MILITARY COMMISSIONS TRIAL JUDICIARY
GUANTANAMO BAY, CUBA

UNITED STATES OF AMERICA **v.** **ABD AL HADI AL IRAQI**	**AE 099** **~~(U)~~ Emergency Defense Motion** to Abate the Proceedings Until Mr. al-Tamir is Physically Competent to Stand Trial **6 September 2017**

1. **~~(U)~~ Timeliness.**

~~(U)~~ This motion is timely filed pursuant to Military Commissions Trial Judiciary Rule of Court 3.7(c).

2. **~~(U)~~ Relief Sought.**

~~(U)~~ The Defense respectfully requests the military judge abate all proceedings until Mr. al-Tamir is physically competent to stand trial. If Mr. al-Tamir is not being operated on today, the Defense further requests that the Commission order the Government to medically evacuate him to the mainland immediately so the necessary operation and related procedures can be performed in time to save at least some of his neurologic functioning.

3. **~~(U)~~ Overview**.

~~(U)~~ "It is well established that the Due Process Clause of the Fourteenth Amendment prohibits the criminal prosecution of a defendant who is not competent to stand trial."[1] Moreover, "[c]ourts have recognized that a defendant who is 'mentally competent' . . . may yet be 'physically incompetent'-- unable, by virtue (for example) of a painful physical condition or

[1] ~~(U)~~ *Medina v. California*, 505 U.S. 437, 439 (1992).

the temporary effects of narcotics, to participate effectively in his own defense."[2] An accused is not physically competent to stand trial if his "presence at trial would substantially increase the risks to his health or life; [or if] his present physical condition is such that it may substantially impair his ability to present a proper defense."[3]

~~(U)~~ Given his current condition, Mr. al-Tamir is physically incompetent to stand trial under both prongs. To date, three medical experts have opined that he is threatened with neurologic damage and possibly paralysis. He cannot meet with Defense counsel or attend Commission sessions without experiencing severe pain, which makes meaningful attention, communication and interaction impossible. In these circumstances, he is physically incompetent to stand trial and the proceedings should be abated until the Government provides him the medical treatment necessary to render him able to participate in his own defense and do so without further harm to his body.

~~(U)~~ **Update**: On the morning of 6 September 2017, after this motion was written and initially submitted, the Defense received a letter from Mr. al-Tamir updating his current medical status since his last communication last week. It appears that the worst-case scenario predicted by the medical experts – permanent neurologic damage and possible paralysis – may already have occurred because of the Government's failure to provide necessary medical care. Mr. al-Tamir was admitted to the hospital on Sunday, 3 September 2017, after losing control of his bladder function. He was told by a staff doctor that "the signs of danger are showing now" – in fact, they had been "showing" for months – and that he needed an MRI within 24-48 hours and

[2] ~~(U)~~ *United States v. Schaffer*, 433 F.2d 928, 930 (5th Cir. 1970).

[3] ~~(U)~~ *United States v. Landsman*, 366 F.Supp. 1027, 1028 (S.D.N.Y. 1973).

immediate back surgery. He was told that the doctor would be communicating with Defense counsel through the SJA on Tuesday, 5 September 2017, about his treatment.

~~(U)~~ Defense counsel heard nothing from the SJA until 1355 today, 6 September 2017, despite multiple emails sent [redacted] beginning on Friday, 1 September 2017 (when counsel sent an email requesting Mr. al-Tamir's medical records and attaching the letter from Drs. Homer Venters and Vincent Iacopino of Physicians for Human Rights clearly stating that "[b]ased on [Mr. al-Tamir's] reported symptoms, there is a possibility of cauda equina syndrome, which could result in permanent neurologic damage and/or paralysis if not diagnosed and treated immediately.")[4] After Defense counsel learned this morning that Mr. al-Tamir had been told that the SJA would be communicating about his medical status, they again wrote to the SJA asking about Mr. al-Tamir's hospitalization and status. The sum total of the SJA response was: "JTF is fully engaged on all aspects of your client's medical condition and treatment. JTF is also tracking and prepared for the impending storm conditions. Updates on both will be made through proper channels as appropriate."[5]

~~(U)~~ As of this writing Defense counsel do not know Mr. al-Tamir's current medical status or the treatment being afforded him. The SJA is stonewalling counsel and the hospital phones are not being answered. What is absolutely clear is that the Government's deliberate indifference to Mr. al-Tamir's urgent, and then emergent, medical needs over a period of years has resulted in a situation where significant neurologic damage may well have already occurred. He has lost control of his bladder and sensation in his urinary tract. He reports weakness and loss of control in his left leg and hand, to the point where walking even a few steps without a

[4] ~~(U)~~ Letter from Drs. Homer Venters and Vincent Iacopino dated 31 August 2017.

[5] ~~(U)~~ Email from SJA to Defense counsel dated 6 September 2017 (Attachment F hereto).

walker or some other support is extremely difficult and physical exercise is "unbearable." He is experiencing constant numbness in the limbs on his left side.

~~(U)~~ Defense counsel have consulted further with medical experts about Mr. al-Tamir's most recent report. They concur that it is absolutely critical that Mr. al-Tamir be operated on immediately.[6] If the Government cannot perform that operation in Guantanamo today, he needs to be medically evacuated to the mainland immediately so the necessary operation and related procedures can be performed in time to save at least some of his neurologic functioning.

4. ~~(U)~~ **Burden and Standard of Proof.**

~~(U)~~ As the moving party, the Defense has the burden of persuasion, by a preponderance of the evidence.[7]

5. ~~(U)~~ **Facts.**

a. ~~(U//FOUO)~~ As documented in his medical records, Mr. al-Tamir has sought treatment for chronic and worsening back pain since 2006.[8] In 2007, Mr. al-Tamir presented low back pain and right side sciatica, resulting in a diagnosis of degenerative disc disease between the L4 and L5 vertebrae.[9] A computerized tomography scan ("CT scan") confirmed the diagnosis.[10]

b. ~~(U//FOUO)~~ In 2008, Mr. al-Tamir was seen for recurring back pain that was, at that point, deemed chronic. Doctors noted in medical records: "Detainee seemed unsteady while standing."[11] By June of 2008, Mr. al-Tamir's back pain had increased to include pain that

[6] ~~(U)~~ These consultations have been conducted by telephone today. Counsel will supplement this motion with their written opinions as appropriate.

[7] ~~(U)~~ R.M.C. 905(c)(1)-(2).

[8] ~~(U)~~ [redacted]

[9] ~~(U)~~ [redacted]

[10] ~~(U)~~ [redacted]

[11] ~~(U)~~ [redacted]

radiated down his left thigh. [12] By August 2008, doctors noted: "Detainee expressed concern about current back pain and length of time" it has taken to resolve the issue.[13]

c. ~~(U//FOUO)~~ Mr. al-Tamir continued to seek treatment through 2008 and into 2009. In August 2009, he reported flare-ups and pain that affected the left side of his body, to include pain radiating from his back to his thighs. Medical providers performed various diagnostic tests but failed to cure the ailment or the pain. X-rays and CT scans continued to show degenerative disc disease.[14]

d. ~~(U//FOUO)~~ In early 2010, a bulging mass was identified on the left side of Mr. al-Tamir's spine.[15] Doctors performed a biopsy on the soft tissue mass. Pathology reports were negative.[16] The mass remains today.

e. ~~(U//FOUO)~~ Throughout 2010, Mr. al-Tamir continued to be seen for chronic back pain. In June 2010, he again reported pain that ran down left side of his leg.[17] Throughout 2010, he received physical therapy, traction table therapy, and regular treatments with a Transcutaneous Electrical Nerve Stimulator unit.[18] These therapies and treatments were ineffective.

f. ~~(U//FOUO)~~ In September 2010, Mr. al-Tamir's medical records reflect he was diagnosed with spinal stenosis. Spinal stenosis is an abnormal narrowing of the spinal canal. The narrowing of the spine causes a restriction to the spinal canal which, aside from pain, can

[12] ~~(U)~~ [redacted]
[13] ~~(U)~~ [redacted]
[14] ~~(U)~~ [redacted]
[15] ~~(U)~~ [redacted]
[16] ~~(U)~~ [redacted]
[17] ~~(U)~~ [redacted]
[18] ~~(U)~~ [redacted]

result in neurological deficits such numbness and loss of motor control.[19] It was at this point, seven years ago, that a doctor first proposed the possibility of surgery.[20]

g. ~~(U//FOUO)~~ Throughout the remainder of 2011 and 2012, Mr. al-Tamir was seen for chronic low back pain. In January 2012, Mr. al-Tamir again reported low back pain radiating to his left knee.[21] In September 2012, he again reported sharp pain radiating from his back toward his left knee.[22] At this point doctors ordered further testing, but it is not clear from the medical records whether that testing was performed.[23]

h. ~~(U//FOUO)~~ Mr. al-Tamir's back pain persisted and his health gradually declined throughout 2012. In November 2012, he continued to report radiating pain from his low back down through his thighs, but, for the first time, reported feeling "pins and needles sensations" in his toes."[24]

i. ~~(U//FOUO)~~ Mr. al-Tamir continued to suffer from back pain between 2013 and 2017, but, despite multiple requests for information and records, the Prosecution has failed to provide complete medical discovery—a failure that has contributed to the Defense not understanding the severity of Mr. al-Tamir's situation until recently. On August 25, 2017, the Defense received some (apparently random) medical records from 2007, 2013, 2014, 2016 and 2017. To date, the Prosecution has not produced a comprehensive set of Mr. al-Tamir's medical records. The Defense has not received any medical records from 2015, very few records from 2016, and only one CT scan exam result from January 2017 that was not produced until August 25, 2017.

[19] ~~(U)~~ http://www.mayoclinic.org/diseases-conditions/spinal-stenosis/home/ovc-20320403.

[20] ~~(U)~~ [redacted]

[21] ~~(U)~~ [redacted]

[22] ~~(U)~~ [redacted]

[23] ~~(U)~~ [redacted]

[24] ~~(U)~~ [redacted]

j. ~~(U//FOUO)~~ A January 2017 lumbar CT scan (without contrast) of Mr. al-Tamir's spine showed anterior wedging of T12 and L1 and anterolosthesis on L4 and L5, which had increased since the previous CT scan. Additionally, there were degenerative changes to L4-S1. It was at this time, a decade after Mr. al-Tamir began complaining of neurological symptoms, that an MRI was first proposed.[25]

k. ~~(U//FOUO)~~ Mr. al-Tamir's health has continued to degrade. In August 2017, he began to experience an increase in the loss of sensation in both feet. The week of August 7, 2017, during attorney-client meetings in preparation for the August pretrial hearings, Mr. al-Tamir began to feel tingling throughout his body. He began experiencing an increased loss of sensation in both hands and both legs, as well as an increase in his muscle weakness. During this period, Mr. al-Tamir described to his defense counsel that his feet felt heavy and weighed down. He also described an increase in the level, sharpness, and frequency of his pain.

l. ~~(U)~~ At an attorney-client meeting on August 9, 2017, defense counsel noticed Mr. al-Tamir open and close his left hand repeatedly during the six-hour meeting. Mr. al-Tamir explained that his hand was numb and he was opening and closing it in an attempt to force feeling back into it. By that evening, Mr. al-Tamir's legs had become so weak that he could not stand up straight or walk.

m. ~~(U//FOUO)~~ On August 10, 2017, a doctor examined Mr. al-Tamir at his detention location. The doctor determined that Mr. al-Tamir's deteriorating condition required transportation to the hospital for additional tests. Some tests were conducted, but, apparently, a prescribed CT scan could not be performed because the hospital staff failed to properly inject

[25] ~~(U)~~ [redacted]

intravenous contrast dye for the scan. Following this hospital visit, Mr. al-Tamir was declared medically unfit for attorney-client meetings.

n. ~~(U//FOUO)~~ Although his condition did not improve, JTF-GTMO cleared Mr. al-Tamir to attend the 14-17 August pretrial hearings. Due to his constant discomfort and concern over bladder control, he attended only one day of the session (the day his presence was required by the military judge).

o. ~~(U)~~ When permitted, Mr. al-Tamir now uses a wheelchair when necessary to move within his detention facility. On at least one occasion, he has been denied the use of a wheelchair without explanation. He does not feel well enough to attend attorney-client meetings, which occur at a facility he must reach by car. Transportation to that facility (which is not wheelchair accessible) -- or anywhere, including the courtroom -- is extremely painful.

p. ~~(U)~~ As of the date of this request, Mr. al-Tamir's condition has not improved and his health continues to decline daily. His condition has compromised his ability to participate in his own defense.

q. ~~(U//FOUO)~~ JTF-GTMO staff have indicated to Mr. al-Tamir that he will be offered two forms of treatment in the coming months: on September 12, he will receive steroid injections into his back; and on October 2, a neurosurgeon will conduct an examination.

r. ~~(U//FOUO)~~ After the Government produced some medical records on 25 August 2017, including a 23 January 2017 CT scan, and further communications with Mr. al-Tamir indicating that his symptoms had significant worsened, on 31 August 2017 the Defense consulted with Drs. Homer Venters and Vincent Iacopino, senior medical staff at Physicians for Human Rights. Based on the Defense account of Mr. al-Tamir's symptoms and medical history, they sent a letter stating, "These symptoms, if accurate, are consistent with serious neurologic

impairment that may be permanent if not diagnosed and treated promptly. Based on the reported symptoms, there is a possibility of cauda equina syndrome, which could result in permanent neurologic damage and/or paralysis if not diagnosed and treated immediately."[26]

s. ~~(U)~~ Immediately thereafter, the Defense retained the services of Dr. James Cobey, an orthopedic surgeon with 30 years experience performing spine surgeries, as an expert consultant.[27] Based on his review of medical records and the 23 January 2017 CT scan, Dr. Cobey opined: "The symptoms reported by the patient are consistent with my review of the available medical records. They suggest compression of the spinal cord and/or spinal nerves and require *immediate diagnostic imaging and surgical intervention* by an experienced neurosurgeon or orthopedic surgeon."[28]

t. ~~(U)~~ With regard to JTF's proposed treatment plan, Dr. Cobey stated: "The current treatment plan as reported, consisting of an anesthesiologist visiting in September and a neurosurgeon visiting in October, is unacceptable, inconsistent with the standard of care, and likely to result in permanent neurologic damage." He concludes: "I urge you in no uncertain terms to take immediate action to effectively diagnose and treat the detainee's medical emergency."[29]

6. ~~(U)~~ **Law and Argument.**

~~(U)~~ "It is well established that the Due Process Clause of the Fourteenth Amendment prohibits the criminal prosecution of a defendant who is not competent to stand trial."[30]

[26] ~~(U)~~ Letter from Drs. Homer Venters and Vincent Iacopino dated 31 August 2017 (Attachment C hereto).

[27] ~~(U)~~ Dr. Cobey's c.v. is attached as Attachment D.

[28] ~~(U)~~ Letter from Dr. James Cobey dated 5 September 2017 (Attachment B hereto) (emphasis added).

[29] ~~(U)~~ *Id.*

[30] ~~(U)~~ *Medina v. California,* 505 U.S. 437, 439 (1992).

Moreover, "[c]ourts have recognized that a defendant who is 'mentally competent' . . . may yet be 'physically incompetent'-- unable, by virtue (for example) of a painful physical condition or the temporary effects of narcotics, to participate effectively in his own defense."[31] An accused is not physically competent to stand trial if his "presence at trial would substantially increase the risks to his health or life; [or if] his present physical condition is such that it may substantially impair his ability to present a proper defense."[32]

~~(U)~~ Given his current physical condition, Mr. al-Tamir is physically incompetent to stand trial under both prongs.

1. ~~(U)~~ Substantial increase in risk to health or life. As to the effect of Mr. al-Tamir's presence at commission sessions on his health, he is suffering an emergency neurological condition created by the Government's failure to provide him with necessary medical treatment required under the accepted standard of care.[33] As of last week, Mr. al-Tamir was losing sensation in his legs and is experiencing the loss of muscle control/motor skills. He periodically loses control of his bladder. Based on his review of the medical records the Defense has received to date and Mr. al-Tamir's symptoms, a medical expert retained by the Defense states: "The current treatment plan as reported, consisting of an anesthesiologist visiting in September and a neurosurgeon visiting in October, is unacceptable, inconsistent with the standard of care, and likely to result in permanent neurologic damage."[34] Two other medical with whom the

[31] ~~(U)~~ *United States v. Schaffer*, 433 F.2d 928, 930 (5th Cir. 1970).

[32] ~~(U)~~ *United States v. Landsman*, 366 F.Supp. 1027, 1028 (S.D.N.Y. 1973).

[33] ~~(U)~~ In fact, the Government's failure to treat him amounts to deliberate indifference to his serious medical condition, and thus constitutes cruel and unusual punishment under the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

[34] ~~(U)~~ Att. B.

Defense has consulted agree.[35] Accordingly, requiring Mr. al-Tamir to attend the October Commission session when he should be having (or, if he receives the required surgery in a timely fashion, recovering from) back surgery will very clearly "substantially increase the risks to his health or life."[36]

2. ~~(U)~~ Substantial impairment of ability to present a defense. Where an accused's physical disability also interferes with his ability to participate in his own defense, courts have applied the standard for mental competence to physical incompetence claims.[37] Accordingly, if the accused's "present physical condition is such that it may substantially impair his ability to present a proper defense,"[38] he is incompetent to stand trial whether the cause is physical or mental. Mr. al-Tamir is incompetent to stand trial under that standard as well. It has become impossible for him to meet with Defense counsel or attend Commission sessions without suffering significant pain. That pain and his other symptoms, including numbness and partial limb paralysis, make it extremely difficult for him to focus his attention during the counsel meetings and hearings.

~~(U)~~ Issues currently pending before the Commission include a variety of areas in which Mr. al-Tamir's participation is critical. His presence at Mr. al-Darbi's cross-examination, for example, is not only his right under the Sixth Amendment Confrontation Clause, but is essential for counsel to ensure competent representation of his interests by counsel. Similarly, outside of court, Mr. al-Tamir must be well enough to participate in attorney-client meetings. That is

[35] ~~(U)~~ Att. C.

[36] ~~(U)~~ *See Landsman* 366 F.Supp. at 1028; *see also e.g. United States v. Jones*, 495 F.3d 274, 276 (6th Cir. 2007) (treating "the district court's order [finding the defendant physically incompetent] as finding Jones mentally incompetent due to a physical disability").

[37] ~~(U)~~ *Id*.

[38] ~~(U)~~ *Id*.

particularly critical with regard to preparation for Mr. al-Darbi's cross-examination, but is true across the board with respect to all topics. To be unable to meet with one's counsel without suffering severe, debilitating and distracting pain is to not be physically competent to assist in one's own defense.

7. ~~(U)~~ **Conclusion.**

~~(U)~~ The Defense respectfully requests this Commission abate the proceedings until Mr. al-Tamir receives the medical treatment required to restore his competence to stand trial. If Mr. al-Tamir is not being operated on today, the Defense also requests that the Commission order the Government to medically evacuate him to the mainland immediately so the necessary operation and related procedures can be performed in time to save at least some of his neurologic functioning.

8. ~~(U)~~ **Oral Argument.**

~~(U)~~ The Defense requests oral argument unless the Commission grants the relief on the filed submissions.

9. ~~(U)~~ **Witness and Evidence.**

~~(U)~~ The Defense reserves the right to present evidence and call witnesses on this motion.

10. ~~(U)~~ **Conference with Opposing Counsel.**

~~(U)~~ The Defense has conferenced with the Prosecution and the Prosecution objects to this motion.

11. ~~(U)~~ **Additional Information.**

~~(U)~~ The Defense does not have any additional information to present.

12. ~~(U)~~ **Attachments.**

A. ~~(U)~~ Certificate of Service, dated 6 September 2017.

B. ~~(U)~~ Letter from Dr. James Cobey dated 5 September 2017.

C. ~~(U)~~ Letter from Drs. Homer Venters and Vincent Iacopino dated 31 August 2017.

D. ~~(U)~~ Curriculum vitae of Dr. James Cobey.

E. ~~(U)~~ [redacted]

F. ~~(U)~~ Email from SJA to Defense counsel dated 6 September 2017.

Respectfully Submitted,

//s//
BRENT RUSHFORTH
Pro Bono Counsel

//s//
JEFFREY A. FISCHER
CAPT, JAGC, USN
Detailed Defense Counsel

//s//
AIMEE COOPER
CDR, JAGC, USN
Detailed Defense Counsel

//s//
ADAM THURSCHWELL
Assistant Defense Counsel

ATTACHMENT A

~~(U)~~ CERTIFICATE OF SERVICE

~~(U)~~ I certify that on 6 September 2017, I filed **AE 099 Emergency Defense Motion** to Abate the Proceedings Until Mr. al-Tamir is Physically Competent to Stand Trial, with the Office of Military Commissions Trial Judiciary and served on Government counsel of record and on counsel for Mr. al-Darbi.

//s//
ADAM THURSCHWELL
Assistant Defense Counsel

Attachment B

September 5, 2017

Defense Counsel:

I am an orthopedic surgeon with extensive experience performing spine surgery for over 30 years. I am writing to express urgent medical concerns regarding your client, who has a history of back pain and leg numbness and recently reported increasing lower extremity weakness and bladder incontinence.

I have reviewed medical records related to his reported problem, including the January 23, 2017 CT scan of the patient. With regard to the CT scan, on the axial views of L4-5, you can see severe hypertrophy of the facet joints. The severe neural encroachment bilaterally could easily progress to central stenosis since the film was taken in January 2017. I have been informed that there are other medical records pertaining to the patient's symptoms, including a July 2017 CT scan with myelogram, which have not yet been provided to defense counsel and which would be necessary for a complete diagnosis of the patient's condition.

The symptoms reported by the patient are consistent with my review of the available medical records. They suggest compression of the spinal cord and/or spinal nerves and require immediate diagnostic imaging and surgical intervention by an experienced neurosurgeon or orthopedic surgeon. While MRI is the preferred imaging technique, a CAT scan can also be performed in conjunction with a myelogram to ascertain the nature and extent of compression. High dose corticosteroids should also be considered to reduce inflammation associated with presumed spinal compression.

The current treatment plan as reported, consisting of an anesthesiologist visiting in September and a neurosurgeon visiting in October, is unacceptable, inconsistent with the standard of care, and likely to result in permanent neurologic damage. I would not expect a simple epidural injection with steroids to have any real effect on a compression problem. The epidural may temporarily help the foraminal stenosis, but would not help the symptoms of the central stenosis.

I urge you in no uncertain terms to take immediate action to effectively diagnose and treat the detainee's medical emergency.

Sincerely,

James C. Cobey, MD, MPH, FACS
Johns Hopkins Bloomberg School of Public Health
4440 Garfield Street
Washington, DC 20007

Attachment C

Through evidence, change is possible.

Physicians for Human Rights

256 West 38th Street
9th Floor
New York, NY
10018

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phr.org

August 31, 2017

To Whom It May Concern:

Physicians for Human Rights has learned from the Military Commissions Defense Organization that a detainee at Guantánamo Bay Detention Center complains of progressive back pain, bladder incontinence, and loss of motor and sensory function in his legs which has recently resulted in an inability to walk. The following description was shared with us today:

> *He's had back problems for years, but it has gotten dramatically worse over the past few months. He sometimes loses feeling in both of his legs; he has lost 90% of the feeling in left leg; his motor control is deteriorating; and he periodically loses control of his bladder. Last week, he was finally given a walker, but he is now unable to use it due to the loss of sensation in his legs.*

These symptoms, if accurate, are consistent with serious neurologic impairment that may be permanent if not diagnosed and treated promptly. Based on the reported symptoms, there is a possibility of cauda equina syndrome, which could result in permanent neurologic damage and/or paralysis if not diagnosed and treated immediately.

Cauda equina syndrome requires emergency diagnosis and MRI, and evaluation by a neurosurgeon for therapeutic intervention, which typically consists of high-dose corticosteroids and surgery.

We urge the authorities to be in immediate contact with medical staff so they can act in a timely manner consistent with the standard of care.

Sincerely,

Homer Venters, MD, MS
Director of Programs
Physicians for Human Rights

Vincent Iacopino, MD, PhD
Senior Medical Advisor
Physicians for Human Rights

Attachment D

JAMES C. COBEY, M.D., M.P.H., F.A.C.S.

CURRICULUM VITAE

Personal Information:

Residence:
4440 Garfield Street, NW
Washington, DC 20007
202-966-2763

Date of Birth: April 23, 1943

Licensure:	Washington, D.C.,	MD8440	Expiration: 12/31/2016
	Maryland	D0010534	Expiration: 09/30/2016
	Maine	MD19775	Expiration: 04/30/2016

Certification:	American Board of Orthopaedic Surgery, Board Certified	1977
Education:	St. Albans School	1953-1961
	Hamilton College, Clinton, New York (A.B. History)	1961-1965
	Johns Hopkins Medical School, Baltimore, Maryland (M.D.)	1965-1969
	Johns Hopkins School of Public Health, Baltimore (M.P.H.)	1967-1968
Residency	NYU-Bellevue Hospital, NY,NY-General Surgery	1969-1971
	Yale University New Haven Hospital- Orthopaedic Surgery	1973-1976
Military	Fort Lewis, USA, Major, Chief Preventive Medicine	1971-1973

Professional Experience:

Washington Hospital Center,	
Senior Active Staff	1976-Present
Sibley Hospital, Courtesy Staff	1976-2010
CIVISTA Hospital, Courtesy Staff	1976-Present
Associate Professor of Orthopaedic Surgery,	
Georgetown University School of Medicine	1992-2004
Professor of Orthopaedic Surgery,	
Georgetown University School of Medicine	2004-Present
Senior Associate, Johns Hopkins Bloomberg	
School of Public Health	2001-Present
Surgeon at Redington -Fairview Hosp, Maine	Dec 2012-
	Jan 2013
	July 2013
Surgeon Gallup New Mexico ,Indian Health Service	Oct -Nov 2013
Surgeon Martinsburg, West Virginia	Sept 2014-
	March 2015
Surgeon, Tuba City, Arizona Indian Health Service	Oct 2015
Surgeon, Tuba City, Arizona Indian Health Service	Feb-March 2016
Surgeon, Tuba City, Arizona Indian Health Service	June 2016
Surgeon ,Tuba City, Arizona Indian Health Service	August 2016

The Meritorious Service Medal of the United States Army	1973
The Frank E. Gibson Prize, Washington Medical Society	1980
The International Service Award of the American Red Cross	1980
The Charles R. Drew Award, American Red Cross, National Capital Chapter	1992
The Community Service Award, Washington Hospital Center	1996
The International Humanitarian Service Award, American Red Cross	1998
Distinguished Alumnus Award from Johns Hopkins University	2001
Frank Annunzio Humanitarian Award of the Christopher Columbus Foundation	2002
Delta Omega Public Health Honor Society.	

Dr. Cobey, as a member of Physicians for Human Rights, shared in the Nobel Peace Prize in 1997 for the International Campaign to Ban Land Mines.

Professional Societies:

Diplomat of the National Board of Medical Examiners	July 1970
Board Certified, American Board of Orthopaedic Surgeons	September 1977
Fellow of the American Academy of Orthopaedic Surgeons	February 1980
Fellow of the American College of Surgeons	October 1980
S.I.C.O.T., The International Society of Orthopaedic Surgery and Traumatology	December 1986

Public Service:

Chairman, Medical Scientific Advisory Board, Pennsylvania Regional Tissue Bank	1977-1980
Board of Trustees, American Wheelchair Sports, Wheelchair Basketball	1979-1980
Board of Governors, Capitol Hill Hospital, WDC	1981-1990
Program Chairman, Orthopaedics Overseas, Bangladesh	1984-1987
Professional Advisory Committee, Visiting Nurses Association	1985-1988
President, Washington Medical and Surgical Society	1985-1986
Chairman, Area Fund Raising Committee, OREF	1986
Program Chairman, Metropolitan Washington Chapter, ACS	1987
Advisory Board, Fogarty International Center, NIH	1988-1990
President, Metropolitan Washington Chapter, ACS	1989-1990
Chairman, American Fracture Association 1991 Annual Meeting	
National Blood Services Advisory Committee, American National Red Cross	1987-1994
Founder, Health Volunteer Overseas	1986
Member Board and Treasurer, Refugees International	1993-2007
Board member and now President of the Medical Society of The District of Columbia	2008-2012
President of the Johns Hopkins School of Public Health Alumni	2007-2012
President of the Medical Society of the District of Columbia	2011-2012
Executive Board of Delta Omega Honor Society of Johns Hopkins	2005- 2014

Gaza Strip – UNRWA Volunteer: Pediatric Malnutrition and Rehydration Centers	June-September 1964
Ilesha, Nigeria – Research Associate	June-August 1966
Limbe, Haiti – General Practice	June-September 1968
Hong Kong – Back Surgery, Pediatric and Adult TB and Polio patients	March-June 1976

Hong Kong – Guest Lecturer, Duchess of Kent Pediatric Hospital, Queen Mary Hospital	March 1976
Cambodia, American Red Cross Volunteer to the International Committee of the Red Cross, Cambodia Relief Action: Medical Coordinator, Camp 204	Dec. 1979-March 1980
Dhaka, Bangladesh and Khatmandu, Nepal – Consultant to Orthopaedics Overseas, Inc.	1984
Mexico City, Mexico – International Red Cross Team, Earthquake Disaster	September 1985
Thailand/ Cambodia – USAID Orthopaedic Consultant, Khmer Medical Care	June-July 1989
Cambodia – Medical Consultant on Mine Injuries, Physicians for Human Rights and Asia Watch	April 1992
Cambodia – American Red Cross Volunteer Surgeon, Kampong Speau Provincial Hospita l	June-July 1992
Transkei/ South Africa – Orthopaedics Overseas Volunteer Lecturer	June 1994
Physicians For Human Rights, Evaluation for violations of Geneva Conventions in Gaza Strip.	September 2001
Surgeon for Medecins San Frontiere. Haiti and Nigeria	March 2010
Evaluation of Surgery in Malawi	June, July 2012
Training orthopaedic surgery with the Catholic Medical Mission Board -Democratic Republic of the Congo	Feb- April 2013
Tanzania Nkorango Lutheran Hospital -trauma and SIGN nail.	July - August 2015

Invited Lectures:

Yale Orthopaedic Association; Towards a Definition of a Flat Foot, June 1976.

Washington Hospital Center: Treatment of Spinal Tuberculosis, September 1976.

Senate Foreign Relations Committee; Refugee Relief on the Thailand/ Cambodian Border, March 1980.

American Red Cross National Convention; the I.C.R.C. Action in Cambodia and Thailand, April 1980.

International Committee of the Red Cross, Geneva; February 1981; Health Planning and Sanitation in Refugee Relief.

National Council for International Health; Workshop on Refugee Relief; Worcester, Massachusetts; October 1982; Fundamentals for a Physician Working in Refugee Relief: Applied Field Sanitation.

National Council for International Health; Workshop on Lebanon; December 1982; Lessons Learned from Refugee Relief Actions.

National Academy of Science; Committee to Study Physician Exchange Programs; April 1983; The History and Experiences of Orthopaedics Overseas.

American Association of Occupational Health Nurses; Annual Convention, April 1983; Mechanical Causes and Treatment of Industrial Back Injuries.

Eastern Field Office of the American Red Cross; May 1983; International Disaster Relief.

Orthopaedic Academic Symposium; Tianjin, China; May 1983; Biomechanics of the Foot.

National Council for International Health, 1983 Annual Convention; Orthopaedics in China Using Combinations of "Traditional: Chinese and "Western" Medicine, June 1983.

American Fracture Association; Orthopaedics in China; April 1984.

National Institutes of Health; The Red Cross at the Mexican Earthquake; Presentation tot he National Disaster Relief Services; January 1986.

Pan American Health Organization (PAHO) Regional Meeting for Disasters; Representatives of the A.R.C.; Costa Rica; March 1986.

National Institutes of Health Data on Disability Workshops; Presentation on Disabilities, Orthopaedic Handicaps; March 1986

American Red Cross; Presentation to International Visitors; Disaster Preparedness in America; September 1986.

Capitol Hill Hospital; Medical Grand Rounds; Presentation on Spinal Problems; September 1987

Washington Hospital Center; History and Future of Tissue Banking of Bone; September 1987.

National Rehabilitation Hospital; Combined Orthopaedic/ Rheumatology Rounds; The Total Knee Replacement; October 1987.

Georgetown University: Center for Immigration Policy and Refugee Assistance, Fundamentals for the Health Care Worker in Internal Medicine, October 1987

The Western New York Orthopaedic Society 38th Annual Dr. Frank N. Potts Orthopaedic Day, Buffalo, New York: Orthopaedics Overseas and Bone Banking with Regional Networking, November 1987

The American Fracture Society Annual Meeting, Birmingham, Alabama: Bone Banking in the United States with emphasis on Current Networking Activities of the American National Red Cross, April 1988.

World Health Organization: Invited Participant, Informal Discussions on the Role of Essential Surgery in Rehabilitation, Geneva, Switzerland, October 1988

Harvard University: Visiting Professor, Brigham & Women's Hospital Grand Rounds, Boston Massachusetts, District Level Health Care in Developing Countries, April 1989.

Washington Hospital Center, Washington, DC: Surgical Grand Rounds, Transplantation Service and Request for Tissue, June 1989.

Johns Hopkins University, School of Public Health, Baltimore, Maryland: Training Health Care Workers in Refugee Camps, December 1989.

Third Symposium on International Voluntary Medical Services, PSEF Tucson, Arizona: A perspective on the Third World and Responding to Catastrophe, March/ April 1990.

SICOT 90, 18th World Congress, Montreal, Canada: Training Medical Person-power to Decrease Disability in the Developing World, September 10, 1990

Fogarty, International Center, National Institutes of Health, Bethesda, Maryland: Issues in Funding for Biomedical Research Training Programs, October 2, 1990.

Johns Hopkins University, School of Public Health, Baltimore, Maryland: Seminar: Lecture on Local Organization of Refugee Caps, November 12, 1990

American College of Surgeons Metropolitan Washington Chapter, Panel Presentation: Current Controversies in Transfusion Medicine, March 2, 1991.

Twentieth Century Orthopaedic Association, 46th Annual Meeting: Land Mine Injuries in Cambodia, September 19, 1991.

Old Dominion University, College of Health Sciences, Norfolk, Virginia: Introduction to International Health Volunteer Organizations, recorded July 22, 1992.

Bolivian-American IV National Medical Convention, Washington, DC: Appropriate Medical Care in Developing Countries, August 5, 1994.

Yale Orthopaedics Society: World Problem of Land Mines, March 31, 1995.

Johns Hopkins University Medical and Surgical Association, Baltimore, Maryland: Training Medical Manpower in Developing Countries, May 10, 1995.

Johns Hopkins School of Public Health, World Problem of Land Mines, July 21, 1995.

International Humanitarian Law, Geneva Conventions, Johns Hopkins University, Introduction to Public Health	January 2000
International Humanitarian Law, Geneva Conventions, Johns Hopkins University, Introduction to Public Health	January 2001
Yale Orthopaedic Alumni, Landmine Epidemic	March 2001
International Humanitarian Law, Geneva Conventions, Johns Hopkins University, Introduction to Public Health	January 2002
New England Orthopaedic Association, Landmine Injuries	September 2002
Hamilton College 50th reunion: Landmine Ban	June 2015

University Service:

Weekly instructor, Anatomy, Georgetown University	1976-1982
Active participant in Grand Rounds teaching, Georgetown Hospital	1976-2002
Advisor and instructor to medical students Refugee Health Program. Helped found and teach this program, that ran over 6 years, Sending medical students to Thailand.	1982
Advisor to Physicians for Human Rights chapter, Georgetown University	2001-2003

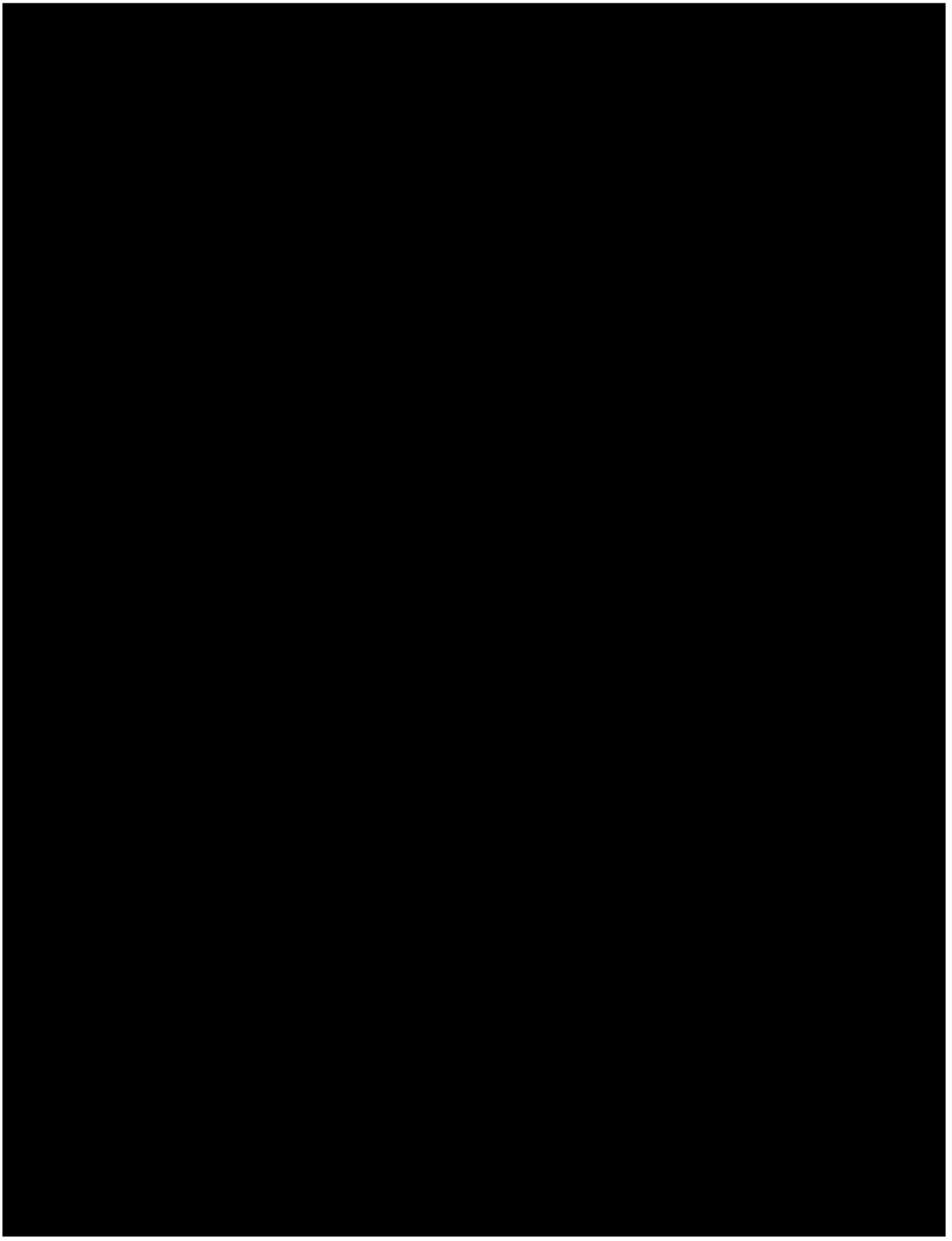
Teaching Activities:

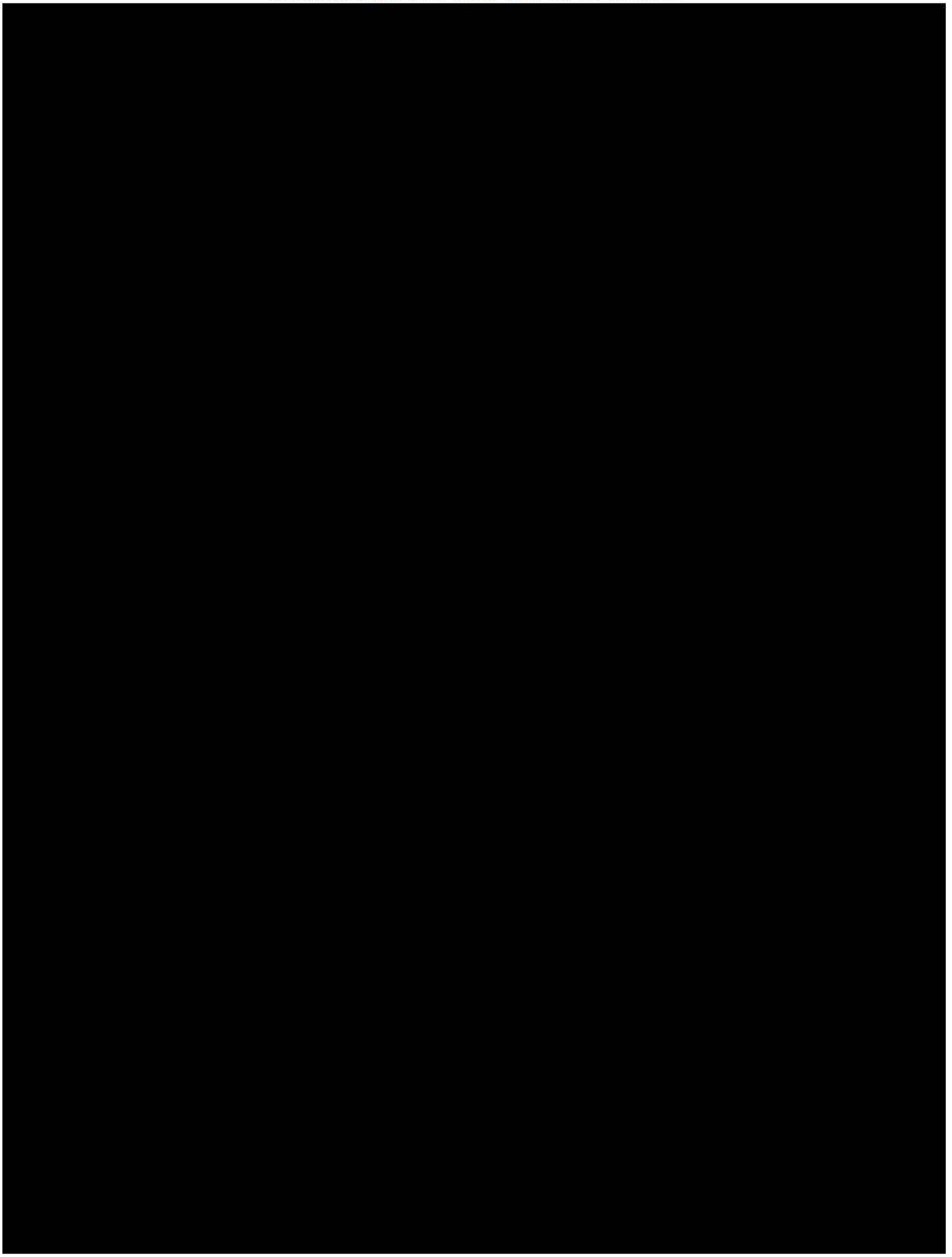
Clinical Associate Professor and teaching to Orthopaedic residents	1976-Present
Teaching medical students in my office weekly	1985-Present
Lecturer in courses on Introduction to Healthcare , annually	1997-Present
Teaching Georgetown University medical students at the Washington Hospital Center	2002-Present

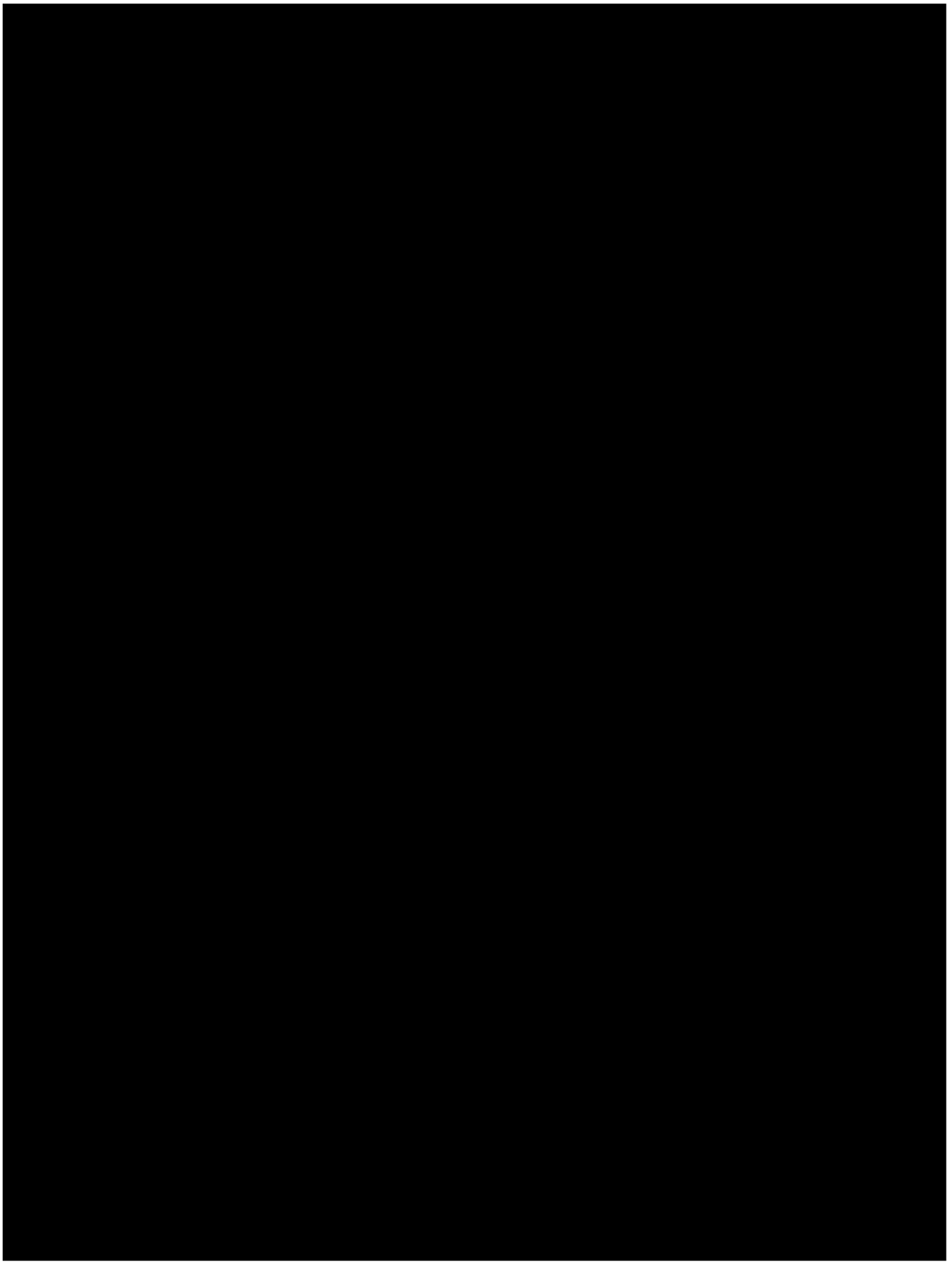
Scholarship and Research:

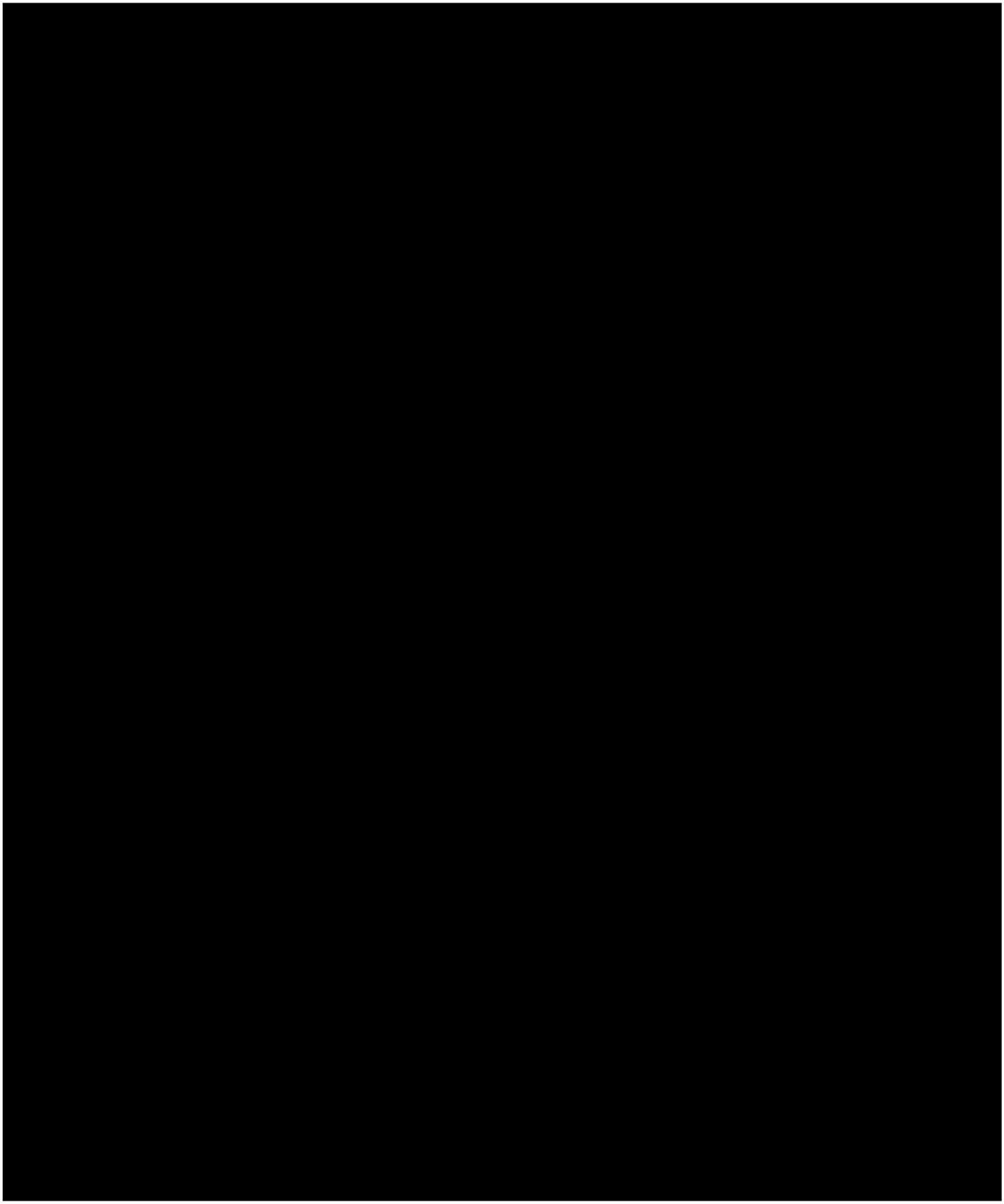
$50,000 Dollar grant from Christopher Columbus Foundation, for on-going International work.	2002

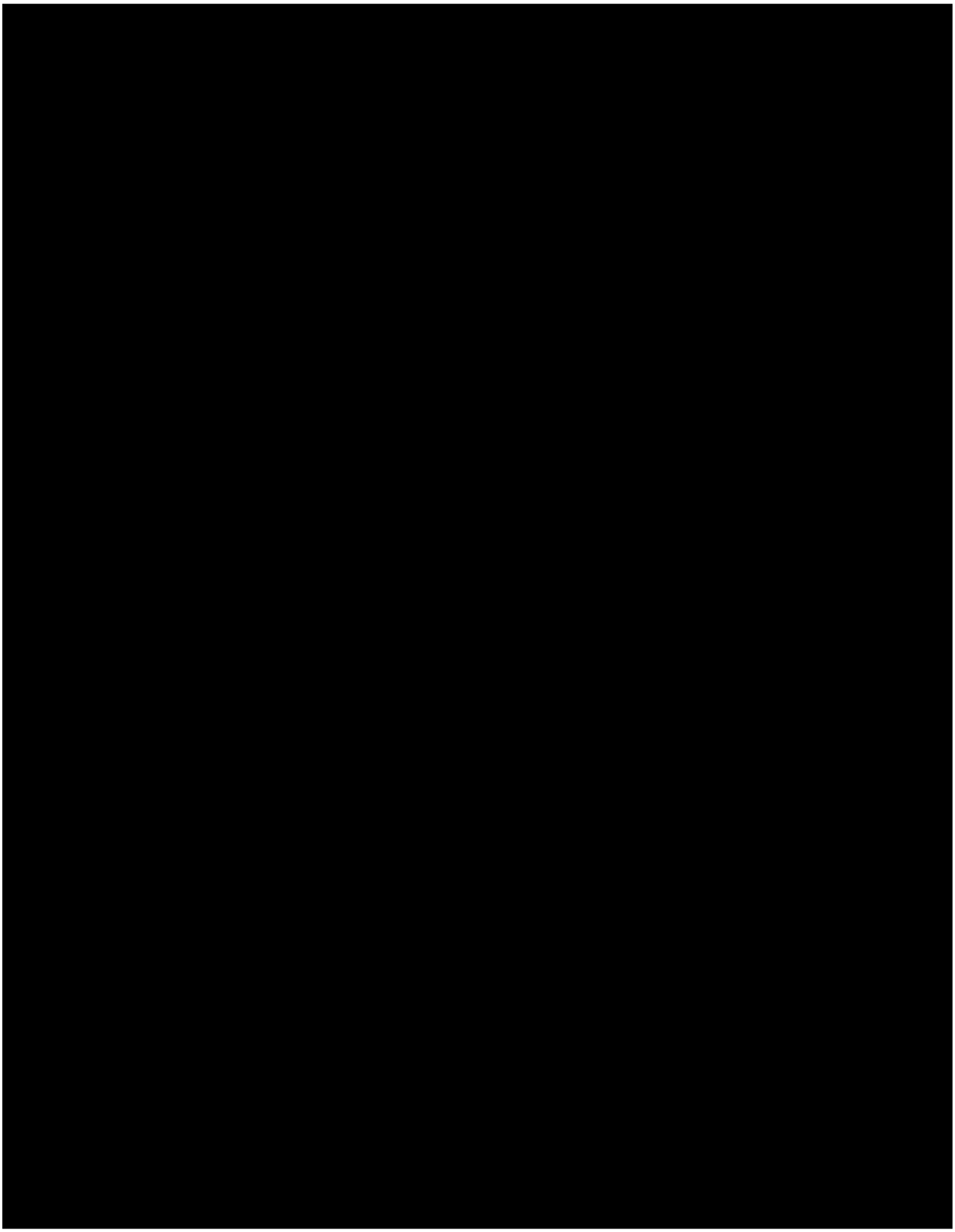
Attachment E

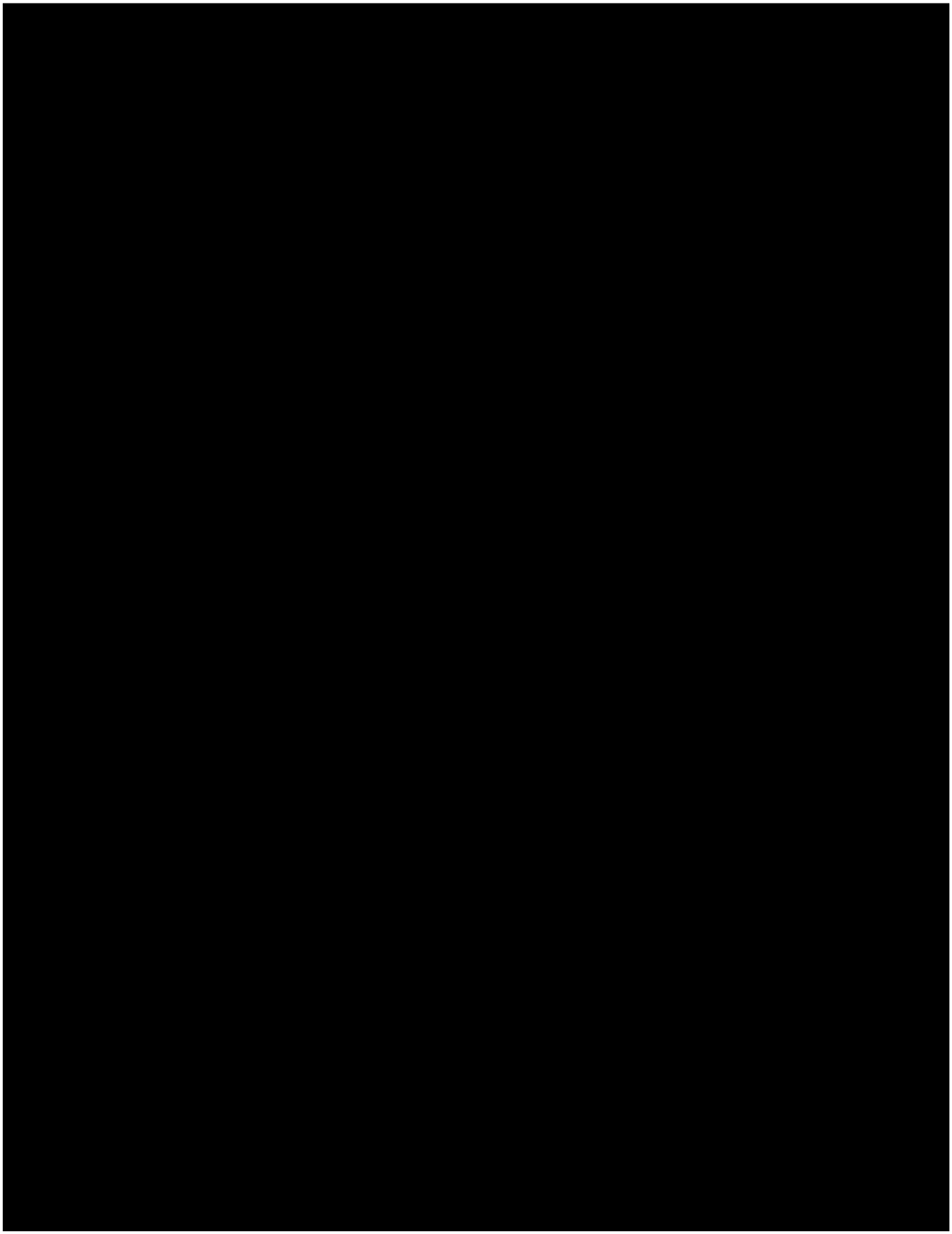


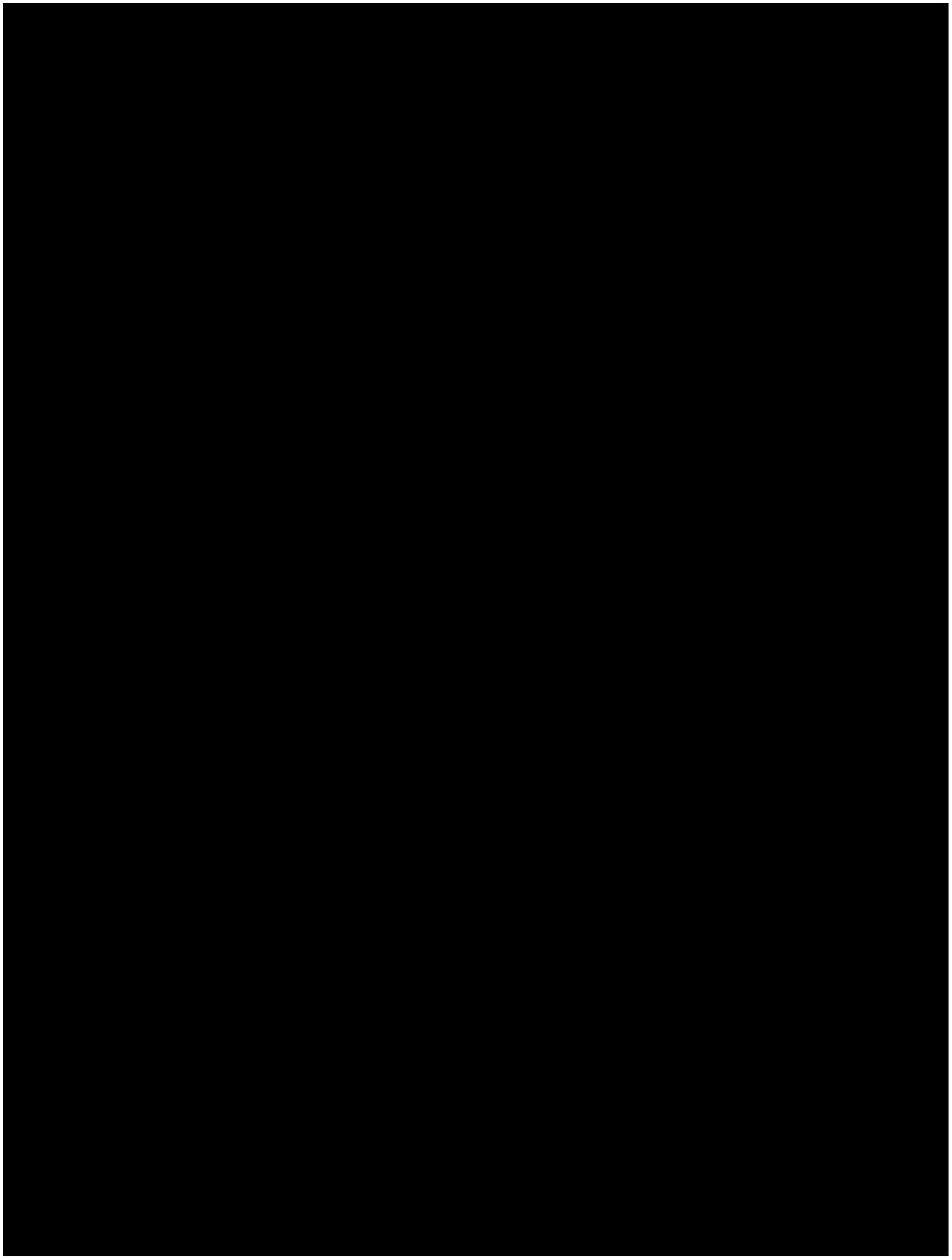












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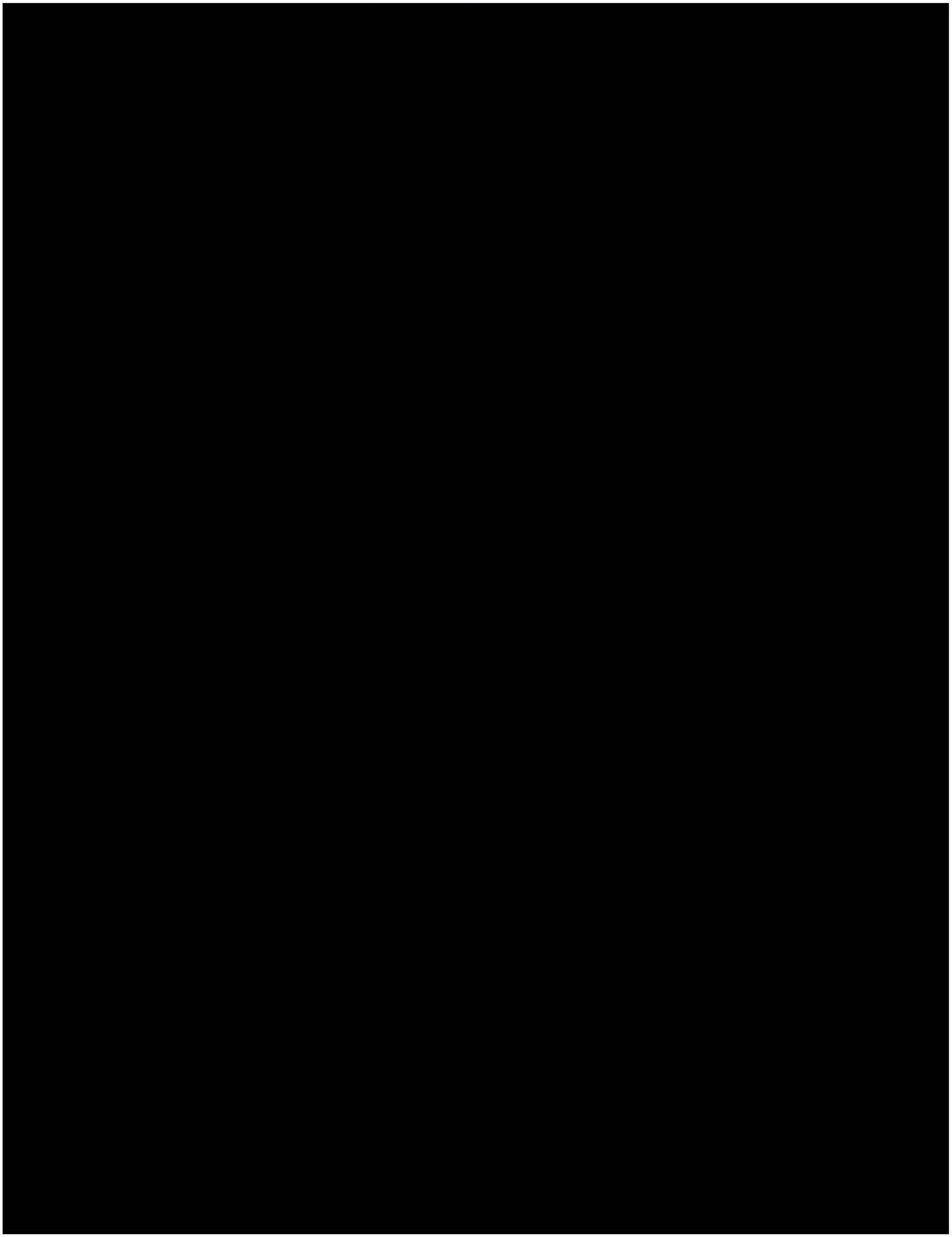

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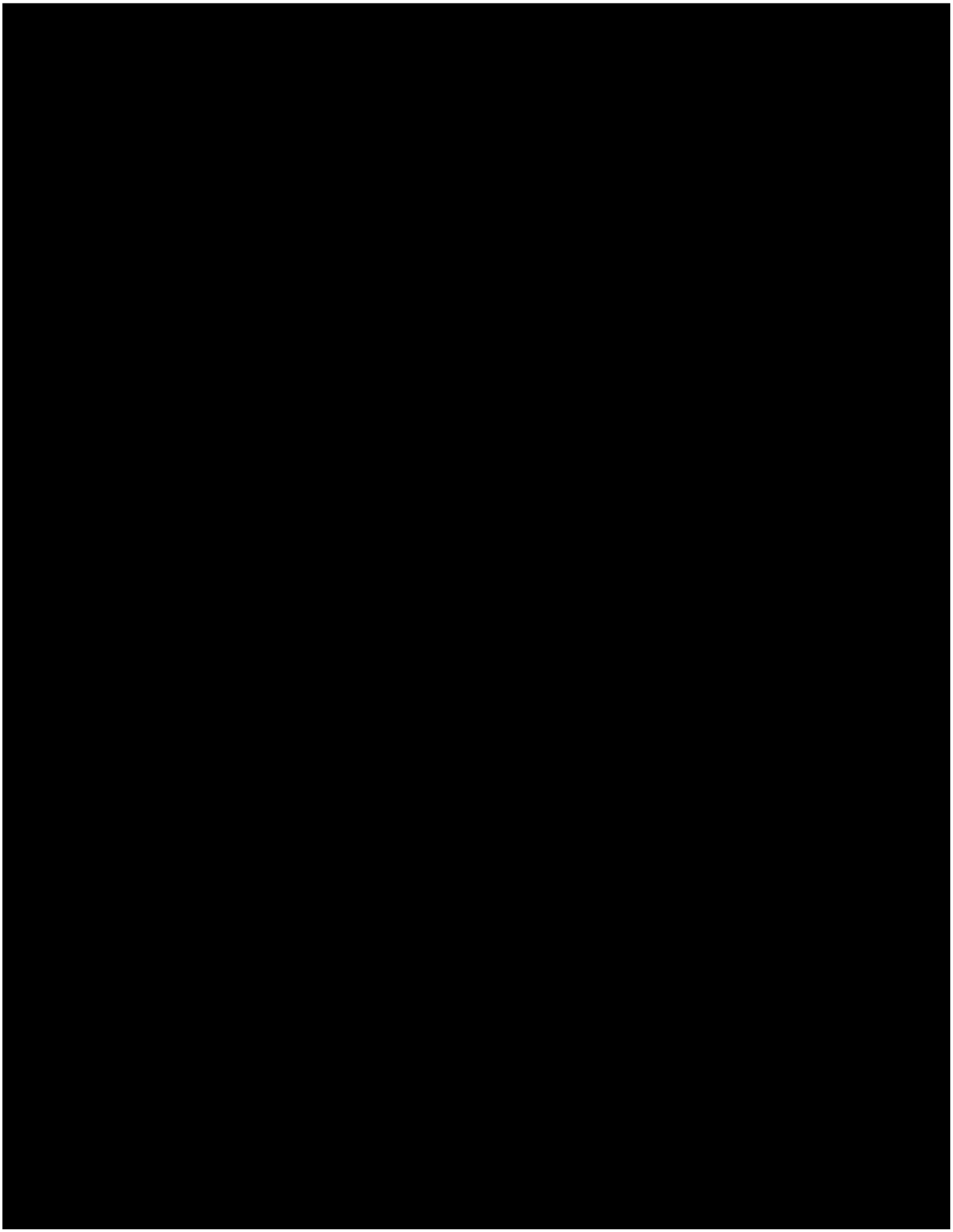

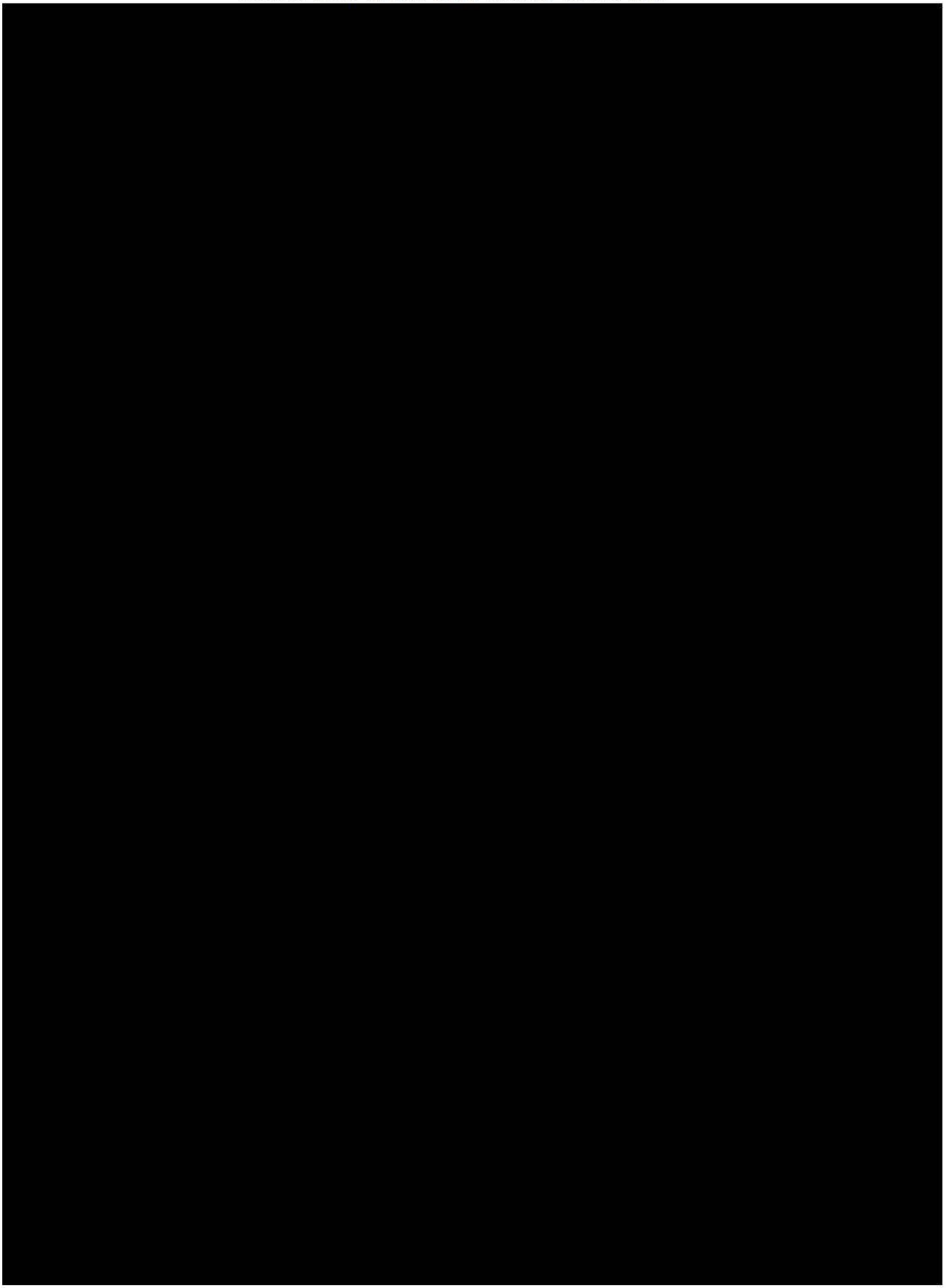

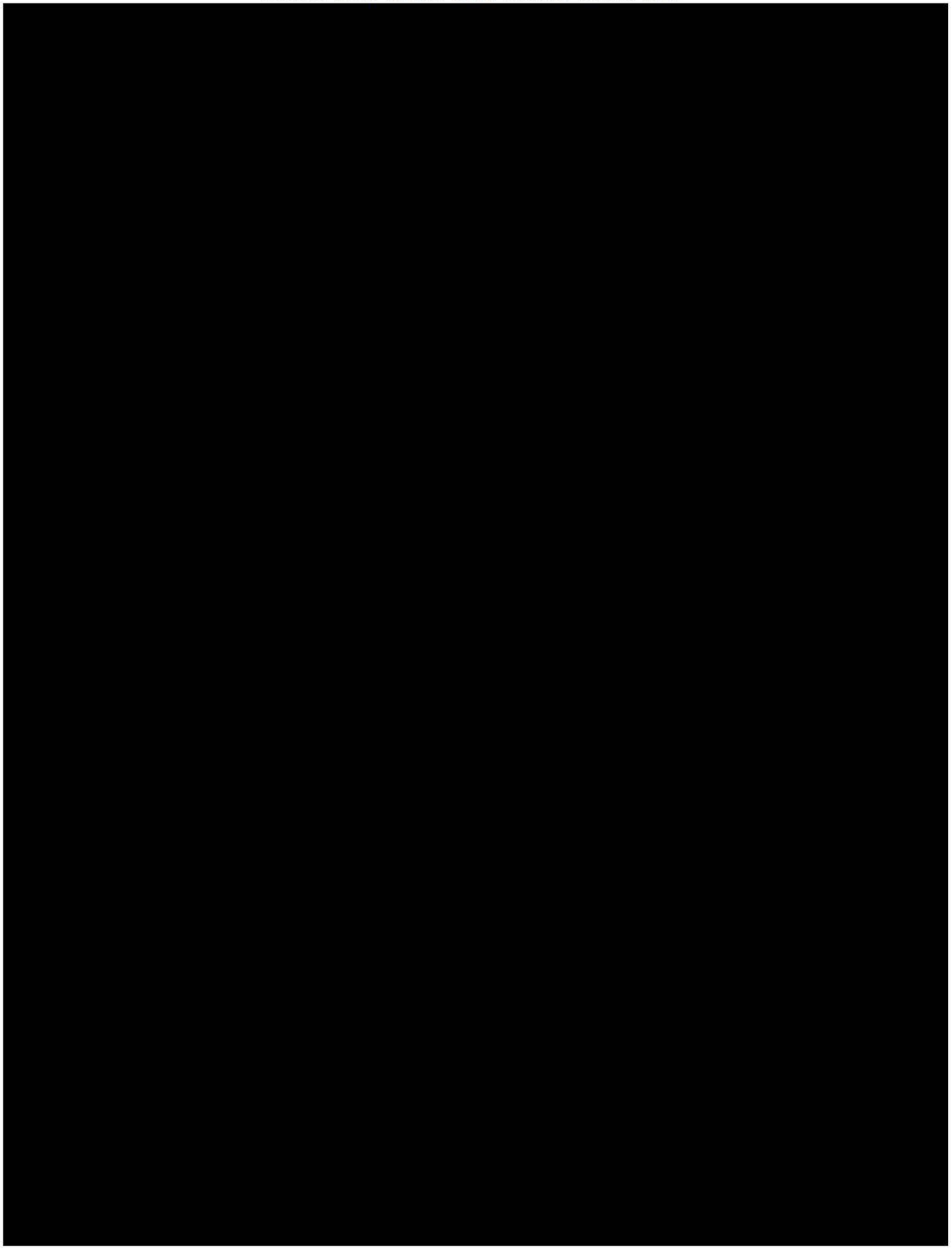

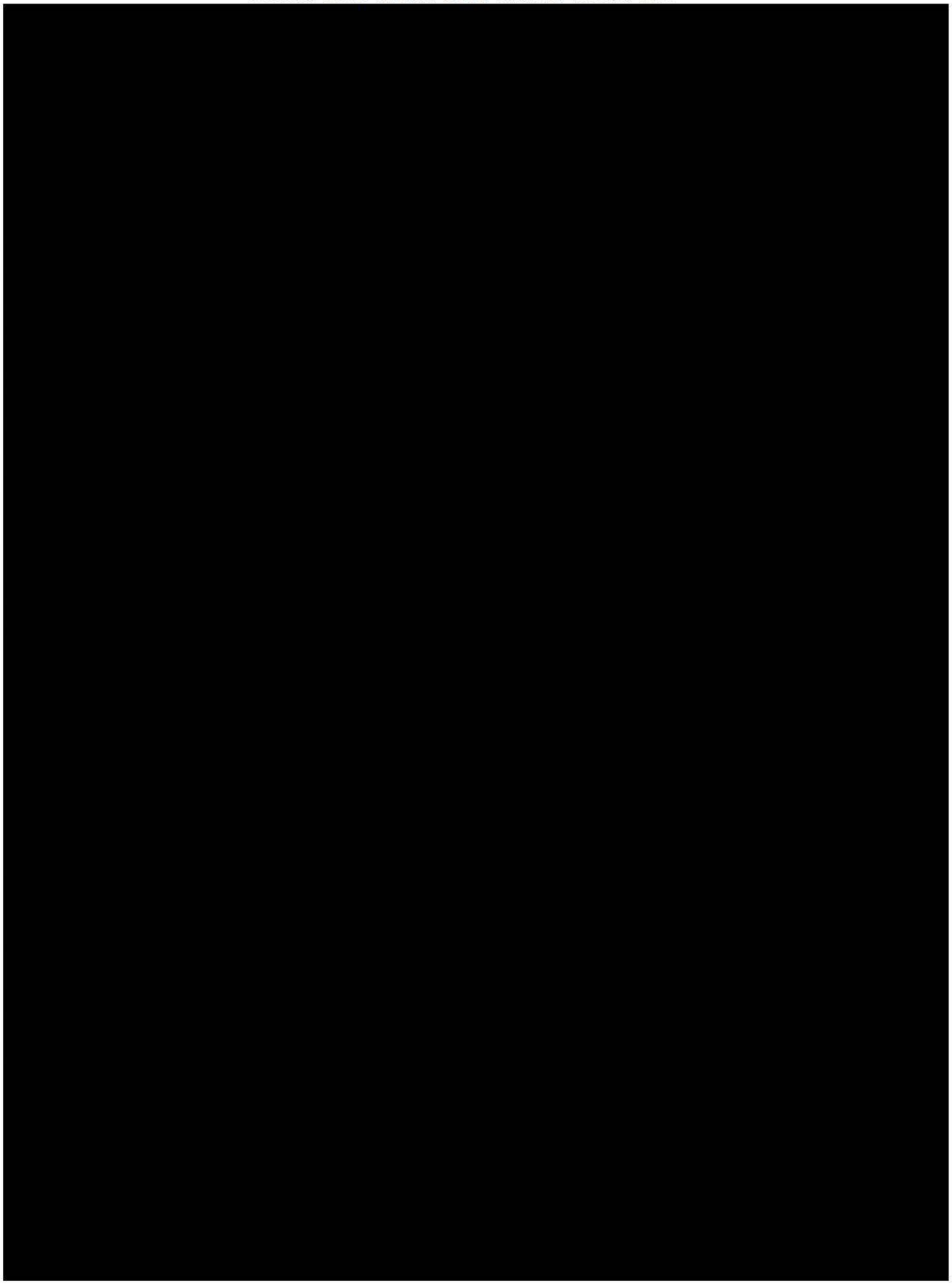

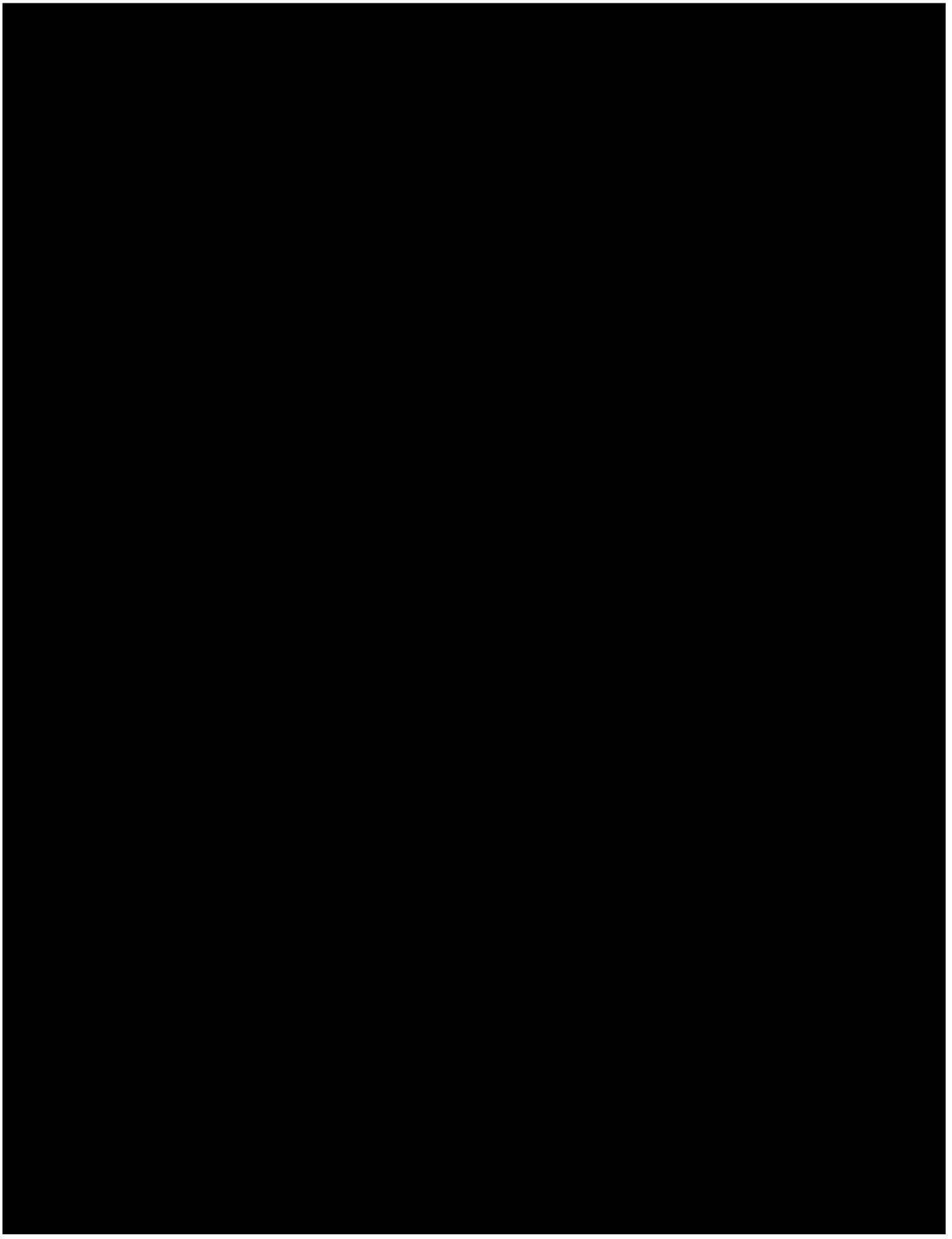

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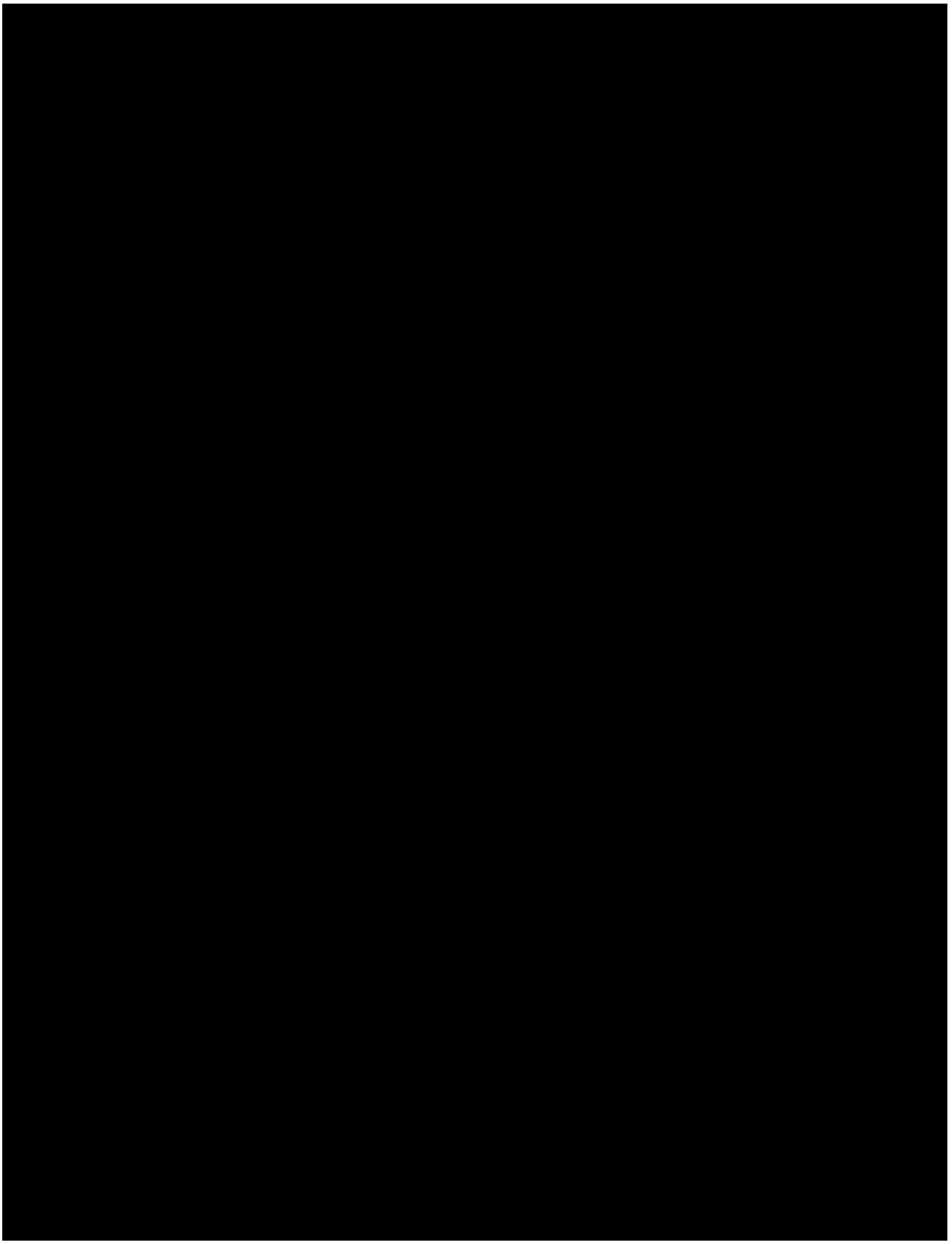

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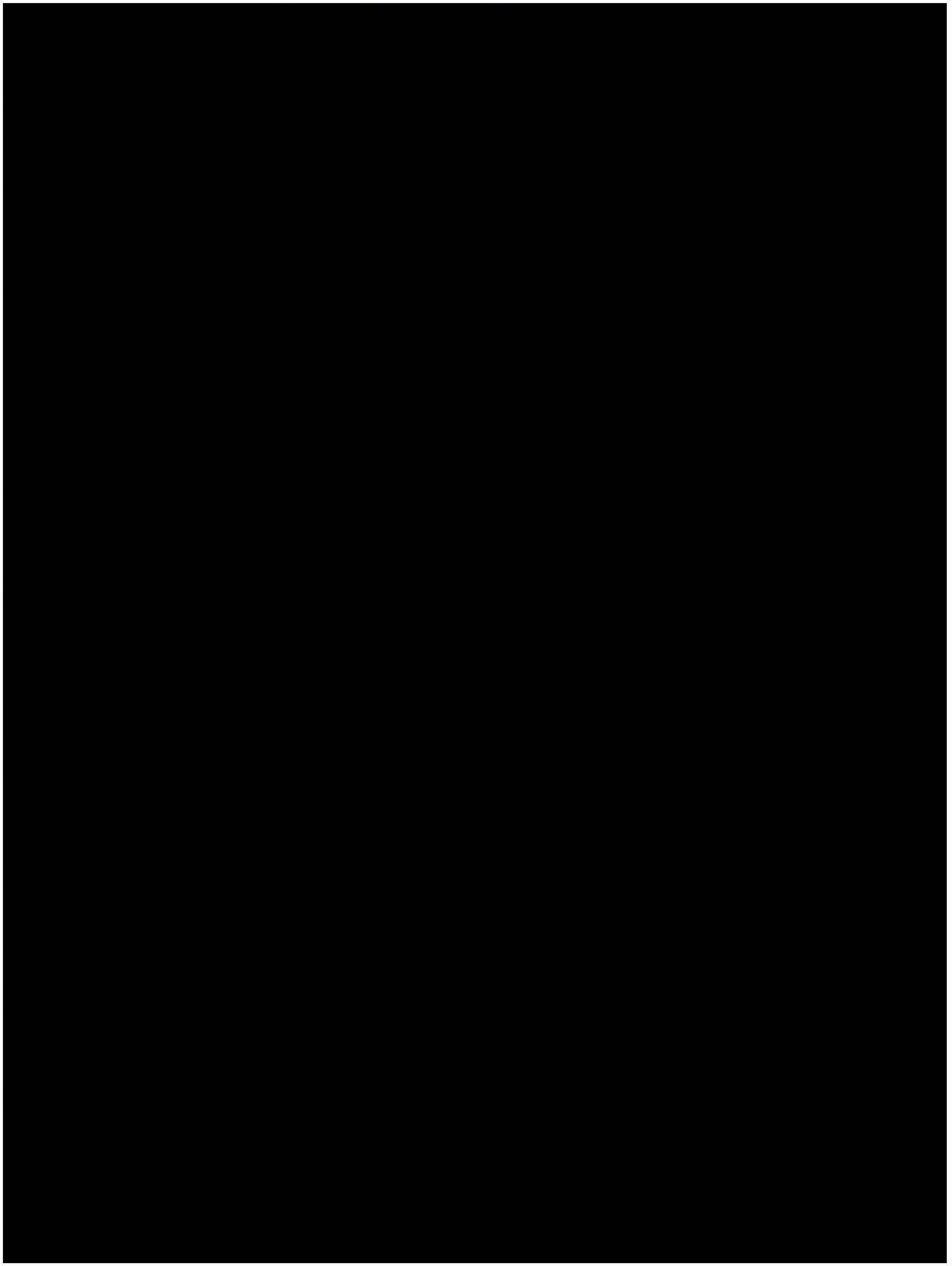

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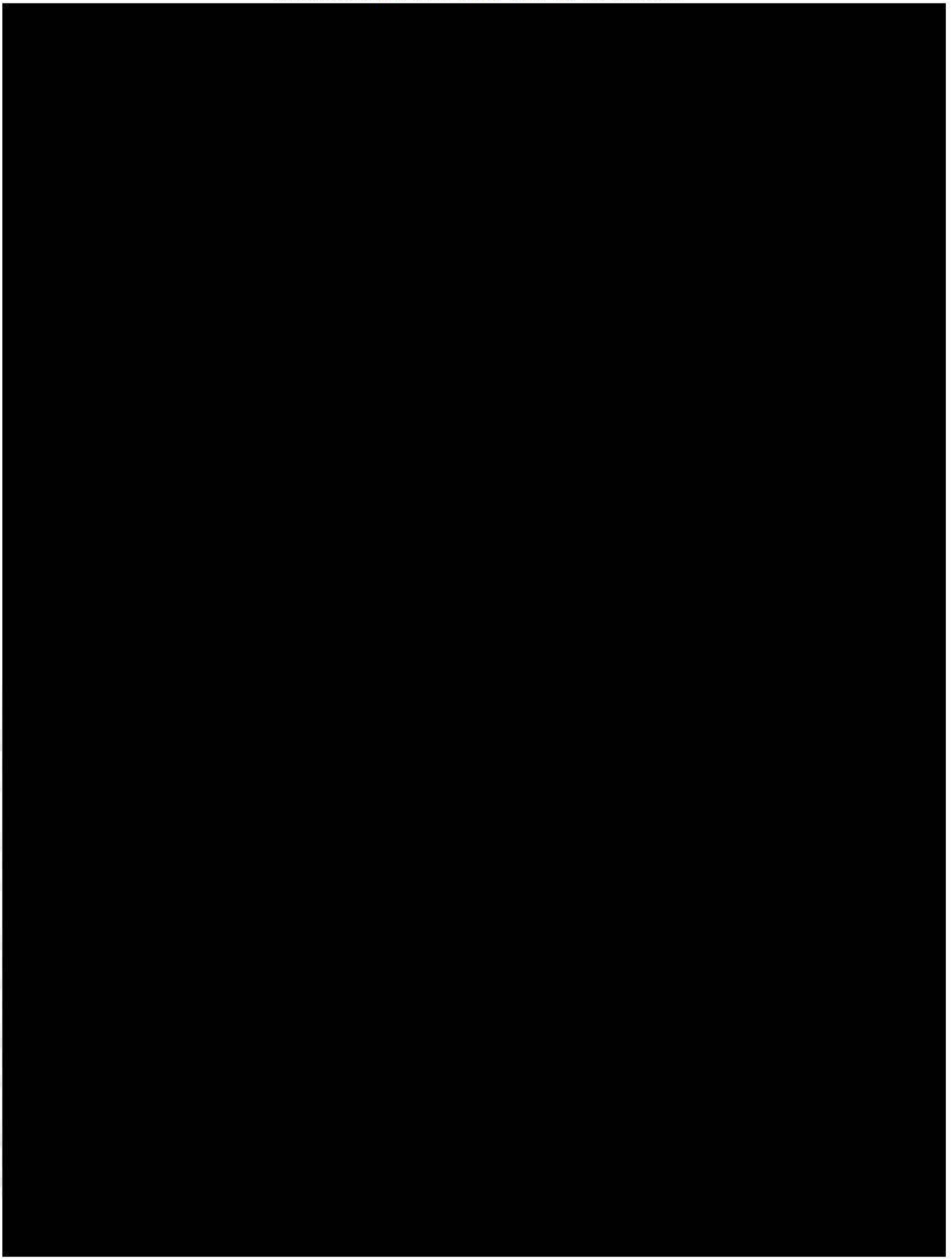

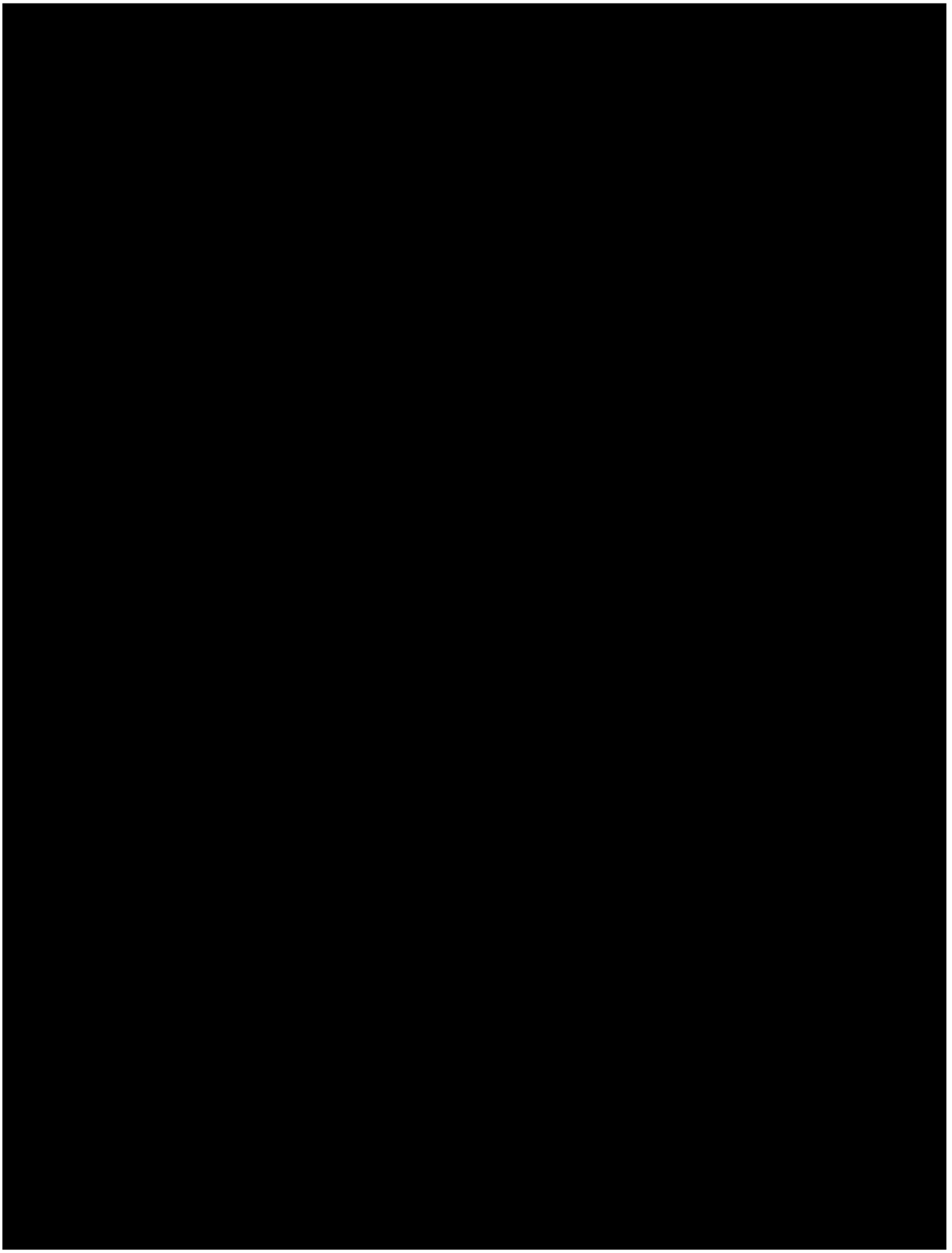

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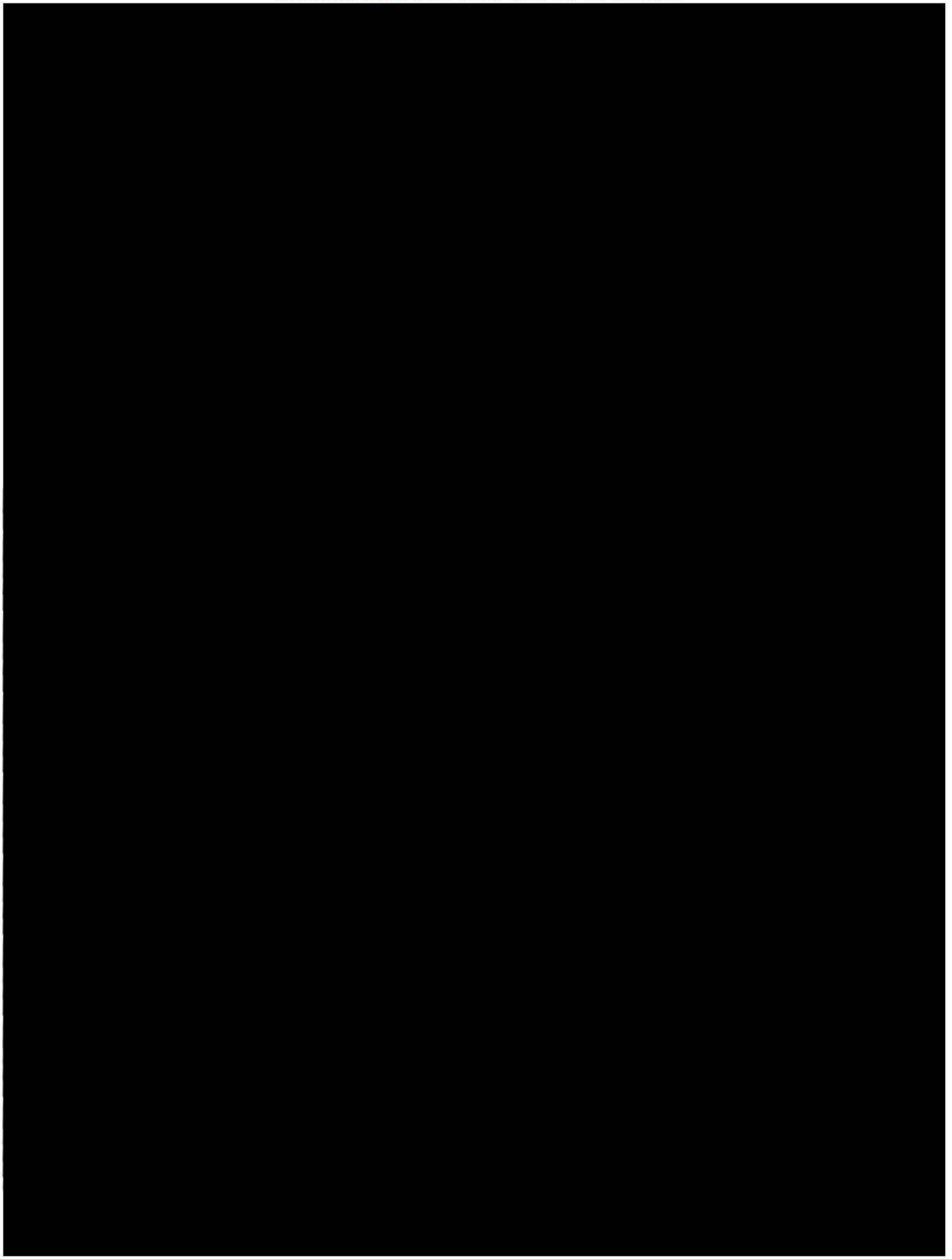

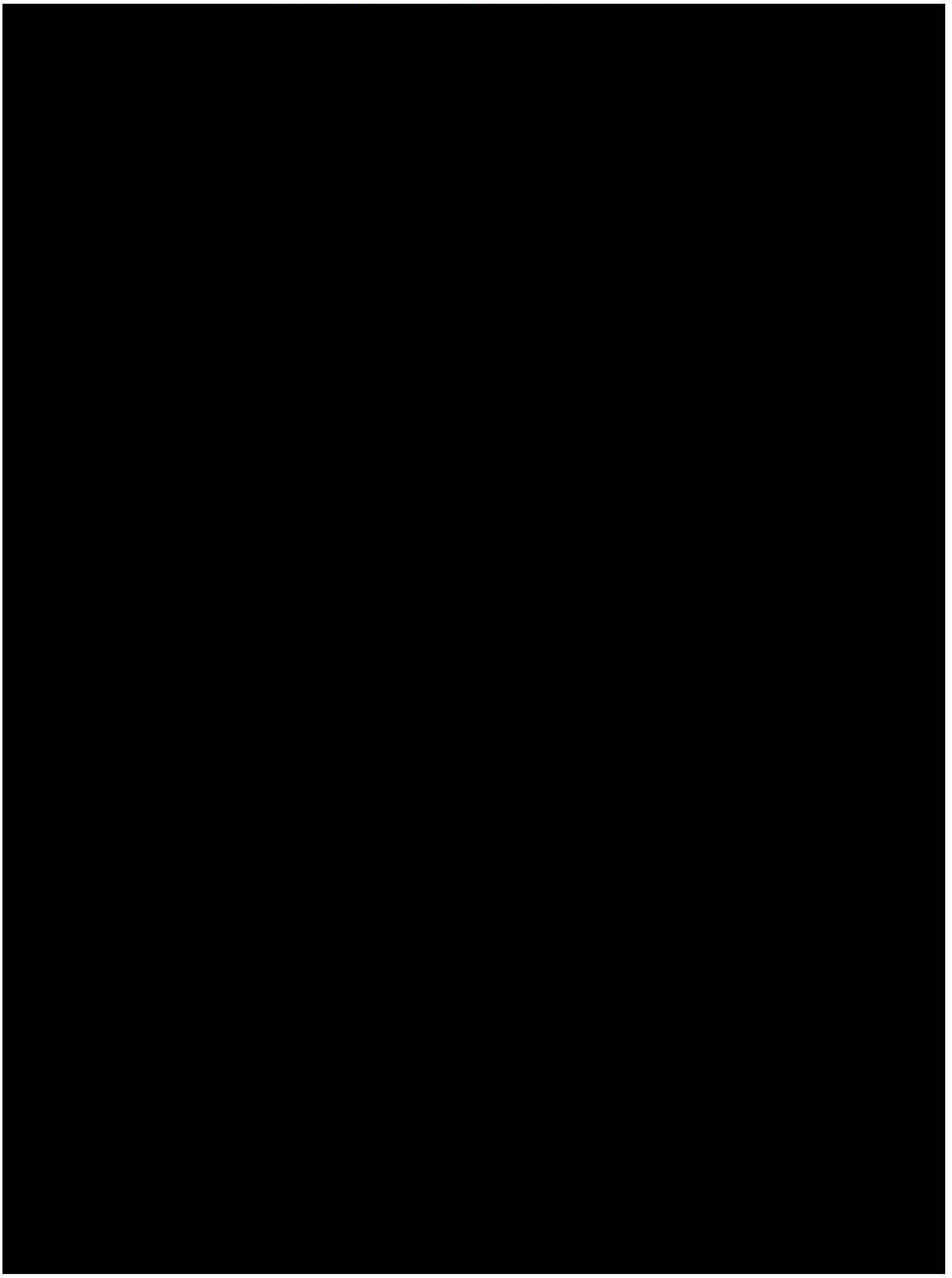

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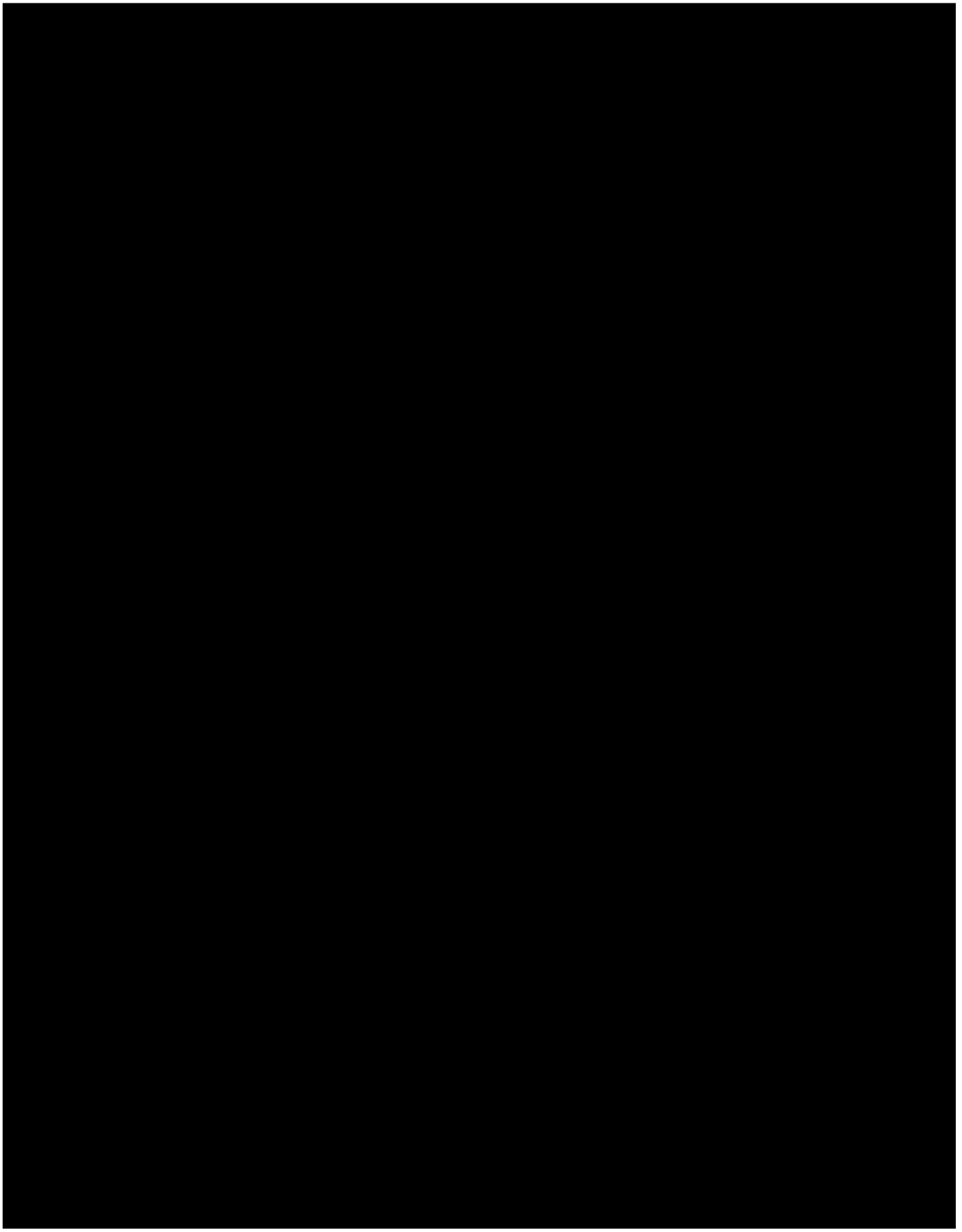

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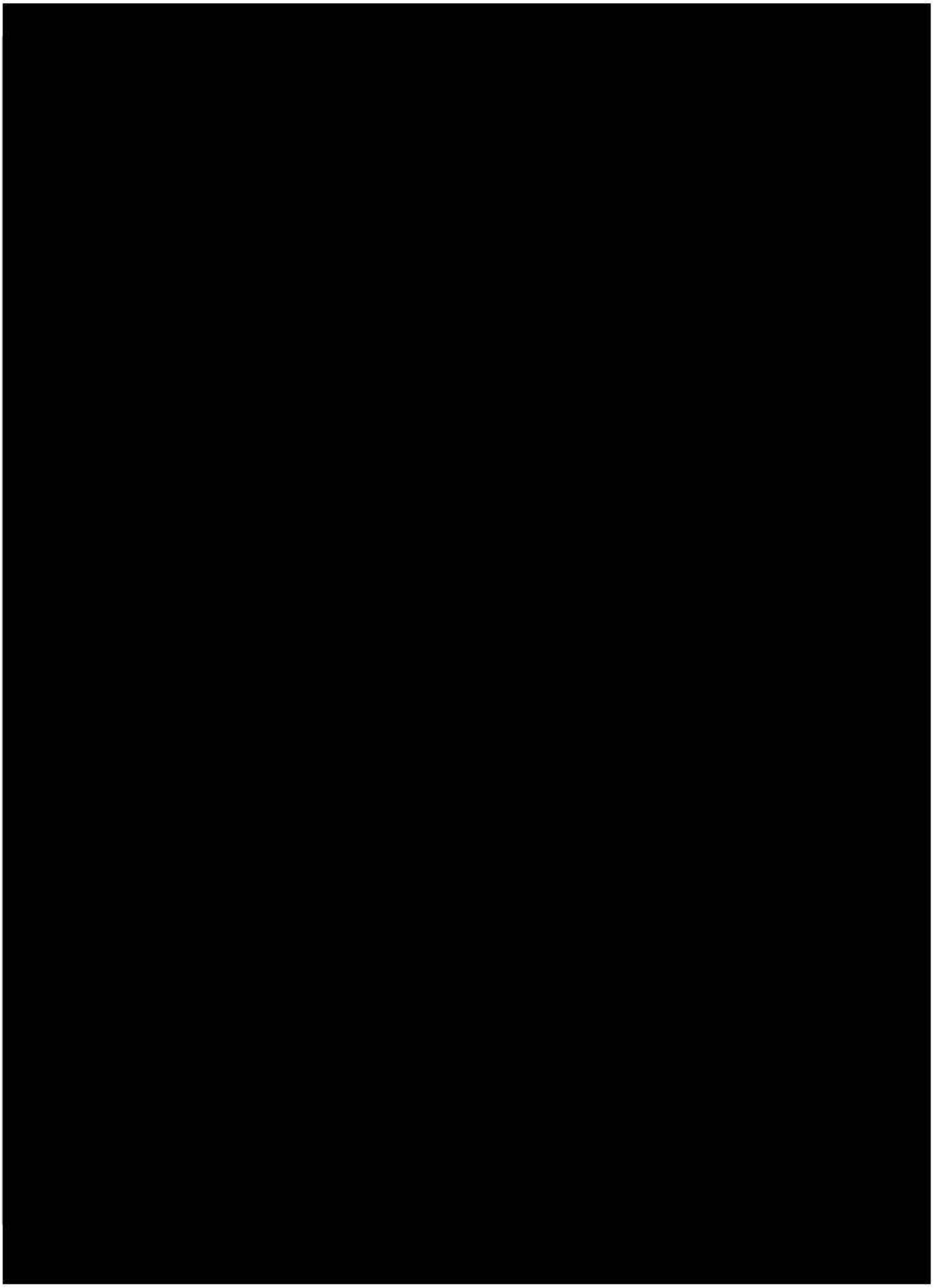

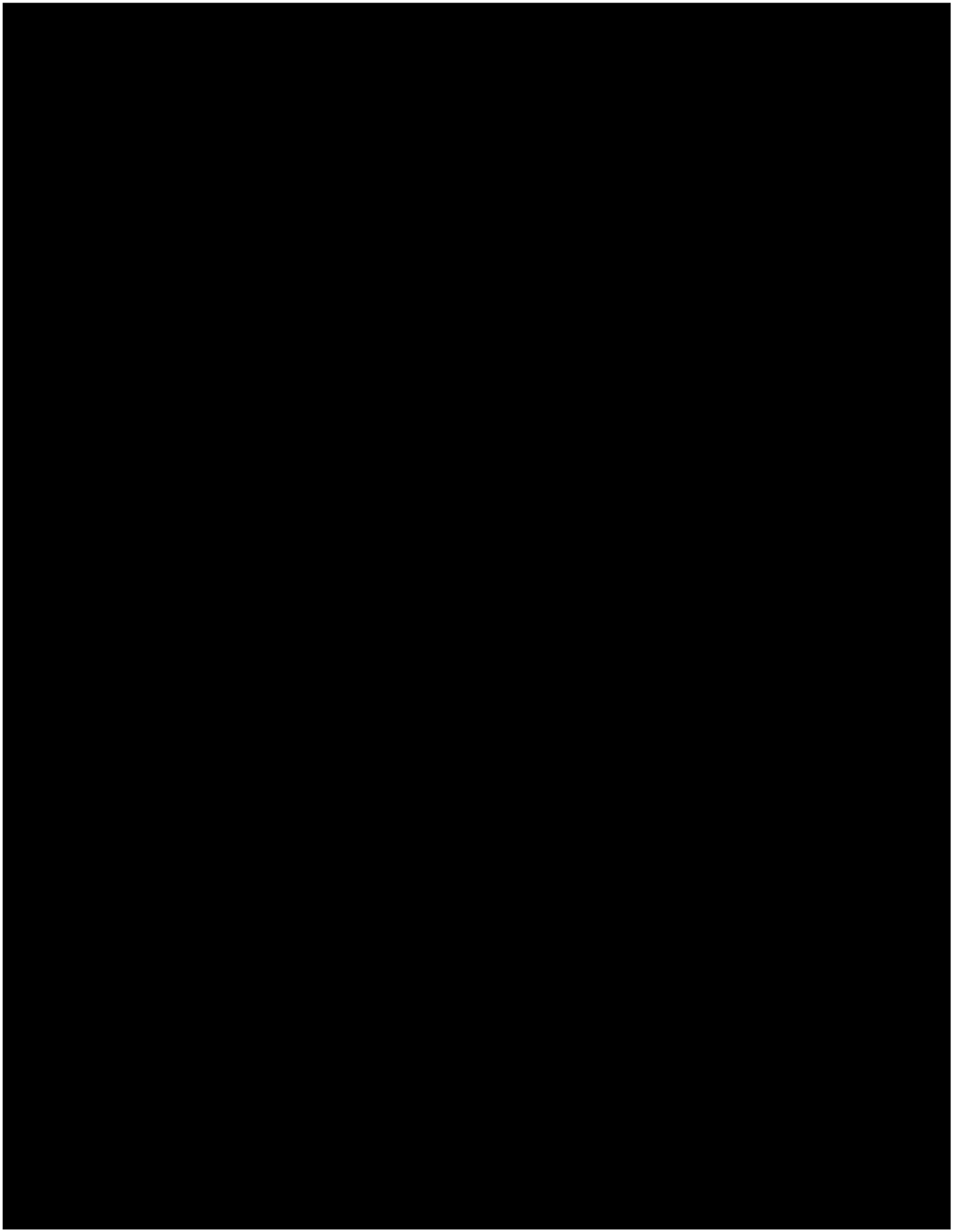

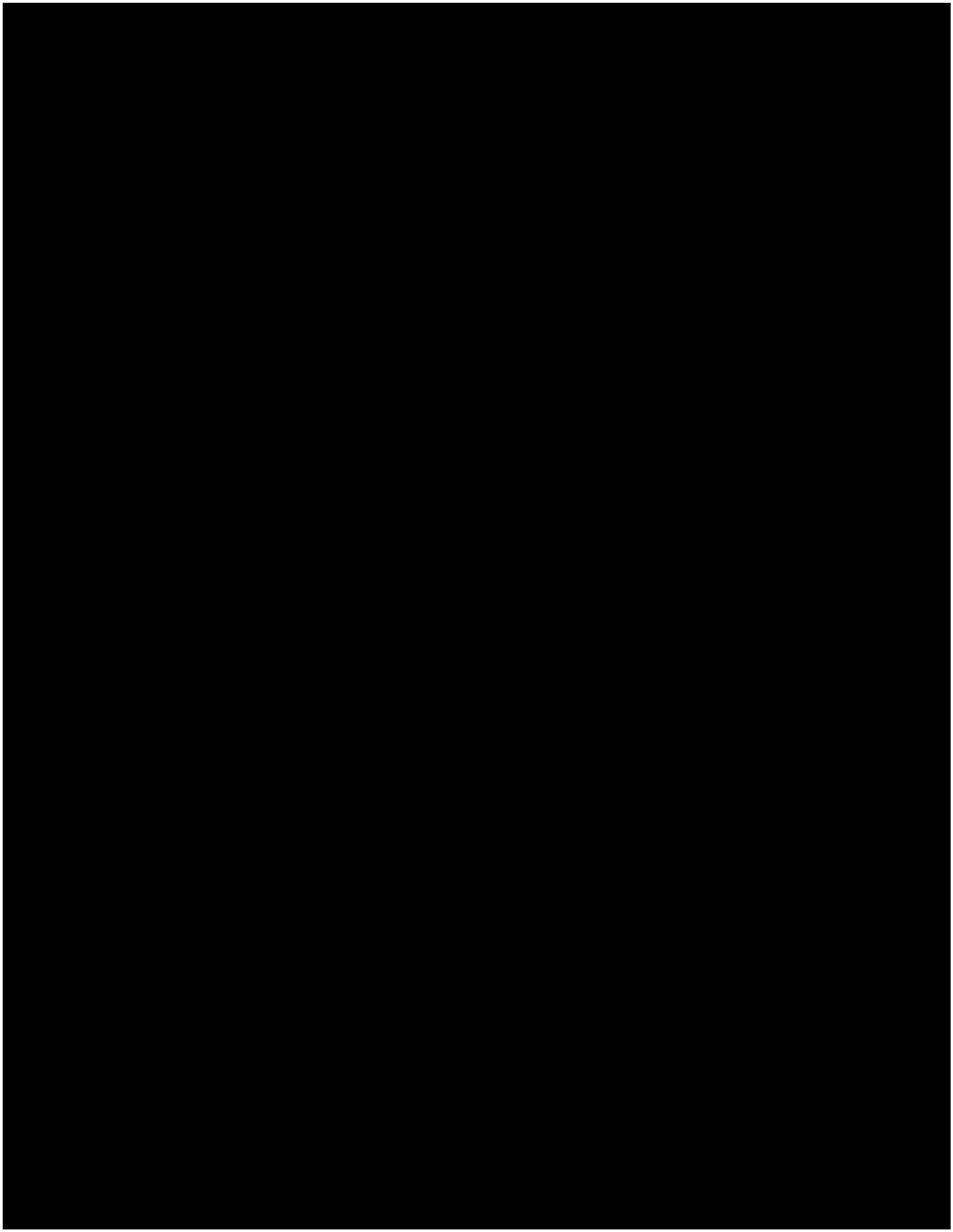

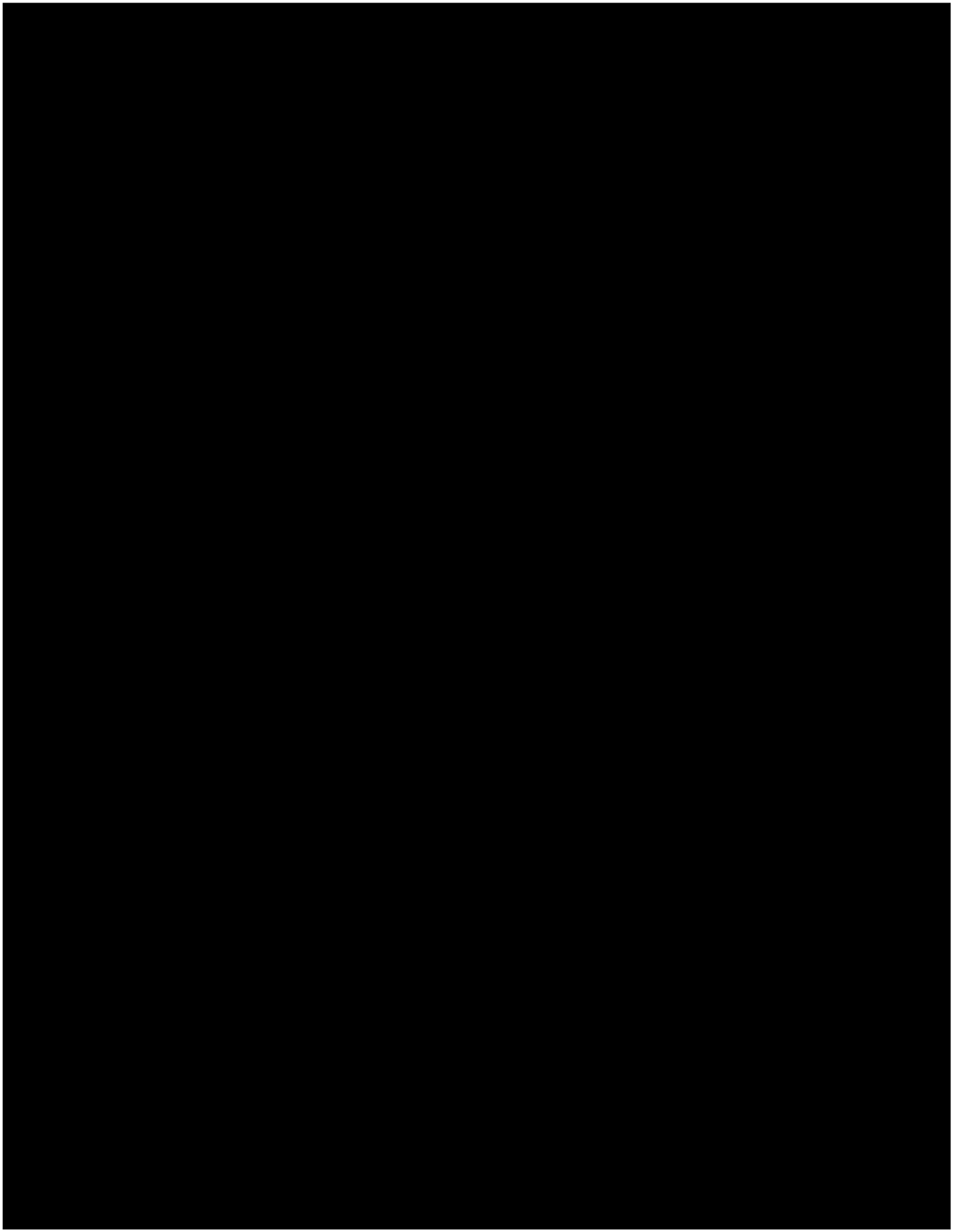

Attachment F

Thurschwell, Adam Mr OSD OMC Defense

From: SOUTHCOM NS Guantanamo Bay JTF GTMO SJA Mailbox LSS [redacted]
Sent: Wednesday, September 6, 2017 1:55 PM
To: Cooper, Aimee M CDR OSD OMC Defense; SOUTHCOM NS Guantanamo Bay JTF GTMO SJA Mailbox LSS
Cc: Thurschwell, Adam Mr OSD OMC Defense; [redacted]
Subject: RE: ISN 10026 ~~(UNCLASSIFIED)~~

Classification: ~~UNCLASSIFIED~~

CLASSIFICATION: ~~UNCLASSIFIED~~

CDR Cooper,

JTF is fully engaged on all aspects of your client's medical condition and treatment. JTF is also tracking and prepared for the impending storm conditions. Updates on both will be made through proper channels as appropriate.

V/r,
LSS

-----Original Message-----
From: Cooper, Aimee M CDR OSD OMC Defense [redacted]
Sent: Wednesday, September 06, 2017 12:43 PM
To: SOUTHCOM NS Guantanamo B[redacted]
Cc: Thurschwell, Adam M CIV (US) [redacted]
Subject: ISN 10026

Good Afternoon,

I have received word that Mr. al-Tamir's doctor was ready to speak with me to coordinate efforts relating to Mr. al-Tamir's health care. This was supposed to have happened on September 5, 2017. As I type this I have not received a response regarding Mr. al-Tamir's health care, my request for his medical records or a call from his physician.

As I understand it, my call with the physician was/is going to be coordinated with your offices.

Can you please provide an update. Mr. al-Tamir's situation is emergent.

R/ CDR Cooper

Aimee Cooper
CDR, JAGC, USN
[redacted]

this communication may contain individually identifiable information the disclosure of which, to any person or agency not entitled to receive it, is or may be prohibited by the Privacy Act, 5 U.S.C. §552a. Improper disclosure of protected information could result in civil action or criminal prosecution.

CLASSIFICATION: ~~UNCLASSIFIED~~