MILITARY COMMISSIONS TRIAL JUDICIARY
GUANTANAMO BAY, CUBA

UNITED STATES OF AMERICA **v.** **ABD AL HADI AL-IRAQI**	**AE 189P** **Government Updated Notice** to the Defense and the Commission Pursuant to AE 189L **29 September 2021**

1. Timeliness

This Notice is timely filed pursuant to the Commission's most recent order regarding the Accused's current health condition.[1] *See* AE 189L.

2. Government's Notice

The Government hereby provides medical notes from an examination of the Accused conducted by the treating neurosurgeon on 22 September 2021. Pursuant to AE 189, the Government will continue to provide biweekly updates (i.e., every two weeks, the next update being due 1 October 2021) on the Accused's medical condition to the Defense and the Commission.

3. Attachments

A. Certificate of Service, dated 29 September 2021.

[1] The Commission has previously ordered the Government to provide biweekly updates about the Accused's health, particularly as it relates to his ability to participate in pretrial proceedings. *See* AE 099I, Interim Order, Emergency Defense Motion to Abate the Proceedings Until [the Accused] is Physically Competent to Stand Trial, dated 29 September 2017; AE 099NN, Second Interim Order, Emergency Defense Motion to Abate the Proceedings Until [the Accused] is Physically Competent to Stand Trial, dated 27 September 2018; and AE 182F, Order, dated 2 October 2020. On 9 September 2021, the Defense filed AE 189K, providing notice that the Accused had reported that "he no longer had feeling in his legs" and may be suffering an emergent medical condition.

B. Medical notes of Neurosurgeon, dated 22 September 2021.

Respectfully submitted,

//s//

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ATTACHMENT A

CERTIFICATE OF SERVICE

I certify that on the 29th day of September 2021, I filed AE 189P, the **Government Notice to the Defense and the Commission Pursuant to AE 189L**, with the Office of Military Commissions Trial Judiciary, and I served a copy on counsel of record.

//s//
CDR Douglas J. Short, JAGC, USN
Trial Counsel
Office of the Chief Prosecutor
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ATTACHMENT B

NEUROSURGEON'S NOTES

22 SEP 2021

ISN: 10026

Neurosurgical consultation:

I was asked to see this 60 year old male with fairly sudden worsening of his RLE pain and paresthesia along with bilateral leg weakness with inability to stand and walk starting on 08SEP2021. This person complained of acute worsening of his chronic RLE paresthesia and dysesthesias along the lateral aspect of his buttocks, thigh and leg down to the bottom of his foot. He relayed intermittent intensification of the sensation along with associated difficulty in standing and walking. He did not report any urinary issues such as incontinence, urgency or inability to void. A medical evaluation was performed at the time including a non-contrast CT scan of his head that showed no specific acute or chronic abnormalities. Subsequently this person has been observed getting up out of bed and a wheelchair unaided and ambulating without assistance. This person still contends that at this point in time he still needs his brother who is housed with him to help him get out of bed and ambulate about their room.

PMH: is pertinent for chronic LB and leg pain and paresthesia dating back to 2000.

He has undergone numerous spinal surgeries:

04 SEP 2017 L4 – 5 – S1 laminectomy

18 SEP 2017 anterior cervical discectomy and fusion using interbody devices, cervical plate and screws and left ilia crest grafting material

Neurosurgical consultant/provider

23 SEP 2017 evacuations of anterior cervical surgical wound hematoma due to post op anticoagulation therapy

08 NOV 2017 replacement of anterior cervical plate and screws with posterior cervical foramenotomies and fusion using lateral mass screws and rods C3 – C6.

21 MAY 2018 L4 – S1 facetectomies foramenotomies and fusion using interbody devices and posterior segmental spinal instrumentation and extension of posterior spinal fusion from C3 – T2 using segmented spinal instrumentation

1984 laparotomy for liver laceration secondary to a soccer injury.

SH –

FH – not significant

ROS: no bowel habit changes noted

Has defuse osteopenia on prior imaging studies.

Physical Exam: Revealed a middle aged male sitting in a wheelchair in no acute distress, his left wrist [redacted]. He was awake and alert and converses well in English. His memory for recent and remote events was good. Vital signs are as noted.

CNS Exam: Cranial nerves are WNL from 2-12, bilaterally.

Reflexes of his UE: 1-2+ bicep/triceps/wrist extensors, bilaterally.

Pupils are equal and round, 3mm diameter, they respond equally to light and accommodation.

The ROM of his C-spine is diminished in lateral bending, flexion, extension and rotation in all directions equally.

The strength was good in all motor groups of his UE bilaterally. Sensation is slightly diminished to light touch and pin prick, bilaterally, in the C6 distribution. Tinnels signs was present in the volar aspect of his left wrist, in the median nerve distribution and at the medial epicondyles in the ulnar nerve distribution, bilaterally.

The ROM of his L spine could not be determined. The strength of his LE revealed: 4/5 in Left knee extension, 5/5 in right knee extension, atrophy of the left thigh musculature more so as compared to the right was seen, left knee flexion 3+/5, right knee flexion 5/5. 5/5 strength was noted in plantar and dorsiflexion of his feet, extension of his great toes, flexion and extension of his hips and abduction and adduction of his hips, bilaterally.

Sensation: Diminished sensation to light tough and pin prick in the R L5 distribution was noted

Reflexes: Left knee 0+, Right knee 2+, Left ankle 1+, Right ankle 1+. No ankle clonus was seen bilaterally.

He was able to able to stand with both knees slightly flexed and took 3 shortened steps with assistance of 2 people. Babinski test with normal responses was seen bilaterally.

Surgical incisions: well healed transverse. L anterior cervical incision 5 cm long, 20 cm long right Para median ABD incision, 15 cm long posterior cervical/thoracic midline incision, 15 cm long midline LS incision with no lumbar lordosis noted.

Review of recent imagining studies of his spine: LS spine with and without contrast April 2021 (CT scan) LS Spine without contrast Sep 2021 (CT scan)

T spine and C spine without contrast SEP 2021 (CT scan)

C, T, LS spine standing plain x-rays SEP2021

Neurosurgical consultant/provider

The CT scans revealed postoperative changes C3-T2 and L4-5-S1. Vascular calcifications are noted in the aortic and iliac arteries. Spinal canal and lateral recess stenosis at the L2-3-4 level with no significant change seen from the 2021 April study to the 2021 September study. Loss of cervical lordosis, thoracic kyphosis, lumbar lordosis is noted. The amount of sagittal imbalance to the mid portion of his L5-S1 interspace cannot be accurately measured.

I-1: symptomatic spinal canal stenosis L2-3-4 with global spinal sagittal imbalance. These findings are chronic in nature and should not lead to an acute deterioration of his LE function/ strength without associated significant trauma. The acute LE weakness reported on 9/8/2021 and 9/13/2021 does not appear to be associated with any imaged spinal abnormality.

2. Osteopenia

P: At this time I believe this person will need further (sometime in the future) surgical intervention upon his T-LS spine. I will see this man again on 24Sep2021 to discuss his options with him. I believe there is no medical reason why he may not attend any of his needed legal proceedings in the foreseeable future.

NEUROSURGEON'S NOTES

24SEP2021

ISN: 10026

I spoke with this man. I have recommend further surgery to correct his spinal condition to include:

1) Restoration of normal spinal canal dimensions from L1-L4.
2) Reestablishing normal spinal alignment both in the coronal and sagittal planes.
3) Providing a strong and durable spinal construct that will not fracture or fail either in the bony fusion or instrumentation.
4) Preventing further disease progression cranial to the spinal construct.

Before further surgical intervention upon this person's spine is done, his osteoporosis must be adequately evaluated. If he is determined to have inadequate bone stock this must be rectified by medical means prior to any planned surgery of his spine can be further accomplished.

At the end of this visit, he did not express the desire to undergo the proposed surgery. He specifically told me that he wished to do everything and anything possible to avoid the needed procedure. He in my estimation did not agree to have the surgery done and therefore was declining to have any further intervention at this present time.

The natural history of degenerative spinal canal stenosis is a gradual decline of neurological function and worsening of other associated symptoms. Acute deterioration in a person's neurological status with this condition is not typically observed. In my over 40 years of

Neurosurgical consultant provider

neurological surgery experiences this physician has never experienced anyone with degenerative spinal canal stenosis developing acute neurological deterioration without associated trauma.

As this person's medical history and condition have been presented to me in my expert medical opinion as a board certified neurological surgeon of the American Board of Neurological Surgeons, it is my belief his spinal abnormalities will require further surgical interventions. This should, however, not be required on an urgent or immediate basis given the natural history of degenerative spinal canal stenosis. I have made all of these statements with a reasonable degree of medical probability.