)(7)(C) had (b)(7)(E) (b)(7)(E). He also noted that ISN156 was "usually allowed to feed animals on doctor's orders because it helped keep him calm."[140] (Exhibit 18)

158. ~~(U//FOUO)~~ JDG and JMG leadership, however, had an understanding quite different from that of the guards and medical personnel. The JDG Commander indicated detainees should not be feeding wildlife, and was not aware of it being an issue other than with pigeons. The JMG Commander stated that he was "not aware that the detainees are feeding wildlife," adding "in my opinion, no detainee should be feeding wildlife." (Exhibits 5, 31)

4. ~~(U//FOUO)~~ JDG Procedure #30: Detainee Camp Rules and Standards of Conduct

159. ~~(U//FOUO)~~ JDG Procedure #30 covers Detainee Camp Rules and Standards of Conduct. The SOP sets out a long list of specific rules for detainees, including that they may not create unsanitary conditions in the camp, such as throwing or storing feces, urine, saliva, or vomit. The SOP authorizes discipline time and the loss of privileges for failure to comply with the rules. (Exhibit 41)

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[138] (U) Commonly referred to as "banana rats," hutias are large rodents found at GTMO.

[139] ~~(U//FOUO)~~ Although not included in her statement, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) offered that she was concerned about the failure to follow the SOP, and did not think that allowing detainees to feed and interact with wildlife was a "good idea." (Exhibit 35)

[140] ~~(U//FOUO)~~ (b)(6),(b)(7)(C),(b)(7)(E) There is nothing in these SOPs or medical records (ISN156) that indicates that either ISN156 or (b)(6) were actually authorized to feed or interact with the wildlife. (Exhibits 48, 48-A, 48-B, 48-C, 48-D)

(b)(6),(b)(7)(C),(b)(7)(E)

160. ~~(U//FOUO)~~ Detainees are classified in a "compliant" or "discipline" status. Detainees who commit "serious offenses" may, at the discretion of the JDG Commander, be re-assigned to Camp V. (Exhibit 41)

161. ~~(U//FOUO)~~ JDG Procedure #30 also establishes a matrix for Basic Issue/Comfort (BI/CI) items for detainees.[141] Generally, items of BI/CI may be exchanged on a one-for-one basis.[142] (Exhibit 41)

162. ~~(U//FOUO)~~ When a detainee commits a camp rules infraction or an offense listed in the Detainee Offense Matrix, (b)(7)(E) The maximum recommendation for any single punishment, (b)(7)(E) the guard force will inform the detainee he has been placed (b)(7)(E) The detainee will serve the discipline time in an assigned cell in Camp V (b)(7)(E) (b)(7)(E)

163. ~~(U//FOUO)~~ According to the SOP, the JDG Commander has the authority to assign detainees who have committed certain offenses to Camp V, Those offenses include (b)(7)(E)

164. ~~(U//FOUO)~~ As discussed earlier in the report, ISN156 had a long history of disciplinary events at JTF-GTMO. Several witnesses indicated that not all of those disciplinary events were consistently addressed. The Camp V OIC (b)(3):10 USC §130b,(b)(6),(b)(7)(C) for example, indicated that she was made aware of the fact that ISN156 was (b)(6) during

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[141] ~~(U//FOUO)~~ A detainee may lose certain items if he is placed on self-harm precautions or on discipline status. (Exhibit 41).

[142] ~~(U//FOUO)~~ The IO interviewed a noncommissioned officer watch commander who related anecdotally that because the one-for-one exchange policy is sometimes violated by the orders of the medical team (eg., "give the detainee extra blankets), some of the guard force feels compelled to take home and wash detainee items rather than risk a detainee outburst upon only receiving one blanket in return from detainee laundry.

[143] ~~(U//FOUO)~~ A GTMO Form 508 is a detainee report addressing discipline incidents. The Detainee Offense Matrix is in JDG Procedure #30. The section for the Detainee Discipline Matrix is blank, and indicates "pending approval." (Exhibit 41)

[144] ~~(U//FOUO)~~ There are two detainee discipline levels – (b)(7)(E) Detainees who complete the specified time on (b)(7)(E) will be changed to (b)(7)(E) for a specified period of time. Once both the (b)(7)(E) are completed without a new violation, the detainee will be returned to compliant status. (Exhibit 41)

[145] ~~(S)~~ (b)(7)(E) detainees serve their discipline time on Camp V.

movements.[146] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated, however, that when she raised the issue with the previous 525th BN Commander he told her that she needed to understand that ISN156 was a special case, and that there were strategic level issues at play. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that she was not aware of the previous command having done anything to "truly address the Soldiers' complaints about ISN156's (b)(6) " (Exhibits 16, 51)

165. ~~(U//FOUO)~~ Other guards reported that up through the days leading up to his death, ISN156 was engaging in indecent behavior. In fact, one guard understood the (b)(7)(E) line of light rotation policy stemmed from ISN156's behavior, and that camp leadership "did not want guards to have to watch [the indecent behavior] for more than (b)(7)(E) at a time." Several guards indicated that they had to watch ISN156 (b)(6) (b)(6) "right up near the window." (Exhibits 6, 14, 29)

166. ~~(U//FOUO)~~ Similarly, a nurse at the BHU/DH ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) noted that ISN156 would (b)(6) while on line of sight and "(b)(6) " (b)(3):10 USC §130b, (b)(6),(b)(7)(C) noted that it was "very difficult for guards to watch" this behavior. There is nothing in the file of ISN156 to indicate that any discipline time was imposed for this type of indecent behavior.[147] (Exhibit 35)

167. ~~(U//FOUO)~~ On 1 August 2012, ISN156 received a Detainee Report for throwing feces at a nurse and guards from a cup in the BHU/DH recreation yard. As a result of the incident, ISN156 was given (b)(7)(E) discipline time. (Exhibits 17, 35, 56)

168. ~~(U//FOUO)~~ On 2 August 2012, ISN156 also received 508 Detainee Reports for "Major Damage to Property" and "Aggravated Assault on Staff," both reports stemming from (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F).[148] As a result of the incident, ISN156 was given a total of (b)(7)(E) (b)(7)(E) of discipline time ((b)(7)(E) for the Major Damage to Property and (b)(7)(E) for the Aggravated Assault on Staff, not to exceed the (b)(7)(E) for a single event.) (Exhibits 54, 55)

169. ~~(U//FOUO)~~ Furthermore, in the days at the DH leading up to his death, ISN156 had again splashed urine on a guard and thrown items onto the tier. (Exhibits 24, 28)

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[146] ~~(U//FOUO)~~ These events occurred under the previous leadership of the JDG and the 525th MP BN. (b)(3):10 USC §130b (b)(6),(b)(7)(C) learned of the issue when Soldiers placed comment cards in the suggestion box of the break room, complaining about the assaults by ISN156. ---- noted that the assaults would happen (b)(7)(E) (b)(7)(E) JDG Procedure #33 (b)(7)(E) According to information from guards, (b)(7)(E) (Exhibits 6, 15, 16, 42)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

[147] ~~(U//FOUO)~~ According to JDG Procedure #30, (b)(7)(E) discipline time at Camp V. "Indecent assault", however, is not defined. According to the Detainee Offense Matrix, (b)(7)(E) (Exhibit 41)

[148] ~~(U//FOUO)~~ (b)(7)(E),(b)(7)(F) (b)(7)(E),(b)(7)(F) and also assaulted several BHU/DH guards (b)(7)(E),(b)(7)(F) a chair, and a flashlight. (Exhibits 11, 17)

170. ~~(U//FOUO)~~ In fact, it was this type of "out of control" behavior that led the JDG Commander to approach (b)(3):10 USC §130b,(b)(6),(b)(7)(C) the morning of 7 September 2012 and ask her whether there was any medical reason that would prevent ISN156 from serving his discipline time.[149] (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) responded that in her opinion, this was "very volitional behavior" and that there was "no psychiatric reason" to prevent ISN156 from serving his discipline time. The JDG Commander indicated that based on that, he decided on 7 September to transfer ISN156 to Camp V (b)(7)(E) (b)(7)(E) (Exhibits 5, 24)

5. ~~(U//FOUO)~~ JDG Procedure #34: Search and Inspection

171. ~~(U//FOUO)~~ JDG Procedure #34 covers Search and Inspection. The SOP requires that detainees be searched every time they are moved from one area to another, regardless of the circumstances or reason for the move. (b)(7)(E) (Exhibit 43)

172. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 43)

173. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 43)

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[149] ~~(U//FOUO)~~ It is unclear for which of the offenses ISN156 was being sent to Camp V to serve discipline time. What is clear is that because of his behavior in the weeks leading up to his death, ISN156 had a large amount of discipline time to serve.

[150] ~~(U//FOUO)~~ (b)(7)(E) (b)(7)(E) The JDG Commander indicated that he is currently in the process of reviewing the (b)(7)(E) (b)(7)(E) The OIC of the BHU/DH and Camp Iguana indicated that COL Bogdan called the Camp OICs into his office on 24 September 2012 to discuss a modified search program and an implementation process. (b)(3):10 USC §130b, (b)(6), (b)(7)(C) understood that there would be (b)(7)(E) (Exhibits 5, 18)

[151] ~~(U//FOUO)~~ Contraband is "any item, article, or substance not issued to detainees, authorized for their use or altered by the detainee." (Exhibit 41)

174. ~~(U//FOUO)~~ The Camp V OIC ([redacted]) indicated that she understands that her guards are conducting [redacted] Noting that the most common thing guards find during searches are excess quantity items (such as too many books), she acknowledged that on other occasions, guards have discovered [redacted] and water flavoring bubbles in the cells.[152] (Exhibit 16)

175. ~~(U//FOUO)~~ Several guards indicated they properly understood provisions of the search and inspection SOP, [redacted] One guard noted that in his opinion, [redacted]

176. ~~(U//FOUO)~~ After ISN156 moved from the DH to Camp V on 7 September 2012, guards at Camp V indicated they searched his belongings and removed items (extra towels, T-shirts) that he was not allowed to have because he was on discipline time, and gave him the remainder of his things, including a foam pillow and linens.[153] (Exhibit 19)

6. ~~(U//FOUO)~~ JDG Procedure #56: Line of Sight

177. ~~(U//FOUO)~~ [redacted] Detainees may be designated for line of sight for [redacted] Detainees on line of sight will be [redacted]

178. ~~(U//FOUO)~~ [redacted] The WC/AWC will brief the guards on line of sight procedures prior to them assuming line of sight duty, [redacted]

179. ~~(U//FOUO)~~ The SOP requires the line of sight guard [redacted] The line of sight guard is required [redacted]

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[152] ~~(U//FOUO)~~ [redacted] noted the flavoring bubbles are distinct from the flavoring packets that detainees are authorized each Friday. [redacted] suspects the source of the flavoring bubbles (contraband) to be certain guards, but she has not been able to identify which guards are bringing in the flavoring bubbles. She indicated the [redacted] (Exhibit 16)

[153] ~~(U//FOUO)~~ Although ISN156 was authorized a mattress, he indicated that he only wanted the foam pillow. Accordingly, when ISN156 was found unresponsive, he was lying directly on the cell floor, where he had appeared to be asleep. (Exhibits 15, 19)

(b)(7)(E)

(Exhibit 45)

180. ~~(U//FOUO)~~ The SOP states (b)(7)(E) Similarly, if a detainee covers (b)(7)(E) or otherwise obstructs the view of the guards, (b)(7)(E) If there is no response, the guard shall call (b)(7)(E) immediately.[154]

181. ~~(U//FOUO)~~ Guards failed to require ISN156 to uncover his (b)(7)(E) after he covered it with a food mixture the night of 7 September 2012. (Exhibit 1)

182. ~~(U//FOUO)~~ Several guards indicated that they were unfamiliar with what the line of sight SOP required with respect to rotation times. (Exhibits 10, 14, 19, 20)

183. ~~(U//FOUO)~~ Other guards indicated they knew what the line of sight SOP required, but for various reasons, chose to ignore the SOP and devised their own rotation times. (Exhibits 1, 6, 8, 25)

184. ~~(U//FOUO)~~ Once it was determined on 7 September 2012 that ISN156 would be transferred from the DH to Camp V, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) recommended ISN156 be on line of sight. Although the Camp V OIC asked whether it could be electronic line of sight, [redacted] recommended direct (physical) line of sight.[155] In the end, (b)(2):10 USC §130b,(b)(6),(b)(7)(C) ordered that ISN156 be placed on electronic and direct line of sight. (Exhibits 16, 24)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

185. ~~(U//FOUO)~~ On the night of 7 September 2012, the night before ISN156's death, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) were the designated line of sight guards on ISN156. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that although he knew the SOP required guards to rotate every (b)(7)(E) he and (b)(3):10 USC §130b, (b)(6),(b)(7)(C) devised a system where they would rotate (b)(7)(E) (b)(3):10 USC §130b,(b)(6) like [redacted], indicated that he knew the SOP required line of sight guards to rotate every (b)(7)(E) (b)(3):10 USC §130b, (b)(6),(b)(7)(C) noted that "some NCOs require us to rotate out every (b)(7)(E) some NCOs say (b)(7)(E) and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) said (b)(7)(E) was fine." At one point, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) left to work on an additional duty (filling out counseling statements). (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that he then pulled line of sight duty for (b)(7)(E). (Exhibits 1, 1-A, 6)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

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[154] ~~(U//FOUO)~~ A (b)(7)(E) indicates a detainee is committing self-harm in a particular location. (Exhibit 47)

[155] ~~(U//FOUO)~~ Although the SOP indicates that the (b)(7)(E) [redacted] (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (b)(7)(E) (Exhibit 24)

186. ~~(U//FOUO)~~ The night of 7 September 2012 was the first time that the Alpha BNCO ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) was in charge of or had conducted line of sight. Acknowledging that he did not know what the line of sight SOP required, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated he understood that (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) were rotating (b)(7)(E) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated he allowed the (b)(7)(E) rotation time because he thought it would be easier on them. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that the day following ISN156's death, 9 September 2012, he learned the SOP required line of sight guards to rotate every (b)(7)(E) [156] (Exhibit 19)

187. ~~(U//FOUO)~~ On the morning of 8 September 2012, the day ISN156 was pronounced dead, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) were the designated line of sight guards on ISN156. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) was on his first day of duty and accordingly was pulling line of sight duty for the first time. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated he was told that he and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) would be rotating line of sight duty (b)(7)(E) (b)(7)(E) [157] (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that although the pre-service training addressed line of sight duty, it did not address rotation times. (Exhibit 10)

188. ~~(U//FOUO)~~ The Alpha BNCO on the morning of 8 September 2012 ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) indicated that although he knew the SOP required the guards to rotate every (b)(7)(E) generally, he permitted Soldiers to "decide how long they want[ed] to rotate line of sight." (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated no one ever told him specifically that day that line of sight duty would be rotated every (b)(7)(E) He indicated the WC ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) put out information at the guard mount on 9 September 2012 that line of sight would be every (b)(7)(E) "from now on."[158] (Exhibit 25, 25-A)

189. ~~(U//FOUO)~~ Generally, guards understood that the (b)(7)(E) (Exhibits 1, 8, 10)

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[156] ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6),(b)(7)(C) did not recall who told him of the line of sight SOP requirements. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that he now understood that the rule exists "so that guards do not get tired or complacent." (Exhibit 19)

[157] ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6),(b)(7)(C) did not recall who told him that he and (b)(3):10 USC §130b,(b)(6) would be rotating line of sight duty every (b)(7)(E) The recollections of (b)(3):10 USC §130b,(b)(6),(b)(7)(C) are largely consistent, except that (b)(3):10 USC §130b,(b)(6) did not recall specifically rotating out on the (b)(7)(E) ——— acknowledged, however, that their rotation times were longer than (b)(7)(E) because he recalled having to deal with another detainee several times that night. The detainee "would not deal with ——— because (b)(3):10 USC §130b,(b)(6) was new." (Exhibit 8)

[158] ~~(U//FOUO)~~ The recollection of ——— varies notably from ——— who indicated that while making his rounds on Alpha Block on 8 September 2012, he specifically told ——— the rotation for line of sight duty for ISN156 would be (b)(7)(E) (b)(5) (Exhibit 15)

7. ~~(U//FOUO)~~ JDG Procedure #66: Medication Pass (Med Pass) Procedures

190. ~~(U//FOUO)~~ JDG Procedure #66 governs Medication Pass (Med Pass) Procedures.[159] Generally, the SOP indicates that (b)(7)(E) The SOP notes the (b)(7)(E) (Exhibit 46)

191. ~~(U//FOUO)~~ According to the SOP, (b)(7)(E) (Exhibit 46)

192. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 46)

193. ~~(U//FOUO)~~ For "high risk" DEA-controlled drugs, the SOP establishes that "(b)(7)(E) (b)(7)(E)"[162] The JDG SOP notes that (b)(7)(E)

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[159] ~~(U//FOUO)~~ There is an entirely separate JMG SOP that also governs medication administration procedures. There is some overlap between the JDG and JMG SOPs governing medication administration. Where items are solely addressed in the JMG SOP, those items are discussed below in the corresponding JMG SOP discussion section rather than here. (Exhibit 50)

[160] ~~(U//FOUO)~~ As noted below in the JMG SOP subsection in the report, the JMG SOP regarding Med Pass differs notably from the JDG SOP governing Med Pass. Significantly, (b)(7)(E) (Exhibits 28, 50)

[161] ~~(U//FOUO)~~ The provision requiring the BNCO to verify that (b)(7)(E) (Exhibit 46)

[162] ~~(U//FOUO)~~ As discussed below, the specific drugs that qualify as high-risk DEA classified drugs are set forth in the JMG SOP. (Exhibit 50)

(b)(7)(E)

(Exhibit 46)

194. ~~(U//FOUO)~~ Several corpsmen indicated that they are (b)(7)(E) (Exhibits 21, 23)

195. ~~(U//FOUO)~~ Indeed, the JMG Training Officer, (b)(3):10 USC §130b,(b)(6),(b)(7)(C), indicated that (b)(3):10 USC §130b,(b)(6),(b)(7)(C),(b)(7)(E)

196. ~~(U//FOUO)~~ Furthermore, a registered nurse assigned to the BHU/DH ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) noted (b)(3):10 USC §130b,(b)(6),(b)(7)(C),(b)(7)(E)

197. ~~(U//FOUO)~~ The understanding of the Training Officer, BHU/DH is entirely inconsistent with that of the JMG Commander ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)) and the Senior Nurse Executive ((b)(3):10 USC §130b, (b)(6),(b)(7)(C)). (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated that with respect to Med Pass, he understood that the corpsman is to provide one medication at a time, and the corpsman is to (b)(7)(E)

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163 ~~(U//FOUO)~~ (b)(7)(E)

164 ~~(U//FOUO)~~ (b)(7)(E) Several corpsmen acknowledged that there was a real risk of detainees hoarding medications. (b)(3):10 USC §130b, (b)(6),(b)(7)(C) for example, noted that because of the risk, he does not ever leave medications in a detainee's splashbox. (Exhibits 6, 21)

165 ~~(U//FOUO)~~ In addition to being the psychiatric mental health nurse at GTMO, [redacted] is also the designated Training Officer for the JMG. Unlike the JDG, who relies on the 525th MP BN to conduct the guard training, the JMG is required to conduct its own training. It is unclear whether [redacted] is referring to the JDG SOP (b)(7)(E) (b)(7)(E) or the JMG SOP (b)(7)(E) (b)(7)(E) (Exhibits 4, 28)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

166 ~~(U//FOUO)~~ Based on her experience as a registered nurse in civilian psychiatric hospital, [redacted] suggested a more robust medication administration program at JTF-GTMO than the Med Pass program currently outlined in the JDG and JMG SOPs. (Exhibit 35)

(b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(3):10 USC §130b,(b)(6),(b)(7)(C),(b)(7)(E)

(Exhibits 31, 38)

198. ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6),(b)(indicated that the policy is a "significant change" since he took command of the JMG on 21 May 2011.[168] (b)(3):10 USC §130b,(b)(6) indicated that because a detainee had just died by hanging on 18 May 2011, it was immediately clear to him that "the risk of suicide was a very serious issue here." (b)(3):10 USC §130b,(b)(6) indicated that he devised the policy because he learned that no detainee had actually killed himself by an overdose, but that certain detainees "had attempted to do so by hoarding and overdosing."[169] (Exhibit 31)

199. ~~(U//FOUO)~~ (b)(3):10 USC §130b,(b)(6) indicated that, consistent with the JDG and JMG SOP, he (b)(7)(E) The Senior Nurse Executive ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) and a BHU/DH registered nurse ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)), (b)(7)(E) (b)(7)(E) (Exhibits 31, 35, 38)

200. ~~(U//FOUO)~~ Nonetheless, in contrast to the SOP and the understanding of (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and (b)(3):10 USC §130b,(b)(6),(b)(7)(C), none of the corpsmen interviewed by the Investigative Team indicated that (b)(7)(E)[170]

8. ~~(U//FOUO)~~ JDG Procedure #82: Detainee Death

201. ~~(U//FOUO)~~ JDG Procedure #82 covers procedures in the event of a detainee death. In the case of an unresponsive or dead detainee, (b)(7)(E)

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[167] ~~(U//FOUO)~~ Another example of the apparent disconnect between the JMG leadership and the medical personnel is illustrated by the comments of a night corpsman. ---- indicated "Since I began my duties here at Camp V 28APR12, I do not recall ever being visited by anyone in my leadership chain. I have felt invisible with no one seeming to even know I was working here." (Exhibit 9-A) (b)(3):10 USC §130b,(b)(6),(b)(7)(C)

[168] ~~(U//FOUO)~~ The statement of (b)(3):10 USC §130b,(b)(6),(b)(7) indicates that he took command of the JMG on 27 May 2012 and that a detainee died by hanging on 18 May 2012 – these dates should read 2011. ---- is one of the few uniformed officers at JTF-GTMO who has been at GTMO for over a year. Again, like with (b)(3):10 USC §130b,(b)(6),(b)(7)(C), it is unclear whether ---- was referring to the JDG SOP or the JMG SOP governing medication administration. Furthermore, it is unclear whether (b)(3):10 USC §130b,(b)(6),(b)(7)(C) is aware that the JMG SOP (b)(7)(E) (Exhibit 31) (b)(3):10 USC §130b,(b)(6),(b)(7)(C) (b)(3):10 USC §130b,(b)(6),(b)(7)(C)

[169] ~~(U//FOUO)~~ The Cultural Advisor has been at JTF-GTMO since 29 September 2005, and accordingly has been present for all nine detainee deaths that have occurred at JTF-GTMO to date (seven suicides and two natural deaths). An interpreter referred to a specific instance of ISN156 hoarding pills, noting that at one point in 2008, ISN156 said something like "here, I could eat these pills if I wanted to kill myself" and showed him and the guard a fist full of pills – "maybe 4 or 5 pills." ---- indicated that the guard confiscated the pills from ISN156. (Exhibits 2, 12, 31) (b)(3):10 USC §130b,(b)(6),(b)(7)(C)

[170] ~~(U//FOUO)~~ Because of the timing of the investigation, interviews, and the drafting of statements, the statements of the corpsmen do not reflect any specific information regarding the (b)(7)(E) not being followed.

(b)(7)(E)

(Exhibit 111)

202. ~~(U//FOUO)~~

(b)(7)(E)

(Exhibit 111)

203. ~~(U//FOUO)~~ Once it was determined that ISN156 was unresponsive and would be transferred out of Camp V for emergency medical treatment, the Camp V Watch Commander, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) tasked an NCO and a guard (b)(3):10 USC §130b,(b)(6),(b)(7)(C) to accompany ISN156. The guards remained with ISN156 from Camp V to the DH,[172] from the DH to the NAVSTA Hospital, and from the NAVSTA Hospital to the morgue. Correctly understanding that their orders were "to stay with the body the whole time," (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and (b)(3):10 USC §130b,(b)(6),(b)(7)(C) stayed with the body until it was brought into the morgue and the morgue door was closed. (Exhibits 13, 29)

204. ~~(S)~~ The Cultural Advisor

(b)(1),(b)(3):10 USC §130b,(b)(6),(b)(7)(C),Sec. 1.4(c)

(Exhibit 12)

VI. (U) JOINT MEDICAL GROUP (JMG)

A. (U) Leadership

205. ~~(U//FOUO)~~ As noted above, the JMG falls under the command and control of JTF-GTMO. The commander of the JMG is Captain Richard Stoltz. (Exhibit 69)

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[171] ~~(U//FOUO)~~ Many of the provisions of JDG Procedure #82 (b)(7)(E) That was not the case with ISN156, as he was found unresponsive in his cell, guards and medical personnel initiated life-saving efforts, and ISN156 was pronounced dead at the NAVSTA Hospital. (Exhibit 111)

[172] ~~(U//FOUO)~~ As explained above, (b)(7)(E) in accordance with the SOP. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) sent the ambulance from the DH to the NAVSTA Hospital once he assessed ISN156 and determined he would receive care more quickly there than if they waited for medical officers to respond to the DH / BHU. (Exhibit 32)

206. ~~(U//FOUO)~~ The JMG Headquarters element (HQ) is composed of the Joint Troop Clinic (JTC), the Detainee Hospital (DH), and J-Smart. (Exhibit 69)

207. ~~(U//FOUO)~~ The total number of detainees at JTF-GTMO under mental health services at any given time is from (b)(7)(E),(b)(7)(F). Approximately (b)(7)(E), (b)(7)(F) of those detainees see only the JMG psychiatrist (b)(3):10 USC §130b (b)(6),(b)(7)(C) (detainees who only need medications and do not require / request counseling), (b)(7)(E), (b)(7)(F) only see the JMG psychologist (b)(3):10 USC §130b, (b)(6),(b)(7)(C) (detainees who only need counseling but do not require / request medications), and the remainder see both the JMG psychiatrist and psychologist.[173] (Exhibit 24)

B. (U) Training

208. ~~(U//FOUO)~~ The JMG is responsible for training the medical personnel providing detainee medical care. The training consists of Skill Validation (RN and technicians), BHU/DH Orientation, Camp V/VI Orientation, Care of Detainees, Enteral Feed Orientation, and Ambulance Operation.[174] There is a specific block on medication preparation / Med Pass, including "How to pass medications." (Exhibits 87, 88, 89, 90, 91, 92, 93, 94)

209. ~~(U//FOUO)~~ There is a separate Medication Administration Competence, including a Competency Statement, initialed by the instructor and the trainee. The Competency Statement includes blocks on how to verify a detainee has swallowed the medication, and how to correctly document on the [Medication Administration Record] MAR when medications are given or refused.[175] (Exhibits 87, 88, 89, 90, 91, 92, 93, 94)

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[173] ~~(S)~~ (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that there are currently [redacted] detainees who he has concerns about their long term care. (b)(6),(b)(7)(C)

(b)(1),Sec. 1.4(c)

The Cultural Advisor [redacted] (b)(1),(b)(3):10 USC §130b,(b)(6),(b)(7)(C),Sec. 1.4(c)

also expressed concern about the ability of JTF-GTMO to provide long-term care for (b)(6),(b)(7)(C) and (b)(6),(b)(7)(C) Exhibits 12, 37)

[174] ~~(U//FOUO)~~ The JMG produced incomplete records for corpsman and nurse training. From the records, it appears that the trainee's rank and duty title determine which blocks of training the trainee receives. The Training Officer was (b)(3):10 USC §130b (b)(6),(b)(7)(C) Although her signature appears to certify the trainee's knowledge of the requirements of the medications pass policy, in her statement, [redacted] stated, (b)(3):10 USC §130b, (b)(6),(b)(7)(C)

(b)(7)(E)

As of Feb 2012, (b)(7)(E) Corpsmen also acknowledged not looking (b)(7)(E) one noted that "we were told during our indoctrination training not to do so, because it would make the detainees mad." The understanding of the JMG commander, (b)(3):10 USC §130b (b)(6),(b)(7)(C) is quite different, as he indicated that the corpsman is to

(b)(7)(E)

(Exhibits 21, 23, 28, 31, 87, 88, 89, 90, 91, 92, 93, 94)

[175] ~~(U//FOUO)~~ The Medication Administration Competence indicates that the trainee will be able to demonstrate a (b)(7)(E) and

210. ~~(U//FOUO)~~ There is also a separate Medication Administration Understanding, signed by the trainee. The Medication Administration Understanding indicates that (b)(7)(E) (Exhibits 87, 88, 89, 90, 91, 92, 93, 94)

C. (U) JMG Standard Operating Procedures (SOPs)

211. ~~(U//FOUO)~~ There are a total of 79 JMG SOPs governing a wide array of detainee operations, ranging from Medical Management of Detainees on Hunger Strike, In-Service

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JMG SOP #117." The trainee will be able to: (b)(7)(E)

In her statement, (b)(3):10 USC §130b (b)(6),(b)(7)(C) indicated that she was told the previous wave had tried to do (b)(7)(E) (b)(7)(E) (b)(3):10 USC §130b (b)(6),(b)(7)(C) (b)(7)(E) (b)(7)(E) (b)(3):10 USC §130b (b)(6),(b)(7)(C) explained that she regularly asks (b)(6) for example, a long-term resident of the DH, (b)(7)(E) and that (b)(6) complies. (b)(3):10 USC §130b (b)(6),(b)(7)(C) offered that in her opinion, (b)(7)(E) and the rapport that he / she has been able to establish with the detainee. (Exhibits 35, 87, 88, 89, 90, 91, 92, 93, 94)

(b)(7)(E)

Training, Nursing Guidelines, Detainee Refusal of Care, and Pharmacy, to Medication Administration Policy.[177] (Exhibit 126)

1. ~~(U//FOUO)~~ JTF-JMG #117: Medication Administration Policy

212. ~~(U//FOUO)~~ JTF-JMG#117 covers the Medication Administration Policy.[178] (b)(7)(E) (Exhibit 50)

213. ~~(U//FOUO)~~ According to the SOP (b)(7)(E) (Exhibit 50)

214. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 50)

215. ~~(U//FOUO)~~ After each medication pass, (b)(7)(E) (Exhibit 50)

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[177] ~~(U//FOUO)~~ Although the current SOP (b)(7)(E) for a total of 79 active SOPs.

[178] ~~(U//FOUO)~~ As noted above, there is (b)(7)(E) (b)(7)(E). The JMG Commander (CAPT Stoltz) indicated that shortly after he took command, he changed the SOP specifically (b)(7)(E) " CAPT Stoltz indicated the JMG is again re-examining the Med Pass SOP, as he is (b)(7)(E) one that corpsmen can more easily absorb. CAPT Stoltz also noted that the JMG is (b)(7)(E) (b)(7)(E) The JDG Commander indicated that "[t]the JDG is working very closely with the JMG to synchronize operations." (Exhibits 5, 31, 46)

[179] ~~(U//FOUO)~~ The JMG SOP governing nursing guidelines also addresses the MAR and how it is to be completed. (Exhibit 49)

216. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 50)

217. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 50)

218. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 50)

219. ~~(U//FOUO)~~ (b)(7)(E) (Exhibit 50)

220. ~~(U//FOUO)~~ The SOP establishes that (b)(7)(E) (b)(7)(E) (Exhibit 50)

221. ~~(U//FOUO)~~ Finally, the SOP indicates that (b)(7)(E) (b)(7)(E) [185] (Exhibit 50)

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[180] ~~(U//FOUO)~~ High Risk DEA medications are (b)(7)(E). Those medications that ISN156 had been recently administered (Table 3 of this report) include Ativan, Percocet, Tylenol #3, Haldol, and Seroquel. (Exhibit 50)

[181] ~~(U//FOUO)~~ The JMG SOP (b)(7)(E) (b)(7)(E) (Exhibit 49)

[182] ~~(U//FOUO)~~ The JMG SOP (b)(7)(E) (b)(7)(E) (Exhibit 50)

[183] ~~(U//FOUO)~~ The JDG SOP (b)(7)(E)

[184] ~~(U//FOUO)~~ The JDG SOP (b)(7)(E)

[185] ~~(U//FOUO)~~ The JDG SOP (b)(7)(E)

222. ~~(U//FOUO)~~ As noted above, (b)(7)(E) (Exhibit 46, 50)

223. ~~(U//FOUO)~~ With respect to the administration of PRN medications, a review of the medical records for ISN156 seems to indicate that the corpsmen are not properly annotating those instances where the detainee requested a PRN medication more than (b)(7)(E) period. (Exhibit 97)

224. ~~(U//FOUO)~~ Regarding the locations of Med Pass, (b)(7)(E) (Exhibits 9, 21, 23A).[186]

225. ~~(U//FOUO)~~ The JDG Commander, COL Bogdan, himself indicated that (b)(7)(E) (b)(7)(E) COL Bogdan indicated that he (b)(7)(E) including ISN156. COL Bogdan indicated that the policy was in place "well before" he assumed command, and that he understood that ISN156 needed to get medications at certain times, and it (b)(7)(E)"[187] (Exhibit 5)

226. ~~(U//FOUO)~~ One corpsman indicated that he (b)(7)(E) "during Ramadan, but not before or after."[188] Another corpsman indicated without reservation that (b)(7)(E) (Exhibits 9, 21, 23A)

227. ~~(U//FOUO)~~ Not all corpsmen are complying with the SOP requirement (b)(7)(E)

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[186] ~~(U//FOUO)~~ The OIC of the BHU/DH ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) and a corpsman assigned to the DH, ((b)(3):10 USC §130b (b)(6),(b)(7)(C)) correctly indicated that it was their (b)(7)(E) (Exhibits 18, 22, 50)

[187] ~~(U//FOUO)~~ The SOP (b)(7)(E) (b)(7)(E) Noting that (b)(7)(E) ((b)(3):10 USC §130b,(b)(6)) (b)(7)(E) (b)(7)(E) (b)(7)(E) Accordingly, ((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) indicated that she asked ---- to put the policy in writing. The medical records for ISN156 include an entry that ---- at one point told the techs that they could (b)(7)(E). For her part, ((b)(3):10 USC §130b,(b)(6)) (b)(7)(E) (Exhibits 24, 35, 48-B, 98)

((b)(3):10 USC §130b,(b)(6),(b)(7)(C)) ((b)(3):10 USC §130b,(b)(6),(b)(7)(C))

[188] ~~(U//FOUO)~~ ---- did not indicate why he understood the rules to be different during Ramadan. (Exhibit 9)

(b)(7)(E)
(Exhibits 9, 50)

2. ~~(U//FOUO)~~ JTF-JMG #60: Cardiac Arrest Procedures

228. ~~(U//FOUO)~~ JMG SOP #60, Cardiac Arrest Procedures, provides that in the event of a the following will apply... (b)(7)(E)
(b)(7)(E)

(U) Part 2: FINDINGS

1. ~~(U//FOUO)~~ Finding: ISN156 had an extensive history of disciplinary and self-harm attempts while detained at JTF-GTMO. (Facts 19-64)

(U) Discussion:

a. ~~(U//FOUO)~~ Disciplinary events spanned from 2002 to 2012 and included assaults on guard force, inappropriate use of bodily fluids, and possession of contraband. Self-harm events spanned from 2003 to 2012, and included ingestion of inedible items, attempted hanging, and cutting. ISN156 frequently expressed suicidal ideations, including writing dark poems, talking about death, and making passive statements about suicide. At various times during his detention, ISN156 was on hunger strike, and at certain points required enteral feeding.

b. ~~(U//FOUO)~~ There was also a significant spike in disciplinary issues in the several weeks before his death. ISN156 threw rocks, striking the guard tower, the tower spotlight, and two guards. Later that same day, while in (b)(7)(E),(b)(7)(F), ISN156 (b)(7)(E),(b)(7)(F)
(b)(7)(E),(b)(7)(F) The night of 31 July 2012, ISN156 began jumping around in his cell and refused to comply with an order to stop jumping. The following morning, ISN156 threw a cocktail of feces and urine from a styrofoam cup at a nurse and the guards, striking them in the face and neck. Later that week, while at BHU (b)(7)(E),(b)(7)(F) ISN156 (b)(7)(E),(b)(7)(F)
During a fit of rage, ISN156 lunged at (b)(3):10 USC §130b,(b)(6),(b)(7)(C) and assaulted several guards. On 6 September 2012, while still at the DH, ISN156 began spontaneously yelling and kicking, threw his urinal, and thereby splashed a guard.

2. ~~(U//FOUO)~~ Finding: Because of his unique medical issues and temperament, ISN156 was not treated like any other detainee. This disparate treatment resulted in significant deviations from SOPs and protocols and caused significant pressure on the guard force. (Facts 22-27)

(U) Discussion:

a. ~~(U//FOUO)~~ There were several instances where ISN156 was either not disciplined or was not required to serve discipline time immediately (rock-throwing incident). ISN156 was able to have a cup full of feces and urine at the recreation yard because of an order by (b)(3):10 USC §130b, (b)(6),(b)(7)(C) permitting ISN156 to take a sheet with him to the recreation yard. The order allowing ISN156 to have a sheet at the recreation yard violated the SOP, and created risk. ISN156 frequently made demands on the guard force (demanding the guards locate (b)(3):10 USC §130b,(b)(6),(b)(7)(C) or a threat of "big problems").

b. ~~(U//FOUO)~~ Much of the guard force and medical personnel felt that ISN156 was not subject to the same boundaries that other detainees were, and that certain provisions of the general JDG and JMG SOPs did not apply to him. Other guards were unfamiliar with what the specific SOP provisions required. Accordingly, guards and medical personnel frequently did not enforce JDG and JMG SOPs with respect to ISN156. Some guards expressed concerns regarding reprisals from leadership if they were to exercise too much force with respect to ISN156.

c. ~~(U//FOUO)~~ Over the course of his ten-and-a-half years of detention at JTF-GTMO, ISN156 moved from camp to camp over 67 times. He was variously housed at Camp X-Ray, Camps I, II, III, V, VI, the BHU and the DH. Some of these moves did cause stress on the guard force and ISN156, but nothing that was overly unusual. Although ISN156 had bad memories of the cell where he was ultimately moved and at least one detainee stated that moving ISN156 to the cell would cause him to commit suicide, the moves themselves did not contribute to the detainee's death.

3. ~~(U//FOUO)~~ Finding: JDG leadership failed to take remedial action to address the problems with the (b)(7)(E),(b)(7)(F) **(Facts 42-43, 54-64)**

~~(U//FOUO)~~ Discussion: Recognizing the potential dangers caused when ISN156

(b)(7)(E),(b)(7)(F)

4. ~~(U//FOUO)~~ Finding: Despite the Force Protection report indicating that ISN156 may be suicidal, COL Bogdan acted reasonably in ordering ISN156 to be moved to Camp V to serve his disciplinary sentence. (Facts 73-91, 170; Exhibit 5)

~~(U//FOUO)~~ Discussion: On 6 September 2012, while still at the DH, ISN156 began spontaneously yelling and kicking, threw his urinal, and thereby splashed a guard. On 7 September 2012, COL Bogdan asked (b)(3):10 USC §130b,(b)(6),(b)(7)(C) whether there was a medical or psychiatric reason that ISN156 could not serve his discipline time at Camp V. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) indicated that ISN156's recent behavior, including his splashing the guard the day before, was entirely volitional. Accordingly, (b)(3):10 USC §130b, (b)(6),(b)(7)(C) indicated there was no reason that ISN156 could not serve his discipline time at Camp V. After the decision was made to move him, (b)(6),(b)(7)(C),(b)(7)(E) Upon receiving the information, the JTF-GTMO Cultural Advisor forwarded the information to COL Bogdan and others. Although COL Bogdan did not receive the email until the following day, he stated that it would not have affected his decision to transfer ISN156 to Camp V, because ISN156 was known to make "melodramatic" statements. In this instance, COL Bogdan acted reasonably as he had to address the frequent misconduct by ISN156. On balance, the suicidal ideation did not stand out compared to any of the other instances. Additionally, line of sight was ordered in an attempt to prevent any self-harm by ISN156.

5. ~~(U//FOUO)~~ Finding: Although guards followed the SOP regarding search and inspection, there are opportunities and ways for a detainee to conceal contraband, including medications. (Facts 89, 120, 139-40, 171-76; Exhibit 5)

(U) Discussion.

a. ~~(U//FOUO)~~ Before giving ISN156's belongings to him after he arrived from the DH, Camp V guards searched them in accordance with the SOP. Guards removed certain unauthorized items, such as extra towels and T-shirts, and gave the remaining, authorized items to ISN156. (b)(7)(E) This creates extraordinary opportunities for detainees to conceal contraband should they choose.

b. ~~(U//FOUO)~~ Additionally, IAW SOP, guards did not search ISN156's Koran. The current version of the JDG SOP, only the Cultural Advisor or interpreters may search a Koran.

c. ~~(U//FOUO)~~ ISN156 was able to successfully conceal contraband, specifically, 24 capsules of Invega, at some point from when he was initially prescribed and administered the medication through the date that he was found unresponsive on 8 September 2012. The way that the JDG and JMG SOPs are drafted created numerous opportunities for ISN156 to conceal the capsules. (b)(3):10 USC §130b,(b)(6),(b)(7)(C) expressed his concerns with the (b)(7)(E) (b)(7)(E) He also noted that his staff is in the process of

searching for where that "directive" initiated. So while the guards did follow proper search SOP, the current version allows opportunities for detainees to hide contraband.

6. ~~(U//FOUO)~~ **Finding: The JDG guard force failed to follow the JDG Line of Sight SOP, violated the JDG and JMG Med Pass SOPs, and should have taken remedial measures after ISN156 appeared to be sleeping an unusual length of time. (Facts 90-106, 177-89, 190-200, 212-27)**

(U) Discussion.

a. ~~(U//FOUO)~~ The failure of guards within the camps to follow the (b)(7)(E) line of sight rotation time and the failure of the leadership – both officers and non-commissioned officers – within Camp V to enforce the (b)(7)(E) line of sight rotation time increases the risk that a line of sight guard, because of fatigue or distraction, will fail to recognize signs that a detainee's behavior or actions have changed over an extended time. Where guards fail to recognize these signs, there is an increased risk that a detainee may, for a variety of reasons, ultimately be found unresponsive.

b. ~~(U//FOUO)~~ When ISN156 arrived at Camp V, he was on electronic and direct line of sight. After he arrived, ISN156 covered his (b)(7)(E) with a food mixture. The guard monitoring the (b)(7)(E) was not able to continue to see what ISN156 was doing. When this occurred, the SOP requires the guard to knock loudly on the cell door and uncover the (b)(7)(E) If the detainee does not respond immediately, the guard is to call (b)(7)(E) Guards violated the SOP when they failed to require ISN156 to uncover his (b)(7)(E) while on line of sight, and failed to call a (b)(7)(E) This failure may have contributed to the death of ISN156 in that it prevented the guard from being able to monitor ISN156 electronically, and from discovering whether something was in fact wrong with ISN156 during the time that the direct line of sight guards say ISN156 was sleeping.

c. ~~(U//FOUO)~~ The line of sight guards on the night shift were rotating out (b)(7)(E) to (b)(7)(E) The guards knew that the SOP required a (b)(7)(E) rotation, but elected not to follow it. On the day shift, several guards were either not familiar with the (b)(7)(E) rotation requirement set forth in the JDG SOP, or were familiar with the requirement and chose to disregard it. At the time that ISN156 was found unresponsive, the day shift line of sight guards for ISN156 were rotating out (b)(7)(E) The AOIC of Camp V on duty knew that guards usually rotated out (b)(7)(E) , and did not know that the line of sight SOP specifically addressed rotation times. The tier NCO that night was on his first duty as an NCO of line of sight, and did not know what the SOP required. He allowed the line of sight guards to rotate out (b)(7)(E) because he thought it would be easier on the guards. The failures by the night and day shift line of sight guards to follow the SOP, and the failure of the NCO to enforce the

standards of the SOP, may have contributed to the death of ISN156 as the failures meant that the guards were not as vigilant as the SOP required in their monitoring of ISN156.

d. ~~(U//FOUO)~~ Additionally, around 0400, [redacted] (b)(7)(E) The SOP does not allow for medications to be distributed in any other way other than that authorized by the SOP. This particular failure to follow the SOP the morning of 8 September 2012 did not contribute to the death of ISN156, as the medications were still in the splashbox at the time that ISN156 was found unresponsive. However, similar failures by medical staff over time, to follow the SOP, may have contributed to ISN156's ability to hoard medications, as discussed below.

e. ~~(U//FOUO)~~ The JDG SOP governing line of sight requires the Watch Commander to check detainees placed on line of sight at a minimum of [redacted] (b)(7)(E) and annotate events in DIMS. The Watch Commander failed to make the line of sight entries into DIMS as required by the SOP. While the failure to make the entries did not contribute to the death of ISN156, the lack of entries did make it difficult after the fact to re-create the immediate events leading up to the point that the guards found ISN156 unresponsive.

f. ~~(U//FOUO)~~ The guard force noted that ISN156 generally had an unusual sleep pattern, in that he usually slept for only a few hours at a time, and even then, continued to move all over his cell in his sleep. From the time he appeared to fall asleep around 2359, 7 September through the morning, the guard force had several opportunities to wake or further check on ISN156. At 0400, the corpsman attempted to wake ISN156 with medications, but ISN156 continued to appear asleep. He also appeared to sleep through morning call to prayer at 0455. ISN156 did not wake up for his recreation yard time, scheduled for 1000-1200. The Watch Commander recalled that the last time he saw ISN156 alive was around 1100. At that time, he checked on ISN156 to see whether he wanted to go to recreation, but because ISN156 appeared to be asleep, he did not disturb ISN156. Around 1200, ISN156 missed the noon call to prayer. At this point ISN156 had appeared to be asleep for approximately 12 hours, had missed both the breakfast and lunch meal, and had not taken medications for more than 12 hours. Although there was no requirement to awake a detainee, it would have prudent to have attempted to do so in these circumstances.

7. ~~(U//FOUO)~~ **Finding: There is inconsistency between the JDG SOP governing brevity codes and the JDG SOP governing line of sight. This inconsistency did not contribute to the death of ISN156. The guard force overall performed admirably with respect to their promptness in responding to the code, their entry into the cell, and their life-saving attempts. (Facts 63, 106-14, 177-89, 201-03; Exhibits 45, 47)**

(U) Discussion.

a. ~~(U//FOUO)~~ The JDG SOP governing brevity codes requires a guard to call a (b)(7)(E) (b)(7)(E) when a detainee is obviously not breathing, as indicated by unresponsiveness, lack of chest movement, and discoloration of the face. The SOP governing brevity codes requires a (b)(7)(E) (b)(7)(E) when a detainee is committing self-harm and a Code Yellow when there is a potentially life-threatening medical condition requiring immediate response.

b. ~~(U//FOUO)~~ The JDG SOP governing line of sight does not address a (b)(7)(E) or a Code Yellow, but does require a guard to call a (b)(7)(E) when a guard suspects a detainee is not breathing or loses line of sight and does not get a response from the detainee after knocking on the cell door. The provisions in the two SOPs are inconsistent with respect to when a (b)(7)(E) should be called. The inconsistent provisions lead to confusion as to when a guard should call a (b)(7)(E) vice a (b)(7)(E)

c. ~~(U//FOUO)~~ The day shift Watch Commander looked into the cell for ISN156 and immediately determined that there was something wrong – ISN156's eyes were open at the point, staring blankly at the cell door and ISN156's skin color looked gray. At that point the Watch Commander called a Code Yellow. Based on his observations of ISN156, the Watch Commander could have immediately called a (b)(7)(E) or a (b)(7)(E) instead of a Code Yellow. The JTF-GTMO AAR evaluating the emergency response found the Watch Commander's call of Code Yellow to be appropriate based on the guard force determining that ISN156 could no longer be seen definitively breathing. The nurse arrived and upgraded the situation to a (b)(7)(E) The Watch Commander's initial call of Code Yellow instead of (b)(7)(E) (b)(7)(E) or a (b)(7)(E) did not significantly affect the medical response to the incident nor did the failure in any way contribute to the ultimate death of ISN156.

d. ~~(U//FOUO)~~ Available guards and the corpsmen from Camp V responded immediately to the (b)(7)(E) arriving to the cell shortly after 1400. The guard team donned their protective gear, entered the cell, secured ISN156, and began basic life support, with (b)(3):10 USC §130b, (b)(6),(b)(7)(C) and (b)(3):10 USC §130b, (b)(6),(b)(7)(C) alternating chest compressions. Adhering to appropriate SOPs, the guard team performed admirably with respect to their promptness in responding to the code, their entry into the cell, and their life-saving attempts.

8. ~~(U//FOUO)~~ Finding: The JMG SOPs require that all detainees requiring medical attention should be immediately transported to the DH. However, the SOP does not account for the unavailability of medical doctors at the DH on weekends. (Facts 111-13, Exhibit 112)

~~(U//FOUO)~~ Discussion. Around 1425, the ambulance arrived from Camp V to the DH. The registered nurse on duty at the BHU/DH (b)(3):10 USC §130b,(b)(6),(b)(7)(C) assessed the situation, and based on the condition of ISN156 and the fact that it was a weekend and there were no medical doctors on site, sent the ambulance to the NAVSTA Hospital. The registered nurse at the BHU

demonstrated quick thinking and sound decision-making based on the circumstances. The stop at the DH did not contribute to ISN156's death but could waste time in other circumstances.

9. (~~U//FOUO~~) **Finding: Several factors contributed to the ability of ISN156 to hoard medications. These factors include inconsistent JDG and JMG SOPs with respect to Med Pass, confusion on the part of the guards, corpsmen, leadership (camp, JDG, and JMG) regarding what the SOPs require, and in many cases, failure to comply with Med Pass SOP requirements. These failures contributed to the death of ISN156 in that they permitted ISN156 to be able to hoard medications. (Facts 190-200, 208-10, 212-27)**

(U) Discussion.

a. (~~U//FOUO~~) The JDG SOP and the JMG SOP governing Med Pass are inconsistent with respect to key provisions.

(b)(7)(E)

b. (~~U//FOUO~~) The JDG and JMG SOPs require

(b)(7)(E)

The failure contributed to the ability of ISN156 to conceal medications.

c. (~~U//FOUO~~) The JMG SOP prohibits

(b)(7)(E)

The failure may have contributed to the ability of ISN156 to ultimately hoard the pills that were found in his stomach.

10. (~~U//FOUO~~) **Finding: The JMG training procedures and record keeping are flawed. This contributed to the Med Pass SOP violations and to confusion of JMG personnel. (Facts 208-27)**

(U) Discussion.

a. ~~(U//FOUO)~~ The JMG does not have a training officer or section devoted solely to the training of JMG procedures. The JMG training officer is a psychiatric mental health nurse at the BHU/DH. She is required to see detainees, administer medications, and also oversee other aspects of nursing operations with respect to the nurses and corpsmen under her charge. Accordingly, she is not able to devote the necessary time and resources to ensure that the training and training records of nurses and corpsmen are consistent and proper.

b. ~~(U//FOUO)~~ The training records for the JMG nurses, corpsmen, and other medical personnel are in many cases missing, incomplete, and/or do not reflect what the trainees later indicate they understood from the training. Several of the training records were signed off on by the Senior Nurse Executive, as recently as 16 October 2012, for training that was allegedly conducted in May 2012. The Senior Nurse Executive is responsible for the execution of the JMG training program. Ultimately, the JMG Commander is responsible for the JMG training program itself. The Senior Nurse Executive acknowledged deficiencies in the maintenance of the training records, and indicated he is working to prevent the problem from happening again.

c. ~~(U//FOUO)~~ There exist deficiencies not only in how the JMG training records are maintained, but in how the actual JMG training is being conducted. Either the information being put out at the training is incorrect, or the training is not being conducted vigorously enough. Either way, the end result is that nurses and corpsmen are confused about what the SOPs require with respect to many aspects of JMG operations, or are aware of the SOPs and are choosing not to follow them.

d. ~~(U//FOUO)~~ Finally, although the JMG training certificates provided indicate that corpsmen and nurses are being trained (b)(7)(E), several corpsmen noted that they in fact were told not (b)(7)(E) because it would anger the detainees. The JMG Training Officer herself indicated that as of February 2012, the (b)(7)(E) (b)(7)(E). The few complete training records that exist for the nurses and corpsmen indicate that in May 2012, trainees were required to sign a (b)(7)(E) (b)(7)(E)

11. ~~(U//FOUO)~~ Finding: The JDG training program is well-supported, in that there is an entire battalion headquarters S-3 section (from the 525th MP Battalion) devoted to ensuring that, among other things, guards are properly trained. (Facts 137-44)

(U) Discussion.

a. ~~(U//FOUO)~~ The battalion S3 conducts the training of the JDG guards. The JDG training records were provided promptly to the Investigative Team and were very well-documented and maintained.

b. ~~(U//FOUO)~~ However, the guards at the BHU/DH are not currently receiving training on the unique challenges presented by detainees housed at the BHU/DH. While the responsibility to provide medical and mental health care to the detainees ultimately rests with the JMG, the BHU/DH guards would better be able to perform their guard functions if they were at least familiar with certain aspects of how the JMG administers care to psychiatric detainees.

12. ~~(U//FOUO)~~ Finding: There are other SOP violations impacting the operations of the Camps. (Facts 145, 147, 153-58, 159, 161; Exhibits 41, 109)

(U) Discussion.

a. ~~(U//FOUO)~~ The JDG SOP prohibits detainees from feeding the wildlife, including banana rats, iguanas, and stray cats, at JTF-GTMO. Guards and medical personnel are failing to enforce this SOP, and detainees consistently feed wildlife while at the recreation areas. This failure to enforce the SOP in no way contributed to the circumstances surrounding the death of ISN156. Permitting detainees to feed the wildlife, however, is creating serious risk that a detainee could be bitten by a wild animal, and is a dangerous practice. The JDG Commander is not aware that detainees are feeding the wildlife, other than pigeons, and the JMG Commander is unaware that detainees are feeding any wildlife.

b. ~~(U//FOUO)~~ The JDG SOP establishes a strict method of control for detainee basic issue and comfort items, which shall be exchanged on a one-for-one basis. Medical personnel at the BHU/DH are causing stress on the guard force by providing detainees additional, unauthorized comfort items, such as blankets. Detainees are aware of the policy that items turned in through official laundry channels will only be replaced by the set number of items authorized. To avoid creating problems with the detainees, the guards at the BHU/DH are taking it upon themselves to launder the additional, unauthorized comfort items, and are returning them to the detainees. Medical personnel, including leadership, are not always aware of the impact that their decisions have on the guard force.

13. ~~(U//FOUO)~~ The JDG and JMG leadership are not communicating sufficiently with each other to ensure that their respective detainee operations practices and policies are consistent and synchronized. (Facts 125-26, 147-48, 158, 195-200, 205-07)

~~(U//FOUO)~~ Discussion: The JDG and JMG leadership are not ensuring that the policies set forth by each are being communicated to the other. Examples of this lack of communication have been provided above in discussions of the differences with brevity codes SOPs and Med Pass SOP. Guards working at the BHU/DH are not familiar with all of the policies and practices of the JMG and the JMG SOPs. When the JMG changes its SOPs, it is not always pushing that information down to the guards at the BHU/DH.

14. ~~(U//FOUO)~~ Finding: The JMG would be better served by a command and staff that is solely focused on JMG operations. (Facts 205-07; Exhibits 31, 38)

(U) Discussion.

a. ~~(U//FOUO)~~ The Joint Medical Group Commander also serves as the Commander of the Guantanamo Bay Naval Station Hospital. As such, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) is dual-hatted. Although there is some degree of overlap between medical operations, the operations at the Joint Medical Group require a great amount of resources and attention due to their unique and challenging nature. Because of how the current commands are structured, (b)(3):10 USC §130b,(b)(6),(b)(7)(C) is not able to devote the time and attention that JMG medical operations require.

b. ~~(U//FOUO)~~ The JMG commander and senior leadership, including the Senior Nurse Executive, are largely removed from several aspects of what is going on at the tactical level at the BHU/DH and the camps. For example, the JMG Commander and the Senior Nurse Executive both understand (b)(7)(E) Another example is that the JMG leadership are unaware that detainees are feeding wildlife, and acknowledge that the practice could be extremely dangerous.

15. ~~(U//FOUO)~~ Finding: The deficiencies and failures identified at the JDG and the JMG are not solely attributable to the short rotation times. (Facts 125-228)

~~(U//FOUO)~~ Discussion: Many of the deficiencies and failures identified in this investigation are due to a failure to synchronize JDG and JMG SOPs, a failure of the JMG to properly train the material contained in the SOPs, and a failure of the JDG and JMG to enforce the SOPs once trained. Ultimately, the JDG Commander and the JMG Commander are responsible for the SOPs, and JTF-GTMO is responsible for ensuring the synchronization of the SOPs.

(U) Part 3: RECOMMENDATIONS

1. Recommendation: The JDG and JMG Commanders and leadership should improve and expand the scope of their communications between the JDG and the JMG.

Discussion: Because the Battle Update Brief does not provide a sufficient forum for the JDG and JMG Commanders to exchange information regarding systemic problems affecting JTF-GTMO detention operations, the JDG and JMG Commanders should, at a minimum, meet biweekly to address such systemic problems.

2. Recommendation: The JDG and JMG should synchronize JDG and JMG SOPs to ensure that they are consistent.

Discussion: By synchronizing SOPs, the JDG and JMG will eliminate inconsistent provisions that currently exist, for example with respect to Medication Administration ("Med Pass") and Brevity Codes and actions to be taken in cases of detainee emergency. The SOPs should be revised to ensure that JDG and JMG personnel are able to execute their respective missions while taking on only acceptable risk. The JDG and JMG Commanders should be the ones ultimately responsible for their respective SOPs.

3. Recommendation: Once the JDG and JMG Commanders synchronize their SOPs, they should ensure that changes and updates are passed down to the guard force and medical personnel.

Discussion: Where there are specific provisions in the JDG and JMG SOPs that affect or assign responsibility to the guards or medical personnel, the JDG and JMG Commanders should ensure that the information is not just flowing vertically (from the Commander down to the operator) but also horizontally between the JDG and JMG.

4. Recommendation: The JMG Commander must better understand how the SOPs are in fact carried out vs. his current understanding which contradicts actual practice.

5. Recommendation: Because of the special challenges presented by detainees with mental health issues at the BHU/DH, the JDG should incorporate a block of training for guards that are assigned to the BHU/DH.

Discussion: The training should familiarize the guard force with general medical principles that apply to detainees under medical or mental health care to enable the guards to better execute their mission. The JMG should be responsible for developing and conducting the additional block of familiarization training.

6. Recommendation: Medical personnel should not have the authority to make decisions that contradict JDG SOPs, without previous command coordination.

Discussion: The JMG Commander should impress upon the medical personnel the fact that their decisions affect the guard force.

7. Recommendation: The 525th MP BN should continue with the current rigorous and comprehensive training program and training records maintenance it currently has in place to train JDG guards.

8. Recommendation: The JMG should establish a training section, whose sole responsibility and mission is planning, coordinating, executing, and documenting all training of JMG personnel.

Discussion: The training of JMG personnel should be reinvigorated and reinforced to ensure that JMG personnel are familiar with SOPs and understand the critical need for the highest compliance with SOPs.

9. Recommendation: JDG and JMG Commanders and leadership must re-enforce and re-train all personnel with respect to SOP requirements for line of sight.

Discussion: To emphasize the real-world importance of following the SOPs, the line of sight training should include specific reference to how failures to follow the SOP regarding line of sight may have contributed to the death of ISN156. JDG and JMG training should include a specific block, to be certified on the training records by the training officer, regarding line of sight. JDG and JMG Commanders should also consider re-introducing a document to reflect a detainee's actions at regular intervals (b)(7)(E) during line of sight.

10. Recommendation: JDG and JMG Commanders and leadership must re-enforce and re-train all personnel with respect to SOP requirements for Medication Administration ("Med Pass").

Discussion: The training should cover key provisions of the SOPs, including (but not limited to), (b)(7)(E) how to properly dispose of refused medications, (b)(7)(E) To emphasize the real-world importance of following the SOPs, the Medication Administration training should include specific reference to how failures to follow and enforce the SOP regarding Medication Administration contributed to the attempted suicides by several detainees. This training should only be conducted after the JDG and JMG Commanders have synchronized and made consistent their SOPs regarding Medication Administration.

11. Recommendation: In the process of synchronizing their respective SOPs, the JDG and JMG Commanders must analyze the risks and benefits associated with either not specifically (b)(7)(E) Once the JDG and JMG Commanders have analyzed the matter from a risk / benefit standpoint, they should revise and finalize their SOPs to clearly reflect their determination regarding whether (b)(7)(E) (b)(7)(E)

12. Recommendation: JDG and JMG Commanders must re-enforce and re-train all personnel with respect to SOP requirements regarding not feeding wildlife.

Discussion: Commanders should engage the Preventive Medicine section to ensure that the Preventive Medicine section is aggressively addressing the issue of wildlife in the camps.

13. Recommendation: The JDG Commander should revisit the issue of whether to

(b)(7)(E)

Discussion: In revisiting the issue, the JDG Commander should consider consulting with the JMG Commander as the matter relates directly to the opportunities for detainees (b)(7)(E)

(b)(7)(E)

14. Recommendation: Commander JTF-GTMO, in coordination with USSOUTHCOM, will review the command and control structure of the JMG and provide a recommendation to address concerns raised in this report.

Discussion: Because of the critical nature and unique complexities presented by detainee medical care, the current JMG Deputy Commander would be a logical choice for an interim commander. The current JMG Commander should continue his role solely as the NAVSTA Hospital Commander. During this interim period, USSOUTHCOM should engage the Navy to assess and determine whether an additional command billet is required for future rotations.

15. Recommendation: JTF-GTMO should establish, with USSOUTHCOM oversight, a rigorous inspection program designed to detect tactical level deficiencies in detainee operations at JTF-GTMO across a broad spectrum of operations, to include medical, legal, and intelligence, and security.

Discussion: The inspection program should require checklists for each section to identify specific deficiencies and should include USSOUTHCOM assets who have training and background with respect to JTF-GTMO and how to conduct rigorous inspections. The inspection program must include a mechanism whereby the inspectors are following through and verifying that JTF-GTMO is promptly and effectively correcting identified deficiencies. The Field-Grade-in-the-Wire program should be entirely revamped and invigorated or eliminated altogether, as it is currently not detecting critical deficiencies in detainee operations at JTF-GTMO.

16. Recommendation: the Commander, JTF-GTMO must provide a concrete, detailed plan and timeline to USSOUTHCOM with respect to how he plans to implement any recommendations made here.[189]

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[189] Many of the recommendations in the report mirror recommendations from earlier investigations, specifically Recommendations 8 and 13 from the investigation into the death of ISN10028 (18 May 2011) and

Discussion: JTF-GTMO has not implemented many of the required changes identified in previous detainee death investigations. The JTF-GTMO Commander should also provide consistent feedback and updates as to how the actual recommendations are being implemented. The JTF-GTMO Commander should determine how best to implement the actual recommendations, but should require the JDG and JMG Commanders to provide him information with respect to the specific recommendations that fall to the JDG and JMG Commanders.

17. Recommendation: Commander, USSOUTHCOM, refer this investigation to Commander, JTF-GTMO, for appropriate corrective and/or administrative action.

Discussion: As noted in the findings, many of the deficiencies and failures identified in this investigation are due to a failure to synchronize JDG and JMG SOPs, a failure of the JMG to properly train the material contained in the SOPs, and a failure of the JDG and JMG to enforce the SOPs once trained. It should be noted that while ultimately, the JDG and JMG Commanders are responsible for the SOPs, and JTF-GTMO is responsible for ensuring the synchronization of the SOPs, both the current JDG and JTF-GTMO Commanders were in the first 90-days of command at the time of ISN156 deaths.

Recommendations 1, 2, 3, 4, 8, 11, 12, 13, 16, 18 from the investigation into the death of ISN782 (1 February 2011). (Exhibits 124, 125)