

(b)(6)

745 - 3
15 - 3 - 245

CENTCOM 005752

31605



DEPARTMENT OF THE ARMY
HEADQUARTERS, 256th BRIGADE COMBAT TEAM
CAMP AL-TAHREER, IRAQ
APO AE 09344

REPLY TO
ATTENTION OF:

April 25, 2005

Claims Office

SUBJECT: Claim # 745-3

(b)(6)

Dear (b)(6)

You have submitted a claim seeking compensation for damages allegedly caused by U.S. Forces. I have thoroughly reviewed your claim pursuant to the Foreign Claims Act (FCA), Title 10, United States Code §2734, Army Regulation 27-20, and Department of the Army Pamphlet 27-162 Claims Procedures.

Allow me to express my sympathy for your loss, however, in accordance with the cited references and after investigating your claim, I find that your claim is **not compensable** for the following reason: Loss Resulted from a Combat Operation. Accordingly, your claim must be denied.

If you are dissatisfied by this action, you may request reconsideration of the decision in accordance with AR 27-20. Any such request must be based on new or additional evidence and should be forwarded to this office. While there is no prescribed format for such a request, it must describe the legal and/or factual basis for relief. Any request for reconsideration should be made in writing within 30 days of your receipt of this letter. Thank you for your kind attention.

Deny - combat

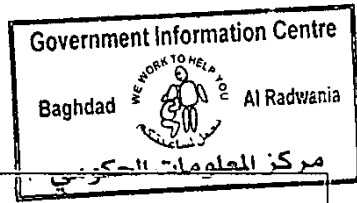
(b)(3),(b)(6)

Major, U.S. Army
Foreign Claims Commission

CENTCOM 005753

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745 - 3
15 - 3 - 2005



Claims Form

To: United States Army Foreign Claims Commission

From: Name: _____
Address _____ (b)(6)

I am _____ (b)(6)

- a. A citizen and national of: Iraq
- b. A permanent resident of: Baghdad (b)(6)
- c. Employed by: _____
- d. Check one () An insurer (x) Not an insurer
- e. Check one (x) A subrogee () Not a subrogee

I hereby make a claim against the United States Government for damages or injuries caused by: (Name, Organization, Military Department, Address, Telephone Number)
Multi National Forces

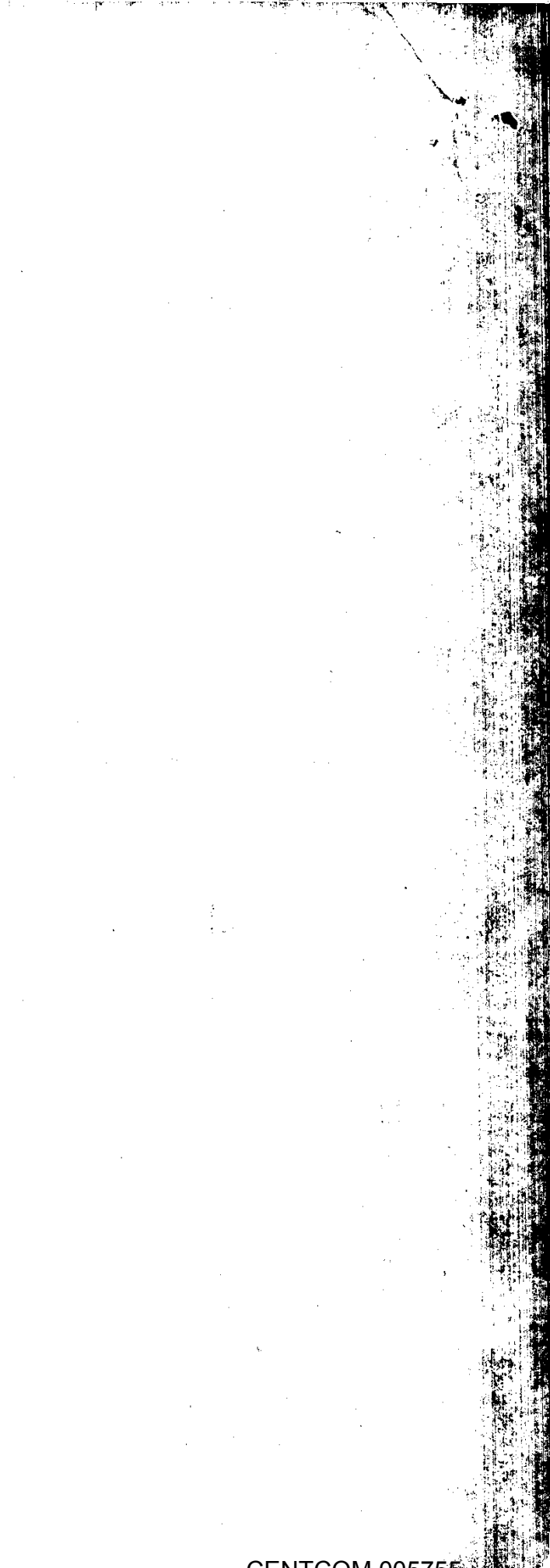
The property damaged is owned by: (If the claim is made as an agent, parent, or guardian, attach a power of attorney or other evidence of authority and fill in the form below for party sustaining the damage or injuries.) _____

My claim arose at: _____ (b)(6) Baghdad Iraq
(City) (Country)

My claim arose on: 2 20 2005
(Month) (Day) (Year)

Give a brief statement of the accident or incident on which the claim for damages to property or for personal injury is based. (Use back of this sheet if necessary.)

on Feb. - 20 - 2005 when I went with my wife and my kids from Baghdad to Al-Garma to visit one of my relatives and on the highway I saw check point for Multi National and when I take subway to move and when I turn I have been shot and my family too from one of the soldiers and that made to get shot on my wife in her head and another hited in my daughter it's (b)(6) gears in her head and she's dead and after that the soldiers take my wife and my daughter to Ibn sena hospital inside green zone. and I won't compensation by that.



Describe nature and extent of property damage or personal injury sustained as result as a result of the above incident.

Hited my wife by bulletes in her head and she is injured now.
Death of my daughter because she had been shot by bulletes
in her head from Multi National Forces.

List in detail the amount of property damage and itemized expenses resulting from the property damage or personal injury: (Attach bills and receipts, if applicable.)

<u>Item</u>	<u>Amount</u>
1- <u>Good money about my daughter</u>	<u>2500 \$</u>
2- <u>Hited my wife by wounded because she had been</u> <u>shot by bullet.</u>	<u>2500 \$</u>
4- _____	_____
5- _____	_____
6- _____	_____

Total: 6000 \$

I was insured to the following extent against the damager or injuries I have sustained:

The name and address of my insurer (if any) is:

(Name) _____ (b)(6) _____ (Address) _____

I claim as damages: (Indicate amount in U.S. dollars and local currency)

\$ 6000 \$ local 8700000 ID

(Signature of Claimant)

Subscribed before me this 15 day of 3, 2005

(Print Name) (b)(6) _____

(Signature) (b)(6) _____



**GENERAL INFORMATION CENTAR,
AL-RADHWANYA, BAGHDAD, IRAQ**



"THE CLAIM'S CONTAINS"

The Claimant name:-...

(b)(6)

- 1- copy of Iraq citizenship + personal I.D. of the wife + personal I.D. of the daughter.....
- 2- Medical report from Ibn Sina hospital/ingreen zone.....
- 3- Medical report from Al-shola hospital.....
- 4- Death certificate from Ibn Sina hospital.....
- 5- Death certificate from Iraq hospital.....



General Information Cent

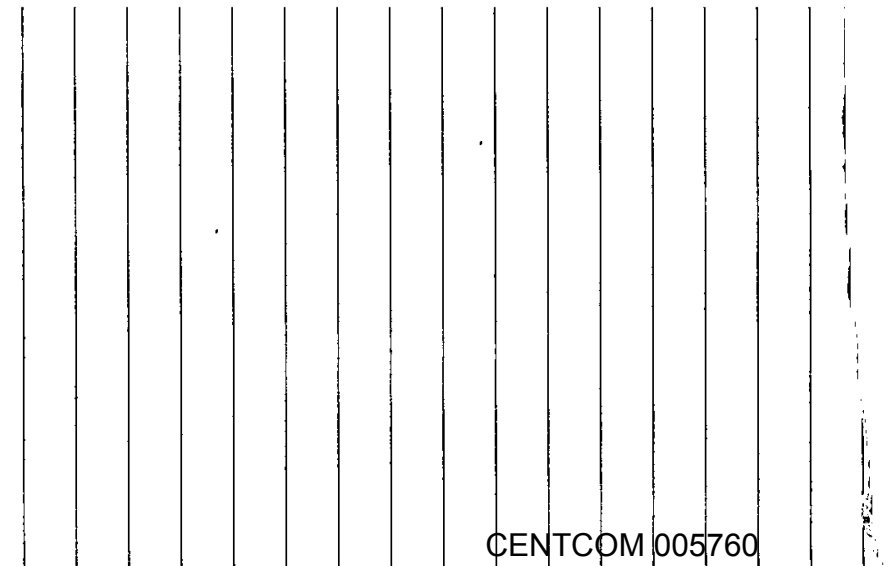
Date:- 75-3-2005.....

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Foreign Language Text, (b)(6)



CENTCOM 005760

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Foreign Language

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(b)(6), Foreign Language

359th Neurosurgical Det
86th Combat Support Hospital

Ibn Sina Hospital
Baghdad, Iraq

NEUROSURGICAL DISCHARGE SUMMARY

Patient Name:

Patient number: (b)(6)

Admit: 20 February 2005

Discharge: 23 February 2005

Reason for Admission: GSW to the head

Hospital Course: Iraqi female s/p GSW to the head at checkpoint. GCS 15 in ER, CT scan revealed a left convexity open depressed skull fx with hematoma. She was taken to the OR and a removal of contaminated bone, debridement of contused brain and tinesh cranioplasty were performed. Postoperatively she was intact. A CT scan revealed no residual fragments or hematoma. Her Wound was clean, dry and intact.

Procedures: Left minicraniectomy with tinesh cranioplasty, 20 February

Pending Issues:

- Scalp sutures removed in 14 days. *8 Feb 2005*

Medications:

- Augmentin x 2 weeks (500 mg po TID)
- Pain meds as needed. (Percocet)

Discharge Instructions:

- Remove suture in scalp in 14 days
- No strenuous activities until 12 weeks have past

Do not hesitate to call me for any questions or issues regarding this patient. I am pleased to participate in his care and wish him a speedy recovery.

Attending Surgeon: (b)(3),(b)(6) MD
LTC MC USA
Commander 359 Neurosurgical Det

86th CSH/359 Neuro
Baghdad, Iraq
APO, AE 09348

(b)(3)(b)(6)

(b)(3),(b)(6), (b)(2)High

February 21, 2005

CENTCOM 005766

CERTIFICATE OF DEATH (OVERSEAS)

Acte de décès (D'Outre-Mer)

NAME OF DECEASED (Nom, Prénom) (b)(6)		COUNTRY OF BIRTH (Pays) France	BRANCH OF SERVICE (Armée)	SOCIAL SECURITY NUMBER (Numéro de l'Assurance Sociale)
DATE OF DEATH (Date du décès)	DATE OF BIRTH (Date de naissance)	SEX (Sexe) <input type="checkbox"/> MALE (Masculin) <input checked="" type="checkbox"/> FEMALE (Féminin)		
EDUCATION (Éducation) LITERATE (Littéraire) ILLITERATE (Illétré)	MARITAL STATUS (Statut Civil) SINGLE (Célibataire) MARRIED (Marié) WIDOWED (Veuve)	RELIGION (Religion) CATHOLIC (Catholique) OTHER (Autre)		
NAME OF NEXT OF KIN (Nom de plus proche parent)	RELATIONSHIP TO DECEASED (Rapport de décès avec le défunt)	CITY OF DEATH AND STATE (Includes ZIP Code) (Ville (Indiquer postal complete))		

MEDICAL STATEMENT (Déclaration médicale)

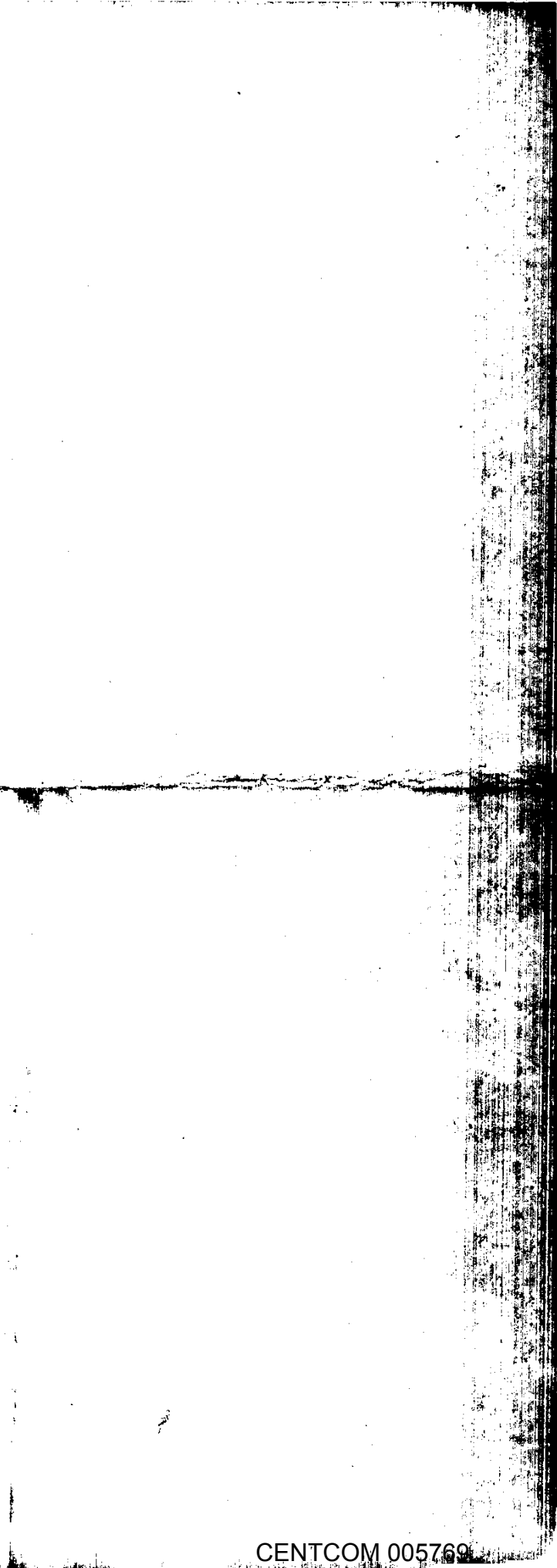
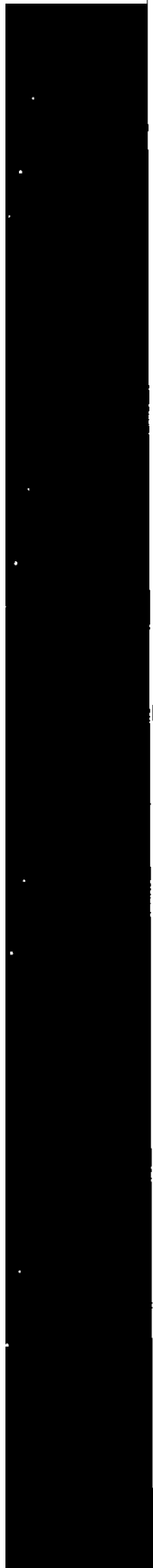
CAUSE OF DEATH (Enter only one cause per line)
Cause du décès (Indiquer qu'une cause par ligne)

DISEASE OR CONDITION OTHER THAN THAT OF DEATH Maladie ou condition étiologique responsable de la mort IMMEDIATE CAUSE (Cause immédiate) IMMEDIATE CAUSE (Cause immédiate) IMMEDIATE CAUSE (Cause immédiate)	ANOXIC BRAIN INJURY GOLD HEAVY	INTERVAL BETWEEN DEATH AND EXAMINATION (Intervalle entre l'attaque et le décès) 12 hr 12 hr
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NAME OF DEATH (Nom du décès) NATURAL (Nécessaire) ACCIDENTAL (Accidentelle) SUICIDE (Suicide) UNKNOWN (Inconnue)	AUTOPSY PERFORMED (Autopsie effectuée) <input type="checkbox"/> YES (Oui) <input type="checkbox"/> NO (Non) MAJOR FINDINGS OF AUTOPSY (Conclusions principales de l'autopsie) NAME OF PATHOLOGIST (Nom du pathologiste) SIGNATURE (Signature) DATE (Date)	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES (Circonstances de la mort suscitée par des causes extérieures) AVIATION ALCOHOL (Alcoolisme & Avion) <input type="checkbox"/> YES (Oui) <input type="checkbox"/> NO (Non)
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DATE OF DEATH (Date du décès) 28 APR 2001	PLACE OF DEATH (Lieu du décès) BAGUINON, FRANCE
I HAVE VIEWED THE REMAINS OF THE DECEASED AND IDENTIFIED THEM AT THE TIME INDICATED AND FROM THE CAUSES SET FORTH ABOVE. J'ai examiné les restes mortels du défunt et je reconnais que les causes mentionnées ci-dessus sont les causes déterminantes du décès.	NAME OF REGISTRAR (Nom du déclarant) (b)(3),(b)(6)
SIGNATURE (Signature) (b)(3),(b)(6)	DATE (Date) (b)(3),(b)(6)

1 None disease, injury or complication which caused death, but not mode of dying such as
 2 None condition contributing to the death, but not related to the disease or condition
 3 Enter the name of the individual, or the relative or de la complication qui a contribué
 4 Enter the condition which contributed to the death, with a brief description of the condition, or a procedure for the death, etc.



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Foreign Language Text, (b)(6)

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following reasons:

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