[The R.M.C. 803 session was called to order at 0844, 7 June 2022.]

MJ [Lt Col ROSENOW]: Commission is called to order. All parties present when we recessed yesterday are again present, both here in the courtroom and in the Remote Hearing Room. I note that Mr. Hadi, the accused, is present with us as well this morning.

Trial Counsel, would you please note for the record where the proceedings are being transmitted by closed-circuit television? And if it's the same as yesterday, you need only make that ----

TC [MR. SHORT]: Your Honor, it's the same as yesterday. And everybody that was here yesterday for the prosecution is here again today.

MJ [Lt Col ROSENOW]: Thank you for that.

Today we had planned to hear witness testimony from the senior medical officer and potentially the chief medical officer pertaining to Appellate Exhibit 214, which we discussed yesterday in the context of determining whether a hearing under M.C.R.E. 505(h) was still necessary. As covered yesterday afternoon, my intent was to begin with testimony from the senior medical officer not requiring the disclosure of classified information and then, if required, take the same

type of testimony from the chief medical officer.

Subject to discussion with the parties at that point and a continuing request from the government, we would have then closed the courtroom to hold a hearing under M.C.R.E. 505(h) to determine the use and relevance of classified testimony from one or both of these witnesses.

Since recessing, a member of my staff was notified by the government with the defense copied that the senior medical officer might be unavailable to testify this morning. That same message confirmed the availability of the chief medical officer at our start time, however.

Trial Counsel, were there any other administrative exchanges overnight apart from the one I just summarized involving my staff that should be noted for the record?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: Defense counsel?

LDC [MS. HENSLER]: No, Your Honor.

MJ [Lt Col ROSENOW]: Thank you.

Trial Counsel, given this change in the senior medical officer's availability, do you still oppose taking testimony from the chief medical officer where the parties agree it does not require reference to classified information this morning?

TC [MR. SHORT]: Your Honor, if I may, I think, you know,

some of their testimony would have overlapped for the matter that's in controversy before the commission in this pretrial hearing. So because the SMO is unavailable, the chief medical officer -- I lose some of the argument that I would've made -- he is standing by to testify.

I continue my objections over some of the other information that we talked about yesterday in terms of just the relevance of where now we know where defense is going to go. Classification aside, their list of topics reveals a lot of nonrelevant information.

And I think what you put on the record yesterday, in light of AE 189II and JJ, I think -- I don't know what's in controversy, right? I mean, there's -- the treating physician and the CMO -- the SMO and the CMO both agree that an MRI is warranted. Both have indicated -- or at least the SMO has indicated that an MRI, there's -- at least the works to get it here, so there's nothing to compel. I don't know what's in -- at controversy, Your Honor.

So to the extent that the CMO testifies, I think -- I think that the topics and information should be geared to and only relevant towards their motion that's pending before the commission.

MJ [Lt Col ROSENOW]: Thank you for that.

Defense Counsel, if you want to be heard briefly, do you believe that issues in controversy that remain might be clarified by testimony from the chief medical officer where that testimony does not include reference to classified information?

DDC [CPT CASCIOLA]: We do, Your Honor, agree with that and we have some further information that we would like to put on the record for the commission when Your Honor's willing.

MJ [Lt Col ROSENOW]: Is it relevant to this matter?

DDC [CPT CASCIOLA]: It is in regards to the CMO's testimony, yes.

MJ [Lt Col ROSENOW]: And is it appropriate for an opening setting?

DDC [CPT CASCIOLA]: It is, sir.

MJ [Lt Col ROSENOW]: Go ahead.

DDC [CPT CASCIOLA]: I wanted to apprise the court that last night at approximately 9:21 p.m., the chief medical officer sent me a message on my cell phone. I did not receive that message until approximately 10:00 p.m. when I exited the ELC. The message asked me to call him. I called him.

He first relayed to me that he wanted to make sure that I understood that the SMO was unavailable and facts regarding the SMO's unavailability. And I certainly

appreciated that, and I told him so.

He also then informed me that he met with trial counsel yesterday afternoon and discussed his testimony, obviously, that would be happening today at the commission, which is proper. As we all know, that happens, and I had spoken to the chief medical officer multiple times.

However, what the chief medical officer then went on to say is that in his conversations with the trial counsel, the trial counsel had conveyed to the chief medical officer that some of his answers to questions may be considered -- and these are the words of the chief medical officer -- predeliberative, and therefore, should not -- some questions should not be answered, and should he be faced with questions, he can use the answer to me and to the commission that that answer would be predeliberative.

The chief medical officer appeared to be very confused by what this meant. It seemed to me to have a chilling effect on his testimony today. He was hesitant to come and testify and give all the information, which because of previous conversations we have had with chief medical officer, we knew he would relay to the commission.

So I wanted to certainly put that on the record, Your Honor, and I would ask the commission and Your Honor to do a

little bit of a fact-finding process to find out more about that conversation between trial counsel and the chief medical officer, specifically in regards to this predeliberative -- I'm going to call it maybe a, quote/unquote, privilege, but there's no such privilege, as Your Honor is well aware.

But I want to make sure that the chief medical officer feels comfortable testifying today, giving testimony that is truthful and unobstructed and clear.

MJ [Lt Col ROSENOW]: I appreciate the averment that you've provided to me. Let me ask: Was there any paralegal or any other individual present for this conversation apart from yourself with the chief medical officer?

DDC [CPT CASCIOLA]: It was over the phone, Your Honor.

MJ [Lt Col ROSENOW]: And is the substance of the message just what you had said, meaning what we have in writing is a request to connect and there's nothing beyond that?

DDC [CPT CASCIOLA]: Yes.

MJ [Lt Col ROSENOW]: So no substance, I would say, included in the written record between the chief medical officer and you?

DDC [CPT CASCIOLA]: It literally says can you call me or can I call you?

MJ [Lt Col ROSENOW]: Understood. I'll hear from the

government in a second, but let me just ask: When you propose the opportunity for the commission to do some fact-finding -- of course, I can always ask questions of witnesses. The normal sequencing is you all call witnesses, you ask your questions, and if there are any remaining questions for the military judge, I have that opportunity. And you may experience me interfering with your examination sometimes in the sense of getting a point of clarification settled right then so that we don't have to come back to it maybe hours later.

In this instance, is there something different or particular about this exchange that makes it not usefully explored in the first instance by the interlocutor, you, or whoever is the representative for the defense?

DDC [CPT CASCIOLA]: Yes, Your Honor. Actually, what we are requesting is that you ask trial counsel about the conversation just so that we are all on the same page as to what was discussed and whether or not there is an assertion of privilege that will be happening during the testimony, because if there's not an assertion of privilege that's going to be happening during the testimony, the defense would then ask for an instruction to the CMO prior to testimony that -- prior to him testifying that, listen, you can answer all questions

truthfully. If the government has an objection, they will make an objection, I will rule on it, just like in any other situation.

MJ [Lt Col ROSENOW]: Understood. I believe it will be manifest if the testifying witness refuses to answer a question -- and this is a general observation, not specific to the chief medical officer -- a witness invokes a privilege or a witness avoids answering a direct question that's posed. We are now oriented as well to the possibility of predeliberative as a term of art perhaps signaling this concern. So understood the defense position on this matter.

Trial Counsel, if you want to be heard on this before we turn towards calling the chief medical officer, you can. I'm not requiring you.

TC [MR. SHORT]: Yes, Your Honor. I think I can clear it up.

Captain Casciola is correct in one aspect. The chief medical officer was a little bit confused of what something I said last night. And when I was getting him to the trailer, he asked me the same question. And I said, look -- I said hold on. I said, I will make objections. You answer the questions.

We are talking about a report that he has authored,

and it is in, I believe, the chop chain, for lack of a better term, and I said to the extent and it's one of their topic lists -- on their topic list of that report. That's his report ----

MJ [Lt Col ROSENOW]: The report to Congress?

TC [MR. SHORT]: Yes, to Congress, Your Honor. That's his report to Congress.

I have -- I never asked him what was in the report, and I clearly advised him that the facts are the facts and he can certainly testify to the facts that probably raise to the same basis to the report as long as they're relevant and leave the objections to me. He was -- he was a little confused on that.

And I think I cleared it up this morning; however, I also had advised him to check with the Office of General Counsel, who would have been, you know, in his chain for that. And I clearly told him that I cannot give him any advice as to how to testify whatsoever, and that he is free to testify to any way and truthfully when he comes in here.

I made sure that he was here this morning. He's willing to testify. I don't believe there's any chilling effect whatsoever. There was that a little bit of confusion. I have no problem with Your Honor clearing it up for him.

And I will maintain that objection throughout his testimony regarding the deliberative process in terms of what's in that report, because that's a report to Congress and there are some classified -- from what I understand. I only asked if it was classified. I asked for the classification, and he indicated that there was a classified addendum. That's all.

MJ [Lt Col ROSENOW]: Thank you for that clarification.

As I understand the concern that's been put to me, first, I will allow inquiry from the defense counsel on this line. That falls easily, at least in my measure, within the broad ambit of Military Commission Rule of Evidence 608(c). So adduce that evidence.

I would highlight to both counsel, as you well know and might have been mentioned in earlier sessions not involving this military judge, but involving this commission, motion practice is not discovery practice. This individual is not being deposed, and generally you're not to use this opportunity to present evidence in support of a prayer for relief to learn new facts.

That general observation that I've given, given the nature of the concerns that have been raised by the defense counsel will be relaxed in slight. And I will allow the

defense counsel to ask more wide-ranging questions as to the interactions with the trial counsel that preceded the taking of his testimony with respect to Appellate Exhibit 214.

That is not a ruling precluding the raising of objections that the M.C.R.E. permit from the government. It's merely table-setting so that the counsel understand what expectations can be set. When called upon, as is my duty, I will rule on objections that are raised. And to the extent, Trial Counsel, that you wish to contest this table setting, as I put it, in the form of targeted objections to scope, relevance, or anything else, you certainly are free to do so within the normal limits of the M.C.R.E.

Are there any additional concerns for the defense or the government regarding this matter at this time? That's the relief I'm providing. So I'm essentially asking, is there any other relief you're requesting, Defense or Government, at this time related to this specific matter before starting examination of the chief medical officer?

DDC [CPT CASCIOLA]: No, Your Honor.

MJ [Lt Col ROSENOW]: Trial Counsel?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: Understood. Is there anything else to take up not already covered before I ask the government to

produce the chief medical officer and then swear him in when he arrives?

LDC [MS. HENSLER]: Sir, there is one administrative matter. I just wanted to note for the record that Brian Ruffin, defense investigator, is no longer present in the -- is not present in the Remote Hearing Room today, but that defense resource counsel Meghan Skelton is present today.

MJ [Lt Col ROSENOW]: In the RHR?

LDC [MS. HENSLER]: That's right.

MJ [Lt Col ROSENOW]: Thank you.

Trial Counsel, anything else?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. Government, if you would, please, produce the chief medical officer and place him under oath.

TC [MR. SHORT]: Your Honor, the bailiff is bringing him in.

Good morning, sir. Could you remain standing and face me. Please raise your -- do you want to swear or affirm, sir?

WIT: Swear is fine.

CAPTAIN CORRY JEB KUCIK, U.S. Navy, was called as a witness for the defense, was sworn, and testified as follows:

TC [MR. SHORT]: Sir, you may have a seat. Please provide

your name, rank, and duty station for the commission.

WIT: Corry Jeb Kucik, Captain, Medical Corp, United States Navy. Currently chief medical officer United States Naval Station Guantanamo Bay, Cuba, Office of Assistant Secretary of Defense for Health Affairs.

TC [MR. SHORT]: Thank you, sir.

MJ [Lt Col ROSENOW]: Defense?

DDC [CPT CASCIOLA]: Your Honor, may I proceed?

MJ [Lt Col ROSENOW]: You can.

DIRECT EXAMINATION

Questions by the Deputy Defense Counsel [CPT CASCIOLA]:

Q. Good morning, sir. How are you?

A. Doing well. How are you?

Q. Doing well, sir. And, sir, would you like to remove your mask? I can ask ----

A. Sure.

MJ [Lt Col ROSENOW]: That's fair. And just so, you know, sir, those are the accommodations that we've made within the context of this military commission. It's important that they be able to see you when they're talking to you, that they can understand you as well. One of the benefits of the witness stand is that you are naturally distanced from everyone else. I would ask you to put back on the mask whenever you end up

departing from your testimony, however.

WIT: Yes.

MJ [Lt Col ROSENOW]: Thank you.

WIT: Thank you, Your Honor.

DDC [CPT CASCIOLA]: Thank you, Your Honor.

Q. Sir, I'd like to start with a little bit about your background and training, if that's fair.

A. Sure.

Q. So what certifications do you have?

A. Well, I am a 2001 graduate of the Uniform Services University. I got my medical degree there. I was a family medicine intern after that, and then a flight surgeon with the Marine Corps. After that, went back to residency at Bethesda for anesthesiology as chief resident there. I finished up there 2008.

After that, I went to Massachusetts General Hospital to train in critical care medicine, so that's my fellowship. After that, I was assigned by the Navy to Los Angeles to teach trauma management for three years in LA County. We have a trauma training program there.

So I'm board certified in anesthesiology, critical care medicine, and undersea and hyperbaric medicine. I've been a chief medical officer for two commands prior to this.

And I'm an anesthesiology board examiner.

Q. And here, sir, at Naval Station Guantanamo Bay, your role is solely as a chief medical officer, correct?

A. Yes. My assignment here is a new one, so some of the details have gradually been worked out. But, yeah, my primary duty is as chief medical officer. I'm dual-hatted with the Navy as the anesthesiology specialty leader, as well; consultant, as you might know in some of the other services.

Q. And, sir, you went through some of the specialties -- the medical specialties that you have. But my understanding is that there's also certifications a physician can get; is that accurate?

A. Yes. Well, it depends on sort of where you want to go with it. Usually what we do is you become a specialist or a primary care physician of some flavor based on your residency, sit for your board examinations in that, and then that is sort of what you're expected to do the rest of your career.

I, having become an anesthesiologist, then didn't really -- I didn't transition from it, but I took on the additional skill set of chief medical officer, which is looking at what is the quality of care being delivered, what are the processes by which you would improve, you know, the healthcare system in which you're working, credentialing, risk

management, quality management, process improvement.

Q. And I do have a question I think goes to what you were just saying, sir. You have a certification or an accreditation from CJCP. Can you explain what that is?

A. Sure. The joint commission, the JC part of that, is the accrediting body for most healthcare -- for a lot of healthcare organizations in the U.S. It's not the only one, but all military hospitals are accredited by the joint commission. And so a CJCP is a certified joint commission professional. So that means that you've been through -- been through the book. And so you know when the surveyors come to visit, you know, they could see, oh, you're a CJCP. There it is right there. That you can speak to the language of quality healthcare and management and improvement.

Q. And I want to go a little further into that, if we can, sir. Lawyers don't know these sorts of things. But when you say that you go through making sure that there's quality healthcare in a facility, is there like a -- is there a rubric that the joint commission goes through when they come to a facility?

A. Yeah. The joint commission will go through several different chapters -- leadership, quality management, medication management, life safety, you know, egress systems,

things like that -- and, you know, we'll give chapter and verse updates pretty much every year as to these are the new standards we're looking at, these are -- you know, this door has to be able to withstand fire for two hours, you know, et cetera. And basically it's just a matter of knowing where to look, having the references on hand, and then being facile enough with the system to find the answers that your -- your bosses, your commanding officer needs.

Q. And in addition to going through things like personnel, and you used the example, sir, of a door, they would also look at all the equipment in a hospital?

A. Right, they definitely would.

Q. Sir, before we really get into the bulk of the questioning today, you and I have spoken before, correct?

A. Uh-huh.

Q. And is that a yes?

A. Yes.

Q. And how many prior occasions?

A. I would think four or five. We sat down on one single day together.

Q. And did I have any influence over your testimony here today?

A. No.

Q. Was there anything that I told you I wanted you to say on the stand today?

A. No.

Q. And, likewise, you met with trial counsel?

A. I did.

Q. And when did that occur, sir?

A. That occurred yesterday.

Q. And my understanding is that there was some discussion during that about something called the deliberative process. Can you clarify that, sir?

A. Well, and I would ask that, you know -- that's kind of beyond my pay grade regarding where that is. Part of the requirement of my job is to publish -- to write a report to Congress, which now is being edited and, you know, reviewed by my home office. So that is not -- you know, that is something, I guess, I need to be somewhat circumspect about going into because of the nature of some of the recommendations there are not quite fit for prime time yet. But, you know, beyond that, the facts of what I've observed here for, you know, the last 22 months are stable.

Q. And, sir, is any part of that report classified?

A. Yes.

Q. And in terms of your recommendations, are those

classified?

A. Some of them are or will be.

Q. In terms of your recommendations specific to Mr. Al-Tamir, are those classified?

A. Probably there are some that would touch on his case, yes.

Q. Did the conversation with trial counsel yesterday in any way influence what you -- what your opinion is now, which is that you, perhaps, should be more circumspect about what you say that's in the report?

A. Well, I was a bit, honestly, surprised about it. I had not thought about the unfortunate timing of the fact that I've got a report I've just finished and submitted now in deliberation and in review and not necessarily having the guidance from my home office of what is okay for, you know, this venue as opposed to what is -- what is simply observable and repeatable fact.

Q. To be clear, sir, have you been instructed by anyone that you cannot divulge unclassified information?

A. No, I have not.

Q. Have you been instructed that there is a privilege that you should assert besides whether or not something is classified or unclassified?

A. It has been suggested but not -- but I've not been so ordered by anyone. What I've recognized, what I've seen, what I interpret as fact are things that I obviously feel comfortable with going into if need be.

Q. The report that you have submitted, you've submitted that at this point to -- is it SOUTHCOM?

A. No.

Q. I'm sorry, then, where did it get submitted to, sir?

A. It is currently with -- I'm a direct report to Assistant Secretary of Defense for Health Affairs. So The Deputy Assistant Secretary of Defense for Health Services Policy and Oversight is my colleague, if you will, regarding detainee matters, even though I direct report to ASDHA, I work very closely with that DASDI subordinate to her on detainee matters.

Q. Do you anticipate that the report will be returned to you with modifications or edits suggested?

A. Yes. I would anticipate that and then we will go through a process of, yeah, that's a better idea versus, nope, I'm really sticking with this one and we'll see. Again, it's a -- it's a new job. It's the first job that the report has been required, and it's a learning process for everyone.

Q. And I do want to touch on that, sir. You mentioned

that this is, basically, a first-time profession that's been developed here, and the initial development of the chief medical officer at Naval Station Guantanamo Bay.

A. Uh-huh.

Q. How long have you been here in that position?

A. I've been here since October of 2020.

Q. And since October of 2020, what have you done to acclimate yourself to the position?

A. There's a lot of chart review. There's a lot of open source review. There was learning the camps and the way that they operate, learning the Joint Medical Group and the manner in which it brings in personnel, it manages personnel, it uses one or the other camps' complement, if you will, in terms of the medical care. Learned about the processes of patient movement, of referrals, of bringing in specialists. Of course, a huge portion of it was, of course, the management of COVID or the, you know, very deliberative delivery of vaccination. The working through some of the political and public affairs aspects of getting the vaccine to the detainees in the first place.

Beyond that, in the workings of the naval hospital as well, which, as you probably know, the naval hospital and the Joint Medical Group are commanded by the same commander, and

so while the JMG is definitely my business, the naval hospital to some degree is where it comes to detainee care and the quality received there.

So splitting time between both of those and then continuing to practice to the degree possible at the naval hospital as part of their medical faculty, mentoring some of the junior officers there and working to the degree possible toward process improvement wherever possible.

I've said it -- I've made no bones about the -- my preference to rather not be the inspector but rather be the PI guy, rather be the good idea fairy, why don't we think about doing it this way or doing it this way. You know, we can probably -- not because I want change for change's sake, but because this is going to become a very demanding mission as the population ages and they need more and more stuff and they need more and more specialty care, and it's going to get harder and harder to get it down here. So we've got to be more efficient with what we do on a day-to-day basis.

Q. Do you feel that, in your opinion, over the two years you have been in the role of chief medical officer, you have a solid understanding of all of the components that go into medical care of detainees?

A. I would say I have a better-than-average

understanding. I think the business aspect of it is a little bit -- it takes a little bit extra time to work through because I don't think those highly reliable sinews have been built as well as you might like. I think the quality is overall above average, but the -- and the access to care, especially at least primary care, is superb.

But again, where you're going to find difficulties and breakdowns and pinch points are the, you know, when we need to see, for instance, this special study or this special provider.

Q. So in terms of access, regular access to medical care the detainees have, in your opinion, that's -- they have good access?

A. Yeah. As far as primary care goes, the detainees can see a primary care physician faster than I can.

Q. The problem comes when a detainee has more complicated medical issues?

A. Right. Right.

Q. And why?

A. Time and distance. Purely that. If it's not resident here on the island and has to be flown down, then there is going to be a time delay. There may not be a go-to person ready, as in, A, we need to find this specialized fill in the

blank. So a request has to go out to whatever servicing organization above, whether that's Naval Medical Forces Atlantic or sometimes we've had to co-opt the Air Force for different aspects.

But there is definitely a multitude of complications that come into that sort of care getting here, whether it's you have to find the person, what do they need, how are you getting them here, is the weather going to cooperate, are they credentialed to get in the door, did they remember to bring everything they possibly could need? Does the naval hospital supposedly have something and then we end up it's -- finding out it's not functional?

Q. When you talk about this sort of latency, time delay, what sorts of periods of delay -- what actual quantitative periods are we talking about? And if you have an example, I'm more than happy to hear it.

A. Well, and it's not something that is simply for care only coming; even if we had to medevac someone off the island, if oftentimes is not within what would be the recommended 24-hour holding period. So some of the work I've looked at that they have kept at the naval hospital has been, you know, an average of 35 hours for medevac off, and that oftentimes is a limitation of lift and weather.

Now, for getting things down here, it depends on what it is we're looking at. I mean, the court-ordered MRI that was in place here took two and a half years to get here.

Q. Let's talk about that particular MRI, since you brought it up, sir. That MRI arrived on island when? Do you know?

A. I don't -- I don't know exactly when it arrived. It was here when I arrived and has been, you know, essentially -- I think it's been operational half of my time here.

Q. When did it first become apparent to you that it was no longer operational?

A. That would have been, I believe, in November of '21; I'm not exactly -- I don't have an exact date. And it was one of these suspicions and got confirmed to me by some of the medical personnel.

Q. And what is wrong with it, to your knowledge?

A. It is now -- my understanding, is now demagnetized. So there was a catastrophic loss of helium, which is required to maintain the magnetism of the working parts of the MRI. It was certainly at a low level of maintenance previously, something that had been discussed both between myself and the JMG commander at the time, as well as in open -- well, in secret forum of a deliberative body that oversees the care

here, the SMACDP, the Senior Medical Advisory Committee for Detainee Policy. But that's not a classified issue that we discussed that.

So it was well known to be a problem, but it was amongst the literally thousands of priorities that have to happen. It was avoidable but not necessarily predictable.

Q. So is it -- is it fair to say there was an MRI here that was working on island?

A. Uh-huh.

Q. Yes?

A. There was an MRI. There still is an MRI, but it is no longer working.

Q. And it's no longer working because there was no maintenance support or chain put in place? Is that accurate?

A. Well, I think it was a string of unforeseen errors regarding it. I think it was originally in place here for what was intended to be a single study. And so the maintenance tail that should have accompanied it was not written as part of the contract.

It was a little bit out of sight, out of mind, in that it was not something that the naval hospital was taking care of, but it was actually on the JMG side and, therefore, was not being -- you know, receiving the same amount of daily

inspection stuff in terms of attention of when the joint commission would come through. When the joint commission would come through, it would not have been surveyed because it's not part of the naval hospital.

So essentially you ended up with, you know, out of sight, out of mind, not with the proper logistics support behind it, not with the proper tech support, both in terms of the radiology tech who is able to run that device, as well as the service technician that would come down from time to time. And that was -- a good portion of that was limitations of COVID travel.

DDC [CPT CASCIOLA]: May I have a moment, Your Honor?

MJ [Lt Col ROSENOW]: That's fine.

[Counsel conferred.]

Q. You said that you suspected the MRI was nonfunctional as of November of 2021, or that's when you became aware of it, sir. Prior to November of 2021, do you know how long prior to that it was perhaps nonfunctional?

A. There were -- I don't have exact dates regarding it; but it was, you know, well known. Is it up? Is it down? Okay, we need to do this study. Okay, yeah, we can probably get it done in terms of, okay, let's fly down the right tech, let's fly down the right service tech. When is the helium

coming? These were, I would say, topics of constant discussion in those periods, both verbally and a couple e-mails.

Q. Okay. So even when it was not completely demagnetized, there was still effort that had to be put into getting the supporting pieces?

A. Yes. It is definitely a very complicated piece of gear that requires both the skill set and the materiel to keep it functioning.

Q. Is there more information that you could give us about the MRI and what occurred in a closed session?

A. I mean, I think the major portions of it we've covered. I don't think there's anything regarding it that is of classified nature. It's simply -- you know, it was simply not as high a priority -- there was a difference in the priority that, you know, differing opinions had ----

Q. Understood, sir.

A. ---- different leadership had amongst JMG and myself.

Q. I'd like to move away a little bit from the MRI -- that first MRI for a minute, sir, and talk about Mr. Al-Tamir's medical issue. You're familiar with Mr. Al-Tamir?

A. I am.

Q. And do you know his diagnosis, sir?

A. Yes, I've been following him closely. We've not spoken, but I read pretty much everything that goes on regarding his care.

Q. And what is his diagnosis as you understand it?

A. Well, he has treated latent TB. He has lumbar spondylosis. He's got some issues with previous cauda equina syndrome and he's got some neurologic damage from that. He's got dysphagia, difficulty in swallowing. He's got some hearing loss, some osteoarthritis in both knees, Achilles tendinosis. Let's see. Hyperlipidemia. He's had some anemia before. We are, of course, worried about osteopenia, bone mass. He's got some GERD, some H. Pylori, plantar fascitis, as I recall. And I think that's about all I remember right now.

Q. Would you categorize him as an above-healthy 60-some-year-old?

A. No, I would not. I would say between his limitations in ambulation, his ability to get around, his ability to weight bear, he's got -- he is of concern. And, you know, we speak -- I and the senior medical officer speak on him quite a lot.

MJ [Lt Col ROSENOW]: Let me jump in for clarification.

The question was posed to you as above healthy. Did you answer that as average, meaning he is less than average in terms of his age?

WIT: I would say, yes. I would say he's less than average. He's more concerning to me than would be a, you know, perfectly ambulatory, well-controlled 61-year-old with the access to the studies and the, you know, potential neurosurgical follow-on interventions that he might be needing.

MJ [Lt Col ROSENOW]: Thank you for that.

Go ahead, please.

DDC [CPT CASCIOLA]: Thank you, Your Honor.

Q. You are aware of prior surgeries he's had?

A. I am.

Q. And how many prior surgeries were there?

A. Specific to his back?

Q. Yes.

A. Five over the span of about eight months.

Q. Were you able to review operating notes or documentation regarding those five surgeries?

A. Some. A lot of it is repetitive, as in, you know, more recent, but, you know, this was noted, this was noted. And then some of the more recent neurosurgical notes, as far

as getting back to every aspect of, you know, his perioperative care, his postoperative care, that was not easily available. But from what I understood, you know, talking to some visiting specialists, talking to SMO, you know, we -- I would say I know well what his issues are.

Q. Is it your understanding that at least some of his surgeries had to occur because of errors made -- and you can correct me if I'm wrong, sir, of course -- errors made in prior surgeries?

A. Well, I think he certainly had complications, so he had to go back to the operating room for a hematoma in his neck that had to be, you know, taken out, evacuated and then stitched back up and, you know, made sure that he didn't have ongoing blood -- bleeding into that space.

Now, there is a -- you know, an expectation or an accepted amount of complication that one must assume with such surgeries. It seems like he's been a little bit more likely to get complications on some things. Part of that is -- you know, as to whether or not that is a factor of technique or a factor of the system in which it was performed is kind of up for debate there.

Q. Are you familiar -- being an anesthesiologist, I assume you're in surgeries?

A. Yeah, quite a few.
Q. Are you familiar with laminectomies, sir?
A. I am.
Q. Have you seen laminectomies?
A. Yes.
Q. Can you estimate how many?
A. Oh, a couple hundred. Not many lately, obviously. It's not a surgery that is done here routinely, so I would say I've not seen any in more than two years. But in centers I've worked in before that do them often, probably somewhere in the 250, 300 range with which I've been involved either as the anesthesiologist or going into the room to assist because it's a complicated manner of putting the patient to sleep on the gurney, making sure you've got all the right monitoring equipment in place, arterial line, et cetera, flipping the patient over, and that takes, you know, a team of several people to do in a coordinated fashion properly.
Q. You just said, sir, that that's a procedure that's not done routinely here on island. Have you ever seen it done on island?
A. No.
Q. Is this hospital equipped to do it?
A. I would say no.

DDC [CPT CASCIOLA]: Your Honor, I would like to publish -- this is AE 214I, I believe.

MJ [Lt Col ROSENOW]: Is this a new exhibit that's not been previously provided to the commission?

DDC [CPT CASCIOLA]: It was provided this morning, Your Honor.

MJ [Lt Col ROSENOW]: 214I?

DDC [CPT CASCIOLA]: Yes. India, I'm sorry.

MJ [Lt Col ROSENOW]: That's fine. How long is this exhibit?

DDC [CPT CASCIOLA]: It's only one page. It's just a picture.

MJ [Lt Col ROSENOW]: Thank you.

Trial Counsel, just because this is the first time I'm seeing it, you may have seen it before, there could have been things happening with staff that didn't get back to me. Just any concern or objection to raise with respect to her utilizing 214I with the witness?

TC [MR. SHORT]: No, Your Honor. I just would -- to the extent that they are going into kind of a discovery mode here, I would kind of levy that objection. But the exhibit itself, no, Your Honor.

MJ [Lt Col ROSENOW]: Understood. To the extent that is

an objection that's been levied, it's overruled at this time.

Defense Counsel, you can go ahead and utilize the exhibit. Do you mean to provide it to the witness or are you going to put it on the screen?

DDC [CPT CASCIOLA]: I would -- either, Your Honor, just as long as the witness can see it.

MJ [Lt Col ROSENOW]: If you end up having an exhibit like this that you intend him to point at, just make sure it's in a form that we can document for the record what he's pointing at. And if you're going to approach him, I need you to wear your mask as you're approaching him. Otherwise, you can proceed in your examination.

DDC [CPT CASCIOLA]: Yes, sir. Thank you.

Q. Sir, are you able to see the picture?

A. Nope. Okay. Yes.

Q. You can see it now, sir?

A. Yes, I can see it.

Q. So this is -- is this -- tell me, sir -- an accurate diagram of what would occur in a laminectomy with fusion? Of course, it's simplified.

A. It is. And, again, to quote the -- to state the obvious, I'm an anesthesiologist. I do work in this sector some, but I don't actually go and cut. I know the anatomy

well because of putting in epidurals, things like that.

As far as my knowledge of the anatomy and the procedural steps in this, once I've got the patient to sleep, once I've got sufficient safety margins in place in terms of monitoring, once we've safely put the patient into the prone position and I've assured, you know, that all the monitors are working, IVs are running, I've got access to blood if we need to, then the surgeon would proceed with, you know, the initial incision, depending on, you know, we obviously make sure we are over the right vertebra involved, and that would be done radiographically with fluoroscopy. So basically, just, you know, laying of an instrument over the one you think you're going to and making sure by shooting a film. Yep, that's the right one. Everybody agrees.

Dissecting down, getting some of the these -- some of the musculature out of the way, and then putting in whatever hardware has to be there, putting in the screws by which to ensure that these -- the hardware stays in place, and that is both a dance between do you have sufficient bone density as well as do you have good monitoring of neurofunction as you proceed, and that's usually done by devices called -- monitoring modalities called somatosensory-evoked potentials or motor-evoked potentials, that means putting small

electrodes into the patient at known spots so that they -- the technician monitoring will see, okay, the sensory system's working, the motor system's working. Oh, we just got a little blip there. It looks like you might have put your screw a little too deep, and then we back up and make sure that ----

So it's a dance between the surgeon, the neuromonitor, and then the anesthesia. We're at this point, basically, trying to, you know, watch the -- watch for any perturbations of blood pressure and heart rate, oxygenation, keeping these sorts of things all as normal as possible while this work is going on.

So basically, this looks, you know, like what I've seen before, but, again, I've never -- I've never been responsible for putting the devices in or the hardware in.

Q. Understood, sir. I'm not going to ask you what size screw you'd use, but I am going to ask you a couple questions based on what you just said, sir.

Is this the sort of procedure, the laminectomy with fusion is, to your understanding, the sixth surgery that Mr. Al-Tamir would have to undergo?

A. That's my understanding of what -- of what the most recent visiting neurosurgeon has gone into. Mr. Al-Tamir's symptoms are now very large -- largely lower extremity. It

matches up with this anatomy and the nerves that come out of this area. And is it likely he -- it's a decision he and his surgeon will have to make, but there is a good possibility he will need another surgery. That is my understanding from reading the visiting neurosurgeon's notes.

Q. Understood. And you also mentioned as part of the surgery the need for fluoroscopy.

A. Uh-huh.

Q. Is that something that -- I'm sorry. That's a yes, sir?

A. Yes, that's correct. I'm sorry.

Q. Is that -- that's okay. Is that something that -- is that equipment that the Naval Station Guantanamo Bay hospital has available to use?

A. My understanding is they have one. It is -- my understanding is it needs some repair currently.

Q. Do they have the personnel that's trained to use it during a laminectomy with fusion?

A. I do not know. At this point, with the amount of turnover that's happened at the hospital, the availability of radiology techs, the, you know, honest assessment of their skill set right now, what certificates they've maintained or not is a -- that would take -- again, that would be part of

the preoperative assessment that would need to go into this very complex soup-to-nuts approach to doing this correctly.

Q. And so ----

DDC [CPT CASCIOLA]: Can I have a moment, Your Honor?

MJ [Lt Col ROSENOW]: That's fine.

[Counsel conferred.]

Q. And are you aware that the availability of experienced radiology technicians was an issue with Mr. Al-Tamir's prior surgeries?

A. I don't know whether it was with his prior surgeries. I don't -- I do know that, you know, needing to bring an MRI tech to the island previously during my tour here has been an issue.

Q. Are you aware if the hospital has the correct -- or not correct, but any fusion hardware?

A. I am not aware if they do. They may have it somewhere in the hospital. I'm not privy to all their different surgical instrument sets. I would be surprised if they did. Those are expensive; and if they're not in use here, and they shouldn't be in use here, there's no orthopedic surgeon, there's no spine surgeon, then they would probably have been repurposed.

Q. You had mentioned, sir, evaluating the bone density of

the patient prior to a laminectomy with fusion.

A. Yes.

Q. Number one, how is that done?

A. Typically it's done by a DEXA scan. It's what's called a dual-energy x-ray absorptiometry is what that stands for. And basically looking at two different levels of x-ray power, you know, the same portion is scanned and on the basis of the difference in uptake of those two types of energy, a T-score can be computed, which is a normalized score that WHO came up with as to what bone density should look like.

MJ [Lt Col ROSENOW]: Defense Counsel -- excuse me. Did you finish your response, sir?

WIT: Yes.

MJ [Lt Col ROSENOW]: All right, thank you.

Defense Counsel, are we near a natural breaking point in your examination?

DDC [CPT CASCIOLA]: Your Honor, we certainly -- I did want to ask him a little bit more about this picture, but then we certainly can be at a breaking point.

MJ [Lt Col ROSENOW]: Since I broke it up by asking the question, Doctor, you may know or not, we have a lot of support staff who are helping this function. And sometimes they need breaks along the way so they can turn over in their

function. And I've been signaled that we should take a break at this point.

So would 15 minutes work for the defense counsel?

DDC [CPT CASCIOLA]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: For the government?

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Sir, I have an instruction for you while we're on this break. Because you are in the middle of your testimony, you will not discuss your testimony or your knowledge of this case with anyone. You should not consult any materials either to refresh your memory or organize your thoughts during this break either. It's as if you are preserved in amber and we have you back here in 15 minutes.

Does that work for you?

WIT: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Any objection to that instruction, Defense Counsel?

DDC [CPT CASCIOLA]: No, Your Honor.

MJ [Lt Col ROSENOW]: Government?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: The commission will be in recess for 15 minutes.

[The R.M.C. 803 session recessed at 0942, 7 June 2022.]

[The R.M.C. 803 session was called to order at 0959, 7 June 2022.]

MJ [Lt Col ROSENOW]: The commission is called to order. Same parties as before both here in the courtroom, in the RHR, remain present. The witness remains on the stand under oath.

Defense Counsel, you may proceed.

DDC [CPT CASCIOLA]: Yes, Your Honor. Thank you.

DIRECT EXAMINATION CONTINUED

Questions by the Detailed Defense Counsel [CPT CASCIOLA]:

Q. Sir, I think when we left off, we were speaking about bone density and a DEXA scan.

A. Yes, that's correct.

Q. Why is it important during a laminectomy with fusion to evaluate the bone density preoperative?

A. Well, as you can see from your schematic from 214I, that where those screws go, L-4 and L-5, you've got to have sufficient density there for those to take hold and safely maintain the fusion hardware in place. If it's not there and you have a breakout of that, it's similar to any other architectural failure. You end up with instability and possibly further injury beneath that site to the spinal cord.

Q. Is a DEXA scan or a DEXA machine the standard of care in evaluating the extent of osteoporosis?

A. Yes, that's the most typically used thing, normalized to, you know, a specific population. And on the basis of that, you compare other populations as to, you know, how Mr. Al-Tamir's bone density might look.

Q. And you may not be able to answer this, sir, but going into a spinal surgery without a DEXA scan, does that influence in any way what instrumentation you would bring in and what personnel you would need to support?

A. Not being a neurosurgeon, I would have difficulty speaking to the particulars of that. But, yeah, in general if you don't have sufficient bone to work with or not of high-enough quality bone, bone that hasn't been weightbearing for some amount of time, bone that has been demineralized, any number of factors there that would go into the surgical planning, it would be ill advised to do -- to assume that the bone density is sufficient here, especially as it has been instrumented before.

Q. So the fact that Mr. Al-Tamir has prior instrumentation or, I guess, fixation, I'm not sure what the correct term is, that influences what happens, then, in the future surgeries?

A. Certainly, yeah, absolutely.

Q. Okay. When you went through the different supporting

personnel in a laminectomy with fusion, you mentioned -- and I don't think I quite caught the term, the name of this individual, but the person that would be monitoring ----

A. Uh-huh.

Q. ---- neurological capabilities?

A. Sure.

Q. Do we have -- and what's the title of that person?

A. It's the neuromonitoring specialist or tech. Typically it's a contracted individual who would come into -- you know, in my experience in a military hospital, those folks will come in for the special case when they're -- when they're scheduled. They show up. They are on time. I don't know who they are necessarily, but they -- I know what they're there to do.

And once the patient is under anesthesia, they go about going ahead and starting to put in all their little monitors, which are, you know, very tiny needles, essentially, that are connected to an electrode, you know, into a machine. And then they can stimulate certain ones and then sense the stimulation at a different one to make sure that that neural pathway is intact.

Q. Do we have one of those individuals on island?

A. No, not to my knowledge.

Q. Do we have that machine on island?
A. Not to my knowledge.
Q. What's the name of the machine?
A. Neuromodulation.
Q. Okay.
A. So you would -- it would be the -- I don't know so much by the name of the machine, but by the name of the -- the test it puts out, the somatosensory-evoked potential or the motor-evoked potential. So, you know, you would sitting and seeing, oh, yes, I can see the patient -- the hand rhythmically twitching, therefore, I know, okay, they're running the test right now.
Q. Is that test the standard of care during a neurosurgery?
A. In my experience it has been. I'm not a neurosurgeon, but, again, I think that I don't know that I've ever been in a multilevel laminectomy, particularly a redo, where that has not been employed.
Q. Okay. There are obviously U.S. servicemembers onboard Naval Station Guantanamo Bay.
A. Quite a few.
Q. If any of those individuals needed this surgery, would it occur at this hospital?

A. No.

Q. Where would it occur?

A. They would be medevac'd to most likely Naval Medical Center Portsmouth; or depending on their service preference, they might go to San Antonio; or depending on their access to other centers, they might go to a civilian center.

Q. And that is because the complication of this surgery in addition to the resources required for the surgery that are not available on island?

A. Yes. Yeah, you go where the resident knowledge, the expertise is.

Q. Having reviewed Mr. Al-Tamir's medical records and being a quite experienced anesthesiologist, in your opinion would it be difficult to get a neurosurgeon to do the sixth surgery of Mr. Al-Tamir on island?

TC [MR. SHORT]: Your Honor, I'm going to object to this question. This is now getting into, you know, not only the discovery and a fishing expedition, but I think it's going into other expertise, a neurosurgeon. I think to some extent that Dr. Kucik can answer that, but to the extent that it's a neurosurgeon's expertise, I would object, Your Honor.

MJ [Lt Col ROSENOW]: I understand the objection as being foundation for the opinion that's being called upon from this

witness about the difficulty involving the procedure being accomplished on island. Is that an accurate recitation of the objection from the government?

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Defense Counsel, why don't you withdraw that question and ask first questions laying the foundation as to his ability to answer it. I would highlight that perhaps this is a difference of opinion about an ambiguity in the call of the question. He might not be in a position -- I'm not saying he is or isn't -- to answer about the difficulty of actually accomplishing on the bed the procedure as against the potential challenges to getting all of the infrastructure and individuals required on island as a condition precedent to allowing someone who is qualified to accomplish the procedure to accomplish it.

I see you nodding along with me. So I'll sustain the objection in the sense that the question could be more clearly posed and thereby help me in understanding the evidence given. Please.

DDC [CPT CASCIOLA]: Certainly, Your Honor. Thank you.

Q. As the chief medical officer, one of your roles is coordinating medical care; is that accurate?

A. It is -- I don't necessarily have a coordinating

mechanism so much as I have an oversight mechanism. I tend to try to let the JMG arrange things to the best of their abilities. I have offered multiple times to be an outlet, a sounding board. If someone asks my opinion or if you need help from my boss, I can go directly to and probably find a few extra things in my side job as the anesthesia specialty leader. I have access to all the other specialty leaders in the Navy, at least -- and essentially to all of them in the services. So if they need a niche requirement, I can help in finding that person.

But for the most part, I try to leave the operational aspects and execution of the planning to the JMG and help as -- again, as I've stated before, I'd much rather be the PI guy than the inspector.

Q. And so part of that, that means that you are -- I'm not going to use the word coordination, because, obviously, that's not something you prefer to do, but oversee the fact that all of these different pieces are coming together to enable a successful surgery?

A. Yes. Yes, I would say yes, that's within my purview.

Q. And is part of overseeing that making sure that there is a neurosurgeon with the proper training and expertise that would be able to come on board?

A. To the extent that I'm able to assess the competence of who comes in, that is done through the credentialing process. It's done through the services. It is also done through the JMG, slash, naval hospital's ability to assess that individual's credentials, make sure they're a quality person. By and large that's on autopilot.

Now, and then add to that the proscription against knowing identities, I don't really get deeply into that. Now, I do from time to time -- well, actually, everyone that's within the JMG that's credentialed, I do a little bit of a quality check on my own, but by and large the visiting folks, I will probably call the specialty leader and say: Is the person you're sending quality? I don't need to know who it is. Essentially, that tends to be the extent of what I do.

DDC [CPT CASCIOLA]: There -- can I have a moment, Your Honor?

MJ [Lt Col ROSENOW]: Take your time.

[Counsel conferred.]

Q. So you are not aware of the identities of the medical specialists who examine the detainees until they come on island?

A. And even then, I'm not oftentimes aware of their names.

Q. You have previously said to me that you thought it would be difficult to get a surgeon to agree to do a sixth surgery on Mr. Al-Tamir on Naval Station Guantanamo Bay. Why is that?

A. Well, again, not being a neurosurgeon, I -- and I don't know the practice patterns of the particular folks that are -- have been involved in his cases before, but as you get more complicated cases like his, the appetite for being involved in some of these cases goes down. And that's just, you know, a fact of medical practice these days.

Add to that the particulars of who Mr. Al-Tamir is, the environment in which someone would be asked to practice, it -- it is my observation that people are very reluctant to get involved. And so it won't be a matter of -- at some point it will be a matter of you will run out of people willing to do a case that complicated, not only anatomically and from past surgeries, but in terms of medicolegal and perceived personal involvement risk.

Q. Is it fair to say that there is a very small pool of individuals that could be drawn from?

A. Military neurosurgery is one of the smallest specialties.

Q. There's been some previous discussion regarding a CT

being sufficient as prediagnostic or preoperative -- for preoperative planning purposes for a laminectomy with fusion.

A. Yes.

Q. Do you agree that the standard of care is an MRI?

A. The standard of care from my understanding, talking to neurosurgeons, that is the preferred method. Not only because it's the one they know the most -- the best and will need intraoperatively for, you know, ensuring they understand every aspect of the anatomy, but also -- although you can get -- you know, there's many ways to skin a cat, but all the other -- the other possibility is not as well known. I don't know if it's superior, but it is, again, not as accepted.

And once -- you know, once you're -- once you've asked a surgeon, any professional, to change however many things in the way they manage their normal procedure, you end up introducing a lot of variation and a lot of uncertainty. So it would be akin to, you know, Hey, Dr. Kucik, intubate this person, you know, the other way, stand facing them instead. Do something completely against what your normal practice is, in a new environment, with new staff, with equipment that you may not have worked on before, in an environment that has other security concerns, and, oh, by the way, we just flew you here emergently and you're sleep deprived. Well, that -- in

safety science and improvement science, that is a setup for failure.

Q. And it is true that there is a difference in the amount of detail you can obtain in an image between an MRI and a CT scan?

A. Yes.

Q. An MRI is more detailed?

A. Yes. For the structures that need to be looked at for a case such as this, yes, it would be preferred.

Q. In terms of the actions taken to acquire an MRI, are you familiar with that?

A. In large -- in broad strokes, yes. I have read and opined previously on the contract for the last one and the sustainment plan for the last one. After its catastrophic failure, I have only been tangentially involved in the decisions of -- you know, basically, I have agreed with the senior medical officer that an MRI needs to be done in this case.

By what method the JTF, JMG, and SOUTHCOM choose to procure it is their lane. But I have made suggestions that, if you do it again, make sure you have all the tail that goes with it. Make sure there's a tech. Make sure there's a service tech. Make sure there's a quality-management person

who is tied to the hospital who is there to ensure it meets all the right specifications under joint commission; and, therefore, it becomes, you know, an inspectable item that is going to be maintained properly.

Q. Now, there seems to be a little bit of -- there seems to be a little bit of tension, and maybe I'm not understanding really the different command structures, but a tension between what JMG is doing and acquiring and what the Naval Station Guantanamo Bay hospital is doing and acquiring. Are those separate?

A. They are separate entities insofar as the naval hospital is a different reporting chain. That goes up to Naval Medical Forces Atlantic in Portsmouth. And then the JMG reports to the JTF commander here on island, who reports to SOUTHCOM. So you're -- but the commanders are one and the same.

So you've got the same Navy captain in charge of the hospital, selected to be the hospital commander by a Navy board, who also has the additional duty of being the JMG commander. So there is a dual reporting. I don't know what the specific, you know, thou shalt do .6 FTE for this one and .4 for that one. I don't know the specific breakdown there.

I have official oversight of the latter, and insofar

as they affect the detainee care and the quality of the staff that might be called in to affect some detainee care are concerned, you know, I do have, I would say, minuscule or some aspect of oversight of what happens in the naval hospital as well.

Q. So you have oversight over these, I'm going to call them, two ladders, two chains ----

A. Uh-huh.

Q. ---- but in terms of what equipment should be acquired, medical equipment, you mentioned that that's not -- that's not within your purview.

A. I would say, is it something that I could get involved in if I wanted to? Yeah. But there are so many other things that are of higher priority that I think it is better off for me to focus on the medical aspects and to try to just encourage the best practices possible amongst those going out to procure these items. You know, maybe you try this route; maybe we lease it initially; maybe you make sure if -- you know, if someone -- if OMC is willing to fund this, then you make sure that this is written into the contract.

Q. Who is the entity in charge of procurement of an MRI?

A. Increasingly it's going to be the Defense Health Agency, so that's another layer of influence and involvement.

As Navy medicine becomes more of a focus on operational medicine and the Defense Health Agency tries to conglomerate all of the military -- brick-and-mortar military treatment facilities, the DHA is going to be increasingly that source.

Until that point, I think locally it would probably have been NAVMEDLOGCOM, Navy Medicine Logistics Command. There are various entities that can be involved in the contracting and procurement of whatever -- by whatever contract vehicle you want to use to get that device down here.

But by and large, you know, that is going to be either the Navy hospital commander asking wearing his Navy medicine hat from Portsmouth or wearing his Defense Health Agency director hat asking the DHA for it.

Q. So those are the -- that's the procurement agency or entity?

A. Yeah, yeah.

Q. Who is the person -- and I'm just going to simplify this for myself, but who clicks "add to cart"?

A. Well, and let me give you one more layer of complication, because, you know, when you -- when you get down to what's being bought for JMG, that's going to be dealt with through SOUTHCOM, so lots of cooks in the kitchen here, so to speak.

But who clicks -- who clicks "add to cart" at this point is going to be -- I think the most likely group on the hook, and I think the latest I've heard is that SOUTHCOM is going to pony up for at least a, you know, a lease portion. But, again, I've not seen the paperwork on this.

Q. Understood. Do you have knowledge of a timeline associated with that?

A. I do not. I've not heard anything definitive regarding the arrival of a new MRI. I just know that, based on the amount of time it takes my household goods to get here, it could be a while.

Q. It could be several months?

A. Uh-huh.

Q. Yes, sir?

A. Yes, it could.

Q. When you say you have not seen the paperwork, it's clear -- it seems clear you have not seen an actual lease for an MRI?

A. No.

Q. And you have not seen what I imagine, being in the military, is the tons of paperwork that precedes getting a lease?

A. Not in the current setting, no. I had seen -- as I

mentioned this before, I'd seen the contract and paperwork for the previous one, but I have not seen anything approximating that for a new buy or a new lease.

Q. JMG, to the best of your knowledge, has been aware that the MRI has been broken since November of 2021?

A. To the best of my knowledge, yes. That's when it came to my attention. I don't know how -- how far back that problem goes prior to my finding it out.

Q. Similar questions regarding the DEXA scan. Is it the same procurement entity, paperwork, et cetera?

A. It would be approximately the same, and fill in the blank for whatever other type of specialty big -- you know, big, fangled device you might have.

Q. Has there been any movement -- even the little movement that we have seen with acquiring an MRI, so discussions about acquiring an MRI, has there been any movement in regards to acquiring a DEXA scan?

A. Not that I have heard. There are ways to approximate, you know, just like the MRI, doing a CT myelogram instead. There are ways to get the right -- the right software as well as the correct ability to read -- someone who is facile with it to do something similar, but, again, still not the -- not the normally accepted and most widely used method to do that

through CT.

Q. And not the way they would do it at Portsmouth?

A. No.

Q. When we talked about the MRI actually coming on island, you said it could take -- you agreed with me when I said it could take several months. Could it also take years?

A. Yes, it could. I think the one that was procured for a different patient, my understanding is it took over two years.

DDC [CPT CASCIOLA]: Your Honor, can I have a moment?

MJ [Lt Col ROSENOW]: That's fine.

DDC [CPT CASCIOLA]: Thank you.

[Counsel conferred.]

Q. We were just talking about how, basically, there's many ways to skin a cat, right? You can do an MRI. You can do a CT. It's not what's accepted or the standard of care, but you can do them?

A. I wouldn't say there are many, but there are -- there are two. You know, everything has one backup of some sort.

Q. Are there health risks -- are there medical risks associated with repeated CT scans of an individual?

A. Absolutely.

Q. And what are those?

A. It's radiation. So when you were talking about getting a lifetime increased radiation dose and then specifically exposing someone to the increased risk of cancer over the lifetime, that is the first one that comes to mind.

Additionally, a lot of times the vasculature needs to be delineated during these studies, and that means putting in a form of contrast dye. And if timed properly, then you can see this is what the vascular tree of such and such organ looks like. And if that -- of course, that dye has to go somewhere. And that typically means it goes through the kidneys and the kidneys then have to suffer -- as the filter of the body, have to suffer another exposure to contrast medium, and that could lead to acute or chronic kidney failure eventually and the need for hemodialysis.

Q. There's no -- there's no risk of radiation with an MRI?

A. There's no -- no, there's no risk of radiation. There's no radiation emitted.

Q. You are aware that over the 16 years that Mr. Al-Tamir's been on island, that he has had repeated CT scans?

A. I'm aware of that.

Q. Do you know approximately how many?

A. I do not. I have made the recommendation to the JMG that all the detainees have lifetime radiation exposure computed to the best of our knowledge, to the best of -- to the degree that it can be computed and then tracked and then carefully shepherded into the future because this will become a -- because CT is on island, because it is the imaging modality that is kind of the default, there is a risk that, you know, you could see cancers developing because of overuse or, you know, use in lieu of some other modality that would be equally effective, possibly superior, and less risky to the patient.

Q. And not only CTs, but X-rays have that risk as well?

A. X-rays do. X-rays are nowhere near as burdensome in terms of the impact or the exposure that you receive, as you would a, you know, typical chest/abdomen/pelvis CT.

DDC [CPT CASCIOLA]: Can I have a moment, Your Honor?

MJ [Lt Col ROSENOW]: That's fine.

[Counsel conferred.]

Q. Just a couple more questions. I appreciate you answering all of our questions.

You mentioned earlier an acronym, SMACD?

A. Yeah, the Senior Medical Advisory Committee for Detainee Programs. SMACDP is the full acronym.

Q. And you have given us some information that's relevant to our conversation here about Mr. Al-Tamir about ----

A. About ----

Q. ---- I guess, SMACD.

A. Well, I think what I recall was the -- was the -- the MRI issue coming up in conversation there during a periodic meeting of that body, and that meets about every two months.

Q. Could you give us further information about that conversation in a closed session?

A. I could give you further in a closed session. I don't know that there's a whole lot more to give other than it was simply mentioned in it and brought to the attention of higher authorities. The SMACDP has voting members from the three services' surgeons general, their representatives, as well as a DHA and then some other joint staff, a few other cats and dogs.

Q. And maybe I'm missing this and you are saying it, but Mr. Al-Tamir's health problems specifically were mentioned in that meeting?

A. I don't specifically recall.

Q. Okay.

A. Oftentimes, again, those meetings we try to keep overarching to the degree of, this is the man training equip

aspect of what is required down here. The individual case discussions sometimes come up, but it is -- it is not really what the forum is for.

Q. Okay.

A. To the degree possible, those decisions rightly -- I try to keep those here, try to influence those to be the purview, remain the purview of the SMO.

Q. Are there reports taken at these meetings? Just yes or no.

A. Yes.

Q. Are those reports classified?

A. They are.

Q. Are there minutes taken at those meetings?

A. Yes.

Q. Are those classified?

A. Yes.

Q. Are the identities of the individuals at that meeting classified?

A. To some degree. The SMOs -- those resident on island except for me, they are deidentified.

Q. Does -- does the use of -- I'm going to butcher this word, but the neuromonitoring, does that influence the techniques used by the anesthesiologist during surgery?

A. Yes.

Q. How so?

A. Well, if you -- the standard approach to general anesthesia for, you know, fill-in-the-blank normal case, is a medication that is -- that, you know, relaxes the patient first, sometimes makes them a little forgetful. Go to the operating room, put all the monitors on, put something in the vein that puts -- that drifts the patient off to sleep. Sometimes -- oftentimes put in what's called a muscle blocker or a paralytic. Sometimes patients don't like to hear that term, but a muscle blockade, so that all the muscles in the body relax. And then the intubation and the surgery itself can be much more easily completed that way.

With neuromonitoring, obviously, when you have motor-evoked potentials and you want to see the twitch of the muscles, you can't use that sort of medication. Similarly, you have to tone down on the volatile anesthetic, the inhaled anesthetic that we typically use to keep -- to maintain anesthesia during a long case rather than a drip. So it's easily titratable. It's not something that, you know, you have running into the vein at a long period of time. You have to replace -- it has great properties in that it is essentially the -- the closest thing we have to a perfect

anesthetic: It's amnestic, it is analgesic, it is -- maintains good hemodynamics, and it is -- to some degree has some muscle-blocking and muscle-relaxation properties.

So because we want to be doing these sorts of surgeries that have MEPs involved, in the muscle-evoked potentials -- motor-evoked potentials, excuse me, then we want to do things that do the minimum amount of blocking of muscle twitch. So, therefore, we would set up a different modality in most of these spine cases, usually called a TIVA -- total intravenous anesthetic -- which is a drip. So trying to, again, use something that we don't always use, but it is specific to, you know, certain types of cases where you want to avoid muscle blockade.

Q. So -- so it's fair to say that the neurosurgery itself is a very delicate dance between ----

A. Uh-huh. Yeah. Yes.

Q. ---- between the surgeon, the anesthesiologist, the technicians, the equipment that you have?

A. Uh-huh.

Q. Yes?

A. Yes, that is true. You know, in any complex aspect of modern care or, fill in the blank, you know, anything that we do these days requires good teamwork, good collaboration, good

coordination, and it matters -- you know, the best teams can predict each other. They work together a lot. They do three of these a day.

You know, some spine centers, that is what you'll see. You'll see, you know, they can get these down to a, you know, two-, three-hour case, the best teams in the world. And the outcomes that you glean from that sort of expertise and high reliability are shown in the numbers in terms of the outcomes that they receive, the lack of complications, the not having to go back to the OR for a complication.

Q. And that sort of well-married team is not available on island?

A. No.

Q. Have you met with Mr. Al-Tamir personally, to his knowledge?

A. No.

Q. Have you -- were you aware that he requested to meet with you?

A. I was.

Q. It's just -- it was something, I assume, you were mandated not to do?

A. As the -- as my job became further defined, it became the -- the guidance that I received from my direct senior that

the preference was strongly that I oversee care, that I not deliver care, and that I, to the degree possible, remain apart from. I would review the notes. I would talk with the physicians. I would give my two cents. I would collaborate with and I would try to facilitate to the degree possible. But beyond that, the guidance I've received, both leadership and legal, has been steer clear and try to remain independent of all sides.

Q. And just to loop back one last thing, sir, to something we clarified earlier, you, in medical terms, qualified Mr. Al-Tamir as a -- as of below-average health, but ----

A. I ----

Q. Go ahead.

A. I would call -- I mean, his -- his weightbearing is of concern. His -- the fact that we've had -- he's undergone now five spine surgeries is a concern. The aforementioned radiologic risk, exposure risk is a concern.

We went through his past medical history previously. Those are -- you know, they are not outside the realm of normal for his age, but it is concerning that we're talking about doing an additional surgery on a back that is not pristine, it is not normal anymore. And because of his

inability to bear weight, I cannot necessarily fully assess, you know, in a way that it would make me comfortable taking him to the OR, his current cardiovascular capacity.

So those are the things we worry about from an anesthesia standpoint of, Hey, can you walk up two flights of stairs? Do you get winded, you know, walking ten yards? If you do, yeah, that might be a concern. There are more formal ways to test, but, you know, writ small, that is kind of very quickly down and dirty what you do to say this is a person I feel is going to do fine with modern anesthetics, and this is someone who will not.

And then on top of that, you add what are the risks of the surgery, as in is this a team that's going to do it in two hours or is it going to take seven? What is the blood loss going to be? Am I going to be able to keep the blood pressure up sufficiently over what might be a prolonged case because of all those aspects we talked about.

Q. In all of those things ----

MJ [Lt Col ROSENOW]: Stand by, Counsel. During the last response, the counsel removed Appellate Exhibit 214I from the screen in front of the witness. Please go ahead.

I'm not saying you have to return it. I'm just documenting for any reviewing authority in this case, if there

is one, that he had available that appellate exhibit up until the moment that you took it away. I'll note that it's back up on the screen. So just make sure that we have that clearly defined.

DDC [CPT CASCIOLA]: Understood, sir.

Q. All of these medical issues with Mr. Al-Tamir make his surgery more complicated, but it also then increases the risk -- the postoperative risks; is that true?

A. Yes, I think that's a pretty safe assumption. It is only an assumption. But, I mean, we might -- you might bring down the crack team who gel almost automatically, have all the right equipment, all got a good night's sleep, all have good perioperative care, and postoperative nursing care is excellent, and there is no -- you know, and everything went perfectly. That is possible.

Is it -- I think the -- the concern I have is the assumption of risk, and so if you don't have everything perfectly lined up, akin to taking off in an airplane is -- you know, is this working correctly, is that working correctly? Yes, yes, yes, yes, yes. Okay. Now we've gone through the most exhaustive checklist possible.

And I would posit that because a patient is not an airplane and you can't -- and you can't say, well, we're not

going to -- we're not going to fly this airplane today, it becomes more complicated. And there's no checklist for that.

We can do our best to find these sorts of things. We can define them down to, you know, the most minuscule detail, but you still are going to have uncertainties with human behavior, with the histories of the providers, that are far different from just taking a new piece off the shelf and putting it on the airplane.

Q. And the bottom line is that Mr. Al-Tamir is in a location that does not have the best team available on island?

A. You do not have the resident expertise to do the work that needs to be done -- would need to be done if another spinal surgery were to be entertained for Mr. Al-Tamir.

DDC [CPT CASCIOLA]: Your Honor, could I just have one brief moment to confer with counsel?

MJ [Lt Col ROSENOW]: That's fine.

[Counsel conferred.]

DDC [CPT CASCIOLA]: I have no further questions for this witness. Your Honor, would you like me to remove the exhibit?

MJ [Lt Col ROSENOW]: Trial Counsel, do you intend to make reference during any cross-examination, if you have one, to Appellate Exhibit 214I?

TC [MR. SHORT]: No. You can take down 214I.

DDC [CPT CASCIOLA]: Thank you so much.

MJ [Lt Col ROSENOW]: Trial Counsel, we've been going for right around 45 minutes. Do you have an idea of your expected length.

TC [MR. SHORT]: Probably five or ten minutes, Your Honor.

MJ [Lt Col ROSENOW]: Please proceed.

TC [MR. SHORT]: If that.

CROSS-EXAMINATION

Questions by the Trial Counsel [MR. SHORT]:

Q. Dr. Kucik, do you know when the laminectomy -- the laminectomy with fusion was recommended?

A. When it was recommended? My understanding is it was relatively -- oh, do you mean the initial or the repeat?

Q. Yes.

A. The initial was -- as I was saying about the initial, was that that happened in September of '17 and -- I'm sorry, that was the ----

Q. Let me clear up, Doctor. I'm talking about the surgery we've been talking about that he wants to undergo now that was recommended ----

A. Oh, okay. So the redo at this point?

Q. Yeah.

A. Yeah, that was the most recent neurosurgical visit I

don't have the exact dates of, but that was I want to say sometime between, I'd say, February or March time frame. I don't recall exactly when the neurosurgeon was down here most recently.

Q. Okay. And then ----

MJ [Lt Col ROSENOW]: February or March of 2022?

WIT: No, I've got it in my notes. My apologies.

MJ [Lt Col ROSENOW]: Sir, are you consulting something up there?

Q. Doctor, do you have notes in front of you?

A. I do have a note.

Q. Okay.

MJ [Lt Col ROSENOW]: I will just cross that bridge when we get to it. And I think we're at that bridge. So, government, is there anything you want to do with this note --

TC [MR. SHORT]: Your Honor, I think his notes are probably just normal medical notes that he takes. I don't need to review them. If he needs to review his notes to have an accuracy on something like that, I don't have any problem with that, Your Honor.

MJ [Lt Col ROSENOW]: I'm just recognizing that notes used during examination are generally referred to as a mode of refreshing recollection of the testifying witness, and

certainly the typical practice would be to make those materials part of the record. But I understand that the government's position is that they have no quarrel or concern with this.

Let me just let you know, Doctor, at this time, if you could turn the notes over ----

WIT: Sure.

MJ [Lt Col ROSENOW]: ---- and not reference them during your testimony, that would be much appreciated. And then we'll deal with whatever follows therefrom.

If you do need to make reference to it, the normal practice would be, again, for you to say, can I consult my notes? That way it's not left to what I saw and then what I said into the audio recording, but instead it's very clearly stated how you're testifying in reference to what. Does that make sense?

WIT: It does, Your Honor.

MJ [Lt Col ROSENOW]: Thank you.

TC [MR. SHORT]: And, Your Honor, I would like to follow-up with a couple questions ----

MJ [Lt Col ROSENOW]: Absolutely.

TC [MR. SHORT]: ---- regarding the notes.

Q. Doctor, did you refer to your notes at all during the

direct examination?

A. Yes, to the past medical history of the patient.

Q. Okay. Thank you for that, Doctor.

And when did you take those notes?

A. These were -- I have a -- I maintain a file on all of the patients, and I typically will keep that in my safe in the office, typically pull out a -- if I'm going to a meeting on something, I'll make a copy of it and then shred it at the end of the meeting ----

Q. And so ----

A. ---- if there's anything of concern there.

Q. And so I guess my -- what I'd like to know is these are notes taken in the course of your profession and what you do here on island in your duties?

A. Exactly, yeah.

Q. Okay. Okay. And so, Doctor, going back to my question, if you have to refer to your notes as to when that laminectomy was recommended.

A. Yes. And if I may refer to my notes, Your Honor, it would have been in September of '21.

MJ [Lt Col ROSENOW]: You may. Thank you.

Q. Thank you. We heard -- a lot of the questions were asked about neurosurgical teams, all sorts of equipment that

would be required for a surgery, a laminectomy with the fusion, and is that a laminectomy, a discectomy, or is that just merely a laminectomy with fusion, Your Honor -- or Doctor?

A. Not my purview. Not my -- when the neurosurgeon says we need to do such and such, the anesthetic implications of it don't really make any difference to us insofar as, you know, what the actual anatomy is, what the actual procedure is. We just know, okay, we're going to have to do this position, we're going to have to do these modalities. We're going to have to make sure the MEPs and SSEPs are working and we're not impinging on those through our anesthetic technique, and then we worry about, you know, positioning blood -- you know, availability of blood, blood loss, et cetera, but those essentially make no difference and have never entered major concern in my practice.

Q. Thanks. So the questions that were asked on direct examination from defense counsel seem to indicate that we wouldn't have something on island, and it was -- many of those questions were finished with "on island."

So the neurosurgeon would -- how would he then perform the neurosurgery in the future?

A. Well, it would have to be a very -- as I mentioned the

checklist, it would have to be a very complex and, you know, multitiered, multispecialist-reviewed list, wish list, of we must bring this. Well, let's make sure we bring two sets of it. Well, we must bring -- we must bring -- make sure that the fluoroscope on island is working, make sure that we're bringing down a proper table on which you can prone a patient, and is also able to accommodate a C-arm fluoroscopy so you can look intraoperatively and see that you're going in the right direction.

The blood is another issue. The medications that we might use for the most part will be here. The anesthetic -- the anesthesia machine, the ability to do the TIVA, the total intravenous anesthetic. Those are all here. The concerns ----

Q. Doctor ----

A. Yeah.

Q. ---- if I may. I think you went just a little bit beyond what I was looking for.

A. Okay.

Q. So would -- after they performed this checklist, say, back in the States, they would bring all that stuff to island?

A. Right, right. So it would probably be loaded up on whatever lift has been previously arranged. For all that

we're talking about here, it would be, you know, some sort of a very -- a military aircraft that would fly it down at that point, and then, obviously, land, obviously bring it across, and try to set it up to the degree possible in a new -- in a -- in a new-to-them operating room, which is kind of small, honestly, by neurosurgical standards.

Q. And so they -- and they also have the ability to take this equipment anywhere around the world, correct?

A. They can, yeah. This has been done. Obviously, neurosurgery has been done in recent conflict in battlefield conditions. And it's been done and done successfully and quite, you know, very good outcomes in many cases that way. That said, of course, those are infantrymen, Marines, sub-elite athletes, if you will.

Q. Understood. And in the past, the past surgeries that Mr. -- that the accused underwent, they brought all the equipment with them as well?

A. There was some resident on island, is my understanding; but by and large, I think pretty much everything had to be brought down that was specific to the instrumentation of the spine.

Q. And -- and when they go through that checklist, they'll check to see if there's -- any of the machines -- I

don't need to be specific with any of the machines, but anything that they need, they'll check to see if it's already here?

A. They will -- yeah, they will -- my understanding is they will ask, Hey, what do you have? It depends on who is answering the question, how familiar they are with what's there already. It might take some time to go assess, yes, we have this; no, we don't have that; we have a fluoro, but it's not working, et cetera. So it's -- it's dependent on the heroics of the person answering the phone.

Q. Okay. And my understanding is, I believe it was the fluoro that in the last surgery, even though there was a working fluoro here, that they brought one for redundancy purposes; is that correct?

A. I have heard that. I don't know that for certain.

Q. And in terms of any future surgeries, they would probably bring two if there were not one working, correct?

A. I would assume that.

Q. And that would be part of the checklist that the surgeon would go through to make sure that they had everything that they needed to perform that surgery correctly, correct?

A. Right. And I would hope that there would be, you know, a multidisciplinary discussion about that planning of,

hey, you need this, hey, you need this. Oh, by the way, we need to -- let's think about the postoperative period, too. What's the monitoring going to be like, you know, so that we don't have, you know, that hematoma that happened previously or you know, some other untoward event from the standpoint of, you know, the whole perioperative period, not just the skin to skin.

Q. And the -- in terms of the checklist in a preplanned surgery, part of that checklist -- or at least part of the planning would be the proper sleep and care of the people that are coming down?

A. That would be preferable. I know that there are not necessarily rules like there are on flight crews for such aspects, and that is -- that is an eccentricity of medicine to some degree that you might find some that feel they can push through as their training might have taught them.

But I would suspect -- and again, this is purely speculation -- those that are brought down to do that, depending on their proclivities, would probably -- I'm going to check my equipment one more time; I'm going to, you know, go through the surgical plan one more time. I don't know.

Q. And that would be the same if they were in the States or if they were down here flying down, correct?

A. Yes. I mean, whenever we enter -- whenever we introduce some unknown -- you know, for instance, I've never been here. So I got up early and I did something I almost never do. I got McDonald's on the way. You just -- you do something different when you are in, you know, a new environment.

Q. Okay. And the SMACD that you were discussing a few minutes ago, it's my understanding -- I just want to kind of make sure that I have the understanding correct, that the problems with the MRI -- you know, getting an MRI machine has been raised to the SMACD?

A. Yes. Oh, it's been talked about at length within that and still -- you know, and I don't -- but I don't think that that was anything necessarily for a decision as much as it was for all parties to be aware. And then what decisions have been made about it have been made, you know, direct between two or three different entities.

Q. So in terms of your recommendation, the SMO's recommendation -- and the SMO's recommendation is the same, to get an MRI machine on island?

A. Absolutely. You know, we -- well, he -- Mr. Al-Tamir definitely needs an MRI if there's going to be further surgical planning done. Now, again, not being the surgeon,

you might find a surgeon who says I can proceed without. That's on his license or her license.

Q. Okay.

A. But I would say that there are going to be very few that would pony up to that risk without every possible standard of care being met.

Q. And the -- and currently the neurosurgeon has recommended an MRI prior to surgery?

A. Yes.

Q. Okay. And so in your position, after recommending the MRI, the SMO recommending MRI, and the neurosurgeon recommending MRI, is it your understanding then that, for lack of a better term, that the higher ups are developing COAs to make sure there is an MRI available?

A. Yes, they are.

Q. And is my understanding also that it's not required that we have a permanent MRI machine on island, that they can be leased and they can be different -- there's different COAs that are available; is that correct?

A. That's correct.

Q. And that's for the people that are involved in the procurement and acquisition of these types of big-dollar equipment, correct?

A. Right. If we're talking only about taking care of Mr. Al-Tamir in terms of surgical planning and then intraop, slash, postoperative care, then yes, it could be a time-limited event. I understand they're looking at a lease with an option to buy; but, yeah, I think it could be something that, you know, this is an acceptable COA.

Q. Okay. And the last MRI machine, I think you had indicated that it was part of a military commission-directed order to have that MRI machine on island?

A. That's my understanding, yes.

Q. And after it arrived, there was -- at least it was used not only for the one that was court-directed, but for multiple detainees; is that correct as well?

A. Yes, the JMG makes do with what it has. And when they're gifted a, wow, I've got this new imaging modality I would never have had otherwise, you better believe I'm going to use it. And I applaud them for adjusting to this new opportunity.

Q. And the accused was -- also underwent MRIs at that time while it was still operable?

A. That's correct.

Q. Okay. Doctor, you mentioned a couple times the assumption of risk, that there's always an assumption of

risk ----

MJ [Lt Col ROSENOW]: Counsel, if I could ask you, could you accomplish the similar line of examination with respect to the DEXA scan machine that you just accomplished?

TC [MR. SHORT]: Your Honor, I had it in my notes and I skipped right over it. Thank you.

MJ [Lt Col ROSENOW]: I don't have your notes here, to be clear, but I expected that would be the follow-on line.

TC [MR. SHORT]: It was supposed to be and I apologize.

Q. Regarding the DEXA scan -- and I just want to make clear, I want to be clear, is there alternatives to the DEXA scan?

A. My understanding is that there is. I've never -- not being a person who looks at DEXA scans a lot, I know the smattering of, you know, how to interpret one, what the T-score means, where it would be in terms of normalized to the population on which the study was done, but -- and I do know that there is an alternative way to do it through a CT scan.

I do not know the relative incidence of having to refer or, you know, depend on an alternative pathway to determine bone density. It just -- it's a -- it can be done, but we don't do it because this is -- this is the standard of care. This is the normal thing that we do throughout the

States. It is regulated. It is normalized. It does not have the same level of radiation exposure and, therefore, it is the -- you know, the de facto preferred method.

Q. And I think you testified that you're not aware of any procurement or acquisition in the works for a DEXA scan?

A. I have not heard anything regarding that.

Q. And has that been raised to the SMACD?

A. The -- yes, it has. It was ancillary to the overarching discussion. And the MRI seemed to be the more pressing concern, and it has, therefore, received the more -- you know, more in-depth consideration.

Q. So I'll go into the assumption of risk. You said that there's an assumption of risk no matter -- you know, with the surgeons coming down here ----

A. Of course.

Q. ---- is that what you testified?

A. Yes.

Q. And there's always an assumption of risk, no matter where you go and do surgery?

A. Yes, absolutely.

Q. And, Doctor, the last thing I do want to touch on is that: Did anybody advise you not to testify towards certain things or either avoid certain things, other than

classification issues?

A. No. No, I -- there were considerations that were brought up previous to this, conversations you and I've had, conversations I've had with the defense, conversations I've had back with my OGC contacts and with, you know, other concerned parties at -- in OSD. But, no, I've never been directed you shall, you shall not, regarding any aspect of nonclassified material.

TC [MR. SHORT]: Okay. That's all I have.

MJ [Lt Col ROSENOW]: Thank you. Defense Counsel, within that scope, anything additional to pose to the witness?

DDC [CPT CASCIOLA]: Your Honor, we have a few questions, but could we please take a break?

MJ [Lt Col ROSENOW]: So since there's a potential exhibit with the witness, I'd like to adjudicate that matter before we pivot forward.

Defense Counsel, what say you regarding the -- I think you said, sir, one page of notes?

WIT: Front and back.

MJ [Lt Col ROSENOW]: Front and back. All right. So two pages if copied.

DDC [CPT CASCIOLA]: Excuse me, Your Honor. We would request a copy of the notes, but we are absolutely fine with

the witness referencing the notes throughout.

MJ [Lt Col ROSENOW]: I didn't catch the last part. You would request a copy, but ----

DDC [CPT CASCIOLA]: But we are fine with him referencing the notes.

MJ [Lt Col ROSENOW]: Throughout his testimony? Understood.

Doctor, is there anything on those notes that falls under any protection of classification or any kind of medical privilege that you might define within the broadest reach of that term?

WIT: No, Your Honor, it's deidentified. It is -- it has nothing from my latest read, my iterative read of the security classification guidance that has anything to do with anything that would not be considered FOUO.

MJ [Lt Col ROSENOW]: Understood, and thank you.

Do you have any disagreement or concern -- I'm going to hear from you, Government, before I order anything with -- during this break there being made a copy of it so that it can be included in the record for any reviewing authority, if there is one in this case?

WIT: I have no concerns. You may need to contact me to interpret my handwriting.

MJ [Lt Col ROSENOW]: Understood. I expected that.

And then, Trial Counsel?

TC [MR. SHORT]: Your Honor, it would still have to go through a classification review by the OCA.

MJ [Lt Col ROSENOW]: So I know there's steps that we have to take here, but, Government, is there a process in place here or -- I guess I should say a mechanism in place here to take a copy and return the item or, because of what you've just described, is the item going to need to be taken by the government and then go through that process?

TC [MR. SHORT]: No, Your Honor. We can take a copy and make sure that it goes through the classification review.

MJ [Lt Col ROSENOW]: So I'll leave that with you to do, and we'll revisit -- I'll intend to revisit this on the record again so that it's plainly explained; but barring intervening circumstances changing this way ahead, it will be attached to the record in some format. If that's in a redacted format and then in an unredacted in a different place, we can manage those issues as necessary.

And then for the point of any reviewing authority to understand this, the construction of the courtroom is such that I can't really see what the witness may be looking at.

I would ask, then, for the individuals calling

witnesses going forward to advise their witnesses that if you come up with material, that's not the normal practice, but the typical response from this tribunal will be to get that marked for the record and go from there.

Is 15 minutes sufficient for you, Defense Counsel, to manage preparation for the next setting?

LDC [MS. HENSLER]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Trial Counsel?

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Sir, do you recall the instruction I had given you last time?

WIT: I do.

MJ [Lt Col ROSENOW]: Thank you. The same instruction applies.

The commission is in recess for 15 minutes.

[The R.M.C. 803 session recessed at 1105, 7 June 2022.]

[The R.M.C. 803 session was called to order at 1123, 7 June 2022.]

MJ [Lt Col ROSENOW]: The commission is called to order. The parties are present as they were before the break. The accused remains present as well. And the witness is on the stand under oath.

Trial Counsel, were you able to make a copy over the

break?

TC [MR. SHORT]: Your Honor, I apologize. I do -- I did misunderstand Your Honor's order on that. And I wasn't sure, because he was still on the stand, whether I should be approaching him and taking his notes from him. Plus, before we turn it over to defense, we would have to go through the security classification review process, Your Honor.

MJ [Lt Col ROSENOW]: I'm tracking that as well. I'm merely asking if you made a copy, and the answer's no, I understand.

TC [MR. SHORT]: No.

MJ [Lt Col ROSENOW]: So that makes it clear to me we should maintain positive control of this if he is released here in a moment or several moments of this item; is that correct?

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. And I'll let you -- when I say we, I'll let you, Government, maintain control.

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Defense Counsel, any concern with that way ahead?

DDC [CPT CASCIOLA]: Your Honor, I have no concern with that way ahead. We would, of course, ask that, once proper

channels are gone through with regard to these notes, that we receive the notes promptly and that they not be redacted since we are almost positive they're not unclassified based on what the witness said.

MJ [Lt Col ROSENOW]: Thank you. The important point for the court -- or the commission, rather, is that the government has acknowledged they will keep hold of these things and we can talk about how they come along and become part of the record. Since there's not a copy that's been made, I'm going to ask those notes to be held by the government. And I got a nod from the witness in understanding.

WIT: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Thank you, sir.

Government?

TC [MR. SHORT]: Your Honor, before we begin, there's one issue I'd like to bring up. Dr. Kucik during the break was reviewing some papers. I don't know if they pertain to this case or if they're some other notes on something else that he's working on, Your Honor. So I would like an inquiry on that.

MJ [Lt Col ROSENOW]: Certainly. Doctor?

WIT: Yes. It was the proceedings of the recent Anesthesia History Association meeting I attended in Denver,

May 12th.

MJ [Lt Col ROSENOW]: Is that anything relevant to these proceedings?

WIT: No, something merely to pass the time.

MJ [Lt Col ROSENOW]: Almost like reading a *Newsweek* magazine, *U.S. News & World Report*? I'm expressing no preference for one or the other.

WIT: Exactly, Your Honor.

MJ [Lt Col ROSENOW]: Understood. Thank you.

Any concern with that, Trial Counsel?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: Defense Counsel?

DDC [CPT CASCIOLA]: No, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. Please don't consult anything while you're answering questions.

If you would, please, proceed, Defense Counsel.

DDC [CPT CASCIOLA]: Yes, Your Honor, thank you.

REDIRECT EXAMINATION

Questions by the Detailed Defense Counsel [CPT CASCIOLA]:

Q. Sir, the trial counsel went through a discussion with you regarding sort of a checklist of items that would be required prior to a surgery; is that fair to say?

A. Yes.

Q. There -- it's impossible, though -- you would agree, it's an impossibility to plan for every potential thing that could go wrong in surgery?

A. There are -- there are varying approaches to doing it, and you will find that different surgeons, different anesthesiologists, they'll all have their own individualized checklist. Some have been standardized. The preoperative checklist that would happen before a surgery, for instance, has more or less been standardized. You know, the operating room nurse says this, the surgeon says this, the anesthesiologist or CRNA says this. Everyone makes sure that all -- we're all on the same sheet of music, all questions have been answered. But that's for, you know, just your standard surgical event that's going to happen on any day in any given OR around the country, around the world.

To predict, you know, all the things that could go askance on, you know, a very complex surgery that requires movement, requires airlift, requires different personnel, credentialing, yeah, that's a much bigger checklist. So would it -- there's more risk to -- there are more unknowns, I guess it's fair to say, than would be the standard mark one motto case that you walk into.

Q. Is it fair to say there is a higher chance of omitting

something you could -- as a physician or a surgeon, come to need in the middle of that surgery?

A. Well, these things are designed -- modern surgical practice, modern anesthesia practice, modern safety science and whatever pathway, the checklist the pilot went through to get you all down here, for instance, these are tried and true because people do not perform well in -- in new environments. You know, we tend to -- this is the way I always do it, this is what I'm comfortable with. I understand why I do it this way. And then you need expertise to manage the very, very small things that fall outside the realm of normal. And that's why we go through, you know, so much training.

But you don't want to use that all the time. This is -- everyone's probably read *Thinking, Fast and Slow*, you know. We think in different ways. To the degree possible we can be on autopilot and then focus -- use our intense focus on the very, very small, very, very few things that are going to be more complicated. That's probably better. That's how we drive here in the morning. That's how we do everything we do. The more complex it gets, the sooner we become task saturated, the sooner we make mistakes, and the sooner the patient suffers for it.

Q. And one of the indicators of -- well, tell me if I'm

wrong. One of the indicators during surgery that there's more cognition being required of the members in the surgery is the length of the surgery itself?

A. Not necessarily. You would get fatigue if you start getting, you know, to a period of time that's beyond the norm. The abnormalities, the perturbations I worry about when you get a surgery longer than for the standard for -- you know, for instance in, you know, let's take a spine case. If it means putting a patient prone for a long period of time, then there are risks to that.

There is airway edema from dependent structures of the face that might make extubation more difficult. There's prolonged blood loss. There's a longer period of anesthesia. There is intraoperative hypothermia that might become a risk if you don't have -- you know, if you've got a lot of exposed skin or an open wound that is, you know, losing heat and vapor to the environment. There's the development of intraoperative blood clots.

There are any number of things that can go wrong, so shorter is better, and we would prefer in practice not to have people under anesthesia for prolonged periods of time. And, you know, not necessarily because this might be prolonged not because someone's, you know, working at the top of their game

the entire time, but it might be simply, oh, I dropped this instrument, it needs to be flashed and cleaned suddenly. So there's a delay that's kind of inherent to any one of these things that comes off the rails.

Q. And just going back again to this checklist very quickly. To your knowledge, there -- is there a checklist currently for Mr. Al-Tamir's sixth surgery?

A. That would be -- well, there are probably -- there are several. I would say that there is what the JTF and JMG and SOUTHCOM have already done in terms of attempting to do this before, lessons learned that have been filed away and hopefully has been gone through with a thorough after action report and said, yeah, this worked well, that didn't so much, let's make sure we improve this.

There is the individual surgeon and what he thinks that he's going to need for certain to bring down here and possibly do that in triplicate. There are the lists of the individual staff members. The anesthesia provider would -- if I were to do this case, I would say, okay, I'm doing a back case. I'm going to go pull my case card for this and I'm going to review, you know, the best knowledge I have from -- from residency and from practice as to, yeah, okay, then I would do this, then I would do this. I would make sure I had

all my medications labeled. So everyone's going to have a checklist of their own.

The movement aspect of it, the, you know, the G-4 aspect of it, all those aspects, you know, not my purview. But, yes, it would be a very complex list when taken from everybody who is going to have a say in this.

Q. Okay. And you mentioned after action report. Does that mean that there are prior checklists and prior after action reports and evaluations of his other surgeries?

A. I have not seen them. I said that in a hypothetical, I hope that this has occurred. But it is a -- again, all of his surgeries occurred before my billet was created. I try to encourage that sort of capture of corporate knowledge. To the degree that I've been successful of that, I can't say.

Q. Some of the items that would be needed that you spoke about needing to come down on island to GTMO -- for example, you mentioned like the table, a few other things, sir.

A. Uh-huh.

Q. Those are items that don't simply get on the rotator or the OMC flight down here, right?

A. That's correct.

Q. It requires a logistical push to get them down here?

A. Yes.

Q. And can all of those things needed that we know are needed for Mr. Al-Tamir's sixth surgery, can they actually physically go in the space available at Naval Station Guantanamo Bay's hospital?

A. It would be a tight fit for the things that would need to be, kind of, put into the room such that, you know, the surgeon could refer to the films as needed for intraoperative confirmation of proper placement. The C-arm, of course, would have to be wheeled in, wheeled out. You'd have to have initial space to bring in a gurney, induce anesthesia, make sure everything is correct, then flip to the other table, and then that gurney would go out of the room.

And then, of course, you'd have to have enough movement space for the anesthesia provider to get over to the delivered blood and do the safety checks there before it's administered. So there are -- there's a significant amount of space for a surgery like this that would be -- it would be tight.

Q. So not only now are we talking about issues with equipment and resourcing and personnel, there is literally an issue with the space of the room that this operation would have to occur in?

A. Naval Hospital Guantanamo Bay was -- my understanding,

was built in the '50s. There simply wasn't the logistics that go into -- there weren't -- there wasn't the technology at that point that was foreseen to be built to. And that's -- and those things have gotten big, and those things have gone to operating rooms that are three, four times the size of what you have at the naval hospital.

So, yes, I would say there are a lot of things that go into it. It would be a very tightly packed room.

Q. And all of this that we're talking about, the logistical support, the resourcing, that's when you know that a spinal surgery is going to be planned, you're planning for that thing to happen. There are emergent spinal surgeries, would you agree?

A. Yes.

Q. And, in fact, Mr. Al-Tamir had an emergent spinal surgery in the past?

A. He had one, yes.

Q. And in that case it would be much more difficult to get everything on all these checklists to line up?

A. Yes.

Q. You spoke a little bit about the alternatives to MRI, the alternatives to DEXA scan, and I think you were basically saying, sir, that in theater we use alternatives because we

don't always have what we need, right?

A. Uh-huh, yes.

Q. But that's in theater in an austere environment with patients that are of a certain standard of health already. Would you say that's fair?

A. I would say to the degree possible you try to prepare in a specific fashion that you know is the most effective. When you have to err or deviate from the norm, you should have good reason and good planning behind it. And, yes, in the cases where that has been successful and these sorts of cases have been done overseas, you know, in response to combat injury, in response to mass casualty, oftentimes -- which is not to be -- not to be -- it's not surprising to anyone to think that a spine surgery done on a 20-year-old Marine will be -- will have better outcomes.

Q. Exactly. And Mr. Al-Tamir, as we've already gone over, is not that person?

A. Correct.

Q. And, in fact, the high-value detainees in general are a geriatric population?

A. None of us are getting younger.

Q. Well, not you, sir, but the detainees, of course, are not either?

A. That's correct.

Q. Yes. Okay.

DDC [CPT CASCIOLA]: Your Honor, I think that's it. Thank you.

MJ [Lt Col ROSENOW]: Trial Counsel, within that scope?

RECROSS-EXAMINATION

Questions by the Trial Counsel [MR. SHORT]:

Q. Yeah. Neurosurgeon that's planning the surgery, he's familiar with the spaces available to him, correct?

A. My understanding is, yes, he's worked down here before. I believe he did one of the previous -- one or more of the previous surgeries, not the -- I think the first two or three, but, yeah, he's been involved since. So he has worked in that space. Again, I don't know this clinician.

Q. All right. And ----

TC [MR. SHORT]: That's all. There's nothing else.

MJ [Lt Col ROSENOW]: Thank you. I don't have any questions for the witness. I do have a question for the defense.

You called this witness. He provided different opinions over the course of his testimony and an introduction that included his experience, his training, his education, and the base of his knowledge. He was not offered as an expert by

the defense and he was not qualified as an expert by this commission.

Defense Counsel, is there anything else on this regard that you wish to accomplish on this witness or would you like the commission to consider his testimony as it was delivered? You have a moment to consult amongst yourselves.

[Counsel conferred.]

DDC [CPT CASCIOLA]: Your Honor, we need do nothing more with this witness.

MJ [Lt Col ROSENOW]: Trial Counsel, you similarly adduced evidence from this witness on cross-examination in the form of opinions. Anything else from the government?

TC [MR. SHORT]: Your Honor, this witness was called in the position of -- in his position as the chief medical officer, not as an expert for the government. He is not a government expert. He is not a defense expert. He has not been retained by either side. And so he should not be considered as an expert, but his testimony and opinions are a matter of the record now. And certainly this is not before a jury where we have to qualify an expert before a jury, Your Honor.

MJ [Lt Col ROSENOW]: I'm certainly not asking you to sort out if I can consider the evidence. I am considering the

evidence that came in without objection, and even if it came in over objection in accordance with the M.C.R.E.

I'm observing that the testimony as given is in the form of a lay witness, not as an expert witness. And I didn't want there to be any confusion from the counsel as to what kind of testimony was received based on the processes that were followed. It appears that there is no confusion. So thank you for that clarification.

I'll go to you first here, Defense Counsel. Do you desire that this witness remain available to provide classified testimony subject to the commission's ruling after a hearing under M.C.R.E. 505(h)?

DDC [CPT CASCIOLA]: Your Honor, he need not remain available today. We anticipate that we will be, based on his testimony, drastically amending the 505 request to narrow it significantly. And so I do not think that we need to do that today, Your Honor. But certainly that's my opinion, I just believe it's more efficient and economic for the commission that we narrow the potential issues.

MJ [Lt Col ROSENOW]: So what I hear from you is the answer is, yes, we want him to be held subject to recall; but, no, we do not expect to be able to call him today because the issues have been winnowed and there might be consensus from

the parties about what remains?

DDC [CPT CASCIOLA]: Yes, Your Honor. In a more succinct way of putting it, thank you.

MJ [Lt Col ROSENOW]: You tell me, I read back, that way we avoid confusion. And I appreciate your patience as I do that.

Trial Counsel, does that work for you as a way ahead?

TC [MR. SHORT]: Your Honor, I renew my objection regarding, you know, that there's nothing -- I don't believe we brought up anything in controversy through this witness. It was more of a discovery type of deposition than anything else. I don't see any need for this witness in the future, as the matters under AE 214 were testified to, even very briefly, actually, that covered under that. And so I think the witness should be excused, Your Honor, and there's no need for any additional testimony whether classified or unclassified, Your Honor.

MJ [Lt Col ROSENOW]: I understand that that's the position you'll arrive at, and I take that to mean as well that you have a preference to not take up right now this question under M.C.R.E. 505(h), or should I take from that something else?

The question that's being presented to us at this

point, Trial Counsel, is should we push along without the defense revising its previous notice into what would be the next step that was agreed upon, talking about what issues might be taken up, if any, inside of a classified setting, or should we forestall that conversation to determine if an additional setting in which he might be able to speak more freely should be had?

TC [MR. SHORT]: Yes, Your Honor, I think it's the latter, if there is additional.

MJ [Lt Col ROSENOW]: And I take from that no concession that there is required from the government's measure such a session. Very well.

Do we have a bailiff who is allowed to move freely around the room and who is masked?

Thank you. If you could recover the one-page document that the doctor was testifying from. Thank you. And you can take that to the trial counsel's table.

Sir, I have a -- stand by.

TC [MR. SHORT]: Your Honor, just for the record, I have received the document; a one-page, two-sided document.

MJ [Lt Col ROSENOW]: Thank you for that.

I've been handed a note, just for all the counsel who are appearing. I understand there are some conventions about

what may be seen on your person by the public, so if we could just all ensure that we are in conformity with those policies. Thank you for that.

Doctor, I have a slightly different instruction than I had delivered before, because we're going to have a longer break here. You are in the, not middle of your testimony because you've gone through direct and cross-examination, but you are being held subject to recall. What that means is while this case is pending, meaning for at least the next several days before you might be here again or potentially longer in the future, do not discuss your testimony or your knowledge of this case with any other witness or potential witness. You can discuss these things with the trial counsel and with the defense counsel.

Additionally, as part of your normal practice, you're allowed to consult materials and accomplish tasks in connection with this case, just like you always were. But because you've started your testimony and you're being held subject to recall, I do require you to refrain from discussing this case or your knowledge of this case with any other witness or potential witness.

Now, to the extent that your job calls on you, for instance, to consult with the senior medical officer, that

would be an anticipated witness in this commission. When your job requires you to handle issues associated with detainee matters for this commission, that's fine and that's acceptable. The line would be easily drawn, though, around any discussion of the questions that you were posed or the answers that you provided. And if you have any doubt about these things, I know that you have the ability to contact the defense counsel or the trial counsel for clarification as to these issues.

Any questions at this point?

WIT: No, Your Honor.

MJ [Lt Col ROSENOW]: Any objection to my instruction or request for further instructions from the government?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: Defense Counsel?

LDC [MS. HENSLER]: Your Honor, just to clarify, we are permitted to consult with the witness regarding potential closed testimony in the interim period?

MJ [Lt Col ROSENOW]: That's exactly right. He is not to discuss his testimony with any other witness or expected witness. He may discuss these things with both trial and defense counsel ----

LDC [MS. HENSLER]: Thank you.

MJ [Lt Col ROSENOW]: ----- as well as their teams.

LDC [MS. HENSLER]: Thank you.

MJ [Lt Col ROSENOW]: There being no objection, then, or request for further instructions, sir, thank you for your time and your testimony. You're excused temporarily.

WIT: Thank you, Your Honor.

[The witness was warned, was temporarily excused, and withdrew from the courtroom.]

MJ [Lt Col ROSENOW]: The witness has departed. Given the information that's been presented, Defense Counsel, are you prepared to answer the question of whether you would still like to call the senior medical officer in an open session?

DDC [CPT CASCIOLA]: Your Honor, we would defer at this time on making a decision regarding calling the senior medical officer. Our understanding is he's not available today anyway, and we would like to review our notes from the testimony today, look over the 505 notice we provided, submit an amended 505 notice, and think through whether or not there are any topics that we need regarding the senior medical officer and perhaps maybe recall him -- I'm sorry, call him, Your Honor, next week.

MJ [Lt Col ROSENOW]: Trial Counsel, do you already know the government's position with respect to calling the senior

medical officer for matters that would be taken up in an open session?

TC [MR. SHORT]: Your Honor, based on the chief medical officer's testimony, anything the senior medical officer with regard to AE 214 would be cumulative and not necessary and a waste of the court's -- the commission's time, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. Having the position of the government may help the defense counsel in preparing their own possession -- position, rather.

And then, Government, there's been a proposal from the defense counsel about the way ahead. Do you have a proposal as to the way ahead?

TC [MR. SHORT]: Your Honor, you mean with regard to the senior medical officer?

MJ [Lt Col ROSENOW]: Or taking up any other matters today or permitting additional briefing and so on and so forth, taking potentially testimony next week rather than later this week. Is this something you would need to consult on or is it something you're prepared to reply to, like my earlier question?

TC [MR. SHORT]: Your Honor, I think that the defense, in terms of deferring certain matters to the future so they can review their notes and so forth, it's fine with the

government, and we can, you know, adjust accordingly as the week goes on and as necessary, Your Honor.

I would like to see their refined 505(g) notice, you know, before -- it would be helpful before going into a 505(h).

MJ [Lt Col ROSENOW]: Understood. What does that mean for the government's position regarding the remainder of today? What, if anything else could be taken up?

TC [MR. SHORT]: Your Honor, I think that was it, right? The things that were on the docket for today was the senior medical officer, the chief medical officer, and possibly -- you know, we've reversed that, and then the 505(h). So I think we're done for the day, Your Honor.

MJ [Lt Col ROSENOW]: At least for the record done for the day. Understood.

Defense Counsel, same set of questions and same concerns about what might be capable of adjudication in an open session after a lunch break, if anything.

LDC [MS. HENSLER]: Your Honor, it's the defense's position there's nothing else that can be adjudicated in an open decision today.

Again, to reiterate the request, we would ask to be permitted to file an amended narrowed 505 notice. We

accomplished, we think, a lot today in the testimony, so we need to, as a team, do our diligence and determine what else we may need in a closed session from the CMO and whether there is, indeed, anything to be gained from testimony from the SMO, but we will need some time to do that deliberation.

MJ [Lt Col ROSENOW]: When you say time, do you mean more than the remainder of today, as I understand it?

LDC [MS. HENSLER]: Yes, sir.

MJ [Lt Col ROSENOW]: Could you state the defense's position with regard to a narrowing of proposed lines of inquiry in a closed setting involving the CMO and the need, if any, for the SMO and, if there is a need for the SMO, the anticipated scope of testimony inside and outside would better in an open and closed session by the end of the day tomorrow?

LDC [MS. HENSLER]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. If the defense is able to meet that standard, is the government anticipating a response in writing?

TC [MR. SHORT]: I would reserve absolutely a response in writing. I believe we've already -- our 505(h) request would take care of any additional information -- you know, would cover if they're narrowing the scope of their 505(g) notice or giving additional particularization of that. So I reserve,

absolutely, to see what it is and if we have to, you know, put in writing, but I think the commission is aware of our position in terms of going forward.

MJ [Lt Col ROSENOW]: I ask that question because one of the answers you were able to provide is we would object, full stop, to the need for the SMO to testify to anything in either setting. And I want to make sure that you have a briefing opportunity like the defense is getting a briefing opportunity. This is a little bit backwards, because normally we rely on written filings and then it's -- if you're lucky or if the circumstances require it, you get the opportunity for oral advocacy, too.

So if the defense were able to meet that standard of tomorrow by the end of the day filing, are you asking for the opportunity to respond by the end of Thursday in writing with a government position, or, instead, would you be prepared to get on the record Thursday?

TC [MR. SHORT]: Yes, Your Honor, either. However, I do -- you know, I temper that a little bit because there's been times where, you know, if it's just narrowing of the 505(g), that's one thing. That's an easy -- that's an easy shot. However, you know, if there's advocacy and, you know, further argument involved in any pleading, then we would have

to maybe even need additional time. But I would think that's -- as it sits right now and how it's couched right now, that's appropriate, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. Give me one moment.

[The military judge conferred with courtroom personnel.]

MJ [Lt Col ROSENOW]: As best I can, and subject to later developments, I've been able to confirm the notional availability of logistical support for us to be back on the record on Friday if the circumstances align and everything develops in the direction we're setting here.

So the direction of the commission, with agreement from the defense that this timeline works, is for them to return back the answers that I had asked for on the issues previously identified by the end of the day on Wednesday, and the end of the day would mean 1730, please, local tomorrow.

The government will then be provided the opportunity until 1730 local on Thursday to file any responsive pleadings to those issues that were previously identified from the defense and that come in on Wednesday.

And everyone should be prepared for the possibility of returning here at 0830 on Friday to either take up oral argument on these matters, if that's required or appropriate, to -- if the SMO becomes available and this commission ends up

determining that we should hear from the SMO, to take up that testimony inside an open session, and then potentially pivoting into the 505 setting that we've talked about in a few different circumstances so far.

I would at least leave open the possibility of being able to return to you a decision, with a written ruling later to follow, on the necessity of closing under 806 and then taking up in a classified setting additional testimony from one or, if there are two, two of those individuals that are involved, the CMO and the SMO. That will require some flexibility, I understand and I appreciate that, from the support staff, but then we will at least all be prepared if the maximum of work is accomplished on that day and the full measure of opportunities for testimony from both witnesses are requested by the defense and granted by the commission.

Does that work for the government as a way ahead?

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Any objection or request for clarification from the government before I go to the defense?

TC [MR. SHORT]: No, Your Honor.

MJ [Lt Col ROSENOW]: Defense Counsel, same questions?

LDC [MS. HENSLER]: Your Honor, my only request would be a logistical one, that the testimony of the SMO, if necessary,

occur at the end of next week. The reason is to free up the rest of this week for the parties to attend to other matters. Also, it's our understanding the SMO is available next week and that his -- so the immediacy of his testimony is not necessarily -- the need is quite as acute.

I'm unaware of whether or not the CMO is available next week. If he is, I suppose I would extend the same request, simply to free up the schedule as much as possible this week to the parties.

MJ [Lt Col ROSENOW]: Back to you, Government. If you have any awareness of their availability, you can state it now.

TC [MR. SHORT]: I don't have awareness of their availability for next week. I do think the CMO is tight, but I'll check with the senior medical officer, Your Honor.

MJ [Lt Col ROSENOW]: Thank you. And that's information that could be provided in your response on Thursday, if you choose to provide it, and we'll go from there.

At present, let's plan as if there's a possibility for Friday, with certainly the flexibility, if it's available, likely to be taken by the commission. If all things are equal and those individuals remain available at the end of next week, that would be the commission's preference, too.

LDC [MS. HENSLER]: One separate but related request, Your Honor. You gave -- provided us criteria on the record for our filing tomorrow. Given that the transcript of today's proceedings may be -- may not be available until much later today or tomorrow morning, I would simply ask that, in some way, this ruling be reduced to writing so that we are meeting Your Honor's expectations with respect to that filing.

MJ [Lt Col ROSENOW]: Certainly. I will recapitulate for it. I think it's pretty straightforward.

The remaining questions are what we had cast as potentially managing in the amended version of the scheduling order. So the first and immediate question is whether or not the defense is still seeking to use any of these matters in additional examination of the CMO. And I say these matters, meaning classified matters. That's the first question. If the answer is yes, what portions in reference back to 214C (Sup).

And then the next issue is, yes or no, we intend to call the SMO. And if the answer to that is yes, in an open session or in an open session and a closed session; and if there is a closed session, the same kind of reference out to 214C (Sup), which says we would want to adduce this particular evidence.

I can provide further detail if there's any concern from either of the parties, but I do not wish to overcomplicate this. It's merely a matter of you being able to, as I think the government's pointed out, narrow. So we already have a superset. It's really about what has been cleaved or what has been removed by your decision.

LDC [MS. HENSLER]: Thank you.

MJ [Lt Col ROSENOW]: Is that sufficient for you to be oriented, Defense Counsel?

LDC [MS. HENSLER]: Yes, it is. Thank you.

MJ [Lt Col ROSENOW]: Government, are you still oriented?

TC [MR. SHORT]: Yes, Your Honor.

MJ [Lt Col ROSENOW]: Trial Counsel, is there anything else to take up before the commission goes into recess?

TC [MR. SHORT]: Your Honor, just one quick thing. Since I guess this afternoon opens up, we do have an M.C.R.E. 505(f) presentation scheduled for tomorrow morning. We would be flexible if you needed to take it up this afternoon or wanted to; if not, we can leave it on the schedule for tomorrow, which is fine.

MJ [Lt Col ROSENOW]: I'm seeing no disagreement from my staff, which suggests to me that they can accommodate that. Would 1500 work for the government so that there's a break and

an opportunity to reorganize?

TC [MR. SHORT]: It should work fine, Your Honor. And I will make some appropriate arrangements.

MJ [Lt Col ROSENOW]: And again, seeing no disagreement from the staff, we'll plan then on 1500 -- defense counsel. Excuse me.

Anything additional to take up?

LDC [MS. HENSLER]: No, Your Honor. Thank you.

MJ [Lt Col ROSENOW]: Thank you. The commission will then be in recess until we return back, which could be in an open session as soon as Friday or potentially some later time next week. Thank you.

[The R.M.C. 803 session recessed at 1205, 7 June 2022.]

[END OF PAGE]