**MILITARY COMMISSIONS TRIAL JUDICIARY**
**GUANTANAMO BAY**

UNITED STATES OF AMERICA

v.

ABD AL-RAHIM HUSSEIN MUHAMMED ABDU AL-NASHIRI

**AE 277**

**DEFENSE MOTION FOR APPROPRIATE RELEIF: ORDER A MAGNETIC RESONANCE IMAGE (MRI) OF MR. AL-NASHIRI'S BRAIN**

4 June 2014

**1. Timeliness**: This request is filed within the timeframe established by Rule for Military Commission (R.M.C.) 905 and is timely pursuant to Military Commissions Trial Judiciary Rule of Court (R.C.) 3.7.c.(1).

**2. Relief Requested**: The defense moves this Commission to order additional medical testing of Mr. Al-Nashiri, specifically, a magnetic resonance image (MRI) of Mr. Al-Nashiri's brain.

**3. Overview**: Dr. Sondra S. Crosby was qualified as an expert before this Commission in the field of diagnosing and treating torture survivors on 24 April 2014. She can say, with a reasonable degree of medical certainty, that Mr. Al-Nashiri is a victim of torture; suffers from chronic, complex Post-Traumatic Stress Disorder (PTSD); and has memory loss associated with his torture. But Dr. Crosby cannot characterize the extent of Mr. Al-Nashiri's memory loss or identify other contributing causes to his memory loss, such as traumatic brain injury, without further testing. Therefore, Dr. Crosby recommends that Mr. Al-Nashiri undergo brain imaging, i.e. an MRI to determine the extent of the damage done to his brain, the scope of his memory loss, and the possible existence of a traumatic brain injury (TBI).

The Government, as the detaining authority, is obliged to provide medical care for those it detains. A detainee is completely dependent on detention facility medical officials for any and all medical care. *See Estelle v. Gamble*, 429 U.S. 97, 103 (1976). With this complete reliance by

the detainee comes a responsibility for the provision of care by the Government. This Commission should find it appropriate to order an MRI, so that Mr. Al-Nashiri can receive the medical care recommended by his doctor.

Further, beyond treatment, the Defense "is entitled to the production of evidence which is relevant, necessary and noncumulative." R.M.C. 703(f)(1). The Defense's ability to obtain orders for witnesses and other evidence "shall be comparable to the opportunity available to a criminal defendant in a court of the United States under article III of the Constitution." 10 U.S.C. § 949j(a) (2009). The MRI will not only result in better treatment and a defendant that may be able to meaningfully participate in his defense, but it will also provide additional evidence in mitigation that is relevant to his past cooperation, or lack thereof, with law enforcement or detention officials, his conditions of confinement, and whether Mr. Al-Nashiri is a continuing threat to society. Without this information, the defense will be precluded from both adequately supporting future suppression motions and presenting a major piece of its presentencing case. Counsel has identified seventy-seven (77) state and federal opinions reversing death sentences due to defense counsel's failure to investigate or present evidence of brain damage or impairment. Denial of this motion will violate the defendant's rights guaranteed by the fifth, sixth and eighth amendments to the Constitution of the United States of America, the Military Commissions Act (MCA) of 2009, the Detainee Treatment Act (DTA) of 2005, treaty obligations of the United States and fundamental fairness.

**4. Burden of Proof and Persuasion**: As the moving party, the defense bears the burden of persuasion as to any factual issues relevant to the disposition of this motion, which it must demonstrate by a preponderance of the evidence. R.M.C. 905(c).

**5. Statement of Facts:**

a. Dr. Sondra Crosby is a defense expert who was approved by the Convening Authority and accepted by this Commission as an expert in the field of diagnosing and treating torture survivors on 24 April 2014. (Attachment A).

b. Dr. Crosby is an internist, licensed by the Commonwealth of Massachusetts, with experience in treating hundreds of victims of torture. *Id.*

c. Dr. Crosby has seen Mr. Al-Nashiri on three occasions, totaling over thirty (30) hours. *Id.*

d. Her examinations included: taking torture histories, inventorying symptoms, and conducting physical examinations. *Id.*

e. Dr. Crosby's medical opinion is that Mr. Al-Nashiri suffers from memory loss because of his PTSD and possibly due to other physical causes. *Id.*

f. Dr. Crosby believes more testing is needed, and would be willing to consult with caregivers at Naval Station Guantanamo Bay, Cuba in order to ensure the testing is conducted properly and will contribute to the overall patient care of Mr. Al-Nashiri. *Id.*

g. On 28 September 2011, the Convening Authority referred this case to a military commission under the Military Commissions Act of 2009 and authorized it to sentence the accused to death. *Id.*

**6. Argument**:

The Supreme Court long ago settled that the government is required to provide adequate medical care to those it keeps in its custody.

> An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torture or a lingering death,' …, the evils of most immediate concern to the drafters of the [Eighth] Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. … We therefore conclude that

> deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' … proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed.

*Estelle v. Gamble*, 429 U.S. 97, 103-05 (1976) (internal citations omitted).

As the Supreme Court noted in *Estelle*, constitutionally adequate medical care is not satisfied by the perfunctory supervision of a health care worker. The medical care provided must actually address the detainee's needs. "[G]overnment officials who ignore indications that a prisoner's or pretrial detainee's initial medical treatment was inadequate can be liable for deliberate indifference to medical needs[.]" *Cooper v. Dyke*, 814 F.2d 941 (4th Cir. 1987); *Miranda v. Munoz*, 770 F.2d 255, 259 (1st Cir. 1985) (upholding denial of judgment n.o.v. where "[i]t could be found that defendants ignored a clear warning that the medical treatment they provided for [plaintiff, a pretrial detainee] was inadequate").

The federal courts settled thirty years ago that an inmate's serious psychiatric or psychological condition presents a "serious medical need," whose neglect is forbidden by the Constitution and requires a judicial remedy. *See*, *e.g.*, *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988); *Partridge v. Two Unknown Police Officers of Houston*, 791 F.2d 1182, 1187 (5th Cir. 1986); *Wellman v. Faulkner*, 715 F.2d 269, 273 (7th Cir. 1983); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir.1979); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (holding that there is "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.").

When comparable health-related issues have gone before the district courts in the Guantanamo *habeas* cases, the district courts have not hesitated to provide adequate remedies.

*See*, *e.g.*, *Tumani v. Obama*, 598 F.Supp.2d 67 (D.D.C. 2009) (ordering appropriate remedies where it was alleged that the conditions of petitioner's detention had caused such severe mental illness that the detainee was no longer able to participate in his *habeas* action); *Husayn v. Gates*, 588 F.Supp.2d 7, 9 (D.D.C. 2008) (petitioner alleged that medications prescribed for him by doctors at Guantanamo cause him to become incoherent, psychotic, and interfered with his ability to write and speak); *Al-Joudi v. Bush*, 406 F.Supp.2d 13 (D.D.C. 2005) (granting remedies where inexperienced medical staff were alleged to be improperly placing intravenous lines to force feed detainees and providing other sub-standard medical care).

The declaration from Dr. Crosby articulates the need for future testing and explains that an MRI is the next logical step in providing adequate medical care to Mr. Al-Nashiri. If JTF-GTMO's personnel lack the knowledge and experience necessary to treat individuals who have been the victims of torture and properly administer an MRI to Mr. Al-Nashiri, Dr. Crosby is happy to consult with them and provide guidance. Furthermore, Dr. Crosby will continue to meet with the accused, evaluate him, and provide treatment necessary to the preparation of his defense. Granting this motion will not only allow for better pre-trial preparation, but ultimately result in a more efficient trial.

Moreover, under the MCA, the accused has a right to present evidence in his defense. 10 U.S.C. § 949a(2)(A) (The accused has a right "to present evidence in the accused's defense[.]") R.M.C. 701(e)(1)(C) requires the trial counsel to provide the defense with any evidence which tends to "reduce the punishment." As stated many times before, this is a capital case. *See Loving v. United States*, 62 M.J. 235, 236 (C.A.A.F. 2005) (recognizing that the unique severity of a death sentence infuses the legal process with special protections that ensure a fair and reliable trial); *see also United States v. Walker*, 66 M.J. 721 (N.M.C.C.A. 2008) (recognizing the

concept that "death is different" in reviewing capital cases). And in preparing a capital defense, the defense must focus on two tasks—preparing a vigorous defense against the underlying evidence and preparing an equally vigorous defense against a possible sentencing hearing. *See*, *e.g.*, R.M.C. 1004 ("The accused shall be given broad latitude to present evidence in extenuation and mitigation.") The realm of relevance in the mitigation and sentencing phase of a capital trial is far more expansive than that realm in the guilt/innocence phase. *Simmons v. South Carolina*, 512 U.S. 154, 163 (1994) (citing *Lockett v. Ohio*, 438 U.S. 586 (1978)); *Eddings v. Oklahoma*, 455 U.S. 104, 110 (1982); and *Barclay v. Florida*, 463 U.S. 939, 948-951 (1983). At times, these two tasks may be intertwined insofar as a defense against the charges is also a mitigating reason against the death penalty.

Evidence of memory loss is relevant and material to the mitigating factors of a capital case that will be considered by members during Mr. Al-Nashiri's presentencing proceedings. Specifically, evidence of memory loss will directly militate against any lack of cooperation with law enforcement and detention officials or lack of rehabilitation potential that the prosecution will present during its case in aggravation. It will also buttress the defense's arguments to suppress past statements of the accused, support arguments for pre-trial confinement credit, and demonstrate to members the extent of the punishment already administered to Mr. Al-Nashiri. Further, the defense's expansive right to present mitigating evidence in a capital case logically includes evidence of mental disease, defect, or abnormality and chronic, complex PTSD, TBI, and the resulting memory loss all fall into that category. Court opinions from the fourth, sixth, and ninth circuits point to a special duty to investigate and present in mitigation evidence of

brain injuries.[1]

This Commission must order an MRI to ensure Mr. Al-Nashiri's adequate medical care and because the defense has a right to present evidence in mitigation relevant and material to Mr. Al-Nashiri's cooperation with government officials, conditions of confinement, and rehabilitative potential.

---

[1] Counsel have identified 77 state and federal opinions reversing death sentences due to defense counsel's failure to investigate or present evidence of brain damage or impairment. See, e.g., Jefferson v. Upton, 130 S. Ct. 2217, 2218-19 (2010) (remanded where appellant suffered serious childhood head injury); Sears v. Upton, 130 S. Ct. 3259, 3262-63 (2010) (finding counsel ineffective for failing to investigate and present evidence of childhood frontal lobe damage as well as teenage drug and alcohol abuse); Porter v. McColllum, 130 S. Ct. 447, 451-54 (2009) (finding counsel ineffective for not to investigating present neuropsychological evidence of brain damage affecting impulse control); Williams v. Taylor, 529 U.S. 362, 370 (2000) (finding counsel ineffective for failure to present, inter alia, "repeated head injuries" and "mental impairments" that might have been "organic in origin"); Detrich v. Ryan, 677 F.3d 958, 985 (9th Cir. 2012) (finding counsel ineffective for not presenting neuropsychiatric evidence in mitigation); Kindler v. Horn, 542 F.3d 70, 85 (3rd Cir. 2008) (holding counsel ineffective for failure to investigate and present mitigating evidence of "frontal lobe impairment"); Bond v. Beard, 539 F.3d 256, 281 (3rd Cir. 2008) (holding counsel ineffective for failing to investigate and introduce evidence of a blow to the head that would have exacerbated brain damage); Correll v. Ryan, 539 F.3d 938, 953-54 (9th Cir. 2008) (noting evidence of brain trauma would have been powerful mitigation evidence); Haliym v. Mitchell, 492 F.3d 680, 714 (6th Cir. 2007) (holding counsel's failure to investigate and present evidence of brain injury constituted ineffective assistance); Frierson v. Woodford, 428 F.3d 982, 989 (9th Cir. 2006) (holding failure to "present mitigating evidence at the penalty phase that included [inter alia] organic brain damage" constitutionally defective); Powell v. Collins, 332 F.3d 376, 397-98 (6th Cir. 2003) (holding defendant was prejudiced by counsel's failure to investigate and present evidence of an organic brain injury at sentencing); Douglas v. Woodford, 316 F.3d 1079, 1089 (9th Cir. 2003) (finding counsel's representation inadequate for failure to present evidence of head injury from car crash); Coleman v. Mitchell, 268 F. 3d 417, 452 (6th Cir. 2001) (holding counsel deficient in failing to introduce evidence of defendant's past, including two hospitalizations for head injuries); Battenfield v. Gibson, 236 F.3d 1215, 1226, 1229 (10th Cir. 2001) (deciding counsel's strategy of appealing jury's sense of mercy was inadequate when deeper investigation would have unearthed mitigation evidence, including evidence of head injury sustained in car accident); Moore v. Johnson, 194 F.3d 586, 614 (5th Cir. 1999) (holding counsel ineffective when counsel put on no mitigation evidence even though evidence of head trauma was available); Emerson v. Gramley, 91 F.3d 898, 906-07 (7th Cir. 1996) (holding counsel ineffective for missing opportunity to provide mitigating evidence of possible childhood head injury); Baxter v. Thomas, 45 F.3d 1501, 1512 (11th Cir. 1995) (holding counsel deficient for failing to present evidence of mental retardation and potential head injuries); Loyd v. Whitley, 977 F.2d 149, 159 (5th Cir. 1992) (finding counsel defective when counsel failed to introduce evidence of defendant's concussion on the day of the crime); Buenoano v. Singletary, 963 F.2d 1433, 1438 (11th Cir. 1992) (noting claim for ineffective counsel exists when counsel ignores "red flags" about defendant's mental health); Blanco v. Singletary, 943 F.2d 1477, 1505 (11th Cir. 1991) (finding inadequate representation for failing to present mitigating evidence of mental illness and organic brain damage); Middleton v. Dugger, 849 F.2d 491, 495-96 (11th Cir. 1988) (holding counsel failed to present evidence , including organic brain damage); *Armstrong v. Dugger*, 833 F.2d 1430, 1433-34 (11th Cir. 1987) (deciding counsel was deficient for not offering evidence of organic brain damage); *Ragsdale v. State*, 798 So. 2d 713, 717 (Fla. 2001) (finding counsel deficient for introducing evidence of head trauma but failing to present behavioral changes following head trauma); *Turpin v. Lipham*, 510 S.E.2d 32, 41-42 (Ga. 1998) (finding that giving jury 2,500 pages of psychiatric records was deficient because indirectly presented evidence of head trauma, mental illness, and brain injuries); *Commonwealth v. Zook*, A.2d 1218, 1231 (Pa. 2005) (finding counsel deficient in failing to present evidence of traumatic brain injury and subsequent changes in behavior).

**7. Oral Argument**: The defense requests oral argument on this motion.

**8. Witnesses**:

A. Dr. Sandra Crosby

**9. Conference with Opposing Counsel**: The defense has conferred with the government and it objects to this motion.

**10. List of Attachments**:

A. ~~(U/FOUO)~~ Declaration of Dr. Sondra S. Crosby, M.D., of 12 May 2014.

/s/ Brian Mizer
BRIAN L. MIZER
CDR, JAGC, USN
*Assistant Detailed Defense Counsel*

/s/Allison Danels
ALLISON C. DANELS
Maj, USAF
*Assistant Detailed Defense Counsel*

/s/ Thomas Hurley
THOMAS F. HURLEY
MAJ, USA
*Assistant Detailed Defense Counsel*

/s/ Daphne Jackson
DAPHNE L. JACKSON
Capt, USAF
*Assistant Detailed Defense Counsel*

/s/ Richard Kammen
RICHARD KAMMEN
*DOD Appointed Learned Counsel*

**CERTIFICATE OF SERVICE**

I certify that on the day of filing I electronically filed the forgoing document with the Clerk of the Court and served the foregoing on all counsel of record by e-mail this 4th day of June, 2014.

/s/ Brian Mizer
BRIAN L. MIZER
CDR, JAGC, USN
*Assistant Detailed Defense Counsel*

# ATTACHMENT

# A

DECLARATION OF DR. SONDRA S. CROSBY, MD

I was accepted by this Commission as an expert in the field of diagnosing and treating torture survivors on 24 April 2014.

I am an internist, licensed by the Commonwealth of Massachusetts, with experience in treating hundreds of victims of torture.

I have seen Mr. al-Nashiri on three occasions, totaling over 30 hours. My examinations consisted of (1) taking torture histories, (2) inventorying symptoms, and (3) conducting physical examinations.

I can say, to a reasonable degree of medical certainty, that Mr. al-Nashiri is a victim of torture. I can also say, to a reasonable degree of medical certainty, that Mr. al-Nashiri suffers from chronic, complex Post-Traumatic Stress Disorder (PTSD) as a result of his abuse.

Like many who suffer from PTSD, Mr. al-Nashiri has memory loss associated with the trauma. I discovered his memory lapses during my evaluation. I am capable of identifying specific details, but will omit them from this declaration in order to avoid divulging any classified information.

I cannot characterize the amount of or other potential contributing causes to Mr. al-Nashiri's memory loss (*e.g.* moderate, significant, etc.) to any degree of medical certainty without reviewing the results of additional testing. I recommend that Mr. al-Nashiri undergo further evaluation, including formal neuropsychological testing, by a clinician experienced in cross-cultural medicine. I further recommend he undergo brain imaging, *i.e.* with brain magnetic resonance imaging (MRI). These tests will further inform our understanding of Mr. al-Nashiri's injuries and resulting symptoms. For instance, this testing may suggest the presence of a Traumatic Brain Injury (TBI) – an injury that would separately contribute to memory loss.

In summary, it is my opinion that Mr. al-Nashiri suffers from memory loss because of his PTSD and, perhaps, other physical causes. More testing is needed, and I would be happy to consult with the caregivers at Naval Station Guantanamo in order to ensure that these tests are conducted properly, and to contribute to the overall patient care of Mr. al-Nashiri.

Sondra Crosby M.D.

Sondra S. Crosby, MD
Associate Professor of Medicine and Public Health
Boston University Schools of Medicine and Public Health
Section of General Internal Medicine
Boston Medical Center

May 12, 2014