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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents*.	Civil Action No. 05-CV-1457 (GK) **Filed Under Seal**

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

Joint Task Force - Guantanamo ("JTF-GTMO") is dedicated to preserving the health and well-being of all detainees in their custody, including through enteral feeding of detainees where necessary to save their lives and prevent serious harm to their health. Petitioner Dhiab (ISN 722) seeks a preliminary injunction against various aspects of JTF-GTMO's enteral feeding policies, but Petitioner has not been approved for, or subject to, enteral feeding since February 19, 2014. Allegations that the United States military has intentionally and unnecessarily harmed Petitioner when he was previously subject to enteral feeding are false. To the extent Petitioner seeks to enjoin enteral feeding procedures that may be applied to him in the future, such claims are speculative and, in any event, lack merit because JTF-GTMO conducts enteral feeding in a medically appropriate, humane, and lawful manner.[1]

Injunctive relief is unwarranted here because Petitioner cannot satisfy any of the four requirements necessary to preliminarily enjoin the enteral feeding procedures.[2] As an initial matter, Petitioner cannot establish an irreparable injury absent his requested injunction because he has not been enterally fed for over two months. Moreover, he cannot show a likelihood of success on the merits. Enteral feedings at Guantanamo Bay are conducted humanely in accordance with the law of war, and not with any intent to harm Petitioner or with any deliberate indifference to Petitioner's health or well-being. Further, even though the reasonable-relation test of Turner v. Safley, 482 U.S. 78 (1987), is the incorrect constitutional test to analyze

[1] Respondents have designated this brief and its attached exhibits (except for exhibit three, Department of Defense Instruction 2310.08E, which is publically available) as protected information under the Protective Order in this case. See Protective Order ¶ 34 (ECF No. 32). Respondents intend to file a motion seeking the Court's approval of this designation and a proposed publicly releasable version of the filings, and will propose a briefing schedule for that motion after conferring with Petitioner's counsel.

[2] Counsel for Petitioner has filed motions seeking substantially the same relief and advancing near-identical arguments in two other cases involving Guantanamo detainees. See Hassan v. Obama, Civ. Action No. 04-cv-1194 (UNA) (ECF No. 1001) (filed Mar. 27, 2014); Rabbani v. Obama, Civ. Action No. 05-CV-1607 (RCL) (ECF No. 306) (filed March 27, 2014).

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Petitioner's particular challenge to the Guantanamo Bay enteral-feeding procedures, the procedures easily satisfy that test. So, while the other three equitable factors to be considered also heavily favor the Government, the requested preliminary injunction should be denied because Petitioner cannot demonstrate a likelihood of success on his claims.[3]

BACKGROUND

Detainees at Guantanamo receive timely and high-quality health care, and all medical procedures used at JTF-GTMO with respect to detainees are justified and meet accepted standards of care. Ex. 1, Decl. of CDR [redacted] M.D. ¶ 8 (CDR [redacted] Decl.). As part of this care, JTF-GTMO seeks to ensure that all detainees, not just those engaged in non-religious fasting ("hunger striking"), maintain a healthy weight. See Ex. 2, Medical Management of Detainees With Weight Loss, Joint Medical Group Standard Operating Procedure 001 (Dec. 16, 2013) (SOP) ¶ I. JTF-GTMO seeks to maintain adequate health and nutrition in the detention population, including preventing serious adverse health effects or death from weight loss and malnutrition. The SOP's goal is to ensure that those detainees who cannot or will not eat or hydrate on their own do not suffer adverse health consequences from their inability to take in nutrition or their voluntary decision not to do so. See id. ¶ II.A.

[3] Petitioner's counsel also makes general allegations regarding Petitioner's access to counsel. These allegations are not material to the underlying application for preliminary injunction which seeks to enjoin Respondents' from implementing various alleged practices related to the administration of enteral feedings. Nevertheless, JTF-GTMO's practice has been that when a detainee refused to attend a habeas attorney-client meeting, JTF-GTMO would inform the attorney of the detainee's refusal and, as a courtesy, would allow the attorney to write an unprivileged note to the detainee in an effort to convince the detainee to attend the meeting. JTF-GTMO personnel would then deliver the note to the detainee in his cell and, in the event the detainee changed his mind and agreed to attend the meeting, JTF-GTMO would attempt to make arrangements for the meeting during the same requested visit session. Due to the logistical requirements necessary to support numerous detainee movements throughout a typical day, which include other attorney meetings, medical appointments, and family phone calls, for a short period in March/April 2014, JTF-GTMO temporarily suspended the practice of facilitating delivery of a courtesy note from counsel to a detainee refusing to attend a habeas meeting. However, JTF-GTMO has now resumed the practice, and the Government has so notified detainee counsel in these Guantanamo Bay habeas cases. See Ex. 11, Habeas Refusal E-mail.

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1. To identify potential weight-loss issues, all detainees are weighed at least monthly. SOP ¶ II.B. Additionally, the guard force reports on any meals skipped by any detainee. Id. ¶ III.B. These monthly weighings and the daily guard reports are reviewed by the Joint Medical Group (JMG) staff, including the Senior Medical Officer (SMO). CDR [redacted] Decl. ¶ 12; SOP ¶ III.C. Based on this review, the SMO may order that a detainee be weighed more frequently. SOP ¶ III.C. Hunger strikers are weighed at least weekly and possibly semi-weekly. CDR [redacted] Decl. ¶ 12. Experience has demonstrated that obtaining detainee weights weekly or semi-weekly is sufficient to properly monitor hunger strikers, including identifying any precipitous weight losses. Id.

Although any weight loss may have medical significance, when the loss reaches the threshold of "clinically significant weight loss," concern for the health of a detainee increases. SOP ¶ II.F.1. The SOP defines clinically significant weight loss as:

> a. The detainee's weight is less than 85% of the calculated ideal body weight (IBW).[4]
>
> b. The detainee has experienced a weight loss of greater than 15% from his usual body weight. For those detainees whose usual body weight[5] is less than their ideal body weight, a weight loss greater than 5% is considered clinically significant.
>
> c. Weight loss or underweight associated with evidence of deleterious health effects during any period of weight loss reflective of end-organ involvement or damage, to include but is not limited to, seizures, syncope or pre-syncope, altered mental status, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are significantly hampered.
>
> d. A pre-existing co-morbidity that might readily predispose the detainee to end organ damage (e.g. hypertension, coronary artery disease or any significant kidney disease).

[4] Ideal Body Weight is defined as [(Height in inches – 60) x 2.3 +50] x2.2. SOP ¶ II.F.4.

[5] Usual Body Weight is defined as the greater of: (i) the weight of the detainee at in-processing physical exam or (ii) the average weight of the detainee for the past twelve months. SOP ¶ II.F.4.

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e. A prolonged period of weight loss, usually defined as [redacted] SOP ¶ II.F.1. Though any of these factors may indicate that weight loss has progressed to the point of medical concern, loss to a level less than 85% Ideal Body Weight is of special concern, given that many hunger strikers refuse physical examinations. CDR [redacted] Decl. ¶ 13. At that level, medical research shows that the risk of morbidity (poor medical outcome) and mortality (death) starts to increase. Id. The body slows all of its processes to conserve energy, as well as pulls energy stores from wherever it can find them. Id. This may cause serious medical consequences, such as severe electrolyte shifts causing seizures and cardiac arrhythmias. Id. It also greatly increases the risk for heart valve disorders, heart failure, bone density loss, muscle loss and weakness, gastroparesis, abdominal pain, and kidney failure. Id. All of these complications can lead to death or permanent disability, with a highly variable amount of medical warning, dependent in part on the individual's underlying medical conditions, before these severe outcomes occur. Id.

When a detainee's weight loss reaches the clinically significant threshold, additional medical intervention begins. First, the SMO directs the detainee's medical provider to conduct a baseline assessment to consider any medical or behavioral cause for the weight loss, including possible tuberculosis. SOP ¶¶ III.D & E. These medical assessments include a complete medical record review and, to the extent that the detainee cooperates, a complete physical. Id. ¶ III.F. As part of the physical, the provider may order clinically indicated laboratory tests (again, assuming the detainee cooperates, see CDR [redacted] Decl. ¶ 14), such as an electrocardiogram, urinalysis, serum basic metabolic profile, and liver function tests. SOP ¶ III.F. In the event of a health-related cause for the detainee's weight loss, treatment options will be explored to determine if the detainee may be restored to a healthy weight without enteral feeding. CDR [redacted] Decl. ¶ 13. Hunger strikers may be referred for a behavioral health assessment and for nutritional counseling. SOP ¶¶ III.G & H. In all cases, a detainee exhibiting

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clinically significant weight loss will be counseled on the need to maintain weight and the consequences of not doing so. Id. ¶ III.H. After this initial assessment, the detainee will be medically reassessed biweekly, unless it is clinically appropriate to do so more or less often. Id. ¶ III.I.

2. A medical decision to enterally feed a hunger striking detainee is carefully considered. Unless an emergency occurs, a finding of clinically significant weight loss is a necessary but not a sufficient condition to prescribe enteral feeding for a detainee. See SOP ¶ III; CDR [redacted] Decl. ¶ 15 (designation for enteral feeding is based on a "comprehensive view of a detainee's health" and the "likelihood of resultant risk if the detainee does not receive nourishment"). By Department of Defense instruction, a hunger striking detainee may be involuntarily treated, including enterally fed, only if such treatment is immediately needed to prevent death or serious harm:

> In the case of a hunger strike, . . . medical treatment or intervention may be directed without the consent of the detainee **to prevent death or serious harm**. Such action must be based on a **medical determination** that immediate treatment or intervention is **necessary** to **prevent death** or **serious harm**, ...

Ex. 3, Dept. of Defense Instr. 2310.08E, Medical Program Support for Detainee Operations, ¶ 4.7.1 (2006) (emphasis added). As a result, if a detainee's medical provider determines that the detainee's life or health is seriously threatened by his weight loss, the SMO or his designee will attempt to obtain voluntary consent from the detainee to intervene. SOP ¶ III.K; CDR [redacted] Decl. ¶ 16.

Many detainees voluntarily participate in enteral feeding upon the advice of medical staff. CDR [redacted] Decl. ¶ 16. If the detainee refuses, however, the SMO will propose a plan for involuntary intervention—including, if appropriate, enteral feeding—to the Joint Medical Group Commander (who is either a doctor or a military health care professional). Id.; SOP ¶ III.L. If they both concur with the plan, approval will be sought from the JTF-GTMO Commander, a

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required step before the plan may be implemented. SOP ¶ III.L; see also Dept. of Defense Instr. 2310.08E ¶ 4.7.1 (requiring a detention-facility commander's approval of his medical staff's recommendation that a detainee be enterally fed). The JTF-GTMO Commander's approval ensures that he is aware of the medical necessity and can assess the effect of the need to enterally feed a detainee on other operations. CDR [redacted] Decl. ¶ 16. If the JTF-GTMO Commander concurs, the detainee is approved for involuntary enteral feeding. See SOP ¶ II.F.2. Though the decision to enterally feed a detainee involuntarily ultimately involves the approval of a non-medical military officer, it is initiated by the responsible treating military medical professionals based on their considered medical judgment that intervention is necessary to protect a hunger striking detainee from serious harm or death.

Notably, approval of a detainee for involuntary enteral feeding does not mean that a detainee will be enterally fed. The approval is based on the need for that detainee to eat to prevent serious health consequences, not on a need that the feeding occur enterally. Accordingly, before each enteral feeding, a detainee is offered the chance to eat a regular meal or to take the enteral liquid nutritional supplement by mouth. SOP ¶ III.O; see CDR [redacted] Decl. ¶¶ 17,19. If he does so, he is not enterally fed. Id.

3. If involuntary enteral feeding is necessary, it is done humanely. The enteral feeding is administered through nasogastric tubes by only physicians or registered nurses who have been trained to perform this procedure. CDR [redacted] Decl. ¶ 19. The protocol for inserting and removing the tubes is designed to minimize discomfort and to avoid inflicting pain on the detainee. When inserting the nasogastric tubes, a lubricant is always used, either a sterile surgical lubricant, viscous lidocaine or olive oil, as the detainee prefers. Id. ¶ 20; see SOP encls. 6 ¶ II & 7. Additionally, a topical anesthetic such as lidocaine is offered, but the detainee may decline the anesthetic. CDR [redacted] Decl. ¶ 20. Anesthetic throat lozenges are also available to the detainees upon request. Id.

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A nasogastric tube is never inserted and then moved up and down. CDR [redacted] Decl. ¶ 21. Instead, it is inserted down into the stomach slowly and directly, and removed carefully. Id. Correct tube placement in the stomach is verified independently by [redacted] medical personnel using auscultation. Id. ¶ 23; see SOP encls. 6 ¶ II & 7. Auscultation involves listening for air bubbles in the stomach when the end of the feeding tube is placed under water and infused with air. CDR [redacted] Decl. ¶ 23. At Guantanamo, JMG medical staff also test tube placement with a 10 milliliter dose of water inserted into the tube, and then aspirating some liquid to observe for stomach fluid, which serves as an additional safety check to confirm proper placement in the stomach. Id.; SOP encl. 6 ¶ II.

4. Nasogastric tube sizes are selected based on capacity to deliver specified nutritional requirements in the safest, quickest, and most comfortable manner possible. Generally, JTF-GTMO uses 8 or 10 French nasogastric tubes for enteral feedings. CDR [redacted] Decl. ¶ 21; SOP encl. 7. An 8 French tube measures 2.64 mm, and a 10 French tube measures 3.3 mm. CDR [redacted] Decl. ¶ 21. Medical staff use a 10 French tube for most detainees unless they complain of nasal or throat soreness or unless there is another medical reason to change the tube size. Id. ¶ 22. The 10 French tube is preferred because its slightly larger size allows the nutritional requirements to be given to a detainee as safely, comfortably, and quickly as possible and because that size is safer and easier to place. Id.

Changing to a smaller tube is a clinical decision. CDR [redacted] Decl. ¶ 22. Smaller tubes can clog and can be harder to place, and some nutritional formulas come with recommendations that they be used with a specific-size feeding tube to accommodate the formula's viscosity. Id. Enteral feeding takes significantly longer when a narrower tube is used. Id. Nonetheless, narrower tubes may be appropriate due to anatomical changes in the nares (nostrils) from congestion, infections, trauma, or foreign bodies, as well as intrinsic or acquired septal deviations. Id.

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5. During enteral feedings, the comfort and safety of the patient is a priority for the medical staff. CDR [redacted] Decl. ¶ 28. The quantity and flow rate of enteral feedings are carefully managed to prevent detainee discomfort. See id. ¶¶ 25-28. Detainees are given only appropriate formula, as determined by standard medical protocol and custom-tailored for the detainee's specific caloric needs to support metabolic functions and to maintain weight. Id. ¶ 27. Different formulas have different caloric values, and those values determine the necessary volume. Id. Most detainees prefer Ensure, which has 250 calories per 237 ml can, but which typically requires two cans per feeding for an average detainee. Id. Each can of Ensure is approximately one cup of liquid, id., so two cans equates to approximately one pint per feeding. In addition to the formula, a detainee may require up to 750 ml of water per feeding (approximately three cups) if he is not hydrating on his own. Id.

Allegations that detainees are being enterally fed more than 2,000 ml of fluid in a short time are false. A detainee who is beginning to be enterally fed and who is not otherwise ingesting any food or liquid may start out with a continuous feeding process, typically in the detention hospital where he can be continually monitored while his nasogastric tube remains in place over a period of days. CDR [redacted] Decl. ¶ 25. During this initial process, the detainee is started at a low feed rate that may provide him with up to 2300 ml of liquid (just over 9.5 cups) ingested [redacted] Id. Since most of the detainees drink water while fasting, they would typically be started at 750 ml of formula [redacted] Id. As the detainee demonstrates tolerance for enteral feeding and his medical conditions stabilizes, he is slowly transitioned to bolus feeding, which is intermittent feeding two or three times each day. Id. When he is ready, the detainee is discharged back to a residence camp, where his enteral feedings will continue. SOP encl. 5 ¶ III.

During feedings that take place in residence camps, careful monitoring of the enteral flow rate continues to ensure the detainee's comfort. During these feedings, the appropriate amount

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of nutritional supplement formula is infused by gravity into the detainee's stomach. CDR [redacted] Decl. ¶ 26. In all cases, flow and volume are started low to ensure tolerance. Id. Medical staff continually observe the detainee for signs of abdominal discomfort and gastric distension. Id.; SOP encl. 6 ¶¶ II, III, IV. When medical staff become aware of any discomfort, either from the detainee or from observation, staff adjust a clamp on the feeding tube to slow or halt the flow to alleviate the symptoms. CDR [redacted] Decl. ¶ 26. Each detainee's tolerance differs; generally speaking, an enteral feeding at Guantanamo typically takes 30 to 40 minutes, but it can take up to two hours. Id. Some detainees who are accustomed to enteral feeding specifically request that the clamp be opened more fully so that the feeding can be accomplished as quickly as possible. Id. Some also ask for water to dilute the feeding solution and allow for a more rapid flow. Id. ¶ 28. Despite their demonstrated increased tolerance, these detainees are carefully monitored as well, because a faster flow increases the risk of vomiting. Id. Any medically related issues or complaints are logged for each feeding. Id.

6. Medications are not placed in the feed solutions, or otherwise given to a detainee, without his knowledge and consent. CDR [redacted] Decl. ¶ 33. Detainees are offered anti-nausea drugs such as Zofran or Phenegran during enteral feedings if nausea is present or experience shows that it is a concern. Id.

Anti-constipation medicines are not offered to a detainee unless medically indicated. Some detainees who suffer from severe constipation request that a liquid laxative be included in the feeding solution. CDR [redacted] Decl. ¶ 33. Laxatives are never used to induce defecation during an enteral feeding. Detainees have, in the past, urinated or defecated on themselves during enteral feedings to delay or abort the feeding. Ex. 4, Supp. Decl. of MGen Jay W. Hood (March 10, 2006) ¶ 12. Should a detainee soil himself (vomit, urinate, defecate) during an enteral feeding, the guard force will immediately take action to assist the detainee, get him fresh clothing, and sanitize the area. Ex. 5, Decl. of Col John V. Bogdan (April 17, 2014) ¶ 15.

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7. Standard procedure for enterally feeding detainees includes withdrawing the feeding tubes after each feeding and using a restraint chair. Both practices are based on past experience, in particular the need to prevent detainees from purging their feedings and from assaulting staff during feedings. In 2005, detainees initiated a mass hunger strike. MGen Hood Supp. Decl. ¶ 3. Enteral feeding protocols at Guantanamo at the time permitted detainees substantial autonomy concerning their feedings: they controlled the caloric content of each feeding, the flow rate, the flavor of the formula, and even the color of the feeding tube. Id. ¶ 4. Nevertheless, most of the hunger strikers continued to lose weight despite enteral feeding either by refusing to accept the appropriate amount of calories or by purging their feedings. Ex. 6, Supp. Decl. of CAPT Stephen G. Hooker, M.D., M.P.H. (March 13, 2006) ¶ 5. Purging was facilitated by the nasogastric tubes, which at the time were left in place between feedings. Id. Detainees used the tubes either to siphon their feedings from their stomach or to stimulate the gag reflex to vomit. Id. One detainee bit his tube in half, requiring an endoscopic procedure to remove it. Id. Most significantly, during this period, there were 189 assaults by hunger-striking detainees on guard force and medical personnel associated with the feedings. MGen Hood Supp. Decl. ¶ 5. These assaults ranged from spitting to throwing urine or feces to striking guards and nurses. Id.

As a result, JTF-GTMO consulted the Bureau of Prisons and modified the Guantanamo Bay enteral-feeding procedures based on Bureau protocols. CAPT Hooker Supp. Decl. ¶ 8. The restraint chair was introduced. Id. The restraint chair is ergonomically designed, and the seat and back are padded. CDR [redacted] Decl. ¶ 30. [redacted] Col Bogdan Decl. ¶ 13. No strap is placed across the detainee's face, though a spit shield may be positioned if the detainee spits or indicates he intends to. Id. The chair provides a safe and reliable location to administer an enteral feeding while reducing the risk of physical harm to both the detainee and the staff. CDR [redacted] Decl. ¶ 30; CAPT Hooker Supp. Decl. ¶ 16. Also, by keeping the detainee restrained for a period after the feeding is complete to allow the

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stomach contents to drain to the small intestine, the ability of the detainees to purge is minimized. CDR [redacted] Decl. ¶ 31.

Similarly, removal of the nasogastric tube also helps minimize purging and, therefore assists in appropriate weight gain and reduced metabolic disturbances. CDR [redacted] Decl. ¶ 24. Removal of the nasogastric tube between feedings is further justified by the practical context of enteral feedings within Guantanamo Bay residence camps. Although nasogastric tubes may be left in place in hospitalized patients (including detainees) for a prolonged period of time if medically necessary, that retention practice is appropriate because a hospital is an environment that allows for continual monitoring of the patient. Id. Such continual monitoring between feedings is not possible for enteral feeders housed in the detention residence camps. See id. Moreover, removal of the tubes between feedings reduces the risk of sinus, nasal, and middle ear infections that is inherent if feeding tubes are kept in place. Id.; see CAPT Hooker Supp. Decl. ¶ 12 (noting several detainees developed ear, nose, and throat problems during the 2005 hunger strike from nasogastric tubes that were left in place). When there is a justifiable medical need, such as an anatomical deformity, JMG staff will allow a detainee to keep the tube in place for up to three days. CDR [redacted] Decl. ¶ 24.

8. When necessary, JTF-GTMO employs Forced Cell Extraction (FCE) procedures to bring detainees to their enteral feeding appointments. FCE is not used as punishment or intended to be used on every detainee who is to be moved, but only on those who indicate or demonstrate the intent to resist; refuse to follow guard staff instructions; cause a disturbance; or endanger the lives of themselves, other detainees, or any JTF-GTMO member. Col Bogdan Decl. ¶ 7.

The FCE practices used at JTF-GTMO are modeled on the rules of force in military corrections facilities and the Federal Bureau of Prisons (see Federal Bureau of Prisons Program Statement P5566.06, Subject: Use of Force and Application of Restraints). Col Bogdan Decl. ¶ 4. The FCE team is a small group of military members who have been specifically trained to

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extract a detainee who is combative, resistive, or possibly possesses a weapon. Id. ¶ 5. There are specific procedures that must be followed for each FCE, including warnings and instructions that must be issued to the detainee and specific steps that are taken at each stage. Id. ¶ 6.

Use of the minimum force necessary for mission accomplishment and force protection is required at all times at Guantanamo Bay, including during FCEs. Col Bogdan Decl. ¶ 5. The amount of force necessary depends on the attendant circumstances, including the amount of resistance by a detainee as well as his physical ability to resist. Id. FCE teams are briefed on the physical and medical condition of each detainee and would be aware prior to an FCE if a detainee has an exceptionally low body weight or a medical condition that might make him more prone to injury. Id. With that information, the FCE team will use the least force needed to help prevent any injury to the detainee during the FCE. Id.

FCEs are used only as a last resort after unsuccessful attempts have been made to obtain a detainee's compliance through verbal persuasion. Col Bogdan Decl. ¶ 7. This includes advising the detainee of the ramifications of his continued refusal to comply and asking him if he will comply without resistance. Id. FCEs may also be used in an emergency when time does not permit verbal efforts to persuade the detainee to cooperate and to follow orders. Id.

In the case of a detainee approved for enteral feeding, a guard will verify that the detainee is scheduled for an enteral feeding that is deemed medically necessary by JMG staff. Col Bogdan Decl. ¶ 10. The guard will inform the detainee that it is time for his enteral feeding and will ask the detainee if he will come out of his cell voluntarily. Id. If the detainee complies, he will walk with the guard to the enteral feeding location in the resident camp. Id. If he refuses to exit his cell, an FCE team will be requested. Id. Once requested and assembled, the FCE team will enter the cell. Id. [redacted] Id. The FCE team then secures the detainee and moves him directly to an enteral feeding restraint chair in the resident camp. Id. A backboard is almost never used for FCEs

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related to enteral feeding because it is not needed to transport the detainee [redacted] Id. Backboards may be used in situations where, for example, a detainee refuses to leave the recreation area. Id. Immediately following an FCE, the detainee will be evaluated by medical personnel and checked for injury. Col Bogdan Decl. ¶ 9. Detainees seldom sustain injuries that require medical treatment. Id.

9. Petitioner was initially approved for enteral feeding on March 23, 2013. See Ex. 7, Decl. of [redacted], M.D. (July 3, 2013) ¶ 24. Thereafter, he received nutrition through a combination of enteral feeding and consuming food and nutritional supplements orally. Id. On October 18, 2013, Mr. Dhiab was removed from the list of detainees approved for enteral feeding, but he was added back to the list on November 6, 2013. See Aamer v. Obama, No. 13-5223 (FRAP 28(j) Letters filed Oct. 4, 2013 & Nov. 8, 2013). [redacted]

[redacted] Ex. 8, Decl. of Ian C. Moss, (May 1, 2014) ¶ 2. [redacted] Id. Petitioner informed [redacted] that he was at that moment ending his hunger strike.[6] Id.

Immediately following this interview, Petitioner began eating food regularly and made numerous statements that he was ending his hunger strike. Ex. 9, Supp. Decl. CDR [redacted] (May 7, 2014) ¶ 4. On February 19, 2014, Respondents accordingly removed Petitioner from the list of detainees approved for enteral feeding. Id. At the time Petitioner was removed

[6] On March 6, 2014, Respondents notified Petitioner's counsel of Mr. Dhiab's acceptance [redacted] and of Mr. Dhiab's decision to end his hunger strike. See Moss Decl. ¶ 3.

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from the list of detainees approved for enteral feeding, he was approved for enteral feeding twice a day. Supp. CDR [redacted] Decl. ¶ 6. As with all detainees approved for enteral feeding, Petitioner was offered the opportunity prior to each enteral feeding to take in sufficient nutrients through either food or consumption of the formula orally, and if he did so he would be cleared from that enteral feeding. Id. During the time he was approved for enteral feeding, Petitioner often drank sufficient formula to meet his nutritional needs, thus enteral feeding was not necessary for one and sometimes both, of the scheduled enteral feedings for the day. Id. Petitioner's records reflect that over an approximately seven week period, from January 1 through February 18, 2014, Petitioner regularly ingested sufficient nutrients on his own and nasogastric enteral feeding was not necessary for 56 of his approximately 90 scheduled enteral feeding appointments. Id. On January 10, 2014, Petitioner was also approved to skip his morning enteral feeding on Mondays and Thursdays to enable him to accommodate religious fasting obligations, provided that he maintained his weight and adhered to the remainder of his enteral feeding schedule. Id. As a result, he was excused from some enteral feeding appointments in accordance with that directive. Id. In the event that he was enterally fed, it was typically with a 10 French feeding tube lubricated with olive oil. Id. During Petitioner's enteral feeding between January 1 and February 18, 2014, the records reflect he typically consumed one 237ml can of Jevity combined with 250ml of water over the course of, on average, 10 minutes. Id.

Since being removed from the enteral feeding list, Petitioner has not been enterally fed. Supp. CDR [redacted] Decl. ¶ 4. In the first few weeks of April, records reflect that he routinely ate food items such as eggs, cream cheese, peanut butter and jelly, chicken and fish. Id. Since being removed from the list of detainees approved for enteral feeding, Petitioner was weighed weekly initially, then every two weeks, and finally monthly in April to track his progress. Id. Petitioner steadily gained weight after resuming a normal diet, going from 152 pounds on February 20,

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2014, to a peak of 163.6 pounds on April 3, 2014, which is 85% of his Ideal Body Weight (IBW). Id.

When Petitioner's counsel conferred with Respondents on April 17, 2014, concerning the motion at issue,[7] Respondents informed Petitioner's counsel that they believed the issue was moot in this case in light of Petitioner's cessation of his hunger strike and his removal from the list of detainees approved for enteral feeding.[8] See ECF No. 203-1 at 35. Nonetheless, on April 18, 2014, Petitioner filed a renewed Motion for a Preliminary Injunction "against abusive force-feeding practices at Guantanamo Bay," challenging the specific manner in which the alleged enteral feeding was being conducted. ECF No. 203. The motion contained no explanation of the facts of Mr. Dhiab's current situation. See ECF No. 203-1 at 18. Instead, the motion repeated a description of Mr. Dhiab's alleged facts as of the summer of 2013, when Petitioner filed his first,

[7] There is no evidence that Petitioner has ever authorized a general habeas claim to challenge the lawfulness of his detention pursuant the AUMF. On July 22, 2005, Petitioner's attorneys, who are no longer counsel in this case, filed this petition for a writ of habeas corpus in Mr. Abu Wa'el Dhiab's name, asserting that such a petition was authorized by Mr. Shaker Aamer (ISN 239) as next friend. ECF No. 1. On July 29, 2008, Judge Hogan ordered Petitioner's counsel to "file a signed authorization from the petitioner to pursue the action or a declaration by counsel that states the petitioner directly authorized counsel to pursue the action and explains why counsel was unable to secure a signed authorization" within 60 days of the order. ECF No. 50. Petitioner's counsel did not do so, and instead later filed an unopposed motion for a stay on January 28, 2009, explaining that as of that date, "for a variety of reasons, Mr. Dhiab has not met with counsel to discuss his case" and seeking a stay "until such time as Mr. Dhiab meets with counsel to discuss his case." ECF No. 108. The Court granted Petitioner's putative counsel's motion on January 29, 2009, staying the case until "such time as Mr. Dhiab is able to consult with counsel in a meaningful way" and requiring Petitioner's counsel to "file a status report every 30 days regarding any change in circumstances." ECF No. 109. The case remained stayed and substantively inactive through May of 2013. In May of 2013, Ms. Cori Crider entered her appearance on behalf of Petitioner. ECF No. 175. Shortly thereafter, Ms. Crider filed a Motion for Preliminary Injunction Against Force-Feeding on behalf of Mr. Ahmed Belbacha in 04-cv-2215 (RMC), Mr. Shaker Aamer in 05-cv-1504 (RMC), Mr. Nabil Hadjarab in 05-cv-2349 (RMC), and Mr. Dhiab in this case. ECF No. 175. The motion included a declaration from Ms. Crider in which she stated that Mr. Dhiab was her client and that Mr. Dhiab had "instructed [her] that he wished to join the motion" for the preliminary injunction against enteral feeding. ECF No. 175-1. That motion was denied by this Court and the denial upheld by the Court of Appeals. The Status Report that Petitioner's counsel filed in connection with the current motion states that "Petitioner confirmed that he wishes to continue his challenge" to enteral feeding procedures. ECF No. 208. Thus the record shows that Petitioner has only challenged his conditions of confinement, not his general detainability under the law.

[8] During this conferral Respondents mistakenly stated to Petitioner's counsel that Mr. Dhiab had been removed from the list of detainees approved for enteral feeding as of February 17, 2014; the correct date of his removal was February 19, 2014. See Supp. [redacted] Decl. ¶ 4.

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failed Motion for a Preliminary Injunction Against Force-Feeding. ECF No. 203-1 at 17. Instead of investigating the facts of Mr. Dhiab's current situation in advance of the filing, Petitioner's counsel opted to file a motion based on prior facts and represented they would submit a supplemental declaration about Mr. Dhiab's current circumstances at an unspecified time after speaking with him by telephone. Id. at 26.

Petitioner's counsel spoke to Petitioner by telephone on April 22, 2014, see ECF No. 208, and, beginning the next day, on April 23, 2014, Petitioner started skipping meals again. Supp. CDR [redacted] Decl. ¶ 6. On April 24, 2014, Petitioner's counsel filed a Status Report and Supplemental Declaration, ECF Nos. 208, 209, in which they reported that Mr. Dhiab wanted to continue to challenge JTF-GTMO's enteral feeding policies, but conceded that Mr. Dhiab had stopped his hunger strike and had not been enterally fed for approximately two months [redacted].[9] ECF No. 209.

Since Petitioner's recent decision to resume skipping meals, Respondents have monitored Petitioner's weight closely and he is now back to being weighed weekly. Supp. CDR [redacted] Decl. ¶ 5. Petitioner's latest weight as of 30 April 2014 was 161.2, which is 84% of his Ideal Body Weight. Id. If Petitioner's condition deteriorates due to lack of eating, JTF-GTMO will follow the standard policies and procedures described above to maintain his health, including, if necessary, the policies governing enteral feeding.[10] Id.

[9] Petitioner's counsel asserted that because Mr. Dhiab [redacted] was "actively considering whether to refuse food altogether." ECF No. 208-1 at 2.

[10] Unrelated to his participation in non-religious fasting, Petitioner suffers from back and kidney pain and exhibits blood in the urine on occasion. See Supp. CDR [redacted] Decl. ¶ 8. On February 14, 2014, he was admitted to the detention hospital for three days for evaluation and monitoring. Id. He was diagnosed with possible nephrolithiasis (formation of kidney stones) and he agreed to blood work and accepted pain medication. Id. On February 26, 2014, he had a CT scan of the abdomen and pelvis, the results of which were normal. Id. Petitioner does have a history of chronic intermittent flank and bladder pain with a negative workup from a urology specialist in the past. He has a follow up appointment with a urologist specialist during their next visit to the base. Id. Contrary to his current allegations, the records do not reflect that he has complained of abdominal pain due to his enteral feedings. Id.; Ex. 10, Supp. Decl. of Colonel John V. Bogdan, (May 7, 2014) ¶ 5.

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ARGUMENT

Preliminary injunctive relief "is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of persuasion." Mazurek v. Armstrong, 520 U.S. 968, 972 (1997) (emphasis in original). Because of the extraordinary nature of this relief, courts should grant preliminary injunctions sparingly. Barton v. District of Columbia, 131 F. Supp. 2d 236, 242 (D.D.C. 2001) (citing Moore v. Summers, 113 F. Supp. 2d 5, 17 (D.D.C. 2000)). A party seeking a preliminary injunction must establish four factors: (1) that it is likely to succeed on the merits, (2) that it is likely to suffer irreparable harm in the absence of the preliminary injunction, (3) that the balance of equities tips in its favor, and (4) that the public interest favors the injunction. Winter v. Natural Res. Defense Council, 555 U.S. 7, 20 (2008); see also Aamer v. Obama, 742 F.3d 1023, 1038 (D.C. Cir. 2014).

In Winter, the Supreme Court held that a party must always demonstrate that irreparable harm is likely—not just possible—before a preliminary injunction may issue. 555 U.S. at 22. By so holding, the Court appears to have rejected the then-existing test in the Ninth Circuit (also used in this Circuit), by which the requisite degree of likelihood of success and the degree of harm to the party seeking the injunction were balanced. See Wash. Metro. Area Transit Comm'n v. Holiday Tours, Inc., 559 F.2d 841, 843-844 (D.C. Cir. 1977) (if movant demonstrates that balance of equities tips sharply in its favor, it need only show a possibility of success on the merits and vice versa). Rather, post-Winter, it appears that parties seeking preliminary injunctions must now fully satisfy all four factors before a preliminary injunction may be entered. The Court of Appeals, however, has specifically reserved the question of Winter's effect on the Holiday Tours-balancing test, finding in all cases post-Winter that the plaintiff would not have prevailed even under the balancing test. See, e.g., Sherley v. Sebelius, 644 F.3d 388, 393 (D.C. Cir. 2011).

The extraordinary remedy of a preliminary injunction is particularly unwarranted here. Petitioner cannot satisfy any of the four factors necessary for a preliminary injunction. Relief

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also would be unwarranted if the Court were to balance the applicable factors under the Holiday Tours test. Specifically, Petitioner cannot make out even a possibility of success on the merits on his enteral feeding claim. As a result, his claim fails under the law of this Circuit. Greater New Orleans Fair Hous. Action Ctr. v. United States Dep't of Hous. & Urban Dev., 639 F.3d 1078, 1088 (D.C. Cir. 2011) (when a plaintiff has not shown a likelihood of success on the merits, there is no need to consider the other three factors). Nor can Petitioner demonstrate any irreparable harm if the injunction does not issue, which also is dispositive. Winter, 555 U.S. at 22. The remaining two factors also both tip decidedly in favor of the Government on Petitioner's claims. Accordingly, Petitioner is not entitled to the extraordinary remedy of a preliminary injunction.[11]

I. Preliminarily Enjoining The JTF-GTMO Enteral Feeding Procedures Is Unwarranted

Petitioner currently is not subject to the practices of which he complains, raising a question with respect to Petitioner's standing. Even if he had standing, enteral feedings are conducted humanely, consistent with the needs for security and good order at Guantanamo Bay and certainly are never done with deliberate indifference to detainees' health, comfort or well-being. Thus, these feedings do not violate any right asserted by Petitioner, rendering injunctive relief unnecessary and improper. Also, even if a constitutional right were implicated in the

[11] Petitioner has also asserted a claim, but presents no argument, regarding so-called genital searches of detainees. Pet's Mem. at 6. Respondents have previously explained the basis, scope, and propriety of such searches in In Re: Guantanamo Bay Detainee Continued Access To Counsel, 12-mc-298 (RCL) (ECF No. 42) and submitted the declarations of Col. Bogdan and General John F. Kelly, Commander of the United States Southern Command, describing the procedures. See ECF Nos. 51, 73. The Court previously limited the use of such searches in the context of counsel visits with detainees (ECF Nos. 46, 47). That order was stayed by the Court of Appeals, and the issue regarding the propriety of the searches is presently pending before the Court of Appeals, USCA Case Number 13-5218. This Court should not take action on Petitioner's claim because he offers no argument on the issue. See Overton v. Bazzetta, 539 U.S. 126, 132 (2003) (burden of proof in challenge to prison procedure lies with the prisoner raising challenge); cf. Lindsey v. District of Columbia, 879 F. Supp. 2d 87, 95-96 (D.D.C. 2012) (argument waived if first presented in reply brief). At a minimum, the Court should take no action on the issue until the Court of Appeals rules on the pending appeal.

manner of the enteral feedings and the balancing test of Turner v. Safley were applicable, it is readily satisfied: legitimate penological—here, military—interests underlie the procedures such that Petitioner's request for injunctive relief should be denied.

A. Petitioner Cannot Succeed On The Merits of His Claims

1. Petitioner Currently Is Not Subject To Enteral Feeding

To satisfy Article III's standing requirement, the party seeking relief must establish a concrete and particularized injury that is actual or imminent, not speculative or hypothetical. Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992); In re Navy Chaplaincy, 697 F.3d 1171, 1175 (D.C. Cir. 2012). Moreover, to obtain prospective injunctive relief, it is not enough to allege a past injury. City of Los Angeles v. Lyons, 461 U.S. 95, 102 (1983); O'Shea v. Littleton, 414 U.S. 488, 495-96 (1974) ("Past exposure to illegal conduct does not in itself show a present case or controversy regarding injunctive relief . . . if unaccompanied by any continuing, present adverse effects."). Rather, the party must demonstrate that there is a "real and immediate threat" that they will suffer some future harm. Lyons, 461 U.S. at 102 (citation omitted) (quoting O'Shea, 414 U.S. at 496). The threatened injury must be "certainly impending" to satisfy the standing requirement for prospective relief. Clapper v. Amnesty Int'l USA, 133 S. Ct. 1138, 1147 (2013) (quoting Whitmore v. Arkansas, 495 U.S. 149, 158 (1990)). "[T]he requirement that a plaintiff demonstrate a likelihood of injury in the imminent future in order to secure an injunction is a well-established rule of law . . . [that] takes on added importance in a case where the Court is asked to regulate the conduct of the Executive in the theater of war." O.K. v. Bush, 377 F. Supp. 2d 102, 113 (D.D.C. 2005) (citing D.L.S. v. Utah, 374 F.3d 971, 973 (10th Cir. 2004)).[12]

[12] Moreover, Petitioner is constrained in this action to seek relief only on his own behalf. As courts have stressed, the usual rule is that a party seeking relief must "'assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties.'" Kowalski v. Tesmer, 543 U.S. 125, 129 (2004) (quoting Warth v. Seldin, 422 U.S. 490, 499 (1975)). This restriction "arises from the understanding that the third-party right holder may not, in fact, wish to assert the claim in question, as well as from the belief that 'third parties

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Petitioner complains of enteral-feeding practices that have been in place since he began enteral feeding in 2013. See, e.g., Pet'r Mem. at 5-14. Petitioner complains about the FCE process, genital searches, restraint chairs, two feedings per day, insertion and withdrawal of feeding tubes at each feeding, use of feedings tubes as thick as 14 French, "unsound" methods to place the feeding tube, the speed of enteral feeding, and procedures that "forc[e] detainees to defecate on themselves." Pet'r Mem. at 5-14.

Petitioner, however, is not currently approved for enteral feeding; he, therefore, cannot claim any current actual or imminent injury traceable to Respondents' enteral feeding policies. Even when Petitioner was enterally fed previously, he was not subjected to a number of the practices alleged in his motion. Petitioner was typically fed using a 10 French tube at an appropriate volume and rate, Supp. Decl. CDR [redacted] ¶ 6. Regardless of Petitioner's general allegation that detainees are forced to defecate on themselves, Petitioner has not alleged that he was subject to any practice that caused him to defecate on himself as a result of the feedings. ECF No. 208-1 ¶ 13; see Pet'r Mem. at 11. Most importantly, nowhere in Petitioner's brief or supporting affidavits is there any claim that he either has been or is currently being enterally fed without a proper medical reason for doing so. The current facts, thus, call into question Petitioner's standing. In summary, Petitioner is not currently subject to any of the alleged practices he challenges, and therefore has failed to make a concrete and particularized showing that the injunction he seeks is necessary to prevent any actual or imminent harm. Consequently, he lacks standing to assert those claims. Regardless, however, Petitioner cannot otherwise demonstrate a likelihood of success with respect to his enteral feeding claims, as explained below.

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themselves usually will be the best proponents of their rights.'" Miller v. Albright, 523 U.S. 420, 446 (1998) (O'Connor, J., concurring) (quoting Singleton v. Wulff, 428 U.S. 106, 113-14 (1976)); cf. Meinhold v. United States Dep't of Defense, 34 F.3d 1469, 1480 (9th Cir. 1994) (striking down a nationwide injunction as unnecessary to provide the plaintiff with the relief that he sought).

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2. The Enteral-Feeding Procedures Are Constitutional

Petitioner rightly acknowledges that it is now a closed issue in this Circuit whether a detention facility may enterally feed a hunger-striking detainee. Pet'r Mem. at 27; see Aamer, 742 F.3d 1023, 1041 (D.C. Cir. 2014). As the Aamer majority stated, the "overwhelming majority of courts" have held that "absent exceptional circumstances prison officials may force-feed a starving inmate actually facing the risk of death." 742 F.3d at 1041; see also id. at 1040-41 (discussing cases).

By so holding, these courts have recognized that, when dealing with a hunger-striking detainee faced with a serious threat to his health, officials ultimately have only three choices—give in to his demands, let him starve himself to death[13] or cause himself grave bodily injury, or enterally feed him. Of these choices, well-reasoned authority recognizes that only the third is viable: the first would result in countless other hunger strikers seeking the same or other relief; the second, in the death of a person for whom officials have a duty of care that could result in threats to U.S. national security or rioting in the detention facility by those who would inevitably blame administrators for failing to save the hunger-striker's life. E.g., Bezio v. Dorsey, 989 N.E.2d 942, 951 (N.Y. 2013). Accordingly, it is now well-settled that while "[f]ree people who are sane have a liberty interest in refusing life-saving medical treatment . . . and likewise in refusing to eat," "either prisoners don't have such an interest or it is easily overridden." Freeman v. Berge, 441 F.3d 543, 546 (7th Cir. 2006) (distinguishing, among others cases, Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990) (which asserts that free individuals have a right to refuse medical treatment)). Thus, officials may enterally feed a hunger-striking detainee to preserve his life and ensure security and order. See Aamer, 742 F.3d at 1043-44. Indeed, this Court has previously upheld the enteral feeding of Guantanamo detainees involving the use of a restraint chair for each enteral feeding. Al Adahi v. Obama, 596 F.Supp 2d 111 (D.D.C. 2009).

[13] According to Petitioner, "It would be an honor to die." See Decl. of Cori Crider ¶ 80 (ECF No. 175-1)

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This overwhelming judicial approval of the need to enterally feed at-risk-hunger-striking detainees renders inapposite Petitioner's arguments to the contrary. Petr's Mem. at 17-21; see Aamer, 742 F.3d at 1039 (this court is "not an arbiter of medical ethics").[14]

As a result, Petitioner has attacked not the fact of his enteral feeding, but the manner in which it is conducted. Most of Petitioner's claims sound as challenges to the conduct of Guantanamo Bay personnel in carrying out enteral feedings:

- enterally feeding detainees in the absence of appropriate medical need;
- forcibly extracting detainees from their cells unnecessarily to feed them;
- unnecessary genital searches during forcible extractions;
- restraining detainees unnecessarily during feeding;
- enterally feeding twice daily;
- inserting and withdrawing nasogastric tubes unnecessarily;
- using tubes that are too big;
- using an unsound method to confirm placement of the feeding tube;
- feeding detainees too fast or too much; and
- medicating detainees improperly.

Although no cases settle the question of how the U.S. courts are to assess the conduct of military personnel conducting detention operations under the law of war in this matter, such conditions-of-confinement claims, including with regard to delivery of medical treatment, are most

[14] Nor does international law -for a number of reasons including the following three explained here- require or, indeed, counsel a different result. The specific sources of international law that Petitioner invokes, see Pet'r Mem. at 23-24, either prohibit treatment that would also be prohibited under the Constitution, see 136 Cong. Rec. S17486-01 (daily ed., Oct. 27, 1990), Reservations, Declarations, and Understandings, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, or are barred from consideration here. See Al-Adahi v. Obama, 613 F.3d 1102, 1111 n.6 (D.C. Cir. 2010) (through the Military Commissions Act, Congress "provided explicitly that the [Geneva] Convention's provisions are not privately enforceable in habeas proceedings"). The international law cases Petitioner cites establish that the current procedures for enteral feeding at Guantanamo Bay are appropriate. See Nevmerzhitsky v. Ukraine, App. No. 54825/00, Final Judgment, ¶ 93-94, Oct. 12, 2005 (Eur. Ct. H.R.), available at http://www.rwi.uzh.ch/lehreforschung/alphabetisch/kiener/Vorlesungen/hs11-1/menschenrechte/unterlagen/CASE_OF_NEVMERZHITSKY_v_UKRAINE.pdf (finding that involuntary feeding to save the life of a hunger-striker is neither "inhuman" nor "degrading" so long as the feeding procedures are no more severe than required); Prosecutor v. Šešelj, Case No. IT-03-67-T, Urgent Order to the Dutch Authorities Regarding Health and Welfare of the Accused ¶¶ 12-14 (Int'l Crim. Trib. for the Former Yugoslavia Dec. 6, 2006) (available at http://www.icty.org/x/cases/seselj/tord/en/061206.pdf) (noting the "lack of uniformity" in domestic and international law regarding feeding hunger strikers and that the European Court of Human Rights has held that "'force-feeding' does not constitute torture, inhuman or degrading treatment if there is a medical necessity to do so, if procedural guarantees for the decision to force-feed are complied with and if the manner in which the detainee is force-fed is not inhumane or degrading").

analogous to, and thus properly evaluated under, the deliberate-indifference standard. See Wilson v. Seiter, 501 U.S. 294, 303 (1991) ("Whether one characterizes the treatment received by the prisoner as inhumane conditions of confinement, failure to attend to his medical needs, or a combination of both, it is appropriate to apply the 'deliberate indifference' standard articulated in Estelle v. Gamble, 429 U.S. 97 (1976)]") (citation and internal quotation marks omitted); O.K. v. Bush, 344 F.Supp.2d 44, 60-63 & n.23 (D.D.C. 2004) (applying standard to claim of inadequate medical care at JTF-GTMO); cf. Geneva Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field of Aug. 12, 1949, art. 12 (wounded and sick combatants during international armed conflict on land "shall not wilfully be left without medical assistance and care").[15] This Court previously applied the deliberate indifference standard when evaluating claims related to JTF-GTMO's enteral feeding policies. Al-Adahi, 596 F. Supp. 2d at 120.

Petitioner, however, invokes the reasonable-relationship test of Turner v. Safley, a test normally used to evaluate whether a prison regulation may validly infringe a constitutional right. 482 U.S. at 89. Perhaps he does so out of a belief that he must, to fit within the jurisdictional

[15] No court has ever definitively addressed the proper standard, if any, to adjudicate conditions-of-confinement claims at a military detention facility for enemy belligerents, such as Guantanamo Bay. Nevertheless, the deliberate-indifference standard is likely the most rigorous standard that would apply. The standard arises under the Eighth Amendment, see, e.g., Wilson, 501 U.S. at 297, and, so, technically applies only to sentenced convicts, Ingraham v. Wright, 430 U.S. 651, 671 n.40 (1977). Further, while the Supreme Court has expressly reserved the question of whether this same standard will apply to pre-trial detainees, City of Canton v. Harris, 489 U.S. 378, 389 n.8 (1989), the constitutional analysis of prison conditions in both the sentenced-criminal and the pre-trial-detainee contexts focuses on the same two factors: (1) whether the procedures constitute punishment, see Wilson, 501 U.S. at 297 (post-sentencing); Bell v. Wolfish, 441 U.S. 520, 539 (1979) (pre-trial), and (2) the need for courts to defer to the expertise of prison officials, see Turner, 482 U.S. at 89 (post-sentencing); Bell, 441 U.S. at 540-41 (pre-trial). Though Petitioner is neither a convict nor a pre-trial detainee, but rather is detained under the Authorization for the Use of Military Force, as informed by the laws of war, these same factors counsel that no standard more rigorous than the deliberate-indifference standard should apply here, see O.K. v. Bush, 344 F. Supp. 2d at 60-63 & n.23 (assuming deliberate-indifference standard applies to Guantanamo Bay detainees); Al-Adahi, 596 F. Supp. 2d at 120 (same), at least to the extent Guantanamo detainees may lay claim to a constitutional analysis in this context, see Kiyemba v. Obama, 555 F.3d 1022, 1026 (D.C. Cir. 2009) (Guantanamo detainees lack constitutional due process rights), vacated and remanded, 559 U.S. 131 (2010) (per curiam), reinstated, 605 F.3d 1046 (D.C. Cir. 2010).

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window opened by Aamer,[16] which analyzed the propriety of the fact, as opposed to the manner, of enteral feeding under Turner. See Pet'r Mem. at 19 (invoking Aamer's newly announced jurisdictional exception). Petitioner also mischaracterizes and misdescribes the SOP in various respects to attempt to fit the SOP within his conduct-based allegations and claims, perhaps to make his challenge look more like an appropriate Turner-type claim. See, e.g., Pet'r Mem. at 27 ("There cannot be any 'legitimate penological interests' . . . in inflicting 'inconvenient' pain and suffering on force-fed detainees . . . .") (internal citation omitted). At bottom, however, Petitioner should have to establish that his enteral feeding is being done with deliberate indifference to his health and well-being and, so, would constitute an unconstitutional condition of confinement for a person held in a U.S. prison.

Accordingly, analysis of Petitioner's motion appropriately begins with a question he fails to address, namely whether enteral feeding is administered in a manner deliberately indifferent to Petitioner's health and well-being and, thus, would amount to an unconstitutional condition of confinement for a person held in a prison. See Al-Adahi, 596 F. Supp. 2d at 120 ("The Court must determine whether there is a likelihood that their alleged mistreatment at the hands of Respondents represents a deliberate indifference to the detainee's serious medical needs.") (internal quotations omitted). As set out below, enteral feeding at Guantanamo Bay is undertaken humanely, despite the difficulty associated with the circumstances of feeding frequently uncooperative hunger strikers in a detention environment. Thus, the procedures, both as written and as they were applied to Petitioner when he was being enterally fed, do not reflect deliberate indifference to Petitioner's health or well-being. Therefore, the procedures could not

[16] The Aamer majority held that conditions-of-confinement challenges could be adjudicated in habeas cases, explicitly rejecting the Government's argument that section 7 of the Military Commissions Act, 28 U.S.C. § 2241(e)(2), jurisdictionally barred those challenges by Guantanamo Bay detainees. 742 F.3d at 1034-35. Nevertheless, the Government objects to Petitioner's motion as jurisdictionally barred under the MCA despite Aamer's holding, not to reargue here what has been foreclosed there, but to preserve its objection.

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be an unconstitutional condition of confinement under the case law applicable to prisoners, and Petitioner's motion fails for this reason.

But even assuming that Turner nevertheless somehow applies to Petitioner's challenge, the result would be the same. Because the challenged procedures as written (and, to the extent Petitioner contends it remains relevant under Turner, as applied) are reasonably related to legitimate military interests in operating the detention facility (that is, what would also be legitimate penological interests in the context of U.S. prisons), Turner would be satisfied and the procedures would be constitutional. As such, whether Petitioner's claim is analyzed under traditional conditions-of-confinement standards, or as Petitioner asserts, under Turner, he cannot show any likelihood of success on the merits of his claim.

a. The Enteral-Feeding Procedures Do Not Transgress the "Deliberate Indifference" Standard

The deliberate-indifference standard comprises two inquiries. First, the deprivation involved must be sufficiently serious; this is an objective test. Farmer v. Brennan, 511 U.S. 825, 834 (1994). Second, a subjective inquiry is involved as to whether prison officials acted with a sufficiently culpable state of mind by "knowingly and unreasonably disregarding an objectively intolerable risk of harm" to a detainee's health or safety. Id. at 846; see Al-Adahi, 596 F. Supp. 2d at 120. Here, a review of the application of each of the JTF-GTMO medical enteral-feeding procedures challenged by Petitioner readily demonstrates that (1) he does not suffer any objectively serious injury from his enteral feeding and (2) the responsible officials are not ignoring risks to his well-being during his enteral feedings. Rather, as set out below, enteral feeding at Guantanamo Bay is conducted, not with deliberate indifference, but humanely. Accordingly, Petitioner's enteral feedings could not be an unconstitutional condition of his confinement. In particular, none of the practices that he challenges—initiation of enteral feeding, withdrawal of the nasogastric tubes, rate of enteral feeding, size of the tubes,

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medications during feedings, restraint chair, and FCEs—evidence any deliberate indifference to the detainees at Guantanamo Bay.

Medical determination of the need for enteral feeding. Although Petitioner asserts that approval for enteral feeding is a military not medical decision and that enteral feeding is often initiated before it is necessary, Pet'r Mem. at 32, the JTF-GTMO Commander does not approve a detainee for involuntary enteral feeding without a medical determination that such action is needed to prevent serious harm to a detainee or his death. Although the JTF-GTMO Commander's approval is required, DoD Instr. 2310.08E ¶ 4.7.1; SOP ¶¶ II.C & III.L, a recommendation for enteral feeding must originate first with the detainee's treating medical provider (a physician or physician's assistant), and then the JMG Senior Medical Officer (a physician), and lastly the JMG Commander (who may be a doctor or a military health professional). SOP ¶¶ II.C & III.L; see also CDR [redacted] Decl. ¶ 16 (noting that the JTF Commander does not initiate the designation of an enteral feeder). Also, when medical personnel do propose that a detainee be approved for enteral feeding, they do so based solely on the medical necessity to protect the detainee from near death or serious physical injury. DoD Instr. 2310.08E ¶ 4.7.1 (decision to involuntarily feed hunger-striking detainees may be based only on "a **medical determination** that immediate treatment or intervention is **necessary to prevent death or serious harm.**") (emphasis added).[17] This is just as Petitioner suggests it should be, clearly undercutting any claim of deliberate indifference from non-medical military interference with enteral feeding.

[17] The Guantanamo Bay weight-management SOP fully conforms to and implements this instruction. See SOP at 1 (listing DoD Instr. 2310.08E as the only reference); see also SOP ¶¶ II.C ("where it is determined by **medical assessment** that continued fasting will result in a **threat to his life or seriously jeopardize [a detainee's] health,**" and the detainee refuses to voluntary consent to treatment, "medical procedures necessary to preserve health and life shall be implemented without consent pursuant to [Dept. of Defense Instr. 2310.08E]"); III.K ("When a **JMG medical provider determines** that the **detainee's life or health** is **threatened** due to weight loss . . ."); III.L ("**If medical intervention is required** . . ." & "it **may be necessary** to intervene involuntarily"); III. M ("If involuntary enteral feeding is **clinically indicated and authorized** . . .") (emphasis added).

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Petitioner's arguments to the contrary misread the SOP. First, he simply ignores the governing DoD instruction and SOP provisions that permit only treating medical personnel to recommend a hunger-striking detainee be approved for enteral feeding, and then only when it is medically necessary. See Pet'r Mem. at 31-33. Second, Petitioner also misreads the SOP to assert that any of several objective criteria—detainee at 85% of his ideal body weight, loss of 15% of his weight, existing co-morbidity, or length of hunger strike—may substitute for sound medical judgment that enteral feeding is necessary to avoid a serious threat to the detainee's life or health. Pet'r Mem. at 30-31. Although it is true that these criteria may inform the exercise of medical judgment, especially in light of the refusal of many hunger-striking detainees' to submit to physical examinations, the criteria neither substitute for that medical judgment nor are inconsistent with the independence of that judgment. CDR [redacted] Decl. ¶ 13 (noting that the decision to seek permission to feed a detainee involuntarily is "made with careful attention being made to the detainee's weight level, rapidity of weight loss, water intake and clinical appearance"). Rather, as noted above, these criteria are used to establish that a detainee's weight loss is clinically significant, which is a necessary but not sufficient condition to seek to feed him enterally. See supra p. 3-5. Accordingly, again the SOP and its implementation are fully consistent with Petitioner's suggested result.

As discussed above, Petitioner is not currently approved for enteral feeding; thus, there has not been any medical determination regarding the need for enteral feeding of Petitioner at this time. Should Petitioner's health deteriorate to such an extent that enteral feeding is necessary to prevent serious harm to his health or life, however, the approval for enteral feeding, by itself, would show that JTF-GTMO is not treating Petitioner with deliberate indifference. To the contrary, by carefully monitoring Petitioner's health and applying the procedures described above, "it is clear that Respondents' treatment of Petitioner[] does not approach 'deliberate indifference.'" Al-Adahi, 596 F. Supp. 2d at 121.

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Insertion and withdrawal of nasogastric tube. The removal of the nasogastric feeding tube after each feeding is not unnecessary, see Pet'r Mem. at 6, nor, more pertinently, does it evidence deliberate indifference. Rather, this procedure results from sound medical judgment and the practicalities of dealing with hunger strikers in a detention setting. Medically, the continuous presence of a feeding tube is not without consequences. In the past, detainees have developed ear, nose, and throat problems attributable to nasogastric tubes left continuously in place, complications often noted with any enteral feeder in any hospital. CDR [redacted] Decl. ¶ 24; CAPT Hooker Supp. Decl. ¶ 12; see Al-Adahi, 596 F. Supp. 2d at 115 n.6 (noting that "leaving the tube in place was causing its own set of medical problems, *i.e.*, sinusitis, bacterial infection, irritation, etc."). As for the practicalities of the environment, leaving a feeding tube inserted in a hospitalized patient may be done because the hospital presents a more controlled environment and allows for continual monitoring of the patient as well as a potential medical need for slower transition of feeding volumes. In the case of detainees who are living in their cells, it is not practical to leave the feeding tube inserted continuously. CDR [redacted] Decl. ¶24. In addition, there is a higher likelihood, as experience from prior hunger strikes has shown, that detainees at Guantanamo in particular can use the nasogastric tube to purge their feeding, either by using the nasogastric tube to siphon out their stomach contents or by using it to stimulate the gag reflex to induce vomiting. CAPT Hooker Supp. Decl. ¶ 5. Accordingly, the practice of inserting and withdrawing the nasogastric tubes does not reflect deliberate indifference, but instead is medically and otherwise appropriate in the unique situation facing the medical personnel.

Nor does the manner in which the nasogastric tubes are inserted reflect deliberate indifference. The SOPs require that medical personnel offer Petitioner a topical anesthetic each time the tube is inserted. CDR [redacted] Decl. ¶ 20. During Petitioner's prior enteral feeding, the tube was fully lubricated prior to insertion with olive oil at his request. See id.; Supp. CDR

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[redacted] Decl. ¶ 8. Consequently, the insertion is accomplished not with deliberate indifference to Petitioner's comfort, but rather humanely.

Method for Verifying Placement of Feeding Tube. Petitioner is simply wrong that the method used by Guantanamo Bay medical staff to confirm the correct placement of the feeding tube is dangerous and unreliable, Pet'r Mem. At 7-8. Auscultation is a proper method to verify that the nasogastric tube is placed in his stomach. Fundamentally, the efficacy of auscultation is both context dependent and a matter of medical judgment, see CDR [redacted] Decl. ¶ 23. Its use in a detention context where hunger-striking detainees often resist being fed and nasogastric tubes need to be removed to prevent purging of feeds and other types of resistance (such as biting the tube in half), is fully warranted. Id. In this regard, Petitioner's suggested alternative— x-ray confirmation of tube placement, Pet'r Mem. at 7,—is not only unworkable, but would itself endanger Petitioner's health from overexposure to radiation. CDR [redacted] Decl. ¶ 23.

Thus, because use of auscultation is a matter of medical judgment constrained by the environment in which the medical issue arises, it cannot constitute deliberate indifference. Estelle v. Gamble, 429 U.S. 97, 107 (1976) (matters of medical judgment do not implicate the deliberate-indifference standard); see Al-Adahi v. Obama, 596 F. Supp. 2d at 122. Moreover, auscultation is performed independently by [redacted] medically qualified individuals who must concur that placement is correct, and then placement of the tube in the stomach is verified before any feeding is commenced by injecting 10 ml of water and aspirating stomach fluid back through the tube, SOP encl. 6 ¶ II. Accordingly, given the need to insert and withdraw the tubes for each feeding, the methods chosen to verify correct nasogastric tube placement do not evidence deliberate indifference.

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Feeding Rate. Contrary to Petitioner's claims,[18] see Pet'r Mem. at 8, JTF-GTMO medical personnel closely monitor and adjust enteral feeding rates to ensure detainees do not suffer unnecessary discomfort. The SOP does not specify a flow rate for the enteral feeding, but does instruct medical personnel to "adjust the rate to the detainee's condition and tolerance." Id., Encl. 6 ¶ II. Additionally, the detainee's tolerance of the feed rate is to be "continuously" observed, and the detainee is to be "assess[ed] . . . for pain to the abdomen, observ[ed] for distention" and, if a problem is noted, the feed rate is to be "slow[ed] . . . until complaint of pain is resolved." Id. ¶¶ III & IV. Consequently, the SOP provides no support for Petitioner's contention that the feeding rate is being manipulated to increase the discomfort of enteral feeding.

Nasogastric Tube Size. Again contrary to Petitioner's claims, see Pet'r Mem. at 7, nasogastric tubes are not inappropriately sized. The SOP does not specify the tube size to use for enteral feeding outside the hospital setting, but the feeding documentation forms appended to the SOP provide for use of only 8 French or 10 French tubes. Id., Encl. 7. While 10 French tubes are preferred because they are more easily placed, 8 French tubes may be used if medically required or a detainee reports nasal or throat soreness. CDR [redacted] Decl. ¶ 22 (noting that smaller diameter tubes are harder to place). As for Petitioner, a 10 French tube was typically used when he was previously enterally fed. Supp. CDR [redacted] Decl. ¶ 6.

Medications. Petitioner asserts that detainees have, in the past, been given anti-constipation medicines that often cause them to defecate uncontrollably during feeding, Pet'r

[18] In Petitioner's first motion for a preliminary injunction against enteral feeding, he alleged that the feeding rate was too slow. ECF No. 175-1 ¶ 74. In Petitioner's current motion, he alleges that the feeding rate was too fast. ECF No. 208-1 ¶ 13. But as noted above, during Petitioner's enteral feeding from January 1 to February 18, 2014, he typically consumed one 237ml can of Jevity combined with 250ml of water over the course of, on average, 10 minutes. Supp. CDR [redacted] Decl. ¶ 6.

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Mem. at 11,[19] but detainees are not medicated during enteral feeding without their consent. It is JTF-GTMO policy to inform detainees of what medications they are receiving and to obtain their consent before providing it to them. CDR [redacted] Decl. ¶ 33. There is no provision in the SOP for providing enterally fed detainees anti-constipation medications simply because they are being enterally fed. A medication would not be provided to a detainee by surreptitiously inserting it into the detainee's feeding solution without his knowledge. Id.

Use of Restraint Chair.[20] This Court previously addressed a challenge to use of the restraint chair in the enteral feeding context and concluded that its use "does not approach 'deliberate indifference.'" Al-Adahi, 596 F. Supp. 2d at 120-22. Petitioner presents no new evidence to alter this result.

While Petitioner claims that the restraint chair is used solely to increase detainee discomfort during enteral feedings, Pet'r Mem. at 3, use of the restraint chair is fully justified at Guantanamo Bay by the need to feed enterally hunger-striking detainees who sometimes do not wish to be fed and are not always cooperative in their enteral feeding. The use of the restraint chair prevents movement so medical staff can safely emplace the enteral feeding tube and facilitate delivery of the feeding solution. Further, the restraint chair helps keep medical staff safe during the enteral feeding process. During the 2005 hunger strike, before use of the restraint chair was implemented, over 189 assaults occurred, including two attacks on nurses who were struck in the face. MGen Hood Supp. Decl. ¶ 5; CAPT Hooker Supp. Decl. ¶ 5. More generally,

[19] Petitioner stated that he did not recall vomiting or defecating on himself during enteral feedings. ECF No. 208-1 ¶ 13.

[20] In the context of U.S. civilian prisons, conditions-of-confinement challenges alleging the use of excessive force—such as Petitioner has alleged here concerning the use of a restraint chair and of FCEs—are analyzed under a standard more favorable to detention officials than the deliberate indifference standard, specifically whether the use of force was in good faith or applied sadistically and maliciously. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Here, however, neither the use of the restraint chair nor FCEs violate even the lesser deliberate-indifference standard.

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the detainees who had to be fed enterally were, and some still are, uncooperative with the procedure. See Al-Adahi, 596 F. Supp. 2d at 115-16 (explaining "history of resistance by detainees and assaults against staff"). The restraint chair addresses these issues by reducing the risk of harm to medical personnel during enteral feeds from a detainee who desires to resist, and by allowing medical personnel to administer a feeding professionally and humanely, without interference from an uncooperative detainee. CDR [redacted] Decl. ¶ 30; CAPT Hooker Supp. Decl. ¶ 16. The decision to implement the use of a restraint chair at Guantanamo Bay was modeled on the procedures used by the Bureau of Prisons. CAPT Hooker Supp. Decl. ¶ 8.

The restraint chair is padded, and [redacted] are ergonomically positioned to safely restrain a detainee [redacted] CDR [redacted] Decl. ¶ 30; Col Bogdan Decl. ¶ 13. No headgear is placed on the detainee's head or face, id., though a mask may be placed over a detainee's mouth if he spits or threatens to spit, Col Bogdan Decl. ¶ 13.

Here, Petitioner has not been placed in the restraint chair since February 7, 2014, even before he was removed from the enteral feeding list. Ex. 10, Supp. Decl. of Colonel John V. Bogdan, (May 7, 2014) ¶ 4. But even if Petitioner could raise a challenge to use of the restraint chair, that claim lacks merit. As this Court has previously held, use of the restraint chair in this context does not constitute deliberate indifference. See Al-Adahi, 596 F. Supp. 2d at 120-22.[21]

Forced Cell Extractions. While Petitioner claims that FCEs are routinely used to punish and demoralize hunger strikers, Pet'r Mem. at 5, FCEs are used if necessary to ensure that a detainee who refuses to go voluntarily to his feeding session receives his scheduled feeding for medically necessary nutrition. Simply put, if an enterally fed detainee is willing to walk to his feeding he is permitted to do so. Col Bogdan Decl. ¶ 10. Before the FCE team is called, the

[21] Petitioner requests, in a single sentence in his brief, an emergency order requiring the disclosure of the new, separate SOP that governs the use of restraint chairs at Guantanamo Bay. Pet'r Mem. at 16-17. Petitioner's improper discovery request falls outside the governing discovery procedures established by the Case Management Order § I.E.2 (ECF No. 78) and should be ignored.

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detainee is encouraged several times to walk his feeding session voluntarily. Id. If the extraction is deemed necessary, it is performed with the least amount of force possible by a team specially trained to do so. Id. ¶ 5. FCEs are never used as punishment. Id. ¶ 7.

Petitioner's supplemental status report alleges that, during FCEs while he was on the enteral feeding list, JTF-GTMO guard staff would intentionally put pressure on his stomach and kidneys to cause additional pain. See Declaration of Cori Crider, ECF No. 208, ¶ 14. This allegation lacks merit. After every FCE, a medical corpsman will ask the detainee, with the assistance of a translator when necessary, whether the detainee has any injuries or otherwise desires medical treatment. Supp. Col Bogdan Decl. ¶ 5. Based on the detainee's response and the corpsman's visual assessment, the corpsman will medically clear the detainee if there are no injuries or medical treatment is not otherwise required. Id. A review of the written records from January 1 to February 19, 2014, reflects that Mr. Dhiab did not raise any complaints to the guard staff or the corpsman during or immediately following an FCE, including any specific complaints about stomach or kidney pain. Id. Mr. Dhiab neither claimed any injuries nor was he treated for any injuries during or following the FCEs described above. Id. Further, the written records reflect that the corpsman medically cleared Mr. Dhiab after each FCE. Id. Physically touching a detainee for the purpose of inflicting pain is contrary to policy and would not be tolerated. Id.

Since being removed from the enteral feeding list, Petitioner has been subject to FCEs on three occasions in order to monitor his weight closely. Id. ¶ 6. On each of these three occasions, FCEs were ordered only after appropriate medical personnel determined that obtaining Mr. Dhiab's weight was a medical necessity and Mr. Dhiab refused to be weighed. Id. The three FCEs were conducted consistent with JTF-GTMO standard procedures for obtaining detainee weight. Id. and see Col Bogdan Decl. ¶ 11. Mr. Dhiab was safely secured to a backboard and moved to the weighing location, while a medical corpsman observed the entire process. The

corpsman medically cleared Mr. Dhiab after each FCE. Supp. Col Bogdan Decl. ¶ 6. Mr. Dhiab neither claimed any injuries nor was he treated for any injuries during or following the FCEs to obtain his weight. Id.

Accordingly, Petitioner was not treated with deliberate indifference either in moving him to or from his enteral feeding or his weight checks or how he is restrained while fed.

* * *

In summary, the issue before the Court is whether it should enjoin the United States military from allegedly violating the law by mistreating Petitioner during the enteral feeding process. The United States military seeks to provide Petitioner with humane treatment and is not deliberately indifferent to Petitioner's needs during the process. As shown above, most of Petitioner's challenges stem from either misreading the SOP or from alleged practices to which neither he nor any other detainee is subjected. As to the other alleged practices to which he objects, the procedures are performed humanely and in a medically appropriate fashion.

Accordingly, the conduct of JTF-GTMO personnel while enterally feeding Petitioner meets neither the objective nor the subjective components of the deliberate-indifference standard. Evaluated objectively, the situation reflects that Petitioner is not deprived of his medical needs; rather, he has been enterally fed to address his medical needs. Further, JTF-GTMO medical personnel do not intentionally or knowingly ignore a known risk to Petitioner's health or well-being during his enteral feedings. Accordingly, the enteral feeding procedures, either as written or as applied to Petitioner, simply would not amount to unconstitutional conditions of confinement.

b. The Enteral Feeding SOP Satisfies Turner's Reasonable-Relationship Test

Because the Guantanamo Bay enteral-feeding procedures would not transgress constitutional conditions-of-confinement standards, as explained above, the analysis of the merits

of Petitioner's claim need go no further. Even if the procedures are considered under the reasonable-relation test of Turner, however, Petitioner's arguments fail.

The Turner standard developed from a long line of Supreme Court precedent grounded on the premise that prison administrators "should be accorded wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security." Bell v. Wolfish, 441 U.S. 520, 547 (1979). This deference recognizes that prison administrators, not the courts, are the subject-matter experts when it comes to operating and safeguarding prisons. See Turner, 482 U.S. at 85 (recognizing that prison administration is an "inordinately difficult undertaking" requiring expertise, planning, and resources that are "peculiarly within the province of the legislative and executive branches"); Procunier v. Martinez, 416 U.S 396, 404-405 (1974) (prison administrators must deal with complex, intractable problems that "are not readily susceptible of resolution by decree").

In Turner, the Supreme Court gave practical application to this deference, holding that a prison regulation that may infringe or is claimed to infringe a constitutional right is nonetheless valid if the regulation is "reasonably related to legitimate penological interests." 482 U.S. at 89.[22] In crafting this reasonable-relationship test, the Court explicitly rejected a strict-scrutiny standard, concerned that the corresponding least-restrictive-alternative analysis would inevitably

[22] The fact that Petitioner is presently detained pursuant to the Authorization for the Use of Military Force, as informed by the laws of war, as opposed to a criminal conviction or authority, does not mean that Respondents lack a legitimate interest in administering life-saving nutrition and medical care to preserve Petitioners' health and life. See In re Grand Jury Subpoena, 150 F.3d 170, 171 (2nd Cir. 1998); In re Soliman, 134 F. Supp. 2d 1238, 1245, 1258 (N.D. Ala. 2001). Courts have concluded that the government has legitimate interests in preserving life and maintaining order and safety regardless of the status of the prisoner's detention. See generally In re Soliman, 134 F. Supp. 2d at 1255 ("Federal Courts generally have approved of force-feeding hunger striking inmates, regardless of whether the person was a convicted prisoner, a pre-trial detainee, or a person held pursuant to a civil contempt order.") Here, Respondents have a legitimate interest and a duty under the law of war to provide the Petitioner with humane treatment.

lead to improper judicial second-guessing of administrators' decisions that the Court sought to avoid. Id.

Seeking to avoid the deference mandated by Turner, Petitioner mistakenly invokes language reminiscent of a least-restrictive-alternative test. E.g., Pet'r Mem. at 19-20 ("force-feeding may be undertaken only if this interest cannot otherwise be achieved without impinging on constitutional rights"); id. at 32 (characterizing alternative to JTF-GTMO SOP as requiring a level of restraint that is the "least restrictive necessary"). But such language simply ignores the well-settled deference to prison officials embodied in the Turner reasonable-relationship test, see 482 U.S. at 89, a deference that should apply even more strongly to military officials operating a detention facility under the law of war.

Besides misconstruing the reasonable-relation test, Petitioner's analysis under Turner is flawed. An antecedent condition to invoking Turner is that a detainee must establish a constitutional right has been infringed. 482 U.S. at 89. But the only right that Petitioner explicitly claims has been infringed is a right to be free from unwanted medical attention. See Pet'r Mem. at 20 (citing Cruzan v. Dir. Mo. Dept. of Health, 497 U.S. 261 (1990)). Aamer establishes, however, that this right—to the extent that it applies to Petitioner—is properly subordinated under Turner to the Government's legitimate military interests in preserving his life and institutional security through enteral feeding. 742 F.3d at 1040. And while the gravamen of his motion appears to be that he has a constitutional right to be free from unnecessary pain, he nowhere asserts that as an independent right, rather asserting it only as a reason that the challenged procedures are unreasonable under Turner. Pet'r Mem. at 27 ("There cannot be any 'legitimate penological interests' . . . in inflicting 'inconvenient' pain and suffering on force-fed detainees . . . .") (internal citation omitted). Thus, it is unclear exactly what right Petitioner claims that the procedures violate.

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But assuming that Petitioner has some constitutional right to be enterally fed in a manner other than how JTF-GTMO is currently doing so, the issue under Turner is quite narrow.[23] Aamer having found constitutional under Turner the enteral feeding of hunger strikers in immediate danger of death or serious harm to their health, the issue raised by Petitioner is whether the medical and ancillary security procedures as written and (only because Petitioner has incorrectly invoked Turner) as applied, satisfy Turner. To justify those procedures, the Government asserts the same two legitimate military interests that underlie the approval of enteral feeding in general: preserving a hunger-striking detainee's life and maintaining institutional security and order. See Aamer, 742 F.3d at 1040 (noting legitimacy of these interests). The issue for decision then is whether the enteral feeding procedures are reasonably related to those two interests. In analyzing this issue, the logical connection between objectives and procedures need only be "valid and rational" and not so "remote as to render the policy arbitrary or irrational." Turner, 482 U.S. at 89-90.

This connection is easily demonstrated here. As set out in more detail above, both as the procedures require and as they are implemented, a decision to feed enterally a detainee is based on the recommendation of the medical personnel who are treating him, a decision based solely on the personnel's sound medical judgment that the procedure is necessary to prevent a threat to a detainee's life or serious jeopardy to his health. Though the procedures require the JTF-GTMO

[23] By proceeding to defend the enteral feeding procedures under Turner, the Government does not concede that Turner applies. The Guantanamo detention facility is neither a prison nor a jail comparable to those in the domestic criminal context. Nevertheless, a standard at least as deferential as Turner should apply here because the security of the facility is a legitimate—indeed, a paramount—governmental interest. Cf. Jean S. Pictet, ed., Geneva Convention Relative to the Treatment of Prisoners of War: Commentary at 238 (Geneva: Int'l Comm. of the Red Cross, 1960) (noting that the duty to care for prisoners of war properly can only be carried out by ensuring discipline in the camps and, so, a considerable portion of the Convention concerns provisions for strengthening camp discipline); Further, the military authorities who administer the facility are entitled to a similar type of judicial deference in their assessments of the security needs of the facility as are civilian prison officials. See Winter, 555 U.S. at 24 (noting great deference owed to professional judgment of military authorities concerning the relative importance of military interests); cf. In re Navy Chaplaincy, 697 F.3d at 1179 (when assessing injunctive relief, courts must defer to professional judgment of military authorities as to the harm that would result to military interests if injunction were to issue).

Commander's authorization to begin enteral feeding, that authorization is the culmination of the medical-recommendation process, not the start. Similarly, as provided by the procedures, medical personnel use appropriate nasogastric tube sizes, carefully monitor feed rates, and do not administer medications to detainees during enteral feedings without the detainees' knowledge and consent. Further, feeding tubes are inserted and withdrawn for each feeding, a procedure that is fully justified based on the realities of enterally feeding detained individuals who are not residing in a hospital, as well as the history of failure from leaving the tubes in place, which allowed detainees to purge their feedings, and the medical concerns of possible infections.

Similarly, restraint chair use is justified by the history of violent resistance to enteral feedings by hunger strikers and by the need to feed hunger-striking detainees who may not be violent but may be uncooperative with their enteral feedings. Additionally, the procedures allow for adjustment when warranted based on an individual detainee's needs and behavior. Lastly, FCEs are used as a last resort when a detainee refuses to leave his cell for a necessary enteral feeding session. Consequently, each of the challenged procedures serves to ensure that enteral feeding is humane and accounts for the needs of the individual detainees. As such, the procedures are reasonably related to the legitimate goals of preventing a detainee from dying or compromising his health from starvation, preventing riots or other unrest from such a detainee's death, and maintaining security and order in the facility.

Petitioner's attempts to evade this conclusion are unavailing. The enteral feeding procedures do not inflict unnecessary pain, and so are not unreasonable on that ground. Nor can Petitioner impugn the reasonableness of the procedures by demonstrating "ready alternatives" that fully accommodate detainee's claimed rights at de minimis cost to valid military interests.[24]

[24] Turner provides four factors to be considered in ascertaining whether a reasonable relationship exists between the government's asserted interest and the challenged policy:

(1) whether a valid, rational connection exists between the challenged prison regulation and a legitimate government interest;

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See Turner, 482 U.S. at 91 (holding that courts should not consider alternatives unless they have "de minimis" cost to penological interests). As demonstrated above, most procedures used at Guantanamo Bay are fully comparable to the alternatives suggested by Petitioner (enteral feeding only on doctor's assessment of immediate need, proper tube size, proper feed rate, no anti-constipation medicine hidden in the nutritional formula), and, to the extent they are not, are justified either medically (tube insertion and withdrawal) or by the legitimate needs of security and order in a detention facility (use of restraint chair and forced cell extraction as needed) or both.

Lastly, Petitioner does not seriously press his argument that Guantanamo Bay may be so secure that institutional security is no longer a legitimate penological or military interest. See Pet'r Mem. at 33. He presents no evidence to support this bare contention, other than to suggest that prior detainee deaths have not resulted in a riot. In contrast, there was a mass hunger strike just last year, and detainees who had been living communally were required to return to single cell living due to their exploitation of camp rules that created an unsafe and insecure environment. Washington Post, Peter Finn, "Guantanamo Bay Detainees and Military Clash, Hunger Strike Continues" (April 23, 2013), available at http://www.washingtonpost.com/world/national-security/military-tries-to-end-guantanamo-bay-hunger-strike/2013/04/13/6cbf9b8c-a469-11e2-82bc-511538ae90a4_story.html; see also Al-Adahi, 569 F. Supp. 2d at 115-16 (describing violent circumstances leading to use of restraint chair). Thus, although Guantanamo

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(2) whether there are alternative means for a detainee to exercise the allegedly infringed right;
(3) whether accommodating that right would adversely impact prison personnel or resources or other detainees; and
(4) whether there are ready, easy alternatives to the challenged regulation..

482 U.S. at 90-91. Petitioner's motion challenges the enteral feeding procedures under only the first and the last factors. Accordingly, Petitioner has waived any argument based on the other two. See Overton v. Bazzetta, 539 U.S. 126, 132 (2003) (the burden of proof under Turner lies with the prisoner challenging the procedure).

is secure, it remains subject to the same legitimate concerns regarding institutional security that have been universally recognized by the courts.

In summary, assuming Turner may appropriately apply to Petitioner's claim, the challenged procedures satisfy the required reasonable relationship to the Government's interests in preserving Petitioner's life and maintaining facility security and order. Given that Aamer has settled the question of whether Petitioner may be enterally fed, and as he is fed humanely in his detention environment, the manner in which he is fed satisfies Turner.

B. The Remaining Three Factors For A Preliminary Injunction Favor The Government

The above analysis readily demonstrates why Petitioner not only cannot show any likelihood of success on the merits but also cannot satisfy any of the other three required factors.

In the absence of a preliminary injunction, Petitioner will not suffer any of the irreparable harms of which he complains. Petitioner is not currently approved for enteral feeding and has not been for some time. Supp. CDR [redacted] Decl. ¶ 4. Consequently, he asks this Court to do exactly what the Supreme Court prohibited in Winter: "Issu[e] a preliminary injunction based only on a possibility of irreparable harm." Winter, 555 U.S. at 22. There, the Supreme Court noted that such speculative relief would be "inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." Id.

By contrast, the harm to the Government if the injunction were to issue is quite evident. The injunction Petitioner seeks would interfere with the legitimate medical and security judgments of JTF-GTMO military personnel as it would require the Court to substitute its judgment for that of the professional medical staff and detention authorities at Guantanamo Bay. See, e.g., Al-Adahi, 596 F. Supp. 2d at 123 (an injunction against use of restraint chair would leave JTF-GTMO "vulnerable to concerted efforts by detainees to use the forced-feeding as an

opportunity to inflict harm on medical and military personnel"). An injunction would also severely chill the exercise of that professional medical judgment because the result of a substituted judgment by the Court would be the threat of sanctions using the contempt power. As a result, detainees' routine attempts to resist or thwart needed nutrition would readily convert into potential legal challenges, raising the specter of sanctions for any mistakes or missteps that might occur. This would unnecessarily interfere with the exercise of the sound medical and security judgments by JTF-GTMO personnel and would be inconsistent with the deference the Supreme Court has stated is owed to prison or military officials.[25]

Lastly, the public interest favors denying the requested preliminary injunction. The lack of an injunction will not affect any public interest in the humane treatment of detainees at Guantanamo Bay because the detainees are treated humanely. On the other hand, the public has a sure interest in preserving the health and safety of persons held in Government custody and in maintaining good order and security of the detention facility at Guantanamo Bay, including the safety of detainees and military personnel alike. Because a preliminary injunction would unnecessarily interfere with the ability of medical personnel to use their best judgment as to when and how to feed enterally a detainee and the security judgments of the detention staff at Guantanamo Bay, the public interest weighs against the relief sought here.

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[25] Petitioner's proposed order calls for the Court to enjoin enteral feeding unless an "independent physician" determines that Petitioner is facing a risk of death or great bodily injury. ECF No. 203-10. Petitioner has offered no substantive argument on the issue, and this Court should accordingly not take action on Petitioner's claim. See Overton v. Bazzetta, 539 U.S. 126, 132 (2003) (burden of proof in challenge to prison procedure lies with the prisoner raising challenge). Furthermore, such an order, without cause, would inject an unspecified outside expert into the administration of the military detention facility and, at a minimum, result in improper interference with Guantanamo Bay officials' judgment in administering the facility and their care of military detainees. Cf. Turner, 482 U.S. at 85 (recognizing that prison administration is an "inordinately difficult undertaking" requiring expertise, planning, and resources that are "peculiarly within the province of the legislative and executive branches"); see also Winter, 555 U.S. at 24 (noting great deference owed to professional judgment of military authorities concerning the relative importance of military interests); In re Navy Chaplaincy, 697 F.3d at 1179 (when assessing injunctive relief, courts must defer to professional judgment of military authorities as to the harm that would result to military interests if injunction were to issue).

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Thus, because each of the four factors decidedly favors the Government, a preliminary injunction is not warranted here, regardless of whether the requested relief is assessed under the Holiday Tours balancing test or, as the Government suggests, under the standard of Winter, under which each element for a preliminary injunction must be established.

CONCLUSION

Petitioner cannot justify the extraordinary remedy of a preliminary injunction. Most notably, he cannot show any likelihood of success on his enteral feeding claim. Nor can he satisfy any of the other three factors for injunctive relief. Accordingly, the application for a preliminary injunction should be denied.

May 7, 2014

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I have served a copy of Respondents' Opposition to Petitioner's Application For Preliminary Injunction, which has been filed under seal, by electronic mail this 7th day of May, 2014, on

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~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents*.	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 1

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

~~(U//FOUO)~~ DECLARATION OF COMMANDER [redacted], M.D.

Pursuant to 28 U.S.C. § 1746, I, [redacted], hereby declare:

1. ~~(U//FOUO)~~ I am a Commander in the United States (U.S.) Navy with over 19 years of active and reserve service. I currently serve as the Senior Medical Officer, Joint Medical Group (JMG), Joint Task Force (JTF-GTMO), Guantanamo Bay, Cuba. I am responsible for the medical care provided to 139 detainees at Guantanamo Bay and supervise the operation of the Joint Medical Group that provides medical care to those detainees.[1] I have served in this position since February 26, 2014.

2. ~~(U//FOUO)~~ I entered the U. S. Navy while attending medical school at the Uniformed Services University from 1994 to 1998. After that I continued my post graduate training in Family Medicine at the Naval Hospital in Jacksonville, FL. Since residency graduation I have served in the active duty Navy for seven years and then in the U. S. Navy Reserves for the last five years. I have been board certified in Family Medicine since 2001.

3. ~~(U)~~ I have personal knowledge of the procedures that are in place for the operation and application of medical care at JTF-GTMO medical facilities, and I am responsible for ensuring that they are followed. I have personally observed the enteral feeding procedure since arriving at Guantanamo Bay. In addition, I have performed enteral placement and ordered it for patients in my civilian practice. Shortly after arriving at Guantanamo Bay, I provided a demonstration of the enteral feeding process to members of the media, a portion of which was recorded and posted to YouTube (available at: https://www.youtube.com/watch?v=ozBAXC1DCU_A).

Joint Medical Group

4. ~~(U)~~ The Joint Medical Group is led by the JMG Commander who reports to the JTF-GTMO Commander. The JMG Deputy Commander is the Executive Officer for JMG. The JMG Commander and Deputy Commander are ultimately in charge of all detainee health care as well

[1] I do not provide or oversee medical care for the [redacted] detainees in Camp 7. Those detainees have their own Senior Medical Officer.

as the health and dental clinics available to U.S. military personnel at Guantanamo. They formally approve all recommendations of the Senior Medical Officer. The Senior Medical Officer is responsible for the medical care of the detainees and supervision of medical care providers. The JMG staff includes licensed, board-certified physicians of different specialties. Specifically, as of March 2014, the medical staff has [redacted] professionally trained individuals, including two family physicians, a physician assistant, an internist/cardiologist, a psychologist, a psychiatrist, a dentist, licensed medical/surgical nurses, corpsmen (formally trained Navy medical personnel akin to a "medic" in the Army), various technicians (lab, radiology, pharmacy, operating room, respiratory therapy, physical therapy and biomedical repair), and administrative staff. The Naval Hospital Guantanamo provides additional consultative services from numerous medical professionals including an anesthesiologist, a general surgeon, an orthopedic surgeon, a licensed dietician, and a physical therapist. We routinely bring in specialists, including medical professionals practicing in the areas of Dermatology, Cardiology, Otorhinolaryngology (Ear, Nose and Throat), Gastroenterology, Urology, and Audiology, and have the ability to request specialists from other areas as needed. Specialists specifically involved in the care of the detainees who practice long term non-religious fasting include nutrition, internal medicine, and behavioral health professionals, all of whom assisted in monitoring and providing specialized care, as needed.

5. ~~(U)~~ All detainees, upon arrival at JTF-GTMO, were given a complete physical examination. Medical issues identified during the examination, or identified during subsequent examinations, are followed by the medical staff. Detainees may request medical care at any time by making a request to guard personnel in the cell blocks or to the medical personnel who make daily rounds on each cellblock. In addition to responding to such detainee requests, the medical staff will investigate any medical issues observed by JTF-GTMO guards or staff. The availability of this care has resulted in thousands of outpatient contacts between detainees and the medical staff, followed by inpatient care as needed.

6. ~~(U)~~ For most medical care requiring in-patient services, detainees are admitted to the JTF-GTMO Detention Hospital. This is a 15-bed medical facility, which is staffed to provide more intensive medical care to the detainees at GTMO. A [redacted] Behavioral Health Services

(BHS) staff supports the outpatient mental health needs of the detainees, and runs the [redacted] Behavioral Health Unit (BHU) designed for detainees requiring inpatient psychiatric care and monitoring. The BHU staff includes a board-certified psychiatrist and a psychologist, as well as psychiatric nurses and technicians. The BHU staff conducts mental health assessments, provides crisis intervention, develops individualized treatment plans, formulates therapy for management of self-injurious ideations or behavior, and provides supporting care and psychiatric medication therapy, as needed, to treat symptoms of major psychiatric disorders. The medical and BHU staff provide appropriate medical and mental health care for all detainees through a coordinated team approach based on individualized treatment plans that account for each patient's condition and circumstances.

7. ~~(U)~~ The JMG is committed to providing appropriate and comprehensive medical care to all detainees. The healthcare provided to the detainees being held at JTF-GTMO is comparable to that afforded our active duty service members. Detainees receive timely, compassionate, quality healthcare and have regular access to primary care and specialist physicians.

8. ~~(U)~~ All medical procedures performed are justified and meet accepted standards of care. A detainee is provided medical care and treatment based solely on his need for such care, and the level and type of treatment is dependent on the accepted medical standard of care for the condition being treated. Medical care is not provided or withheld based on a detainee's compliance or noncompliance with detention camp rules or based on his refusal to accept food or drink. Medical decisions and treatment are not made or withheld as a form of punishment or discipline.

Medical Management of Detainees with Weight Loss

9. ~~(U)~~ It is the policy of the Department of Defense to support the preservation of life by appropriate clinical means and standard medical intervention, in a humane manner, and in accordance with all applicable medical standards. Accordingly, there are procedures and/or protocols for providing medical care to detainees, which are to be followed at all times by all medical personnel at the Detention Hospital and throughout JTF-GTMO, including for detainees who meet the criteria for approval for enteral feeding.

10. ~~(U)~~ JTF-GTMO's protocol for managing detainees with weight loss is modeled on those used by the Federal Bureau of Prisons as outlined in Program Statement P5562.05. A number of medical writings and manuals, cited in Enclosure 8 to the December 16, 2013 Standard Operating Procedure (SOP) for Medical Management of Detainees with Weight Loss, provide additional underpinnings for our protocol. As I understand from discussions with others, our current protocol has evolved since 2005 and was developed in consultation with subject matter experts, including three consultants from the Federal Bureau of Prisons. This is more fully explained in declarations by Major General Hood (dated 10 March 2006) and Dr. Stephen Hooker (dated 1 March 2006 and 13 March 2006) that were filed in Mohammed Al-Adahi et al v. George W. Bush (Civ. No. 05-280) and are attached here. I am familiar with the content and history of these declarations.

11. ~~(U)~~ I am aware that in recent months, the JMG has revised its procedures related to management of detainees with weight loss and those who are approved to be enterally fed.[2] The December 16, 2013, procedure, like those that preceded it, is based on Department of Defense Instruction 2310.08E, Medical Program Support for Detainee Operations, Section 4.7.1, which requires a medical determination that immediate intervention is needed to prevent harm or death to a detainee. The revisions made in late 2013 were intended to better describe how detainees are approved for enteral feedings and to provide further information about care provided to long-term enteral feeding patients. The December 16, 2013 procedure describes the overall assessment of a detainee's health condition and possible causes for weight loss that help JMG staff determine his level of risk and the potential need to provide nutrition through enteral feeding. The close coordination between primary care providers and the Senior Medical Officer (SMO) as well as review of all medical information available ensures that decisions about enteral feeding are properly made. Reliance on one factor alone can be subject [redacted] and does not provide the best data to determine whether enteral feeding is necessary. The current procedure explains how JMG staff members work together and evaluate detainees

[2] The March 5, 2013 version of the SOP was superseded by a new version on November 14, 2013. Shortly after the November version was issued, a number of typographical errors were identified. The current version was issued on December 16, 2013. There are few differences between the November and December versions, and all are non-substantive.

with weight loss. This policy is given continual and close review and evaluated for potential revisions and improvements in light of experience and medical science developments.

Assessment and Observation of Detainees with Weight Loss

12. ~~(U)~~ The JTF-GTMO guard force monitors detainee consumption of meals and maintains records of when detainees do not eat the provided meals. These records are shared with JMG staff who will then review the clinical medical information for any detainee who has been noted as having missed meals. The JMG Senior Medical Officer (SMO) undertakes a daily review of detainees who are of interest based on weight loss that includes looking at weight trends, overall nutritional intake, and the detainee's medical conditions. The SMO remains in continual communication with other JMG staff regarding observable detainee weight changes. At a minimum, medical staff members attempt to weigh all detainees monthly and non-religious fasting detainees weekly. There have been some subtle variations of the weight-check schedule for detainees exhibiting weight loss in the past, but we have determined that weekly, or sometimes twice weekly, weight checks are adequate to properly monitor them, including identifying a precipitous drop in weight as well as to show weight gain over time. Using this data, the SMO will determine if a detainee qualifies as having clinically significant weight loss, which would signal the need for further action to safeguard the detainee's life and health.

13. ~~(U//FOUO)~~ Clinically significant weight loss occurs when (1) a detainee weighs less than 85% of the calculated ideal body weight (IBW); (2) a detainee has experienced a loss of weight greater than 15% of the detainee's usual body weight; (3) there is evidence of deleterious health effects accompanying the weight loss that reflect end-organ involvement or damage (such as renal failure, cardiac arrhythmia, seizures, syncope (loss of consciousness) or pre-syncope (for example, blurred vision or faintness), altered mental status, metabolic derangements, and muscle wasting); (4) there are significant changes in a detainee's vital signs; (5) there is a pre-existing co-morbidity (a medical condition that increases the risk of poor outcome associated with weight loss, dehydration and malnutrition); and/or (6) the detainee has one or more diseases or disorders occurring with a primary disease or disorder. Weight loss to a level less than 85% Ideal Body Weight is used as a criteria for determining that a detainee has clinically significant weight loss because detainees often refuse physical evaluation of their condition such as vital signs, full

physical exams, electrocardiography (EKG) or lab work that would provide other objective data about the detainee's health condition. More importantly, medical research shows that at 85% IBW, the risk of morbidity (poor medical outcome) and mortality (death) starts to worsen. The body slows all of its processes to conserve energy, as well as pulls energy stores from wherever it can find it. This may result in serious medical consequences, such as dehydration and severe electrolyte shifts causing seizures and cardiac arrhythmias. It also greatly increases the risk for heart valve disorders, heart failure, bone density loss, muscle loss and weakness, gastroparesis, abdominal pain, and potential kidney failure. All of these complications have the ability to lead to death or permanent disability. The amount of warning before these death or disability may occur is not clear and depends on the individual's underlying medical conditions, hydration status, and rate of weight loss. An overall medical assessment, including review of a detainee's personal background, current health condition, and other potential health-related causes that might explain the weight loss, always accompanies the SMO's consideration of risk related to the detainee's percentage of Ideal Body Weight. In the event of other health-related causes for weight loss, there may be available treatment options to address those causes and help restore the detainee to a healthy weight without the use of enteral feeding. This multi-factorial decision is made with careful attention being made to the detainee's weight level, rapidity of weight loss, water intake and clinical appearance.

14. ~~(U)~~ When the SMO has determined that a detainee has experienced clinically significant weight loss, the SMO will direct the detainee's primary medical provider, either a doctor or physician's assistant, to conduct a formal evaluation of the detainee to determine if there is a medical or behavioral cause of the weight loss. The medical staff carefully assesses each detainee's health by means of physical and psychological examinations, weight monitoring, personal observation and laboratory tests. The ability to monitor a detainee's health is affected by the detainee's willingness to cooperate with medical staff. The detainee's primary medical provider will discuss the findings of the comprehensive evaluation with the SMO in order to determine appropriate medical care.

Approval for Enteral Feeding

15. ~~(U)~~ One outcome of the assessment by the primary medical provider and JMG team (SMO, Deputy Commander and mental health provider) is that a detainee may be designated as approved for enteral feeding. Medical personnel will approve enteral feeding only when it becomes medically necessary to preserve a detainee's life and health. This determination is based on a comprehensive view of the detainee's health (as detailed above) and likelihood of resultant risk if the detainee does not receive nourishment.

16. ~~(U)~~ Many detainees voluntarily participate in enteral feeding upon the advice of medical staff. However, if a detainee does not voluntarily participate, the SMO may direct medical treatment or intervention without the detainee's consent to prevent death or serious harm. Such action must be based on a medical determination that immediate treatment or intervention is necessary to prevent death or serious harm. In such instances, the SMO, in coordination with the detainee's primary provider and the Commander Joint Medical Group (CJMG), will seek authority from the Commander of the Joint Task Force (JTF Commander) to begin enteral feeding without the consent of the detainee in accordance with DoD Instruction 2310.08E, Section 4.7.1, which requires such approval. My understanding is that the JTF Commander is involved in this decision to ensure his awareness that this action is being taken and its potential impact on other operations. Significant deference is given to the SMO's recommendation, and the commanders recognize that the SMO's role in these discussions is to articulate what medical care is needed for a certain detainee. It is my understanding based on discussion with previous SMOs and my command leadership as well as my own personal experience that the JTF Commander routinely concurs with the recommendation of the SMO to begin enteral feeding without the detainee's consent and that the JTF Commander has not historically taken unilateral action to begin enteral feeding of a detainee without his consent if the SMO did not believe it to be medically necessary.

17. ~~(U)~~ Joint Medical Group personnel provide extensive counseling and detailed warnings to the detainees concerning the risks of their failure to eat or drink prior to the commencement of enteral feeding, and periodically thereafter if the detainee continues to refuse normal food and/or drink. Medical personnel (including behavioral health professionals) continually remind detainees who persist in their refusal to consume meals and water that this behavior could

endanger their health or life. During these conversations, the medical personnel explain that their role is to preserve and promote the detainee's life and health and urge the detainees to voluntarily accept enough nutrients to increase their weight and improve their health. Medical personnel also explain how and why the enteral feeding regime will be implemented to preserve their life and health. Even after a detainee is approved for enteral feeding, he is offered the opportunity to eat a standard meal or consume the liquid supplement orally in advance of every enteral feeding and if he agrees, he will not be enterally fed.

18. ~~(U)~~ Once a decision has been made to approve a detainee for enteral feeding, JMG staff continues to perform an ongoing assessment of the detainee's medical condition and his need to be enterally fed. Our goal is always to restore a detainee to a normal, healthy weight and eating habits that include regular meals. We look at detainee weight trends and other clinical factors such as meal or calorie intake, and medical comorbidities every day to determine whether detainees should remain approved for enteral feeding. We continually assess what would happen if a detainee stopped his intake of food and fluids and how his clinical history and other factors bear upon the consequent health risks.

Enteral Feeding Tube Size

19. ~~(U)~~ The enteral feed is administered through the use of nasogastric tubes if detainees refuse to drink the liquid supplement on their own. Feeding through those tubes is only conducted by physicians or credentialed registered nurses, and only when medically necessary to preserve a detainee's health and life. The application of the enteral feeding process is carried out in accordance with prior training received at accredited nursing schools and training conducted here at JTF-GTMO. In my medical career, I have placed many of these tubes as well as had a tube placed on myself upon my taking this position as SMO.

20. ~~(U)~~ When inserting nasogastric tubes, a lubricant is always used. In all cases, a topical anesthetic such as lidocaine (a widely used local anesthetic) is offered, but the detainee may decline the anesthetic. Prior to insertion, the medical professional will lubricate a sterile nasogastric tube with a lidocaine gel, surgilube, or olive oil at the detainee's request. Anesthetic throat lozenges are also available to the detainees on request.

21. ~~(U)~~ Physicians or registered nurses insert the enteral feeding tube in accordance with standard medical protocol. JTF-GTMO uses 8 or 10 french tubes. An 8 french tube measures 2.64 mm and a 10 french tube measures 3.3 mm. The difference in size between them is barely discernible to the human eye. A nasogastric tube is never inserted and then moved up and down. Instead, it is inserted down into the stomach slowly and directly, and removed carefully. Medical personnel remove, insert or administer nasogastric tubes in a manner designed to minimize discomfort and to intentionally avoid inflicting pain or harm to the detainee.

22. ~~(U)~~ Medical staff use the 10 french tube for most detainees unless they complain of or report nasal or throat soreness or there is another medically-related reason to change the tube size. The 10 french tube is most often used because its slightly larger size allows the nutritional requirements to be given to a detainee as safely, comfortably, and quickly as possible and is safer and easier to place. Changing to a smaller tube is a clinical decision. Smaller tubes can clog and can be harder to place, and some nutritional formulas come with recommendations that they be used with a specific sized feeding tube due to viscosity of the formula. Enteral feeding takes significantly longer when a small tube is used. Nonetheless, smaller tube size may be needed due to anatomical changes in the nares such as congestion from allergies, infections, trauma or foreign bodies, as well as intrinsic or acquired septal deviations.

23. ~~(U)~~ Tube placement is confirmed using the auscultation method with confirmation by [redacted] independent medical personnel. The auscultation method involves listening for air bubbles when the end of the feeding tube is placed under water and infused with air. Although auscultation is not the preferred method in the medical community, it remains the standard of care in prison settings. At Guantanamo, JMG medical staff also test tube placement with a dose of water, which serves as an additional safety check to confirm proper placement. Other options to check tube placement include the radiographic confirmation with the use of a chest x-ray, which is the standard in the medical community and can be a good option for patients in a hospital setting, especially those at high risk of tube misplacement. However, radiographic confirmation presents a risk to patients in the form of exposure to radiation, which would not be tenable for long-term enteral feeding patients at Guantanamo who are enterally fed one to two times daily over a

period of many years. I would not leave a tube in for a lengthy period, such as a month at a time, due to the increased risk of infection, so radiation would still be an issue for Guantanamo detainees. Another option is the gastric aspiration method. This method requires suctioning stomach contents through the nasogastric tube and testing the acidity level for confirmation that the tube is placed in the stomach. This method is being currently tested as an option, though implementation requires the use of a significantly larger tube. Tube misplacement has occurred in the past, though as far as I am aware, it has always been identified and corrected before the enteral feeding was started through the use of verification methods and medical staff's attention to signs or symptoms from the detainee that suggest misplacement, such as hoarseness, severe coughing, or shortness of breath. If the tube is misplaced, it is immediately taken out and replaced correctly.

Tube Removal Between Feedings

24. ~~(U)~~ Our standard procedure is to remove the enteral feeding tube after each feeding. This is consistent with enteral feeding in a prison population. In general, hospitalized patients (including both detainees and non-detainees) may keep tubes for a prolonged period of time if medically necessary. This may be done because the hospital presents a more controlled environment and allows for continual monitoring of the patient as well as a potential medical need for slower transition of feeding volumes. In most cases, there is no medical need to hospitalize the detainee patients at Guantanamo, or keep the tube in place, but when there is a justifiable medical need, such as an anatomical deformity, JMG staff will allow a detainee to keep the tube in place for up to three days. Tube removal reduces the risk of sinus, nasal, and middle ear infections that is inherent in keeping the feeding tube in place. Removal of the tube after each feeding also reduces the ability of detainees to purge feeds and therefore assists in appropriate weight gain and reduced metabolic disturbances. Removal also prevents detainees from biting the feeding tube in half while in place and potentially swallowing it, which would require them to undergo an endoscopic retrieval procedure. In general, infections are a known complication to leaving any medical device inserted into a patient for a prolonged period of time.

[redacted]

Enteral Feeding Rate

25. ~~(U)~~ A detainee who is beginning enteral feeding and who is not ingesting any food or liquid may start out with a continual feeding process in which he may be provided with up to 2300ml of liquid (just over 9.5 cups) [redacted] Since most of our detainees drink water while fasting, they would typically be started at 750ml [redacted] Continuous feeding is done in the hospital under careful supervision and is started at a lower rate and volume and increased to goal over a few days. As the detainee demonstrates tolerance for enteral feeding and stability of his medical condition, he is slowly transitioned to bolus feeding, which is intermittent feeding two or three times each day.

26. ~~(U)~~ After verification of tube placement, an appropriate amount of nutritional supplement formula is infused by gravity into the detainee's stomach. This flow rate and time can be highly variable based on the duration of the fast, the viscosity and volume of the formula, the size of the tube and the patient medical comorbidities, such as gastric distension and processing time. Observing for signs of abdominal discomfort and gastric distension, caused by the introduction of air into the stomach, help determine the detainee's tolerance to the rate and volume of the enteral feeding. When medical staff are alerted to this discomfort, either through communication from the detainee or direct observation, staff reduce the rate at which the feeding solution is being provided to alleviate these symptoms. In all cases, flow and volume are started low to ensure tolerance. Rate is slowed or halted based on patient tolerance. Some patients can tolerate a very rapid delivery rate without problem. For instance, one detainee routinely and comfortably consumes 750ml of feeding solution and water in 10 to 20 minutes. In addition, I recently observed a non-detainee patient be enterally fed using a 16 french tube in which 750ml of feeding solution was delivered by gravity in approximately five minutes without any issue or discomfort. Concentrated and fiber-fortified formulas (also used in U.S. hospitals) can be used to reduce volume and enhance digestion, respectively, and to make the procedure as comfortable as possible, though this has been declined by most detainees. Each patient is different, but generally speaking, an enteral feeding at Guantanamo typically takes 30 to 40 minutes, and can take up to two hours.

27. ~~(U)~~ Detainees are given only appropriate formula, as determined by standard medical protocol and custom-tailored for the detainee's specific caloric needs to support metabolic functions and to maintain weight. Different formulas have different caloric value, and this can also impact the necessary volume. Most detainees prefer Ensure, which has 250 calories per 237ml, but will require two cans of Ensure at a feeding to meet average energy and fluid needs. Each can of Ensure is approximately one cup of liquid. A typical detainee would consume two cans of Ensure during each feeding, though if he was not drinking any fluids on his own, he may have up to 750ml two times per day at a rate that is controlled. Some detainees also request that water is added to the enteral feeding solution. The overall volume of feeding solution and water is slowly increased over time to ensure that a detainee can tolerate that intake at a given rate.

28. ~~(U)~~ The feeding tube can adjusted by medical staff to control the rate of the feeding. The medical staff carefully monitors the process the entire time, adjusting the rate and amount of nutrients and fluids given if there are any indications of discomfort from the detainee. Some detainees who are accustomed to enteral feeding specifically request that the clamp be opened more fully so that the feeding can be accomplished as quickly as possible. Some also ask for water to be included to dilute the feeding solution and allow the flow to be more rapid. A faster flow can increase the risk of vomiting, so we monitor feedings and ensure that the rate is comfortable and safe for the detainee. Medical personnel also observe the detainee's heart rate and blood pressure regularly during the enteral feeding. They continuously monitor the detainee for swelling, redness, and discoloration. Any medically-related issues or complaints are logged for each feeding. The comfort and safety of the patient is a priority for the medical staff. In all instances, we begin by enterally feeding detainees at a very slow rate and continuously transition to ensure that the detainee can tolerate feeding at a faster rate.

29. ~~(U)~~ All detainees being enterally fed are assessed daily by a medical professional and are subject to regular and periodic review by a physician team twice per month to ensure the feeding process is being effective, safely administered through proper use of our [redacted] confirmation of tube placement, 10ml water bolus rapidly pushed, and the use of continuous medical monitoring, and tolerated by the detainee. In addition, the detainee's health is closely monitored through direct observation and medical testing to ensure he receives the appropriate daily

amounts of nutrition and hydration and to assess any complications or need for modification of the regime. The JMG staff includes a Quality Control Nurse who conducts regular audits to ensure this process follows our procedural instructions. This audit is reviewed to identify any problems in the system and to maintain continual awareness of areas for possible improvement. JMG staff engage in discussions about their experiences with enteral feedings and ways to make it as safe and humane for the detainees as possible.

Enteral Feeding Restraint Chair

30. ~~(U)~~ Typically, when a detainee receives an enteral feed, he is placed in a restraint chair in a designated location in the resident camp. A restraint chair is utilized to ensure the safety of the guard staff, medical staff, and the detainee. Use of a restraint chair also helps to ensure that the detainee is properly positioned and stabilized for the insertion of the feeding tube and that the right amount of nutrition is received and retained by the detainees. A restraint chair is also used in United States federal correctional facilities and provides the safest and most reliable method for the administration of the nutritional requirements needed to protect and preserve the detainee's health and life. The chair is not used to deliberately inflict pain on detainees, or as a form of punishment or retaliation against them. The chair is ergonomically designed for the detainee's comfort and protection, with a padded seat and padded back support. Straps are positioned [redacted] to ensure the detainee is safely restrained. If needed, guard staff applies a spit shield to the detainee's face to prevent him from spitting on guards or nurses during the enteral feeding procedure. Furthermore, to ensure any risk is minimized, the detainee is constantly monitored by medical personnel while in the restraint chair. Some detainees have been participating in long term non-religious fasting for many years. Because of their ongoing compliance, some of these detainees are no longer considered a risk to medical personnel during this procedure, or they have mild medical conditions that require the rates to be slower. They have been allowed to receive enteral feeding in a cushioned recliner chair while watching television.

31. ~~(U)~~ A detainee is kept in the chair for only the time required to administer a feeding and to ensure the nutritional supplement is digested properly. A 10-15 minute observation period is necessary to ensure the detainee has tolerated the feeding and to permit digestion of the

nutritional formula. If the medical staff does not ensure the nutritional formula is properly digested, a detainee could induce vomiting and therefore place his health and life at greater risk. Detainees are offered pain relievers, such as ibuprofen, if they indicate any discomfort from the feeding procedure.

32. ~~(U)~~ Prior to enteral feeding, detainees are always permitted to use toilet facilities, which are available in their cells as well as in recreation areas. If they request to use the restroom prior to a feeding, that request will be accommodated, and a feeding can be delayed or rescheduled as needed. I have not personally observed a detainee having a bowel movement during enteral feeding nor have I heard that this has happened.

Medications During Feedings

33. ~~(U)~~ Reglan is the brand name for one of many drugs that are used to treat vomiting. Reglan is very rarely used by our medical staff as there are other anti-nausea drugs, such as Zofran or Phenergan, that are just as effective and have a reduced risk of negative side effects. Reglan is most commonly used in gastroparesis patients though it is often used for nausea in acute migraine treatment as well. It has been offered to patients suspected for gastroparesis at Guantanamo, though due to its side effect profile, it is not typically used. Some detainees who suffer from severe constipation often request that a liquid laxative be included in the feeding solution. This is given only upon their request. It is a liquid prescription and often larger volume, so it is easier for the detainee to take it via the nasogastric tube. Medications are not placed in the feed solutions, or otherwise given to a detainee, without his knowledge and consent.

Meals During Ramadan

34. ~~(U)~~ JMG staff makes every effort to accommodate the religious and cultural practices of the detainees. As has been done in the past, barring any unforeseen emergency or operational issues, JTF-GTMO will accommodate religious practices during Ramadan. JTF-GTMO will modify the hours of meal delivery, including enteral feeding, in accordance with the fasting hours, and detainees will be provided with a mid-night snack. JTF-GTMO has sufficient medical personnel on hand to provide detainees with the proper nutrition in a manner that is accordance with

Ramadan's fasting requirements. Accordingly, enteral feedings will be administered after sundown each day during Ramadan. At the end of Ramadan, detainees may participate in morning Eid prayer and feast meals will be offered to all detainees, including those who are engaged in non-religious fasting. Upon completion of Ramadan, the standard enteral feed schedule will then resume.

I declare under penalty of perjury under the laws of the United States of America that the forgoing is true, accurate and correct.

Dated: 17 APR 2014

[redacted]
Commander, Medical Corps, U.S. Navy

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents*.	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 2

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

~~UNCLASSIFIED//FOUO~~

JOINT MEDICAL GROUP JOINT TASK FORCE GUANTANAMO BAY, CUBA Title: MEDICAL MANAGEMENT OF DETAINEES WITH WEIGHT LOSS	SOP NO: JMG 001 Effective Date: 16DEC2013
SCOPE: JOINT MEDICAL GROUP, JOINT TASK FORCE , GTMO	

REFERENCES:

(a) DoDI 2310.08E Medical Program Support for Detainee Operations, 2006.

ENCLOSURES:

(1) Refusal to Accept Food or Water/Fluids as Medical Treatment
(2) Weight Loss Medical Evaluation Sheet
(3) Weight Loss Medical Flow Sheet
(4) Approval Authority for Initiation of Involuntary Enteral Feeding
(5) Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees on Long Term Non Religious Fast
(6) Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss
(7) Enteral Feeding Nursing Note
(8) Medical Equations, Calculations and Weight Formulas

I. BACKGROUND

A. A prolonged period of time without adequate food and water will have adverse health effects on the individual detainee and potentially the greater detainee population. Weight loss may be an indicator of long standing malnutrition or of an underlying medical problem, such as malignancy or infectious disease. Identification and early medical management of detainees with weight loss may prevent adverse health effects and death.

B. Patients with weight loss can be expected in any detained population. Maintaining adequate nutrition and health within a detained population is challenging. The medical management of detainees with weight loss in GTMO has evolved over time. The current medical management of detainees with weight loss in GTMO has been developed using procedures adapted from the Federal Bureau of Prisons.

II. POLICY

A. The DoD and Joint Task Force Guantanamo (JTF-GTMO) policy is to protect detainees' physical and mental health and provide appropriate treatment for disease. This includes preventing

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any serious adverse health effects or death from weight loss, chronic underweight or malnutrition. The Joint Medical Group (JMG) staff will provide health care monitoring and medical assistance as clinically indicated for detainees with weight loss.

B. Weight is one of the central non-invasive indicators of the health of the detainee. Historically, it has been shown that simple visual monitoring of detainees may miss clinically significant weight loss. Therefore, all detainees will be weighed at least monthly. Detainees who are of concern to the medical staff will be weighed more frequently as clinically indicated. Every attempt will be made to obtain weights voluntarily; however, weights may be obtained involuntarily to ensure compliance with this policy.

C. In the event a detainee refrains from eating or drinking to the point where it is determined by medical assessment that continued fasting will result in a threat to his life or seriously jeopardize his health, JMG medical personnel will make reasonable efforts to obtain voluntary consent for medical treatment. If consent cannot be obtained from the detainee, medical procedures necessary to preserve health and life shall be implemented without his consent pursuant to reference (a). When involuntary feeding/fluid hydration is medically required, the JMG Senior Medical Officer (SMO) will inform the JMG Commander. When the SMO and JMG Commander reach concurrence, they will inform the JTF Commander and request written approval to administer involuntary feeding/fluid hydration.

D. JMG will not initiate involuntary feeding/fluid hydration without the JTF Commander's knowledge and written approval. This approval authority does not preclude the Medical Officer from performing any emergent actions deemed medically necessary to preserve life and health.

E. Preventing [redacted] is important to maintaining good order and discipline in the detention environment, and in protecting detainee health. The procedures outlined in this SOP will be protected from release to detainees and other personnel, including JTF staff and visitors without a need to know, consistent with FOUO designation.

F. Definitions.

1. Clinically Significant Weight Loss. For the purposes of this instruction, clinically significant weight loss is defined as:

a. The detainee's weight is less than 85% of the calculated ideal body weight (IBW).

b. The detainee has experienced a weight loss of greater than 15% from his usual body weight. For those detainees whose usual body weight is less than their ideal body weight, a weight loss of greater than 5% is considered clinically significant.

c. Weight loss or underweight associated with evidence of deleterious health effects during any period of weight loss reflective of end-organ involvement or damage, to include, but is not limited to, seizures, syncope or pre-syncope, altered mental status, significant metabolic

derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are significantly hampered.

d. A pre-existing co-morbidity that might readily predispose the detainee to end organ damage (e.g. hypertension, coronary artery disease or any significant kidney disease).

e. A prolonged period of weight loss, usually defined as [redacted]

2. **Enteral feeder.** A detainee who the JTF Commander has authorized for involuntary feeding via an enteral feeding tube. It is important to note that an enteral feeder may or may not actually receive an enteral feed via a nasogastric tube on any specific day. Enteral feeders may still elect to eat a meal or to drink liquid nutrition despite being designated an enteral feeder

3. **Adequate Caloric Intake.** The number of calories required by a detainee to support daily metabolic functions and to maintain weight. Although this number varies by individual, for the purposes of this instruction, adequate caloric intake is considered to be [redacted] daily.

4. **Formulas:**

Usual Body Weight (UBW) = the greater of the following:
i. The weight of the detainee at in-processing physical exam.
ii. The average weight of the detainee for the past twelve months.

Ideal Body Weight (IBW) = [(Height in inches – 60) x 2.3 + 50] x 2.2

% Ideal Body Weight (% IBW) = [Current Weight (pounds) / Ideal Body Weight (pounds)] x 100

% Weight Loss (% WL) = [Usual Body Weight (pounds) – Current Weight (pounds) / Usual Body Weight (pounds)] x 100

III. Medical Management of Detainees with Weight Loss

A. Effective management of detainees with weight loss requires a close partnership between the JMG medical staff and the Joint Detention Group (JDG) guard force.

B. JDG guard forces monitor each detainee's consumption and refusal of meals and water and report this information daily [redacted] which is forwarded to the JMG SMO daily.

C. The JMG SMO or his designee will review [redacted] for all detainees who have missed meals. The SMO will review the clinical information pertaining to any detainee listed [redacted] as having missed meals, to include that detainee's weight trend.

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The SMO may order a detainee weight at that time, or may order that the detainee be weighed more frequently than what is normally required for detainees in this instruction.

D. If the result of a detainee weight qualifies as a clinically significant weight loss, the SMO will direct the detainee's medical provider to conduct an assessment. The intent of the assessment is to consider any medical and or behavioral cause of the weight loss.

E. Because of the presence of latent untreated tuberculosis in the detainee population, any detainee who loses [redacted] will have a chest radiograph to rule out the possibility of active tuberculosis.

F. Using Enclosure (3), *Weight Loss Medical Flow Sheet*, a medical provider will perform a complete medical record review, an intake (food/fluids) history, and a general physical examination to include vital signs, weight, and Percent Ideal Body Weight (% IBW). The medical provider may order clinically indicated laboratory tests to assess the detainee's physical and metabolic status, including but not limited to EKG, urinalysis, serum basic metabolic profile, liver function tests (LFTs), Magnesium (Mg), phosphate (PO4) and calcium (Ca). Once completed, Enclosure (2) will be signed by the medical provider and placed in the detainee's medical record.

G. The SMO will notify the Officer-in-Charge of the Behavioral Health Services (BHS) of any detainees who are added or removed from the list of individuals participating in long term non-religious fasting. If indicated, the BHS will perform a mental status exam and psychological assessment of the detainee. Documentation of the results of this exam and follow-up treatment plan will be placed in the detainee's medical record.

H. A JMG medical provider will advise each detainee who displays clinically significant weight loss as to the need to maintain weight. The medical provider may offer a nutritional consult. The medical staff will explain to the detainee via a linguist the health risks faced by the detainee resulting from clinically significant weight loss and encourage the detainee to resume eating sufficient food and drinking water. Documentation of this counseling will be placed in the detainee's medical record.

I. After the initial medical evaluation, the medical providers will continue to assess the health of the detainee biweekly or as clinically indicated and document their findings using Enclosure (3), *Weight Loss Medical Flow Sheet*, available electronically on the network share drive.

J. The medical provider will discuss the medical care of the detainee with the SMO biweekly or as clinically indicated. The SMO will brief the chain of command of any serious medical issues concerning the detainees.

K. When a JMG medical provider determines that the detainee's life or health is threatened due to weight loss, immediate medical intervention may be indicated. In such a case, the JMG medical provider will notify the SMO. The medical provider shall attempt to obtain voluntary

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consent for intervention. The medical provider shall document their counseling efforts and treatments in the detainee's medical record.

L. If medical intervention is required for a detainee who is losing weight, the SMO will notify the JMG Commander. The SMO or his designee will attempt to obtain voluntary consent for the intervention. If the detainee continues to refuse reasonable care necessary to safeguard the detainee's health, it may be necessary to intervene involuntary. If this occurs, the SMO will discuss the care plan with the JMG commander. If the SMO and the JMG Commander concur with the proposed care plan, the JMG Commander or SMO will make a specific involuntary intervention request to the JTF Commander. Upon approval from the JTF Commander, the SMO will order the treatment. Usually, the SMO/JMG Commander will receive the JTF Commander's authorization [redacted] email.

M. If involuntary enteral feeding is clinically indicated and authorized, Enclosure (4), *Approval Authority for Initiation of Involuntary Enteral Feeding*, will be completed by the SMO and placed in the detainee's medical record. These detainee will then be designated as an enteral feeder.

N. The SMO or his/her representative will report detainees approved for enteral feeding via the JMG [redacted] SITREP to leaders within the JTF with a demonstrated need-to-know, including JTF Commander. [redacted]

O. Enteral feeders will be fed according to a schedule approved by the SMO as coordinated with the guard staff. All enteral feeders will be offered standard detainee meals daily. If the detainees refuse meals, they will be offered to consume the enteral feed solution orally. If they refuse their meals and the opportunity to consume their enteral feed solution orally, they will be asked to accept enteral feeding voluntarily. Only after they refuse all of the above will involuntary enteral feeding be initiated.

P. Clinical protocols for enteral feeding using graduated, continuous, and intermittent enteral feed infusions are found in Enclosure (5), *Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees with Weight Loss*, which also includes guidance for the management of common electrolyte deficiencies. If the SMO deems it medically safe (e.g. low risk of re-feeding syndrome) based on the duration of the detainee's fast, involuntary enteral feeding may be initiated with graduated intermittent feeds as opposed to a continuous infusion.

Q. Enclosure (6), *Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss*, establishes the steps to be used in performing enteral feedings, and Enclosure (8), *Medical Equations, Calculations and Weight Formulas* will be used to calculate caloric goals/needs.

R. Routine deviations from the above procedure for specific detainees must be approved by Commander, JTF-GTMO.

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S. Enteral Feeders will be weighed weekly, or more frequently as clinically indicated. Any continued weight loss in these detainees will be reported to the Commander, JTF.

IV. Weighing of Detainees

A. The JMG Weight Monitoring Nurse will review the [redacted] frequently throughout each month ensuring each detainee has a weight entered for the current month.

B. The JMG Weight Monitoring Nurse will notify the JMG OICs and charge nurses of all detainee ISNs that need to be weighted for the month.

C. The JMG OICs will notify the JDG Watch Commander (WC) or Block NCO which detainee weights are still needed. Once the weights are obtained, the JMG Corpsman will report the detainee ISNs and weights to the charge nurse for documentation.

D. Detainee weights may be obtained on the cell blocks, during routine clinic and medical space visits, or while the detainee is an inpatient in the Detention Hospital or Behavioral Health Unit.

E. Scales will be zeroed prior to measurement.

F. Detainees should stand in the center of the scale without assistance and without touching walls or any nearby objects. If the detainee is unable to stand, he may be weighed while sitting in a feeding chair or wheelchair using a wheelchair scale, but the weight of the chair must be subtracted from the total weight obtained.

G. When detainees are weighed while on backboards or wearing shackles or other restrictive devices, the weight of those devices will be subtracted from the measured weight.

H. Once the guards have the detainee on the scale, a JMG member, usually a Hospital Corpsman assigned to the area where the detainee is located, will note the weight and give the measurement to the JMG Charge Nurse, who will forward the weight to the JMG Weight Monitoring Nurse. The JDG guard staff will enter the weight [redacted].

I. The JMG Weight Monitoring Nurse will report to the JMG Commander via the SMO and the JMG Deputy Commander any detainee who is overdue on their weights.

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V. Monitoring Detainee Weights

A. The Charge Nurse will document the weight on the [redacted] in the detainee's medical record.

B. The SMO will receive daily information on missed meals and detainee weights [redacted]

C. The Weight Monitoring Nurse and the SMO will review [redacted] for trends and analysis no less than monthly to identify any detainee whose weight loss has become clinically significant as defined above and to obtain a long term overview of all detainee weights.

VI. Reporting Detainee Weights

A. Detainees being monitored for weight loss will be reported [redacted]

B. The JMG Commander and the JMG Deputy Commander may request special analysis of the information [redacted] from the SMO at any time.

VII. Dietary Consultation

A. JMG providers may request a dietary consult for the detainee with the NH GTMO dietician for detainee education and recommendations to achieve optimal weight, potential medical consequences of obesity, health benefits of maintaining a normal IBW of 85% to 100%, and strategies to reduce weight and limit caloric intake.

VIII. In-processing

A. Upon first arrival to JTF-GTMO, the height and weight of each detainee will be determined and recorded [redacted]

IX. Out-processing

A. Each detainee scheduled for transfer from JTF-GTMO will be weighed during out-processing. The detainee's in-processing and out-processing weights will be noted on the final narrative summary.

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X. Cessation of Enteral Feeding

A. Most detainees will commence oral feeding on their own at some point. [redacted] they will no longer be designated enteral feeders. These detainees will continue to be monitored for their weight, fluid consumption and caloric intake. [redacted] a detainee may be considered for less frequent medical monitoring. [redacted] the SMO will notify the JMG Commander. If the SMO and JMG Commander concur, they will request from the JTF Commander permission to resume enteral feeding.

B. For evidence of malabsorption or other select cases, the SMO, with the approval of the JMG Commander, will determine an individualized care plan for transitioning an enteral feeder back to an oral diet. Generally, a three- to five-day period is sufficient for the transition to an oral diet. If the detainee has been intermittently consuming food by mouth during a period of weight loss, the transition to an oral diet may be achieved sooner.

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Refusal to Accept Food or Water/Fluids as Medical Treatment

Detainee Number _____ Age _____ Date _____

The above detainee has refused food and/or water as medically recommended by the Medical Officer.

The grave risks of not following the medical advice directing him to eat life-sustaining food and to drink water/fluids have been explained to the detainee. He states he understands that as a direct result of his refusal to eat and/or drink, he may experience hunger, nausea, tiredness, feeling ill, headaches, swelling of his extremities, muscle wasting, abdominal pain, chest pain, irregular heart rhythms, altered level of consciousness, organ failure and/or coma. He states he understands that his refusal to eat life-sustaining food or drink water/fluids and to follow medical advice may cause irreparable harm to himself or lead to his death. He states he understands that this is not a complete list of the risks involved with the refusal to follow medical advice.

The detainee states he understands the alternatives available to him including oral food and fluid oral rehydration solutions, oral nutritional supplements, and intravenous fluid hydration.

The detainee states he fully understands the risks to his health if he does not accept food and water as advised above.

Translator/ Witness Signature_____

Medical Provider Signature _____

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Enclosure (1)

Weight Loss Medical Evaluation Sheet

Detainee Number: _____ Date of Evaluation: _____

Date of Onset: _____ Drinking Fluids Yes No

Number of Meals Missed: _____

HPI:

_____

MEDS

_____

ALLERGIES: NKDA or _____ FOOD ALLERGIES: _____

PMH

Physical Assessment:

In processing Wt: _____ lbs Usual Wt _____ lbs/date: _____ IBW _____

Current Wt: _____lbs _____% IBW %Wt Loss: _____

Heart Rate: _____ BP: _____/_____ RR _____ T _____ LOC: Yes No

Other Pertinent Physical Exam and Laboratory Findings:

Assessment: Detainee with Weight Loss

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. See *Refusal to Accept Food or Water/Fluids As Medical Treatment*, Enclosure (1).
2. Document and execute follow up plan.
3. Other:

Medical Provider: _____

Enclosure (2)

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Weight Loss Medical Flow Sheet

Ordered Weight frequency:

Detainee ISN: ###

Date	Drinking ?	Eating?	Document caloric intake am EF po B	am EF po L	pm EF po D	pm EF po Other	[illegible]	[illegible]	(lbs)	Comments: dizzy, nausea, constipation, diarrhea, abd pain unable to pass tube
2013	ml	Y/N							Weight	(ambulatory, coherent, alert, oriented verbal, etc)

Signature Attending Physician

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Enclosure (3)

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
Date/Time	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry) JTF-JMG, Medical Department, Guantanamo Bay, Cuba

Approval Authority for Initiation of Involuntary Enteral Feeding

Detainee ISN has experienced clinically significant weight loss.

He meets the following clinical criteria for involuntary enteral feeding:

___ There is evidence of deleterious health effects reflective of end organ involvement or damage, to include, but not limited to, seizures, syncope or pre-syncope, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are hampered.

___ There is a pre-existing co-morbidity that might readily predispose to end organ damage (e.g. hypertension, coronary artery disease or any significant heart condition, renal insufficiency or failure, endocrinopathy, etc.).

___ There is a prolonged period of weight loss.

___ The detainee is at a weight less than 85% of his calculated Ideal Body Weight (IBW).

___ The detainee has experienced significant weight loss (greater than 15%) from previously recorded or in-processing weight.

___ The detainee's UBW is less than his IBW and he has lost greater than 5% of his UBW

Involuntary feeding is required to prevent risk of death or serious harm to health.

Written approval to initiate involuntary enteral feeding has been obtained from Commander, Joint Task Force Guantanamo as required per Standard Operating Procedure 001. (Note: e-mail written approval is acceptable)

Senior Medical Officer, JTF-GTMO/JMG

DETAINEE'S IDENTIFICATION NUMBER:

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDICAL RECORD
STANDARD FORM 600 (rev. 9/85)

Enclosure (4)

Clinical Guidelines for the Evaluation, Resuscitation, and Feeding of Detainees with Weight Loss

*****Note: These are *only* Guidelines. Clinical presentation of the patient will determine the individualized patient plan of care prescribed by the Credentialed Medical Provider! *****

Once a detainee with weight loss meets the criteria for enteral feeding, the following protocol may be initiated. If clinically indicated, after initial IV fluid resuscitation, the SMO may initiate intermittent or continuous enteral feedings of the detainee. In the event of multiple detainees with weight loss, isolating patients from each other is vital to prevent them from achieving solidarity and coercing other detainees to also lose weight. [redacted] initial IV fluid resuscitation lasting approximately 24 hours can occur in the Detention Hospital. Afterwards, the detainee should be transferred back to the camps to begin enteral feeding in an environment of single cell operations.

I. Hospital Day #1: Admit to the Detention Hospital

Assess vital signs upon admission and periodically as clinically indicated thereafter.

Assess need for fluid resuscitation.

If not drawn recently, consider obtaining a complete blood count (CBC), basic metabolic panel, calcium (Ca^{++}), magnesium (Mg^{++}), phosphorous (phos), and creatine kinase (CK).

Consider a 12 lead EKG upon admission.

The detainee's weight should be obtained and recorded upon admission and daily thereafter, unless a lesser frequency is clinically indicated.

When fluid resuscitation is medically indicated, it should begin with a 1-2 liter intravenous (IV) bolus of (isotonic crystalloid) normal saline or Ringer's Lactate. The amount of the IV bolus will be decided after reviewing the detainee's medical history for any co-morbid diseases.

Thiamine 100 mg IV one time dose, administered prior to giving any Dextrose or D_5 may be ordered and administered in the clinic [redacted]

Follow with standard IV fluid hydration formulation: one liter of D_5 ½ normal saline with 20 mEq KCL, one vial of (water soluble) MVI, 500 mg of magnesium sulfate, one vial of trace elements, and 1 mg of folic acid. Run the IV fluid @ 100 ml/hr for 10 hours. Oral supplements with potassium phosphate, magnesium oxide, folate, and multivitamin may be substituted if the patient will take by mouth.

Once the IV isotonic crystalloid rehydration fluid has infused, administer maintenance fluids of D_5 ½ normal saline with 20 mEq KCL @ 100 ml/hr, [redacted]

PRN medications

1) Glucose, 50 grams (D_{50}, 1 amp) IV if blood sugar < 60 and detainee lethargic or unresponsive.

2) Tylenol 650mg PO Q 6 hrs PRN pain, headache.

3) Mylanta 15-30 ml PO Q 4 hrs PRN indigestion, heartburn.

II. Hospital Days #2 and #3: Initiation of Enteral Nutrition

Proceed with enteral feeding tube placement and feeding as per Enclosure (6) using an 8 to 12 French feeding tube.

When the patient is at high risk for refeeding syndrome, consider ordering the following labs on days 2-4 of enteral feeding: basic metabolic panel, calcium, magnesium, phosphorus.

Intermittent Enteral Nutrition

If patient is clinically stable, nutritional supplementation can usually be provided via intermittent feedings.

This is usually accomplished using a daily or twice daily schedule with an appropriate quantity of the daily calories being delivered at each feeding. If enteral feeding is initiated via the intermittent method, titrate to goal gradually over several days to decrease the risk of refeeding syndrome. [redacted]

Medical restraints (e.g, chair restraint system) should be used for the safety of the detainee, medical staff, and guard.

The recommended requirements to maintain intermittent feedings instead of continuously are as follows:

[redacted]

2) Four cans of Pulmocare, Jevity 1.5 Cal, TwoCal HN, or equivalent nutritional supplement.

3) Labs as needed to validate normal electrolyte status.

4) Stable clinical condition.

III. <u>Discharge from Detention Hospital:</u> Detainee Moves to Feeding Location

Once the detainee is medically stable the Medical provider will determine when the detainee can be discharged from the Detention Hospital and transferred to the feeding location in the camps. Prior to leaving the DH, the detainee's feeding tube will be removed. Medical staff shall determine the minimum number of enteral feedings necessary to meet the detainee's required nutritional needs.

Management of Enterally Fed Detainees Who Have Resolution of Their Weight Loss

The medical staff will manage these individuals to avoid complications associated with the resumption of oral nutrition.

[redacted] the attending physician deems it to be medically appropriate, enteral feeding will be discontinued and oral self-feeding by the detainee shall resume.

Resumption of Oral Nutrition Includes the Following Strategies

a. Offer the detainee his choice of available standard detainee meals.
b. Monitor the detainee for evidence of refeeding syndrome, often characterized by decreased serum phosphorus, magnesium, and potassium levels and peripheral edema.
c. [redacted] the SMO deems it medically appropriate, the detainee can usually be removed from the weight loss list.
d. Enteral feeding shall resume at any point it becomes medically necessary in accordance with this SOP.

Resolved Weight Loss Follow-up Care

a. A medical provider will perform a complete medical evaluation on all prior enterally fed detainees within approximately 2 weeks after resumption of a regular diet. This medical evaluation will include vital signs, weight, physical examination, and labs if clinically indicated.
b. Prior enterally fed detainees found to have ongoing medical needs or exhibit signs and symptoms associated with re-feeding syndrome will have follow up visits as medically indicated.
c. A member of the medical staff will counsel the detainee regarding the health risks associated with further weight loss.

d. The medical provider may consider submitting a consult request to NH GTMO nutritionist for optimal diet evaluation and planning

Management of Common Electrolyte Deficiencies

Hypokalemia – Replace potassium with KCL elixir/tablets, 10 milliequivalents for every 0.1 mEq/L below the normal value of 4.0 in the detainee's serum. For example, if a detainee has a serum potassium of 3.4 mEq/L, 60 milliequivalents of KCL elixir/tablets should be ordered.

Hypomagnesaemia – Replace with magnesium oxide. Crush four 400 mg tablets (approximately 960 mg of bioavailable magnesium) and mix in water before adding to enteral solution. Continue daily until normal serum Mg^{++} level is confirmed by lab draw. Oral magnesium may cause diarrhea. Alternatively for severe hypomagnesaemia, 1-2 grams of magnesium sulfate may be infused intravenously over 30 minutes.

Hypophosphatemia – Replace with 4 packets of K-phos daily (total of 1000 mg of phosphorus, 1112 mg of potassium, and 656 mg of sodium daily) until normal serum phosphorus level is confirmed by lab draw. Alternatively, for severe hypophosphatemia, 15 mmol of sodium phosphate mixed in 250 ml of ½ NS may be given over 4-6 hours. Usually, this is repeated for a total of 4-8 doses.

Nursing Staff Clinical Procedure Checklist for Intermittent Enteral Feeding of Detainees with Weight Loss

NOTE: IF THE RN OR HM FEELS THEY ARE IN ANY DANGER OF PERSONAL HARM DURING AN ENTERAL FEED, THEY ARE TO WITHDRAW FROM THE SITUATION AND IMMEDIATELY INFORM THE GUARDS OF THEIR CONCERNS.

I. **Preparation for Enteral Feeding:**

- ☐ Verify Provider's Orders.
- ☐ Confirm detainee was offered an oral, liquid meal.
- ☐ Prepare feeding solution according to Provider's Orders [redacted]
- ☐ Clearly mark enteral feeding reservoir bag with detainee's ISN and date.
- ☐ [redacted]

  Note: if the detainee must be enterally fed in a hospital bed or on a gurney, ensure head of bed is elevated 45 degrees
- ☐ [redacted]
- ☐ Direct the guards to wash the detainees hands if they are soiled with feces or other bodily substances.
- ☐ [redacted]
- ☐
- ☐ Obtain a new enteral feeding tube.
- ☐ Initiate medical monitoring of detainee: assess vital signs, circulation, discomfort.
- ☐ Initiate Enteral Feed Nursing Note.

II. **Initiate Enteral Feeding:**

- ☐ Perform Enteral Feeding Time Out, at least [redacted] JMG Staff members participate.

The Registered Nurse will place the feeding tube in the stomach as follows:

- ☐ Prepare feeding tube with viscous lidocaine, olive oil, or sterile surgical lubricant according to the detainee's choice.
- ☐ Offer the detainee topical anesthesia (viscous lidocaine) to the affected nostril.
- ☐ Gently pass the feeding tube via the nasal passage into the stomach.
- ☐ If required to reduce head and jaw motion during insertion of the EF tube:
  - o While the detainee is seated and appropriately restrained in the feeding chair, [redacted] guard will position themselves behind the detainee and hold the detainee's head in the midline position.
  - o [redacted]

Enclosure (6)

[redacted]

- ☐ If a detainee is attempting to bite or chew the tube, the RN will ask the detainee to open his mouth for a visual confirmation that the tube is intact. If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF.

Confirmation of Feeding Tube Placement: [redacted] JMG Staff Members, including at least [redacted] Registered Nurse, will confirm proper tube placement as follows:

- ☐ Insert 10 mLs of air into the tube as a [redacted] JMG staff member auscultates the stomach.
- ☐ Auscultate the stomach while the [redacted] JMG member inserts 10 mLs of air into the stomach.
- ☐ Simultaneous auscultation is permissible as long as [redacted] JMG members are able to independently confirm tube placement.
- ☐ Insert 10 mL test dose of water, aspirate, observe for return of stomach fluid.
- ☐ If there is any doubt about correct tube placement, remove the feeding tube.

Following confirmation of tube placement, continue with the following steps:

- ☐ Tape the feeding tube to the detainee's nose and forehead.
- ☐ Connect the feeding tube to the reservoir bag.
- ☐ Begin the feed flow, adjust the rate to the detainee's condition and tolerance.

III. During Enteral Feeding:

- ☐ Ensure a Hospital Corpsman is present with the detainee and observing the detainee's condition and tolerance of the feed continuously throughout the entire administration of the enteral feed procedure.
- ☐ Report any detainee threats of physical assault or exposure to body fluids to the guard staff immediately.
- ☐ The detainee is not to be in the restraint chair for more than two hours.

IV. RN Assessment and Intervention:

- ☐ Assess detainee for nausea: if present, offer PRN medication as ordered.
- ☐ Assess detainee for pain to abdomen, observe for distention; slow rate until complaint of pain is resolved.

V. Completion of Enteral Feeding:

- ☐ Once feeding is complete, gently remove the feeding tube.
- ☐ Assess detainee for nausea, discomfort.
- ☐ Complete Enteral Feed Nursing Note.
- ☐ Document number of calories administered via enteral feeding on the Enteral Feed Nursing Note and Weight Loss Medical Flow Sheet.

[redacted]

Enclosure (6)

- Flush the enteral feed reservoir bag with at least 300 mL of tap water or until clean. The reservoir may be used again for the same detainee on the same day. Dispose of the reservoir bag at the end of the day.
- Following completion of enteral feeding, the guard force will return the detainee to cell and observe his status.

VI. Detainee Biting of Enteral Feed Tube:

A detainee undergoing enteral feeding (EF) may attempt to bite and swallow the feeding tube, requiring serial exams, ongoing medical care, and possible removal of the tube via an EGD procedure. Identification of these detainees and management of the EF tube will assist the RN in reducing the incidence of this event. The following guidance is provided:

- When the detainee attempts to bite or chew the tube, the RN will direct the detainee to open his mouth for a visual confirmation that the tube is intact.
  - If the detainee refuses, the RN shall immediately remove the tube, inspect it for damage, and re-insert it to accomplish the EF following enteral feeding tube insertion guidelines outlined in this SOP.
- When the detainee positions the tube between his teeth, the nurse will:
  - Simultaneously turn off feed and stabilize the proximal end of the tube.
  - Direct the guard staff to stabilize detainee's head in the midline position.
  - Maintain traction on the proximal end of the tube until the detainee releases the tube from between his teeth. This may take considerable time.
  - Remove the tube from the detainee's nose.
- For detainees who continually attempt to bite the tube, the RN will direct guard staff to maintain 1:1 visual monitoring of detainee during EF sessions.

VII. JMG Staff Responses to Detainee:

- Detainee directs a change to EF contents or order of contents:
  Respond: **"This is the formula that the doctor has ordered for your nutritional requirements. I am not permitted to make any changes to the order."**
- Detainee demands to speak to the doctor:
  Respond: **"I will write a note in your chart for the doctor"**
- Detainee directs the nurse to place him in a particular location during EF:
  Respond: **"That decision is made by the guards."**

VIII. Quality Improvement Strategies

- The JMG Quality Management Nurse, in collaboration with SMO, SNE and the Medical OICs will implement performance measures to identify performance benchmarks and gaps in implementing the JMG Enteral Feeding process.

- Measurements will be structured to identify gaps in performance and develop strategies to reduce those gaps and maximize enteral feeding effectiveness and efficiency.

- The JMG Quality Management Nurse will collaborate with the JMG Training Officer to structure training sessions as needed to maximize enteral feeding program outcomes.
- Performance measures may include any of the following:
  - Hospital Corpsman or Registered Nurse present to directly observe detainee during entire administration of enteral feed.
  - All results for labs ordered during Weight Loss Medical Evaluation are in chart.
  - Post Weight Loss Medical Evaluation completed within 2 weeks and in chart.
  - Detention Hospital admission weight obtained, listed in chart.
  - Thiamine (PO or IV) administered before Dextrose or D5 for new long-term fasters.
  - Detainee not in restraint feeding chair longer than 2 hours.
  - Enteral feed Nursing Note is complete, signed by RN and in chart.
  - Enteral feeding tube placement confirmed by [redacted] JMG staff, including at least [redacted] RN.
  - Enteral Feed Reservoir bag is clearly marked with detainee's ISN and date.
  - Detainee is fed with a new enteral feeding tube each time.
  - Form: *Refusal to Accept Food or Water/Fluids as Medical Treatment* completed and in chart.
  - Form: *Approval Authority for Initiation of Involuntary Enteral Feeding* completed and in chart.

~~FOR OFFICIAL USE ONLY~~

STANDARD OPERATING PROCEDURE: SOP: JTF-JMG # 001
MEDICAL MANAGEMENT OF DETAINEES WITH WEIGHT LOSS Page 21 of 24

ENTERAL FEED NURSING NOTE

ISN:		AM/PM		Date:	

Detainee placed in restraints/restraint chair by guard staff for enteral feeding procedure.

INITIAL ASSESSMENT/VITAL SIGNS

☐ Detainee required Forced Cell Extraction to restraint chair/gurney or ☐ Detainee ambulated to feed chair/gurney.
Detainee placed in chair/gurney at _____.
☐ Detainee refused vital signs (For long-term fasters only)
☐ Vital Signs: T_____ HR _____ RR _____ BP_____ O2 sat _____% Weight_____ ☐ Pulses WNL x 4
☐ Detainee denies nausea/vomiting ☐ Detainee denies pain
☐ Other _____

PROCEDURE NOTE: INSERTION OF FEEDING TUBE

☐ Enteral Feeding Time Out performed with [redacted] Feed Team members.
Using: ☐ olive oil ☐ 2% viscous lidocaine ☐ sterile lubricant, an ☐ 8Fr ☐ 10Fr enteral feeding tube was inserted in the
☐ Right ☐ Left nostril using standard nursing procedure.
☐ Placement in stomach was confirmed by air auscultation by [redacted] JMG staff (at least [redacted] RN) and test dose with 10ml water.
Type of Nutritional solution: ☐ Pulmocare ☐ Ensure ☐ other _____ amount: _____ml _____ calories
Additives water _____ml ☐ MgO _____ mg ☐ Thiamine_____mg ☐ K-Phos _____mg ☐ Multivitamin X ____ tab
Other:

ASSESSMENT DURING ENTERAL FEEDING

Enteral feeding initiated at_____.
Circulation assessed using at least one of the following every 15 minutes while restrained:
☐ No skin discoloration noted ☐ No edema noted ☐ Pulse Rate/Rhythm WNL ☐ Capillary Refill Time <3 seconds
Complains/ Complications during feed: ☐ None ☐ Other _____

POST ENTERAL FEEDING ASSESSMENT

Enteral Feeding completed and Enteral Feeding Tube removed at _____.
Detainee's condition post enteral feed:
☐ Detainee denies pain ☐ Detainee denies nausea/vomiting ☐ No Injury/complaint noted
☐ Injury/complaint noted. Describe:_____
Physician notified (if applicable): Name:_____ Time:_____

Restraints released at _____ **and detainee released to guard staff**

☐ Detainee required Forced Cell Extraction back to cell *OR* ☐ Detainee ambulated back to cell.
HM/RN note:

_____

_____

_____

_____

HM signature: _____ **Date/Time:** _____

RN signature: _____ **Date/Time:** _____

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Enclosure (7)

[redacted]

MEDICAL EQUATIONS, CALCULATIONS AND WEIGHT FORMULAS

Determination of Energy Requirements: TOTAL CALORIE PER KILOGRAM METHOD

Classification	Kcal/kg
Morbid obesity	20
Starvation, Ventilated, Intensive Care Unit	25
Ambulatory Maintenance	25-35
Malnutrition/ Moderate Stress	30-35
Severe Injuries/ Stress	35-45

HARRIS -BENEDICT EQUATION:

Men (kcal/day) = [66.47 + (13.75 x weight (kg)) + (5 x height (cm)) – (6.76 x age)] x activity factor x stress factor

Activity Description	Factor	Stress Description	Factor
Chair or bed bound	1.2 x BEE	Elective surgery	1 – 1.1 x BEE
Seated work with little movement	1.4 – 1.5 x BEE	Multiple trauma	1.4 x BEE
Seated work with little strenuous leisure activity	1.6 – 1.7 x BEE	Severe infection	1.2 – 1.6 x BEE
Standing work	1.8 – 1.9 x BEE	Peritonitis	1.05 – 1.25 x BEE
Strenuous work or highly active leisure activity	2 – 2.4 x BEE	Multiple/long bone fractures	1.1 – 1.3 x BEE
30 – 60 minutes strenuous leisure activity 4 – 5 times/week	2.3 – 2.7 x BEE	Infection with trauma	1.3 – 1.55 x BEE
		Sepsis	1.2 – 1.4 x BEE
		Closed head injury	1.3 x BEE
		Cancer	1.3 – 1.45 x BEE
		Burns	1.5 – 2.1 x BEE
		Fever	1.2 x BEE (per 1°C >37°C)

Determination of Protein Requirements:

Condition	Grams/kg/day
Renal Failure/Dysfunction	0.6 – 0.8 (40 gram min)
Dialysis Patients (moderate stress)	1 – 1.2
Dialysis Patients (high stress) Sepsis Liver Failure/Cirrhosis Re-feeding Syndrome	1.2 – 1.5
Multiple trauma	1.3 – 1.7
Catabolism	1.2 – 2
Post-op	1 – 1.5

[redacted]

Enclosure (8)

Determination of Fluid Requirements:

	Free Water Requirement
1st 10 kg	100 mL/kg
2nd 10 kg	50 mL/kg
Each kg >20 kg	20 mL/kg (≤50 years)
	15 mL/kg (>50 years)
Method 2 – Age	
Young Athletic Adult	40 mL/kg
Most Adults	35 mL/kg
Elderly Adults	30 mL/kg
Method 3 – Energy Expenditure	
1 mL/kcal energy expenditure	

Sources:
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4. Shikora S, et al. *Nutritional Considerations in the Intensive Care Unit.* Iowa: Kendall/Hunt Publishing Company: 2002.
5. Shronts EP ed. *Nutrition Support Dietetics Core Curriculum*, 2nd ed. Rockville, MD: American Society of Parenteral and Enteral Nutrition: 1993.
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8. Zaloga, GP. *Nutrition in Critical Care.* St. Louis: Mosby: 1999

Enclosure (8)

~~UNCLASSIFIED~~

STANDARD OPERATING PROCEDURE: SOP: JTF-JMG # 001
MEDICAL MANAGEMENT OF DETAINEES WITH WEIGHT LOSS

APPROVED BY:

[redacted] [redacted] 16 Dec 13
CDR, JMG
Commander, Joint Medical Group Date

RECOMMENDED BY:

[redacted] [illegible] 16 Dec 13
Signature/ Printed Name Required: ☒ Yes ☐ No
Deputy Commander, Joint Medical Group Date

/
Signature/ Printed Name Required: ☐ Yes ☐ No
Senior Medical Officer Date

/
Signature/ Printed Name Required: ☐ Yes ☐ No
Senior Nurse Executive Date

/
Signature/ Printed Name Required: ☐ Yes ☐ No
Director For Administration Date

/
Signature/ Printed Name Required: ☐ Yes ☐ No
Medical Planner Date

/
Signature/ Printed Name Required: ☐ Yes ☐ No
Senior Enlisted Leader Date

/
Signature/ Printed Name Required: ☐ Yes ☐ No
Director, Behavioral Health Services Date

REVIEW LOG: Directorate Reviewer:
Sig: Date:
Sig: Date:
Sig: Date:

P SUPERCEDED/ CANCELLED THIS DATE.

/
Signature/ Printed Name
Commander, Joint Medical Group Date

~~UNCLASSIFIED~~

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents.*	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 3

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

Department of Defense
INSTRUCTION

NUMBER 2310.08E
June 6, 2006

USD(P&R)

SUBJECT: Medical Program Support for Detainee Operations

References: (a) Assistant Secretary of Defense (Health Affairs) Memorandum, "Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States," June 3 2005 (hereby canceled)
(b) DoD Directive 5100.77, "DoD Law of War Program," December 9, 1998
(c) DoD Directive 2310.01E, "The DoD Detainee Program," August 18 1994, under revision
(d) DoD Directive 5136.1, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," May 27, 1994
(e) through (k) see Enclosure 1

1. PURPOSE

This Instruction:

1.1. Reissues Reference (a) as a DoD Instruction.

1.2. Establishes policy and assigns responsibility, consistent with References (b) through (d), DoD Directive 3115.09, and Section 1403 of the Detainee Treatment Act of 2005 (References (e) and (f)) for medical program support for detainee operations.

1.3. Reaffirms the responsibility of health care personnel to protect and treat, in the context of a professional treatment relationship and established principles of medical practice, all detainees in the control of the Armed Forces during military operations. This includes enemy prisoners of war, retained personnel, civilian internees, and other detainees.

2. APPLICABILITY AND SCOPE

This Instruction applies to the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all

other organizational entities in the Department of Defense (hereafter referred to collectively as the "DoD Components").

3. DEFINITIONS

3.1. Behavioral Science Consultants (BSCs). Health care personnel qualified in behavioral sciences who are assigned exclusively to provide consultative services to support authorized law enforcement or intelligence activities (similar to behavioral science unit personnel of a law enforcement organization or forensic psychology or clinical social work practitioners supporting the criminal justice, parole, or corrections systems).

3.2. Detainee. The definition in Reference (c) applies to this Instruction.

3.3. Health Care Personnel. An individual who has received special training or education in a health-related field and who performs services in or for the Department of Defense in that field. A health-related field may include administration, direct provision of patient care, or ancillary or other support services. Health care personnel include, but are not limited to, individuals licensed, certified, or registered by a government agency or professional organization to provide specific health services. Health care personnel covered by this Instruction include those assigned as BSCs and also include members of the Uniformed Services, civilian employees, and contractor personnel in a health-related field acting in support of any DoD Component.

4. POLICY

It is DoD policy that:

4.1. Basic Principles. Health care personnel (particularly physicians) perform their duties consistent with the following principles.

4.1.1. Health care personnel have a duty in all matters affecting the physical and mental health of detainees to perform, encourage, and support, directly and indirectly, actions to uphold the humane treatment of detainees and to ensure that no individual in the custody or under the physical control of the Department of Defense, regardless of nationality or physical location, shall be subject to cruel, inhuman, or degrading treatment or punishment, in accordance with and as defined in U.S. law.

4.1.2. Health care personnel charged with the medical care of detainees have a duty to protect detainees' physical and mental health and provide appropriate treatment for disease. To the extent practicable, treatment of detainees should be guided by professional judgments and standards similar to those applied to personnel of the U.S. Armed Forces.

4.1.3. Health care personnel shall not be involved in any professional provider-patient treatment relationship with detainees the purpose of which is not solely to evaluate, protect, or improve their physical and mental health.

4.1.4. Health care personnel, whether or not in a professional provider-patient treatment relationship, shall not apply their knowledge and skills in a manner that is not in accordance with applicable law or the standards set forth in Reference (c).

4.1.5. Health care personnel shall not certify, or participate in the certification of, the fitness of detainees for any form of treatment or punishment that is not in accordance with applicable law, or participate in any way in the administration of any such treatment or punishment.

4.1.6. Health care personnel shall not participate in any procedure for applying physical restraints to the person of a detainee unless such a procedure is determined to be necessary for the protection of the physical or mental health or the safety of the detainee, or necessary for the protection of other detainees or those treating, guarding, or otherwise interacting with them. Such restraints, if used, shall be applied in a safe and professional manner.

4.2. Medical Records. Accurate and complete medical records on all detainees shall be created and maintained. Medical records must be maintained for all medical encounters, whether in fixed facilities or through medical personnel in the field.

4.3. Treatment Purpose. Health care personnel engaged in a professional provider-patient treatment relationship with detainees shall not participate in detainee-related activities for purposes other than health care. Such health care personnel shall not actively solicit information from detainees for other than health care purposes. Health care personnel engaged in non-treatment activities, such as forensic psychology, behavioral science consultation, forensic pathology, or similar disciplines, shall not engage in any professional provider-patient treatment relationship with detainees (except in emergency circumstances in which no other health care providers can respond adequately to save life or prevent permanent impairment).

4.4. Medical Information. Health care personnel shall safeguard patient confidences and privacy within the constraints of the law. Under U.S. and international law and applicable medical practice standards, there is no absolute confidentiality of medical information for any person. Detainees shall not be given cause to have incorrect expectations of privacy or confidentiality regarding their medical records and communications. However, whenever patient-specific medical information concerning detainees is disclosed for purposes other than treatment, health care personnel shall record the details of such disclosure, including the specific information disclosed, the person to whom it was disclosed, the purpose of the disclosure, and the name of the medical unit commander (or other designated senior medical activity officer) approving the disclosure. Similar to legal standards applicable to U.S. citizens, permissible purposes include preventing harm to any person, maintaining public health and order in detention facilities, and any lawful law enforcement, intelligence, or national security-related activity.

4.4.1. When the medical unit commander (or other designated senior medical activity officer) suspects the medical information to be disclosed may be misused, or if there is a disagreement between such medical activity officer and a senior officer requesting disclosure, the medical activity officer shall seek a senior command determination on the propriety of the

disclosure or actions to ensure the use of the information will be consistent with applicable standards.

4.4.2. Consistent with applicable command procedures, International Committee of the Red Cross physicians shall be given access to review medical records of detainees during visits to detention facilities.

4.5. Reportable Incident Requirements. Any health care personnel who in the course of a treatment relationship or in any other way observes or suspects a possible violation of applicable standards, including those prescribed in References (b), (c), and (e), for the protection of detainees shall report those circumstances to the chain of command. Health care personnel who believe such a report has not been acted upon properly should also report the circumstances to the medical program leadership, including the Command Surgeon or Military Department specialty consultant. Officials in the medical program leadership may inform the Joint Staff Surgeon or Surgeon General concerned, who then may seek senior command review of the circumstances presented. Other reporting mechanisms, such as the Inspector General, criminal investigation organizations, or Judge Advocates, also may be used.

4.5.1. Health care personnel involved in clinical practice activities shall make a written record of all reports of suspected or alleged violations in a reportable incident log maintained by the medical unit commander or other designated senior medical activity officer.

4.5.2. Health care personnel carrying out BSC functions under Enclosure 2 shall also comply fully with the reportable incident requirements of paragraph 4.5. They shall make a written record of all reports of suspected or alleged violations in a reportable incident log maintained by the detention facility commander or other designated senior officer.

4.6. Training. The Secretaries of the Military Departments and, as appropriate, Combatant Commanders shall ensure health care personnel involved in the treatment of detainees or other detainee matters receive appropriate training on applicable policies and procedures regarding the care and treatment of detainees. This training shall include at least the following elements:

4.6.1. A basic level of training for all military health care personnel who may be deployed in support of military operations and whose duties may involve support of detainee operations or contact with detainees. The overall purpose of this training is to ensure a working knowledge and understanding of the requirements and standards for dealing with health care of detainees.

4.6.2. Periodic provision of refresher training consistent with the basic level of training.

4.6.3. Additional training for health care personnel assigned to support detainee operations, commensurate with their duties.

4.7. Consent for Medical Treatment or Intervention. In general, health care will be provided with the consent of the detainee. To the extent practicable, standards and procedures for obtaining consent will be consistent with those applicable to consent from other patients.

Standard exceptions for lifesaving emergency medical care provided to a patient incapable of providing consent or for care necessary to protect public health, such as to prevent the spread of communicable diseases, shall apply.

4.7.1. In the case of a hunger strike, attempted suicide, or other attempted serious self-harm, medical treatment or intervention may be directed without the consent of the detainee to prevent death or serious harm. Such action must be based on a medical determination that immediate treatment or intervention is necessary to prevent death or serious harm, and, in addition, must be approved by the commanding officer of the detention facility or other designated senior officer responsible for detainee operations.

4.7.2. Involuntary treatment or intervention under subparagraph 4.7.1. in a detention facility must be preceded by a thorough medical and mental health evaluation of the detainee and counseling concerning the risks of refusing consent. Such treatment or intervention shall be carried out in a medically appropriate manner, under standards similar to those applied to personnel of the U.S. Armed Forces.

4.7.3. Detention facility procedures for dealing with cases in which involuntary treatment may be necessary to prevent death or serious harm shall be developed with consideration of procedures established by Title 28, Code of Federal Regulations, Part 549 (Reference (g)).

4.8. Role of the Armed Forces Medical Examiner (AFME) in Death Investigations. As required by the Secretary of Defense Memorandum dated June 9, 2004 (Reference (h)), if a detainee dies, the commander of the facility (or if the death did not occur in a facility, the commander of the unit that exercised control over the individual) shall immediately report the death to the cognizant Military Criminal Investigation Organization (MCIO). The MCIO shall contact the Office of the AFME, which shall, consistent with Reference (h), Section 1471 of title 10, United States Code, and DoD Instruction 5154.30 (References (i) and (j)), determine whether an autopsy will be performed. The body will be handled as directed by the Office of the AFME. The determination of the cause and manner of death will be the sole responsibility of the AFME or other physician designated by the AFME.

4.9. Health Care Personnel Management. As a matter of personnel management policy, except as provided in this paragraph, health care personnel's support of detainee operations is limited only to providing health care services in a professional provider-patient treatment relationship in approved clinical settings, conducting disease prevention and other approved public health activities, advising proper command authorities regarding the health status of detainees, and providing direct support for these activities. Medical personnel shall not be used to supervise, conduct, or direct interrogations. Health care personnel assigned as, or providing direct support to, BSCs, consistent with Enclosure 2, or AFME personnel, are the only authorized exceptions to this paragraph. The Assistant Secretary of Defense for Health Affairs (ASD(HA)), or designee, must approve any other exceptions to this paragraph.

4.10. BSCs. Standards and procedures for BSCs are established in Enclosure 2.

4.11. Effect on Legal Obligations. Nothing in this Instruction may be construed to alter any legal obligations of health care personnel under applicable law.

5. RESPONSIBILITIES

5.1. The ASD(HA), under the Under Secretary of Defense for Personnel and Readiness, shall:

5.1.1. Supervise implementation of this Instruction and provide supplementary direction, as necessary.

5.1.2. Coordinate with the Chairman of the Joint Chiefs of Staff, the Under Secretary of Defense for Policy, the Under Secretary of Defense for Intelligence, the General Counsel of the Department of Defense, the Secretary of the Army as Executive Agent for administration of detainee operations policy under Reference (c), and, as appropriate, with other Heads of DoD Components regarding activities under this Instruction.

5.2. The Secretaries of the Military Departments shall:

5.2.1. Implement training programs consistent with paragraph 4.6.

5.2.2. Ensure health care personnel assigned to duties as BSCs have been appropriately trained, consistent with the standards and procedures in Enclosure 2.

5.2.3. In assigning health care personnel to duties as BSCs under Enclosure 2, allow health care personnel to volunteer for the assignment, to the extent practicable and consistent with mission requirements.

5.2.4. Establish systems and procedures to ensure the ability of all health care personnel to comply with all requirements of this Instruction and any additional implementing guidance.

5.3. The Secretary of the Army, as Executive Agent, consistent with DoD Directive 5101.1 (Reference (k)), for administration of detainee operations policy under Reference (c), shall establish training and certification standards for the training required by paragraph 4.6.

5.4. The Commanders of the Combatant Commands through the Chairman of the Joint Chiefs of Staff, shall plan for, execute, and oversee medical program support for detainee operations within their respective commands in accordance with this Instruction.

6. EFFECTIVE DATE.

This Instruction is effective immediately.

William Winkenwerder, Jr., M.D.
Assistant Secretary of Defense (Health Affairs)

Enclosures – 2
E1. References, continued
E2. Standards and Procedures for BSCs

E1. ENCLOSURE 1

REFERENCES, continued

(e) DoD Directive 3115.09, "DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning," November 3, 2005
(f) Section 1403 of the Detainee Treatment Act of 2005, Pub. L. No. 109-163, Title XIV
(g) Title 28, Code of Federal Regulations, Part 549, Subpart E, "Hunger Strikes, Inmate," current edition
(h) Secretary of Defense Memorandum, "Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the United States," June 9, 2004
(i) Section 1471 of title 10, United States Code
(j) DoD Instruction 5154.30, "Armed Forces Institute of Pathology Operations," March 18, 2003
(k) DoD Directive 5101.1, "DoD Executive Agent," September 3, 2002

E2. ENCLOSURE 2

STANDARDS AND PROCEDURES FOR BSCs

E2.1. BSCs are authorized to make psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, including interrogation subjects, and, based on such assessments, advise authorized personnel performing lawful interrogations and other lawful detainee operations, including intelligence activities and law enforcement. They employ their professional training not in a provider-patient relationship, but in relation to a person who is the subject of a lawful governmental inquiry, assessment, investigation, interrogation, adjudication, or other proper action. Requirements in this Instruction applicable to BSCs are also applicable to other health care personnel providing direct support to BSCs.

E2.1.1. BSCs may provide advice concerning interrogations of detainees when the interrogations are fully in accordance with applicable law and properly issued interrogation instructions.

E2.1.2. BSCs may observe, but shall not conduct or direct, interrogations.

E2.1.3. BSCs may provide training for interrogators in listening and communications techniques and skills and on results of studies and assessments concerning safe and effective interrogation methods and potential effects of cultural and ethnic characteristics of subjects of interrogation.

E2.1.4. BSCs may advise command authorities on detention facility environment, organization and functions, ways to improve detainee operations, and compliance with applicable standards concerning detainee operations.

E2.1.5. BSCs may advise command authorities responsible for determinations of release or continued detention of detainees of assessments concerning the likelihood that a detainee will, if released, engage in terrorist, illegal, combatant, or similar activities against the interests of the United States.

E2.1.6. BSCs shall not support interrogations that are not in accordance with applicable law.

E2.1.7. BSCs shall not use or facilitate directly or indirectly the use of physical or mental health information regarding any detainee in a manner that would result in inhumane treatment or not be in accordance with applicable law.

E2.1.8. To ensure that detainees do not obtain the mistaken impression that health care personnel engaged in clinical care of detainees are also assisting in interrogations, BSCs shall not allow themselves to be identified to detainees as health care providers. BSCs shall not provide medical care for staff or detainees (except in emergency circumstances in which no other health care providers can respond adequately to save live or prevent permanent impairment). BSCs

shall not provide training in first aid, sanitation, or other health matters. Absent compelling circumstances requiring an exception to the rule, health care personnel shall not within a three-year period serve in the same location both in a clinical function position and as a BSC.

E2.1.9. BSCs shall not provide medical screening (which is a health care function) to detainees, nor act as medical monitors during interrogation.

E2.1.10. BSCs may consult at any time with the psychology or other applicable specialty consultant designated by the Surgeon General concerned for this purpose regarding the roles and responsibilities of BSCs and procedures for reporting instances of suspected noncompliance with standards applicable to detainee operations.

E2.2. As a matter of professional personnel management, physicians are not ordinarily assigned duties as BSCs, but may be so assigned, with the approval of ASD(HA), in circumstances when qualified psychologists are unable or unavailable to meet critical mission needs.

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents*.	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 4

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MOHAMMED AL-ADAHI, et al., Petitioners/Plaintiffs, v. GEORGE W. BUSH, et al., Respondents.	Civil Action No:05-280 (GK)

SUPPLEMENTAL DECLARATION

Pursuant to 28 U.S.C. § 1746, I, JAY W. HOOD, hereby state that, to the best of my knowledge, information, and belief, the following is true, accurate, and correct:

1. As stated in my previous declaration, I am a Major General in the United States Army, with 30 years of active duty service. I currently serve as Commander, Joint Task Force-Guantanamo, Guantanamo Bay, Cuba (JTF-GTMO). I have served in that position since March 2004. JTF-GTMO conducts detention and interrogation operations in support of the Global War on Terrorism, coordinates and implements detainee screening operations, and supports law enforcement and war crimes investigations. Our detention mission is conducted in a humane manner that protects the security of both detainees and JTF personnel at Guantanamo Bay. In my capacity as Commander, I am responsible for all aspects of JTF-GTMO operations. The information contained in this declaration is based on my personal knowledge or information supplied to me in my official capacity. My aim in this declaration is to more clearly lay out the rationale for the enteral feeding procedures we are using, provide additional background

concerning our efforts to ensure detainees in our charge, including Mr. Bawazir, were not able to commit suicide or do serious harm to themselves throughout the hunger strike, and provide specific information with regard to Mr. Bawazir's care and treatment. No detainee at Guantanamo Bay has died due to the hunger strike or otherwise.

2. Torture, abuse, or mistreatment of any kind, of detainees in our custody at Guantanamo Bay, by any member of the Joint Task Force, is not condoned or tolerated in any way. The men in our custody are treated humanely and held in a safe, secure environment. The security force and medical staff diligently and professionally perform their duties in this regard, and I take every appropriate step to ensure that is the case. The enteral feeding procedures instituted with respect to some detainees in December 2005, and used in the case of Mr. Bawazir, are modeled after procedures used in U.S. Federal Prisons, and were approved by me after a less restrictive method of enteral feeding used from August 2005 to December 2005 proved to be ineffective. I reached this decision after carefully evaluating the recommendations of over a half dozen doctors, including a forensic psychiatrist, a team of consultants from the Federal Bureau of Prisons, and my own medical staff, Staff Judge Advocate, and Security Force Leadership.

3. From the onset of the current hunger strike in August 2005, various detainees clearly stated or indicated that the purpose of this strike was to protest their continued detention, and that they intended to draw wide media attention to the strike in order to mount international pressure on the US Government to release them. In fact, from the onset of the hunger strike, detainees reported to us they would continue the strike until they were released or dead. Other detainees, not participating in the strike, confirmed that they believed this strike was very dangerous and

that a "fatwa" or religious decree had been issued directing that three detainees should die of the hunger strike as martyrs—thereby increasing the international outrage over the death of a Muslim being held at Guantanamo Bay. Our information from detainees was that leaders among the detainee population had appointed specific detainees to be the martyrs to demonstrate their commitment and to bring pressure for the closure of Guantanamo. We were also informed by detainees that they were being threatened with harassment and abuse in efforts to coerce them to participate or continue to participate in the hunger strike. I took this threat very seriously, and put in place systems to examine and track each detainee's medical status. I received daily updates and held meetings with my staff three times a week to review the health of each hunger-striking detainee and explore ways we could encourage them to abandon the strike. The staff saw a photo of each detainee, and the attending physician and the Detention Hospital Commander briefed their medical status—including most recent detainee weights; lab results of concern; meals or snacks consumed; and water intake. Mr. Bawazir began his strike on 11 August 2005, and was one of a committed core of approximately 30 detainees who showed no signs of ending the strike.

4. Through August and September 2005 we continued to track detainees' medical status. On 3 September 2005, after reviewing a medical recommendation for involuntary feeding, I directed the involuntary feeding of Mr. Bawazir. The medical approach used for involuntary feeding of Mr. Bawazir and other detainees from the September through November 2005 time frame was very conciliatory. Detainees were initially involuntarily fed in the Detention Hospital; most were restrained by 2-point restraints in their hospital beds, but were permitted to communicate freely with other hunger strikers in an open ward. Detainees, including Mr. Bawazir, accepted the

nasal gastric feeding tubes from medical staff, noting that they were doing so under protest, but typically without violence. Soon, however, detainees began to refuse feedings or attempt to limit medical care and the intake of nutritional fluids. Believing the hunger striking detainees would abandon the strike when they discovered we were committed to enteral feeding and would not let them die or do long term injury to themselves, the medical staff patiently entertained numerous detainee requests and demands. The medical staff, to include attending doctors, frequently negotiated with detainees over the amount of calories that each would receive, the flavor of the nutritional formula used (e.g., butter pecan, chocolate, vanilla, or strawberry), the color of the feeding tubes to be used, the flavor of the throat lozenges, and the types of candies available. In their own words, as one detainee in the Detention Hospital taunted a guard: "I am the king and you are my servant. I ask you to give me water, honey and medicine. This is my place and I ask you to do everything for me." The detainees typically controlled the flow and amount of each feeding. Many detainees, and specifically Mr. Bawazir, requested and were provided honey, olive oil, and garlic as a supplement to their nutritional fluid.

5. Our efforts to encourage the detainees, including Mr. Bawazir, to accept treatment or to begin to eat were unsuccessful. Through October and November, the number of hunger strikers requiring enteral feeding grew to 24. Alternate feeding sites were established in a Detention Hospital annex and on one detention block of Camp 3. During this period, most detainees continued to resist treatment, often refusing to accept the amount of nutrients directed by Doctors. Our information was that various detainees were encouraging resistance even to the taking of detainees' weight, with the goal of provoking forceful or inappropriate reactions by JTF-GTMO personnel. This resistance manifested itself in violent behavior on several occasions

when medical and security staff were physically assaulted, spat upon, and cursed by detainees, including Mr. Bawazir. Dr. Hooker's declaration describes Mr. Bawazir's resistant and occasionally violent behavior. As an example, on 18 October 2005, Mr. Bawazir threatened both security and medical staff by using his intravenous (IV) pole as a weapon to destroy lighting fixtures and ceiling tiles inside the Detention Hospital. During that incident, he ignored repeated demands to put the weapon down. During this same riotous event, another hunger striking detainee struck a nurse in the mouth. During the time period of 1 September 2005 through 7 March 2006, there were 189 physical assaults by hunger strikers against our guard force or medical staff. These assaults ranged from spitting to throwing bodily fluids to striking the medical staff or guards. Most importantly, during the November time frame, the detainees' overall health continued to decline.

6. As indicated in Doctor Hooker's declarations, on 15 December 2005, approximately two-thirds (19 of 29) of the detainees, including Mr. Bawazir, participating in the hunger strike had become significantly malnourished (less than 75% of their Ideal Body Weight) and were at great risk for serious complications. Our concern for the health of several hunger strikers continued to increase as several detainees developed more serious complications related to their malnourishment that required treatment and monitoring in the Guantanamo Naval Station Hospital. As reflected in Dr. Hooker's declaration, laboratory results showed low or abnormal levels in key physiological measures, and some detainees, including Mr. Bawazir, were at risk of organ damage or life threatening infection. The longer Mr. Bawazir and others remained in a malnourished state, the greater the risk of serious medical complications.

7. In late November 2005, I asked for external assistance in evaluating our hunger strike efforts. First, a forensic psychiatrist visited JTF-GTMO on 6-14 December 2005 and evaluated our management of the hunger strike. He made a number of recommendations to include establishing a protocol for involuntary feeding to ensure that adequate nutrition and fluids were retained in order to counter detainee efforts to not accept the nutrition. Three consultants from the Federal Bureau of Prisons, including a medical doctor and a physician's assistant who had experience in the treatment of hunger strikers, visited JTF-GTMO on 17-22 December 2005. They agreed with the assessment of the forensic psychiatrist and recommended that we adopt and implement the Federal Bureau of Prisons model for managing hunger strikes to include the use of a restraint chair to ensure the efficacy of the medical treatment and care.

8. In December 2005, after reviewing the recommendations of visiting experts, and consulting with leaders on our medical staff, my Staff Judge Advocate, and Joint Detention Group Commander, and based on this group's combined recommendations, I directed that we implement several of the recommendations offered by visiting experts and introduce the use of a restraint chair system for involuntary feeding. Use of the restraint chair allows us to carefully monitor and guarantee appropriate nutritional intake by detainees being enterally fed.

9. From September 2005 to December 2005, extensive efforts were made to develop a safe and effective method of restraining a detainee in a medical bed for the administration of involuntary feedings. These efforts included modifying hospital beds with a variety of soft restraint devices, inserting plywood and backboards to support the upper torso, and rehearsals with medical staff and guard forces to validate efficacy. We were unable to develop a restraint system that allowed

us to safely and adequately secure the detainee and provide the proper position for safe and effective enteral feedings. Our tests indicated that these alternative methods would have been ineffective with a violent detainee and result in risk to the medical personnel and security guards. The upright, padded, ergonomic design of the restraint chair system provides an ideal modality for the safe and efficient feeding of a hunger-striking detainee.

10. Based on information I received from the medical staff, it was clear that Mr. Bawazir was attempting to combat our efforts to provide an appropriate level of nutrition under the prior enteral feeding protocol used beginning in September 2005 and that he was suffering chronic and recurrent sinus symptoms that resulted in a recommendation that feedings be accomplished with the feeding tube inserted and removed for each feeding. Accordingly, Mr. Bawazir was involuntary fed using the new protocols, including a restraint chair system beginning on 11 January 2006, in order to guarantee he was receiving the prescribed nutrition. I could not allow Mr. Bawazir's health to continue to decline, nor could I allow him to remain at the precipitous weight level he had attained in late December 2005 and early January 2006. Before the chair restraint system was utilized with respect to a detainee, each detainee, including Mr. Bawazir, was individually evaluated by medical professionals, including a physician and nutritionist, to determine the detainee's ability to tolerate their feeding plan and the appropriate quantity of nutrients and fluids essential to improving their health and preventing death or serious injury.

11. I cannot confirm by any specific observation of guards or others that Mr. Bawazir was purging under the prior enteral feeding protocol. I do know, however, that at times prior to 11 January 2006, Mr. Bawazir spent time in his cell with a towel over his head and that the guard

force would respect his privacy. I also know that even when his caloric intake went up under the prior protocol, his weight went down and stayed at dangerous levels. I can also confirm that other enterally fed detainees were caught by the guard force purging while under a towel or bed sheet.

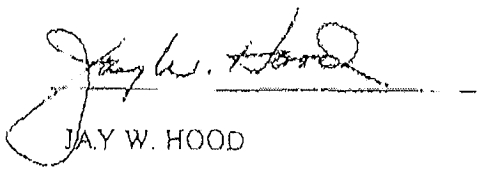
12. I can also confirm that there is no record that Mr. Bawazir ever urinated or defecated while in the restraint chair. Both guard records and medical records were reviewed, and there is no evidence of Mr. Bawazir urinating or defecating in the restraint chair even though such an incident, had it occurred, would normally be noted either in guard or medical records. There are records of a very small number of other detainees who did urinate or defecate in the chair, even after having been given an opportunity to use the toilet in their cell prior to their feeding. Since we began using the restraint chair system, over 700 meals have been fed to 29 detainees. In all of those feedings, records establish that only four detainees have urinated or defecated for a total of 20 occasions. Once these few detainees found that the tactic of soiling the chair would not work to delay their feeding, the incidents ceased. The detainees are warned 30 minutes in advance of a feeding in the restraint chair and strongly encouraged to use the toilet prior to being put into the restraint chair. Because it is the guard force that must clean up the mess, every step is taken to encourage the detainee to use the toilet prior to a feeding.

13. I take very seriously my responsibility to ensure that the detainees in JTF-GTMO custody are treated safely and humanely, and I have exercised that responsibility in the management of the hunger strike. From the outset of the hunger strike, we attempted to manage it in a fashion that provided detainees the greatest autonomy and deference consistent with the need to provide

them with nutrition and appropriate medical care. As discussed above, it was only when it became clear that the initial protocol of managing the hunger strike was not effective in maintaining the detainees' health and could not be continued without risks to the detainees' health and the safety of the JTF-GTMO staff, that the use of the restraint chair system for enteral feeding was implemented. The restraint chair was not implemented, and is not used, as a form of punishment of, or retaliation against, detainees, or to deliberately inflict pain on detainees. Instead, it allows health care professionals at Guantanamo Bay to provide the appropriate medical care and enteral feeding that is required to preserve the detainees' lives and health in a safe, efficient, effective, and controlled manner. The success of the new protocol is embodied in Mr. Bawazir. He is now healthy, having been well cared for, and has not been allowed to die or commit martyrdom.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true, accurate, and correct.

Dated: March 10, 2006



JAY W. HOOD

Major General, USA

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents*.	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 5

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

DECLARATION OF COLONEL JOHN V. BOGDAN

~~(U)~~ I, Colonel John V. Bogdan, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. ~~(U)~~ I am a Colonel in the United States Army, with 30 years of service. I currently serve as the Joint Detention Group (JDG) Commander of Joint Task Force-Guantanamo (JTF-GTMO), at the Naval Station, Guantanamo Bay, Cuba. As such, I am responsible for all aspects of detention operations at JTF-GTMO and am familiar with all areas of detention within JTF-GTMO, including the conditions and operational policies and procedures of the various detention areas. I have held this position since June 7, 2012.

2. ~~(U)~~ This declaration is based on my own personal knowledge and information made available to me in the course of my official duties.

Forced Cell Extraction Procedures

3. ~~(U)~~ When necessary, JTF-GTMO employs Forced Cell Extraction (FCE) procedures to bring detainees to their enteral feeding appointments. As the JDG Commander, I am responsible for these procedures.

4. ~~(U)~~ The physical security of JTF-GTMO personnel and detainees is of paramount importance to our operations. Use of the minimum force necessary for mission accomplishment and force protection is required at all times. The FCE practices used at JTF-GTMO are modeled on the rules of force in military corrections facilities and the Federal Bureau of Prisons (see Federal Bureau of Prisons Program Statement P5566.06, Subject: Use of Force and Application of Restraints).

5. ~~(U//FOUO)~~ The FCE team is a small group of military members specializing in the extraction of a detainee who is combative, resistive, or possibly possesses a weapon at the time of extraction. Guards are trained to use the minimal force necessary for mission accomplishment and force protection. The amount of force necessary depends on the attendant circumstances.

including the amount of resistance by a detainee as well as his physical ability to resist. FCE teams are briefed on the physical and medical condition of each detainee and would be aware prior to an FCE if a detainee has an exceptionally low body weight or a medical condition that might make him more prone to injury. With that information, the FCE team will use the minimal force needed to help prevent any injury to the detainee during the FCE process.

6. ~~(U//FOUO)~~ In addition to the extensive training they receive in advance of being assigned to an FCE team, the team members receive regular training on the proper procedures to conduct FCEs and how to handle aggressive or non-compliant detainees. This includes training during each shift and often involves practice drills. There are specific procedures that must be followed for each FCE, including warnings and instructions that must be issued to the detainee and specific steps that are taken at each stage of the FCE. Individuals assigned to an FCE team train on and rehearse these procedures extensively.

7. ~~(U//FOUO)~~ The FCE team is not used as punishment or intended to be used on every detainee who is to be moved, but only on those who indicate or demonstrate the intent to resist, refuse to follow guard staff instructions, cause a disturbance, or endanger the lives of themselves, other detainees, or any JTF-GTMO member. For instance, a detainee who agrees to voluntarily accompany guard staff to his enteral feeding appointment will not be forcibly extracted from his cell. The FCE team is used only as a last resort after unsuccessful attempts have been made to obtain a detainee's compliance through verbal persuasion and without the use of physical force. This includes advising the detainee of the ramifications of his continued refusal to comply and asking him if he will comply without resistance. FCEs may also be used in the event of an emergency, when time does not permit efforts to verbally persuade the detainee to cooperate and follow orders. The use of the FCE team, when appropriate, is the necessary level of force to respond to the level of resistance by a detainee or to respond to an emergency situation.

8. ~~(U//FOUO)~~ The use of an FCE team to respond to a detainee's refusal to follow guard instructions or in response to a disorder or disturbance must be requested [redacted]

9. (U) Immediately following an FCE, the detainee will be evaluated by medical personnel and checked for injury. Detainees seldom sustain injuries that require medical treatment.

10. (U) In the case of a detainee approved for enteral feeding, a guard will verify that a detainee is scheduled for an enteral feeding that is deemed medically necessary by JMG staff. The guard will inform the detainee that it is time for his enteral feeding and will ask the detainee if he will come out of his cell voluntarily. If the detainee complies, he will walk with the guard to the enteral feeding location in the resident camp. If he refuses to exit his cell, an FCE team will be requested. Once requested and assembled, the FCE team will enter the cell. [redacted] The FCE team then secures the detainee and moves him directly to the enteral feeding restraint chair [redacted] in the resident camp. A backboard is almost never used for FCEs related to enteral feeding because it is not needed to transport the detainee [redacted] Backboards may be used in other situations, such as if a detainee refuses to leave the recreation area or in order to be weighed.

11. (U//FOUO) Forced cell extractions are also sometimes necessary in order to obtain a detainee's weight. When medical staff has requested to obtain the weight of a detainee who is approved for enteral feeding, a guard will inform the detainee that he has to be weighed and ask the detainee if he will come out of his cell voluntarily. If the detainee agrees, he is weighed, and his weight is recorded. If he is combative or refuses to leave his cell voluntarily to be weighed, the guard staff will contact medical staff to determine if obtaining the detainee's weight is considered to be a medical necessity. If it is, then the guard will request an FCE team who will enter the detainee's cell, secure him to a backboard and move him to the designated location to be weighed on an industrial weight scale. The backboard ensures the detainee remains stationary during the weighing process, providing an accurate reading of his weight. After his weight is obtained, he is returned to his cell. A medical corpsman is present and observes the entire process.

Restraint Chairs

12. ~~(U)~~ Restraint chairs are used to provide a safe and secure environment for medical personnel to care for detainees. They can be used to control the movement of a detainee and to facilitate his medical care during enteral feeding or for another purpose. The decision to use a restraint chair for enteral feeding was made before I arrived at Guantanamo Bay. I understand that this subject has been raised in past litigation and is discussed in declarations by former JTF-GTMO Commander, Brigadier General Hood, and Dr. Stephen Hooker that were filed in March, 2006, in Mohammed Al-Adahi et al v. George W. Bush (Civ. No. 05-280) and attached here. The restraint chair is still used today and continues to mitigate the potential security threat to JTF-GTMO personnel as well as ensure that the right amount of nutrition is received and retained by the detainees.

13. ~~(U)~~ The restraint chair used for enteral feeding [redacted] Guard staff secure all restraints and exercise care to ensure that a detainee is not injured in the process. Guard staff keep the detainee's head stabilized throughout the movement into the chair. Once the detainee is seated in the chair, a spit shield may be placed on him if he begins spitting or indicates he will do so to keep him from spitting on the guards and nurse during insertion and placement of the enteral feeding tube. Most often, there is no need for the spit guard. In addition, [redacted] guard stands behind the detainee and will hold the detainee's head with his hands if medical staff need assistance to secure the detainee's head during placement of the enteral feeding tube. No headgear is placed on a detainee while he is seated in the restraint chair. . Restraints are applied for the minimum possible time period and are used so that medical staff can provide acute medical care or to protect a detainee from inflicting injury to himself or others. Medical personnel do not participate in applying the custodial restraint devices at any time or for any reason. Rather, this is done only by the JDG guard staff.

14. ~~(U)~~ There is a small group of detainees who have been enterally fed for a significant period of time and who are routinely compliant with enteral feeding. The Senior Medical Officer and I conferred and agreed that for those detainees, we would allow the use of a soft chair [redacted] The chair reclines, and the detainees may watch television or play video games while being enterally fed. This chair [redacted] is used as part of an

effort to help detainees improve their eating habits and thus their overall health. We began allowing the use of the soft chair for this small group of long-term enteral feeders in October, 2013. All other detainees are enterally fed in the [redacted] restraint chair described above. The restraint chair helps to control movement during enteral feeding to ensure it is safely completed.

15. ~~(U)~~ Detainees have regular access to toilet facilities in their cells. They are always permitted to use the facilities prior to enteral feeding. Guard staff will honor a detainee's request to use the restroom prior to a feeding. I have not heard of detainees having bowel movements or urinating during enteral feedings. If this happened, JTF-GTMO personnel would take immediate action to assist the detainee, get him fresh clothing, and sanitize the area. JTF-GTMO would not allow a detainee to remain in clothing soiled by feces or vomit. In addition, if a detainee vomited during enteral feeding, that would be immediately addressed due to concerns about aspiration. Detainees are aware of the risk that they could aspirate if they vomit during the feeding, and I am unaware of any detainee vomiting during enteral feeding. A quick response to address bowel movements or vomiting during enteral feeding in the event that they occurred is consistent with JTF-GTMO's requirement and commitment to provide humane treatment to the detainees.

I declare under penalty of perjury that the forgoing is true and correct.

Executed on 17 APR 14.

JOHN V BOGDAN
COL, MP
Commanding

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner,* v. BARACK H. OBAMA, *et al.*, *Respondents.*	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 6

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

MOHAMMED AL-ADAHI, et al.,

Petitioners,

v.

GEORGE W. BUSH, et al.,

Respondents.

Civil Action No. 05-280 (GK)

SUPPLEMENTAL DECLARATION

Pursuant to 28 U.S.C. Section 1746, I, Stephen G. Hooker, MD, MPH, hereby state that, to the best of my knowledge, information, and belief, the following is true, accurate, and correct:

1. As stated in my previous declaration, I am a licensed physician and a Captain in the United States Navy with 22 years Active Federal Commissioned Service. I currently am the Officer-in-Charge, Detention Hospital, Joint Task Force-Guantanamo, Guantanamo Bay, Cuba. I am directly responsible for the medical care provided to detainees and presently oversee the operation of the Detention Hospital that provides medical care to the detainees being held at Guantanamo Bay.

2. As the Officer-in-Charge of the Detention Hospital, I am the direct supervisor of the physicians and medical staff, who provide medical care to the detainees. I have personal knowledge of the procedures that are in place for the operation of the Detention Hospital and t

am responsible for ensuring that they are followed. I have personal knowledge of, or have received information in the course of my responsibilities concerning, the matter related to the allegations made by petitioner's counsel in their emergency motion of February 24, 2006, for injunctive relief on behalf of Mr. Mohammed Bawazir.

3. The following background on the hunger strike is essential to understanding the questions regarding Mr. Bawazir. On November 10, 2005, I became the Officer-in-Charge of the Detention Hospital. From the beginning, I was very concerned about the detainees who were hunger-striking. There had been a continual decline in their weights and health, in spite of heroic and exhaustive efforts by the medical staff. I felt that the management of the hunger strike needed to be re-evaluated. I was convinced that we needed to reevaluate our equipment, staffing, training, and procedures to address the medical needs of the detainees and to prevent the loss of life. Therefore, recommendations were made to Major General Hood to bring experts to Guantanamo Bay who could assess the current situation and make recommendations to improve our management of the hunger strike. We committed ourselves to taking the additional steps necessary to preserve the lives and health of the detainees who were hunger strikers, and to prevent other hunger strikers from declining to a dangerous state of malnutrition.

4. The model for managing the hunger strike that had been used from August 2005 to November 2005 was based on a voluntary or compliant system for feeding the detainees. The detainees were given a large degree of control, which, unfortunately, they exercised through bartering and negotiation regarding their caloric intake and other aspects of care, as well as through deception, intimidation, and misconduct designed to thwart the care being offered. The initial approach was

for the medical staff to attempt to develop a strong relationship of cooperation and trust with the detainees in the hope that the detainees would eventually agree to receive all the nutrients and medical care required to maintain their health and their lives. Compassionate and concerned medical staff urged the detainees to increase their caloric intake and to accept appropriate medical care. Unfortunately, this did not work. In actuality, the health of the detainees continued to decline as they progressed toward their stated goal of death by starvation. Repeatedly, I had detainees who were hunger-striking tell me they wanted to die, and, at times, that they wanted other detainees to die, also. For example, one detainee shared with me that a fatwa had been announced early in the hunger strike with paradise being promised to the detainees who died first. Detainees also made general threats against Americans, as well as specific threats against members of the medical staff and their families. When detainee control of the hunger strike was threatened, it would lead to verbal and physical assaults, including throwing excrement and urine on guards and medical staff.

5. When detainees were initially involuntarily fed in the Detention Hospital, they were able to communicate with each other in an open ward. The detainees often encouraged one another to continue the hunger strike and resist efforts of the medical staff to provide them with optimal nutrition. There were several small violent group demonstrations in the Detention Hospital by the hunger strikers when the detainees did not agree with medical or guard force policies. The doctors, nurses, and medics were commonly verbally and physically assaulted, including being spit upon and having urine thrown on them. The prior Officer-in-Charge of the Detention Hospital was spit upon and had urine thrown on him. Two nurses were punched in the face. Most importantly, the enteral feeding protocol that had been in place from the initiation of the

hunger strike was ultimately not effective in reversing the malnutrition and steady decline in the health of a number of the hunger strikers. This was due to detainees undermining or sabotaging the feeding efforts by negotiating for less nutritional formula during a feeding; refusing the caloric intake recommended by the doctors; self-purging (often covertly) of feedings; or otherwise resisting staff efforts to provide appropriate care. As noted in my prior declaration, some detainees took advantage of the constant presence of the feeding tube by using it to siphon or purge recently introduced formula contents. One detainee bit his tube in half and swallowed it, requiring endoscopic retrieval.

6. Mr. Bawazir was among the detainees who routinely were uncooperative with, and resistant of, the medical staff's efforts to improve their health. This included refusing to receive the appropriate caloric intake to improve his weight. Examples from his medical record of his medical non-compliance and resistance include:

a. On 10 October 05 he "refused feeding" and "meds."

b. His behavior was documented in his medical chart on 18 October 05 as follows: "He became belligerent and aggressive, standing on (the) bed with a pole" during a violent outbreak in the Detention Hospital.

c. He regularly refused documentation of his vital signs, including on 28 October, 3 November, 21 November, 26 November, 2 December, 16 through 19 December, 21 and 22 December, 24 December, 25 December, and 30 and 31 December 2005.

d. He feigned coming off of his hunger strike on two occasions (1-5 November and 19-21 November 2005) to stop enteral feeding, apparently in an effort to decrease his caloric intake. He used these opportunities to communicate with other hunger

strikers, which ultimately served to strengthen his resolve to continue the hunger strike and resist the efforts of medical personnel.

e. Because of his recurrent sinusitis and continued facial pain, on 21 November 2005, Mr. Bawazir was transferred to the Naval Base Hospital Detainee Acute Care Unit (DACU) for his enteral feedings. While there, he received a CAT scan of his sinuses that revealed maxillary sinusitis. In addition, at this time, he was placed on a 24-hour infusion of feedings to try to reverse his serious state of malnutrition. He accepted this treatment for 48 hours without significant resistance, and caloric goals were being met. However, immediately after another hunger-striking detainee arrived at the DACU and chastised Mr. Bawazir for being compliant with his feedings and encouraged him to resist, he resisted the continuous infusion and demanded that he be allowed to "fast." He demanded that we limit his caloric intake to 1000 calories per day, which was not enough to sustain his life or health. Mr. Bawazir would not accept more than 1000 calories a day from 25 November 2005 until 30 November 2005, despite pleas from several different doctors. His medical record documented him as being "non-compliant with enteral feeds" (25 November 2005 note), "refuses medically necessary kcal AMA (Against Medical Advice)" (27 November 2005 note); and "non-compliant with enteral feedings" (29 November 2005 note).

f. On 1 December 2005, Mr. Bawazir told a doctor on rounds (with an interpreter present) that he would take no feedings without the use of force, and that his lawyer told him that by resisting his feeding and making medical personnel use force, it would look better in court.

g. On 21 December 2005, Mr. Bawazir refused to allow laboratory tests despite pleas from the medical staff and required medical restraints to obtain his labs.

7. There were a number of factors that appeared to greatly strengthen the resolve of the detainees who were hunger-striking. For example, there seemed to be some internal and external coordination of the hunger strike. I concluded this because some of the terminology used by the detainees was similar and appeared rehearsed. Also, the detainees would anticipate the visits of their lawyers and would modify their level of cooperation or behavior based on that. Further, as noted above, the hunger-striking detainees were very strongly influenced by each other. This was certainly evident in Mr. Bawazir's case. For example, as noted above, on one occasion the comments of another detainee caused him to cease his cooperation with medical staff. On another occasion, he indicated he would resist being fed in accordance with directions that had been given by his lawyer. Lastly, on yet another occasion, he expressed fear for the safety of his family if he voluntarily stopped his hunger strike. Since Mr. Bawazir made conflicting statements during his hunger strike, it was impossible to know when he was being truthful.

8. When we realized that we had to change our management of the hunger strike to protect the lives and health of the detainees, several subject matter experts were invited to Guantanamo Bay in December 2005 to evaluate our current system. A forensic psychiatrist visited Guantanamo Bay on 6-14 December 2005 and evaluated our management of the hunger strike. From 17-22 December 2005, three consultants from the Federal Bureau of Prisons, including a medical doctor and a physician's assistant, who had experience in the treatment of hunger strikers, visited Guantanamo Bay. They agreed with the assessment of the forensic psychiatrist and

recommended that we adopt and implement the Federal Bureau of Prisons model for managing hunger strikes. In this model, medical staff provides care through enteral feedings twice a day, with close monitoring of the patient. Hunger strikers are placed in a restraint chair to ensure the safety of all involved and to ensure that the required amount of nutrition is given and retained.

9. I place great value on my personal interaction with the detainees. I also know that other doctors on my staff regularly met and interacted with hunger-striking detainees, including Mr. Bawazir. On numerous occasions, these individual encounters with the detainees lasted 30 minutes or more. From the beginning of my time as the Officer-in-Charge of the Detention Hospital, I have sought to develop constructive and meaningful relationships with the detainees. This is the way I treat people, and it was consistent with direction of the Commanding General. In November and December 2005, I would visit the detainees in the medical facilities multiple times per week, inquiring as to their health and seeking to do whatever I could to see that their health improved. My relationship with most of them was characterized by sincere concern and warmth. There were those who would not interact with me for reasons known only to them, but I always made myself available to any detainee who wished to see me. During these rounds and visits, I would, at times, urge the detainees to allow us to give them enough nutrients to increase their weights and improve their health. I told them that my job was not to stop the hunger strike, but to preserve and promote their lives and health. The weight and condition of the detainees, including Mr. Bawazir, had become so alarming that I regularly advised them of the danger of overwhelming infections because of their compromised immune systems, of falling and sustaining serious injury because of their weakened bones and loss of muscle mass, and of metabolic abnormalities that could lead to life-threatening arrhythmias or permanent organ

damage. All of these complications had the potential to lead to death or permanent disability. To leave detainees in a state of significant malnutrition or continue with a means for managing the hunger strike that was not resulting in adequate improvement in the detainees' health was unacceptable. Their bodies had been stressed to a significant degree, and already they were suffering complications related to their chronic malnutrition. Also, it was important to separate the detainees to help ensure adequate infection control, preventing the transmission of infections. I also could not adequately ensure the safety of my own medical staff and the guards using the previous means of managing the hunger strike.

10. As far as my personal relationship with Mr. Bawazir, I would speak to him or see him regularly when I made rounds, usually multiple times a week. In December 2005, I spent a number of hours with him over about three different visits. As I sat Middle-Eastern style in front of him on the floor, I listened to his concerns; I urged him to consider his health and the dangers of what he was doing; and I told him my intent was not to stop the hunger strike, but to improve his health and sustain his life.

11. Mr. Bawazir began his hunger strike on approximately 11 August 2005. On 15 August 2005, he was counseled by a medical provider on the medical dangers of a hunger strike and advised to consume adequate food and water to preserve his health and life. He persisted in his hunger strike and was admitted to the Detention Hospital on 1 September 2005 for dehydration. At the time of Mr. Bawazir's admission to the Detention Hospital he weighed 106 pounds, which is 78.3% of his Ideal Body Weight (IBW). He was started on enteral feedings on 4 September 2005. A graph is attached to this declaration showing the chronological weights and caloric

intakes of Mr. Bawazir during and after his hunger strike. The graph clearly demonstrates continued weight loss and a worsening malnourished state, despite clinically and nutritionally appropriate enteral feedings. Despite receiving 1800-2400 calories from 1 December 2005 onward, the method of enteral feeding being used for Mr. Bawazir still resulted in weight loss. This indicated that he was purging his feedings. His weight trend, showing a negative decline, was typical of the majority of the hunger strikers who were being enterally fed in the September - December 2005 timeframe.

12. Under the previous method of enteral feeding, in which the feeding tube was left in place for extended periods of time, several of the detainees had complaints about the persistent presence of the feeding tube causing throat or nose pain. Several detainees experienced ear, nose, and throat (ENT) problems such as sinusitis and otitis media. Mr. Bawazir developed recurrent ENT problems when his tube was continuously left in place. He was treated in mid October 2005, late November 2005, late December 2005, and early January 2006 with antibiotics for sinusitis. In late November, a CAT scan of his sinuses revealed maxillary sinusitis. A board certified otolaryngologist, brought in especially to see several hunger strikers who had developed ENT problems, evaluated Mr. Bawazir on 4 January 2006 and specifically recommended "In- Out feed(s) if possible" because of his chronic and recurrent sinus symptoms. The possible consequences from recurring clinical sinusitis are not trivial and can include a brain or bone abscess, meningitis, or chronic bone changes of the sinuses. Since he ended his hunger strike, Mr. Bawazir has had no further episodes of sinusitis. A detailed outpatient chart review for the year before his hunger strike (August 2004 through August 2005) revealed no complaints or symptoms of sinusitis. Mr. Bawazir's sinusitis was clearly related to leaving the feeding tube in

place. There was clear clinical benefit to adopting the feeding methods employed by the Federal Bureau of Prisons to alleviate Mr. Bawazir's sinus difficulties.

13. By early January 2006, at 71.7% of IBW, Mr. Bawazir was bordering on severe malnutrition, which is defined as <70% IBW, despite substantial efforts over 4 ½ months to reverse his weight trend. In addition to his recurrent sinus infections, he also had evidence of a low blood cell count on several routine lab checks, suggesting a weakened ability to fight infections. His white blood cell count and absolute neutrophil count were below normal in the following laboratory tests: White blood cell count (WBC) of 2.3 compared to a normal > 4.0, absolute neutrophil count (ANC) of 710 compared to a normal >1500 on 10 January 2006; WBC 2.2, ANC 500 on 28 December 2005; WBC 2.4; ANC 730 on 9 December 2005; and WBC 2.8, ANC 570 on 12 September 2005. Neutrophils are used in fighting bacterial infections. His low WBC and ANC level probably contributed to his multiple sinus infections. As further evidence of his weakened immune system, in early January, Mr. Bawazir was treated for a diarrheal illness caused by an opportunistic infection (*Clostridium Difficile*). Aside from impairment of his immune system, of which there is clear clinical and laboratory evidence, other long term effects that Mr. Bawazir may have eventually suffered because of significant malnutrition include loss of skeletal and heart muscle mass, loss of brain function, heart dysfunction, decreased respiratory muscle strength, impaired wound healing, endocrine (thyroid and gonadal) dysfunction, and bone loss.

14. Based on the factors discussed above, use of the restraint chair feeding system was clinically appropriate for Mr. Bawazir. Those feedings began on 11 January 2006. Approximately 2500

calories per day were provided through the feedings. Based on our medical assessment as to calories needed to improve Mr. Bawazir's weight and health and considering his ability to tolerate the feedings appropriately, we used the procedures discussed in my prior declaration. In addition, Mr. Bawazir had access to bottled or other drinking water while in his cell between feedings. The use of this feeding system resulted in weight gain for Mr. Bawazir. He ended his hunger strike on or about 24 January 2006. In his initial restraint chair feedings, Mr. Bawazir was led to the restraint chair and minimum force necessary was used to secure him. After his initial feedings, Mr. Bawazir would walk to the chair and sit down for the feedings. Continued use of the restraint chair was appropriate, however, given the possibility that Mr. Bawazir could decide to engage in violent behavior. As noted in my prior declaration in this case, Mr. Bawazir had a physical examination and assessment performed on 26 February 2006. He is in good health and spirits. His present weight is 137.5 pounds (101% of his IBW), and he is eating well.

15. We have successfully completed over 700 enteral feedings using the restraint chair system through 10 March 2006. The three hunger strikers who continue to be enterally fed using this model are all above 90% of IBW and are doing very well clinically. During the entire time the restraint chair model has been used for enteral feeding, there have been no serious problems or significant complications.

16. The restraint chair system was never intended to punish detainees, retaliate against them, deliberately inflict pain on them, or force them to come off the hunger strike. Rather, the system was implemented to ensure the safety of all involved and to ensure the effectiveness of the feedings in order to preserve the detainees' lives and health. We have done this with as much

compassion and care as possible. My charge and guidance to the medical staff has always been to provide compassionate and quality care, characterized by kindness, professionalism, and concern. Repeatedly, I have told them that they are never to compromise their personal conduct or the quality of the medical care they provide to the detainees, regardless of how the detainees may treat them. I have strongly emphasized that our job is not to stop the hunger strike, but to protect, preserve, and promote the life and health of the detainees. The medical staff at JTF-GTMO has consistently given professional, high-quality care to the detainees they have treated, who, in return, have regularly treated the staff with reproach and disdain. The staff should be greatly esteemed and highly regarded by the great nation they so proudly serve.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true, accurate, and correct.

Stephen G. Hooker

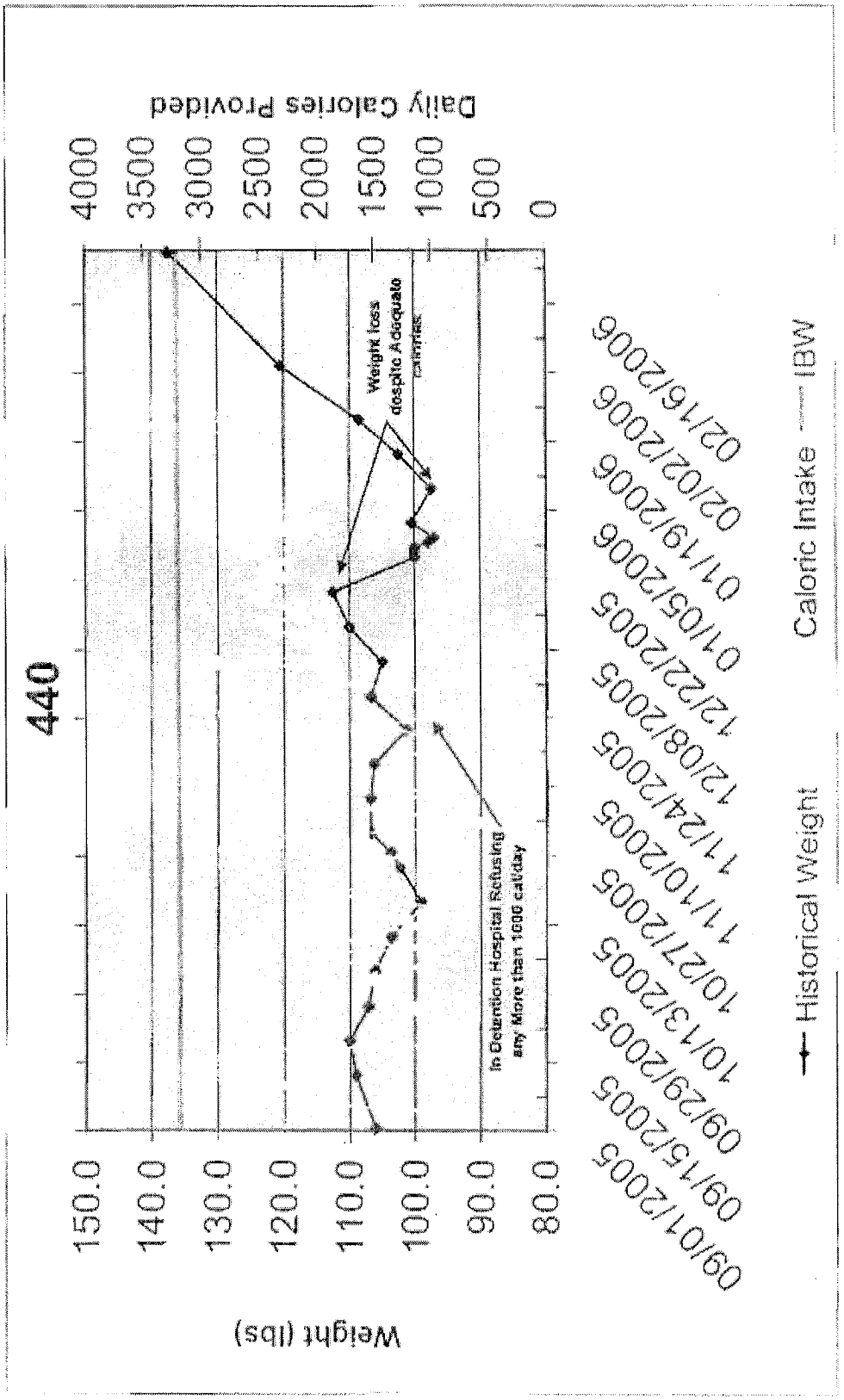
STEPHEN G. HOOKER, MD

Captain, Medical Corps, U.S. Navy

Officer-in-Charge

JTF-Guantanamo Detention Hospital

Executed on: 13 March 2006



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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB,

Petitioner,

v.

BARACK H. OBAMA, *et al.*,

Respondents.

Civil Action No. 05-CV-1457 (GK)

~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 7

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

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~~(U//FOUO)~~ DECLARATION OF COMMANDER [redacted], M.D.

~~(U//FOUO)~~ Pursuant to 28 U.S.C. § 1746, I, [redacted], hereby declare:

1. ~~(U//FOUO)~~ I am a Commander in the United States Navy with over 15 years of active and reserve service. I currently serve as the Senior Medical Officer, Joint Medical Group, Guantanamo Bay, Cuba. I am responsible for the medical care provided to detainees at Guantanamo Bay and supervise the operation of the Joint Medical Group that provides medical care to the detainees being held at Guantanamo Bay. There are currently 166 detainees being held at the detainee camp at Guantanamo Bay, Cuba. I have served in this position since [redacted]

2. ~~(U//FOUO)~~ [redacted]

3. ~~(U)~~ I have personal knowledge of the procedures that are in place for the operation and application of medical care at all JTF-GTMO medical facilities and I am responsible for ensuring that they are followed. Due to my responsibilities, I have personal knowledge of, or have received information in the course of my responsibilities concerning, the matters raised by ISNs 238 (Nabil Hadjarab), 239 (Shaker Aamer), 290 (AJuned Belbacha) and 722 (Abu Wa'el (Jihad) Dhiab) through their counsel in their 30 June 2013 "Application for a Preliminary Injunction against Force-Feeding." This declaration is based on information made available to me through my official duties and from the medical records of ISNs 238, 239, 290, and 722.

JOINT MEDICAL GROUP

4. ~~(U)~~ The Joint Medical Group staff consists of licensed, board-certified physicians of different specialties. Specifically, as of June 2013, the hospital staff has approximately 147 professionally trained individuals. The JMG provides services from numerous medical professionals including an anesthesiologist, a general surgeon, an orthopedic surgeon, family physicians, internal medicine physicians, a psychiatrist, a psychologist, a physician's assistant, a licensed dietician, dentists, and a physical therapist. In addition, the staff includes licensed medical surgical nurses, corpsmen (formally trained Navy medical personnel akin to a "medic" in the Army), various technicians (lab, radiology, pharmacy, operating room, respiratory,

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physical therapy, information technology and biomedical repair), and administrative staff. We have routinely brought in specialists, including medical professionals practicing in the areas of Dermatology, Cardiology, Ear Nose and Throat, Gastroenterology, Neurosurgery, Urology, and Audiology, and have the ability to request specialists from other areas as needed. Specialists specifically involved in the care of the detainees on hunger strike include nutrition, internal medicine, and behavioral health professionals, all of whom assisted in monitoring and providing specialized care, as needed.

5. ~~(U)~~ All detainees, upon arrival at JTF-GTMO, were given a complete physical examination. Medical issues identified during the examination, or identified during subsequent examinations, are followed by medical staff. Detainees may request medical care at any time by making a request to guard personnel in the cell blocks or to the medical personnel who make daily rounds on each cellblock. In addition to responding to such detainee requests, the medical staff will investigate any medical issues observed by JTF-GTMO guards or staff. The availability of this care has resulted in thousands of outpatient contacts between detainees and the medical staff, followed by inpatient care as needed.

6. ~~(U)~~ Outpatient healthcare provided to the detainees is provided at the medical facility in the detention camps as well as the Detention Hospital. The Detention Hospital is a 15-bed facility that is comparable to a small community hospital in the United States. For medical procedures beyond the capability of the Detention Hospital, the detainees are transferred to the Naval Base Hospital at Guantanamo Bay. As noted above, we can and have requested that specialists be flown in to provide care to detainees when the medical need warrants it.

7 ~~(U)~~ The Joint Medical Group is committed to providing unconditional, appropriate, and comprehensive medical care to all detainees. The healthcare provided to the detainees being held at JTF-GTMO rivals that provided in any community in the United States and is comparable to that afforded our active duty service members. Detainees receive timely, compassionate, quality healthcare and have regular access to primary care and specialist physicians.

8. ~~(U)~~ All medical procedures performed are justified and meet accepted standards of care. A detainee is provided medical care and treatment based solely on his need for such care and the level and type of treatment is dependent on the accepted medical standard of care for the condition being treated. Medical care is not provided or withheld based on a detainee's

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compliance or noncompliance with detention camp rules or on his participation in a hunger strike. Medical decisions and treatment are not withheld as a form of punishment. Moreover, the medical staff has no involvement in discipline decisions made by detention personnel.

Hunger Strike Protocols

9. ~~(U)~~ It is the policy of the Department of Defense to support the preservation of life by appropriate clinical means and standard medical intervention, in a humane manner, and in accordance with all applicable standards. Accordingly, there are procedures and/or protocols for providing medical care to detainees, which are to be followed at all times by all medical personnel at the Detention Hospital and throughout JTF-GTMO, including for detainees who are participating in a hunger strike. JTF-GTMO's hunger strike protocol follows the Federal Bureau of Prisons' model and guidelines for managing hunger strikers. The protocol used by the Joint Medical Group equals or exceeds the standard of care available at accredited hospitals in the United States.

10. ~~(U)~~ A detainee can be designated a hunger striker by the JTF-GTMO Senior Medical Officer (SMO), in conjunction with input from the Detention Hospital medical staff and the Commander, Joint Detention Group (CJDG), based on the detainee's intent, purpose, and behavior. Weight loss to a level less than 85% of the detainee's Ideal Body Weight (IBW) will also designate a detainee as a possible hunger striker as will missing nine consecutive meals. The medical staff carefully assesses each hunger-striking detainee's health by means of physical and psychological examinations, weight monitoring, personal observation and laboratory tests. The ability to monitor a detainee's health is affected by the detainee's willingness to cooperate with medical staff. Joint Medical Group personnel provide extensive counseling and detailed warnings to the detainees concerning the risks of their failure to eat or drink when they begin a hunger strike, prior to the commencement of enteral feeding, and periodically thereafter if the detainee continues to participate in the hunger strike. Medical personnel (including behavioral health professionals) continually remind detainees who persist in their hunger strike that this behavior could endanger their health or life. During these conversations, the medical personnel explain that their role is to preserve and promote the detainee's life and health (not to stop the hunger strike) and urge the detainees to voluntarily accept enough nutrients to increase their weight and improve their health.

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11. ~~(U)~~ If medical personnel determine the detainee's refusal to voluntarily consume adequate food or nutrients could now threaten his life or health, I make a recommendation to the Commander of the Joint Task Force that the detainee be approved for enteral feeding. Even after the Commander authorizes the use of enteral feeding for that detainee, the detainee is always offered the opportunity to eat a standard meal or consume the liquid supplement orally, instead of being enterally fed. If the detainee continues to refuse to eat or consume the liquid supplement orally, medical personnel will only implement enteral feeding when it becomes medically necessary to preserve a detainee's life and health. The medical personnel explain to the detainee how and why the enteral feeding regime will be implemented to preserve the detainee's health and life.

12. ~~(U)~~ The enteral feed is administered through the use of a nasogastric tubes. Feeding through those tubes is only conducted by physicians or credentialed registered nurses, and only when medically necessary to preserve that detainee's life and health. The application of the enteral feeding process is carried out in accordance with prior training received at accredited nursing schools and training conducted here at JTF-GTMO.

13. ~~(U)~~ When inserting nasogastric tubes, a lubricant is always used. In all cases, a topical anesthetic such as lidocane (a widely used local anesthetic) is offered, but the detainee may decline the anesthetic. Prior to insertion, the medical professional will lubricate a sterile nasogastric tube with a lidocane gel or surgilube, or olive oil at the detainee's request.

14. ~~(U)~~ Registered nurses insert the enteral feeding tube in accordance with standard medical protocol. JTF-GTMO uses 8, 10, or 12 french tubes, which are smaller than the 16 french tubes used by the Bureau of Prisons. A nasogastric tube is never inserted and then moved up and down. Instead, it is inserted down into the stomach slowly and directly, and removed carefully. Medical personnel do not remove, insert or administer nasogastric tubes in a manner intentionally designed to inflict pain or harm on the detainee.

15. ~~(U)~~ Typically, anesthetic throat lozenges are also available to the detainees on request. After verification of tube placement, an appropriate amount of nutritional supplement formula is infused by gravity into the detainee's stomach. This process typically takes 30 to 40 minutes. Concentrated and fiber-fortified formulas (also used in U.S. hospitals) are used to reduce volume and enhance digestion, respectively, and to make the procedure as comfortable as

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possible. Detainees are given only appropriate formula, as determined by standard medical protocol and custom-tailored for the detainee's specific needs. The medical staff carefully monitors the process the entire time, adjusting the rate and amount of nutrients and fluids given if there are any indications of discomfort from the detainee. The comfort and safety of the patient is a priority for the medical staff.

16. ~~(U)~~ All detainees being enterally fed are assessed daily by a medical professional subject to regular and periodic review by a physician to ensure the feeding process is being safely administered and tolerated by the detainee. The detainee's health is closely monitored through direct observation and medical testing to ensure he receives the appropriate daily amounts of nutrition and hydration and to assess any complications or need for modification of the regime.

17. ~~(U)~~ When a detainee receives an enteral feed, he is placed in a restraint chair. A restraint chair is utilized to ensure the safety of the guard staff, medical staff, and the detainee. The restraint chair is also used in United States federal correctional facilities and provides the safest and most reliable method for the administration of the nutritional requirements needed to protect and preserve the detainee's health and life. The chair is not used to deliberately inflict pain on detainees, or as a form of punishment or retaliation against them. The chair is ergonomically designed for the detainee's comfort and protection, with a padded seat and padded back support. Straps are positioned to ensure the detainee is safely restrained. Furthermore, to ensure any risk is minimized, the detainee is constantly monitored by medical personnel while in the restraint chair.

18. ~~(U)~~ A detainee is only kept in the chair for the time required to administer a feeding and to ensure the nutritional supplement is digested properly. Therefore, an observation period is necessary to ensure the detainee has tolerated the feeding and to permit digestion of the nutritional formula. If the medical staff does not ensure the nutritional formula is properly digested, a detainee could induce vomiting and therefore place their health and life at greater risk. The entire process generally lasts less than an hour. Detainees are offered pain relievers, such as ibuprofen, if they indicate any discomfort from the feeding procedure.

Reglan Use

19. ~~(U)~~ JMG protocol is to obtain voluntary and informed consent as a routine part of any testing, treatment or medical procedures, following a review of the risks and benefits with the detainee, as well as any available alternatives. In the absence of such consent, involuntary treatment or medication is only implemented when necessary to preserve the detainee's health and life. Reglan is very rarely used by our medical staff as there are other anti-nausea drugs that are just as effective. Reglan or other medications are not placed in the feed solutions, or otherwise given to a detainee, without his knowledge and consent.

Meals During Ramadan

20. ~~(U)~~ JMG staff makes every effort to accommodate the religious and cultural practices of the detainees. As has been done in the past, barring any unforeseen emergency or operational issues, JTF-GTMO will accommodate religious practices during Ramadan, which begins on 8 July 2013. JTF-GTMO will modify the hours of meal delivery, including enteral feeding, in accordance with the fasting hours, and detainees will be provided with a mid-night snack. Although the number of enterally fed detainees is greater than in the past, JTF-GTMO has shifted existing resources and has sufficient medical personnel on hand to provide detainees with the proper nutrition in a manner that is in accordance with Ramadan's fasting requirements. Accordingly, enteral feedings will be administered after sundown each day during Ramadan. At the end of Ramadan, detainees may participate in morning Eid prayer and feast meals will be offered to all detainees on 8 and 9 August 2013. Upon completion of Ramadan, the standard enteral feed schedule will then resume.

Medical Condition of Petitioners

21. ~~(U)~~ Nabil Hadjarab (ISN 238) is presently in good health. He is currently not hospitalized and at his last medical evaluation, all of his vital signs were normal. His current weight is 130 lbs, which is 95% of his ideal body weight of 136 lbs. Mr. Hadjarab was designated as a hunger striker on March 8, 2013. He was approved for enteral feeding on 21 March, 2013 and, since then, he has at times been enterally fed and at times chosen to consume food and nutritional supplements orally. Although Mr. Hadjarab was prescribed Reglan on 21 March 2013 on an as needed basis, he declined the medication and it has not been prescribed since that time.

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22. ~~(U)~~ Shaker Aamer (ISN 239) is presently in good health. He is currently not hospitalized and at his last medical evaluation, all of his vital signs were normal. His current weight is 157 lbs, which is 95% of his ideal body weight of 165 lbs. Mr. Aamer was designated as a hunger striker on 25 March 2013, but has not been approved for enteral feeding. Mr. Aamer has never been prescribed nor administered Reglan.

23. ~~(U)~~ Ahmed Belbacha (ISN 290) is presently in good health. He is currently not hospitalized and at his last medical evaluation, all of his vital signs were normal. His current weight is 120 lbs, which is 85% of his ideal body weight of 140 lbs. He was designated as a hunger striker on March 7, 2013. He was approved for enteral feeding on April 13, 2013 and, since then, he has at times been enterally fed and at times chosen to consume food and nutritional supplements orally. The JMG is aware of his prior nasal surgery and therefore makes every effort to accommodate his situation during the enteral feeding process. Mr. Belbacha has never been prescribed nor administered Reglan.

24. ~~(U)~~ Abu Wa'el (Jihad) Dhiab (ISN 722) is presently in good health. He is currently not hospitalized and at his medical evaluation, all of his vital signs were normal. His current weight is 155 lbs, which is 81% of his ideal body weight of 190 lbs. He was approved for enteral feeding on March 23, 2013 and, since then, he has at times been enterally fed and at times chosen to consume food and nutritional supplements orally. Mr. Dhiab has never been prescribed nor administered Reglan.

I declare under penalty of perjury under the laws of the United States of America that the forgoing is true, accurate and correct.

Dated: 7/3/13

[redacted]

~~(U//FOUO)~~ [redacted]
Commander, Medical Corps, U.S. Navy

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner,* v. BARACK H. OBAMA, *et al.*, *Respondents.*	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S
APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 8

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

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DECLARATION OF IAN C. MOSS

I, Ian C. Moss, pursuant to 28 U.S.C. § 1746, hereby declare and say as follows:

1. I assumed the position of Adviser to the Special Envoy for Guantanamo Closure in April, 2012. As Adviser to the Special Envoy, I support the Special Envoy in the execution of his duties, and assist with diplomatic engagements and transfer negotiations. The information contained herein is based on my personal knowledge and on information provided to me in my official capacity.

2. This declaration is submitted in support of the Government's opposition to Abu Wa'el Dhiab's Application for a Preliminary Injunction and Immediate Order for Disclosure of Protocols, filed on April 18, 2014. [redacted] I was present for the interviews [redacted] conducted with a number of detainees, including with Mr. Dhiab. [redacted] Mr. Dhiab immediately raised his arms and informed [redacted] that he was at that moment ending his hunger strike.

3. On March 6, 2014, I and Andrew Warden, a U.S. Department of Justice attorney, phoned Cori Crider of Reprieve, one of Mr. Dhiab's attorneys, to inform her that her client had accepted [redacted] During that phone call, I related the events that had occurred during the interview as I recalled them, including that her

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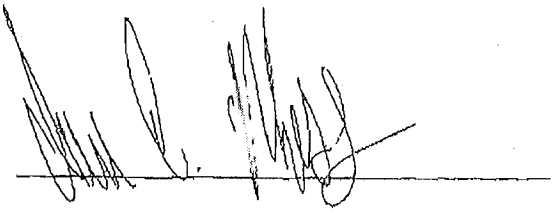
client, [redacted] had expressed his decision to cease his hunger strike [redacted]

4. [redacted]

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 01, 2014.



Ian C. Moss

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents.*	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 9

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

~~(U//FOUO)~~ SUPPLEMENTAL DECLARATION OF COMMANDER [redacted] M.D. REGARDING MEDICAL STATUS OF MR. ABU WA'EL (JIHAD) DHIAB (ISN 722)

Pursuant to 28 U.S.C. § 1746, I, [redacted], hereby declare:

1. ~~(U//FOUO)~~ I am a Commander in the United States (U.S.) Navy with over 19 years of active and reserve service. I currently serve as the Senior Medical Officer, Joint Medical Group (JMG), Joint Task Force (JTF-GTMO), Guantanamo Bay, Cuba. I am responsible for the medical care provided to 139 detainees at Guantanamo Bay and supervise the operation of the Joint Medical Group that provides medical care to those detainees. [1] I have served in this position since February 26, 2014.

2. ~~(U//FOUO)~~ I entered the U. S. Navy while attending medical school at the Uniformed Services University from 1994 to 1998. After that I continued my post graduate training in Family Medicine at the Naval Hospital in Jacksonville, FL. Since residency graduation I have served in the active duty Navy for seven years and then in the U. S. Navy Reserves for the last five years. I have been board certified in Family Medicine since 2001.

3. ~~(U)~~ I have personal knowledge of or have received information in the course of my responsibilities concerning the matters raised by Mr. Abu Wa'el (Jihad) Dhiab (ISN 722) through his counsel in his Application for Preliminary Injunction filed on 18 April 2014. This declaration is based on information made available to me through my official duties, discussions I personally had with other JMG medical staff involved in the medical care and treatment of Mr. Dhiab, and a review of Mr. Dhiab's medical records.

4. ~~(U)~~ Mr. Dhiab is presently in fair health. His active health issues are completely unrelated to his weight or his previous participation in non-religious fasting. He is currently not hospitalized and is not approved for enteral feeding. Mr. Dhiab was removed from the list of detainees approved for enteral feeding on 19 February 2014 after his weight stabilized, he began eating food regularly and he made numerous statements that he was ending his hunger strike. Mr. Dhiab commented to JTF personnel that he stopped his hunger strike due to his desire to be healthy for his potential resettlement to a third country. Since that time, he has not been enterally fed. Mr. Dhiab has steadily gained weight since 19 February 2013, going from 152 pounds on 20 February peaking at 163.6 pounds on 3 April, which is 85% of his Ideal Body Weight (IBW). Since being removed from the list of detainees approved for enteral feeding, Mr. Dhiab was weighed weekly initially, then every two weeks, and finally monthly in April to track his progress. There is no agreement with Mr. Dhiab to weigh him only once per month in exchange for his agreement to eat a small amount of food, however in practice, if detainees are

[1] I do not provide or oversee medical care for the [redacted] detainees in Camp 7. Those detainees have their own Senior Medical Officer. Mr. Dhiab is not in camp 7.

eating regularly, their weights are changed to a monthly basis after showing stability. Mr. Dhiab was eating regularly for the last two months until 23 April 2014, when he began to refuse meals. Prior to that date, regular food was his main source of food, though he could choose to have a meal supplement if he desired. For example, in the first few weeks of April, records reflect that he routinely ate food items such as eggs, cream cheese, peanut butter and jelly, chicken and fish.

5. ~~(U)~~ As of 23 April 2014, Mr Dhiab started skipping many meals again; we have continued to monitor his weight closely and he is now back to being weighed weekly. His latest weight as of 30 April 2014 was 161.2 which is 84% of his Ideal Body Weight. If Mr. Dhiab's condition deteriorates due to lack of eating, JTF-GTMO will follow the standard policies and procedures to maintain his health, including, if necessary, the policies governing enteral feeding as explained in my declaration dated April 18, 2014.

6. ~~(U)~~ As noted above, Mr. Dhiab was removed from the list of detainees approved for enteral feeding on 19 February 2014. At the time Mr. Dhiab was removed from the list of detainees approved for enteral feeding he was approved for enteral feeding twice a day. As with all detainees approved for enteral feeding, Mr. Dhiab was offered the opportunity prior to each enteral feeding to take in sufficient nutrients through either food or consumption of the formula orally and if he did so, he would be cleared from that enteral feeding. During the time he was approved for enteral feeding, Mr. Dhiab often drank sufficient formula to meet his nutritional needs, thus nasogastric enteral feeding was not necessary for one and sometimes both, of the scheduled enteral feedings for the day. Mr. Dhiab's records reflect that over an approximately seven week period, from 1 January – 18 February, Mr. Dhiab regularly ingested sufficient nutrients on his own through regular food as well as drinking his enteral supplement so that nasogastric enteral feeding was not necessary for 56 of his approximately 90 scheduled enteral feeding appointments. On those occasions when Mr. Dhiab was enterally fed, the records reflect that he typically consumed one 237ml can of Jevity combined with 250mL of water over the course of, on average, 10 minutes. On 10 January Mr. Dhiab was also approved to skip his morning enteral feeding on Mondays and Thursdays to enable him to accommodate religious fasting obligations if he maintained his weight and adhered to the remainder of his enteral feeding schedule. As a result, he was excused from some enteral feeding appointments in accordance with that directive. In the event that he was enterally fed, it was typieally with a 10 French feeding tube lubricated with olive oil.

7. ~~(U)~~ Mr. Dhiab suffers from severe back and kidney pain and exhibits blood in the urine on occasion. On 14 February he was admitted to the detention hospital for three days for evaluation and monitoring. He was diagnosed with possible nephrolithiasis (formation of kidney stones) and he agreed to blood work and accepted pain medication. On 26 February 2014 Mr Dhiab had a CT scan of the abdomen and pelvis, the results of which were completely normal. The records do not reflect that he has complained of abdominal pain due to his enteral feedings. Mr. Dhiab does have a history of chronic intermittent flank and bladder pain with a negative workup from a urology specialist in the past. He has a follow up appointment with a urology specialist during their next visit to the base. He rarely complains of pain, but has refused medieations as well as his last provider appointment on 2 May 2014.

I declare under penalty of perjury under the laws of the United States of America that the forgoing is true, accurate and correct.

Dated: 07 MAY 2014

[redacted]

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB, *Petitioner*, v. BARACK H. OBAMA, *et al.*, *Respondents*.	Civil Action No. 05-CV-1457 (GK) ~~Filed Under Seal~~

RESPONDENTS' OPPOSITION TO PETITIONER'S APPLICATION FOR A PRELIMINARY INJUNCTION

EXHIBIT 10

~~FILED UNDER SEAL PURSUANT TO PROTECTIVE ORDER~~

DECLARATION OF COLONEL JOHN V. BOGDAN

~~(U)~~ I, Colonel John V. Bogdan, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. ~~(U)~~ I am a Colonel in the United States Army, with 30 years of service. I currently serve as the Joint Detention Group (JDG) Commander of Joint Task Force-Guantanamo (JTF-GTMO), at the Naval Station, Guantanamo Bay, Cuba. As such, I am responsible for all aspects of detention operations at JTF-GTMO and am familiar with all areas of detention within JTF-GTMO, including the conditions and operational policies and procedures of the various detention areas. I have held this position since June 7, 2012.

2. ~~(U)~~ This declaration is based on my own personal knowledge and information made available to me in the course of my official duties. This declaration is intended to address allegations made by Abu Wa'el (Jihad) Dhiab (ISN 722) in his recently filed Application for Preliminary Injunction.

3. ~~(U)~~ Previously, I provided a declaration describing the search procedures JTF-GTMO guard staff use when transporting detainees outside of their cellblock. (*See generally* "Declaration of Colonel John V. Bogdan," originally filed in *Hatim v. Obama*, Civ. No. 05-1429, attached). That declaration primarily described the standard search procedure for external detainee movements. For internal detainee movements, such as within a detention block or to an enteral-feeding appointment, the JTF-GTMO guard staff uses a [redacted] search procedure. [redacted]

4. ~~(U)~~ A review of the written records from 1 January to 19 February 2014, when Mr. Dhiab was approved for enteral feeding, reflects that an FCE team was called to move him to his enteral-feeding appointment 21 times. On those occasions, Mr. Dhiab was placed in the [redacted] restraint chair to undergo enteral feeding. Mr. Dhiab has not been placed in a restraint chair since 7 February 2014.

5. ~~(U)~~ It is my understanding that Mr. Dhiab alleges that during the FCEs, while he was approved for enteral feeding, he complained of pain in his stomach and kidneys and, in response, JTF guard staff would intentionally put pressure on those areas to cause Mr. Dhiab additional pain. After every FCE, a medical corpsman will ask the detainee, with the assistance of a translator when necessary, whether the detainee has any injuries or otherwise desires medical treatment. Based on the detainee's response and the corpsman's visual assessment, the corpsman will medically clear the detainee if there are no injuries or medical treatment is not otherwise required. A review of the written records from 1 January to 19 February 2014 reflects that Mr. Dhiab did not raise any complaints to the guard staff or the corpsman during or immediately following an FCE, including any specific complaints about stomach or kidney pain. The written records also reflect that Mr. Dhiab neither claimed any injuries nor was he treated for any injuries during or following the FCEs described above. And the written records reflect that the corpsman medically cleared Mr. Dhiab after each FCE. Physically touching a detainee for the purpose of inflicting pain is contrary to policy and would not be tolerated.

6. ~~(U)~~ On 19 February 2014, Mr. Dhiab was removed from the list of detainees approved for enteral feeding but his weight continued to be closely monitored by the Joint Medical Group. In accordance with that close monitoring, between 19 February and 27 March, an FCE team moved Mr. Dhiab to be weighed on three occasions. A detainee is subject to an FCE for purposes of weighing only when medical personnel have indicated that obtaining the detainee's weight is a medical necessity. On each of the three occasions that Mr. Dhiab was subject to an FCE for purposes of weighing, the appropriate medical personnel determined that obtaining Mr. Dhiab's weight was a medical necessity. Further, the three FCEs were conducted consistent with the procedures explained in paragraph 11 of my declaration dated 17 April 2014. Mr. Dhiab was safely secured to a backboard and moved to the weighing location, while a medical corpsman observed the entire process. The corpsman medically cleared Mr. Dhiab after each FCE. Mr. Dhiab neither claimed any injuries nor was he treated for any injuries during or following the FCEs to obtain his weight. As of the date of my declaration, Mr. Dhiab has not been subject to an FCE since 27 March 2014.

I declare under penalty of perjury under the laws of the United States of America that the forgoing is true and correct.

Executed on 07 MAY 14.

John V. Bogdan
Colonel, Military Police
Commanding

Warden, Andrew (CIV)

From: Warden, Andrew (CIV)
Sent: Friday, May 02, 2014 5:28 PM
To: [redacted]

To:

[redacted]

To: [redacted]
Subject: GTMO -- Habeas Visit Information

Dear counsel:

I am writing to clarify practices at Guantanamo Bay in the event a detainee refuses to attend a habeas attorney-client meeting.

JTF-GTMO's practice has been that when a detainee refused to attend a habeas attorney-client meeting, JTF-GTMO would inform the attorney of the detainee's refusal and, as a courtesy, would allow the attorney to write an unprivileged note to the detainee in an effort to convince the detainee to attend the meeting. JTF-GTMO personnel would then deliver the note to the detainee in his cell and, in the event the detainee changed his mind and agreed to attend the meeting, JTF-GTMO would attempt to make arrangements for the meeting during the same requested visit session (*e.g.*, the same morning or afternoon as the scheduled visit).

This practice remains unchanged; JTF-GTMO, however, wants to caution counsel that, due to the logistical requirements necessary to support numerous detainee movements throughout a typical day, which include other attorney meetings, medical appointments, family phone calls, etc., it is often not logistically possible to facilitate a meeting for that particular scheduled visit session (morning or afternoon) once a detainee refuses. By the time the visit refusal process described above runs its course, guard force resources necessary to move the detainee from his cell to the attorney-client meeting room are occupied with other detainee movements. Rearranging these guard force resources at the last minute is challenging and frequently results in more complications to the detainee movement schedule, such as disrupting the timing of other scheduled attorney-client meetings or medical appointments, ultimately adversely affecting other detainees.

Due to these concerns, for a short period in March/April 2014, JTF-GTMO temporarily suspended the practice of facilitating delivery of a courtesy note from counsel to a detainee refusing to attend a habeas meeting, but has now resumed the practice. Therefore, JTF-GTMO staff will continue the courtesy of delivering an unprivileged letter from counsel, but with an understanding that it may not be possible to support the originally scheduled meeting as a result of the detainee's refusal.

The following clarifies this practice in whole. First, JTF-GTMO policy is to advise detainees when they have an attorney meeting or call scheduled, and to be specific in describing the nature of the appointment. We have received feedback from habeas attorneys over the years that detainees allege that JTF-GTMO staff do not always notify detainees that the requested movement is for an attorney-client meeting and that lack of information leads the detainee to refuse the movement unnecessarily. To be clear, JTF-GTMO staff advises the detainee in advance of their scheduled meeting that it is a legal meeting (or legal call as appropriate) so detainees can knowingly decide whether to attend those meetings. To help facilitate detainee attendance to their meetings, JTF-GTMO encourages attorneys to send legal mail or have phone calls with the detainees in advance of the visit date to inform the detainees of the upcoming visit date so the detainees can be prepared for the forthcoming movement. Second, in the event the detainee refuses to move to the designated meeting area after the final notification, JTF-GTMO will notify habeas counsel of the refusal promptly. If counsel would like, they may send an unprivileged note to the detainee in an effort to convince him to attend a visit with the attorney while the attorney is on the island, and JTF-GTMO will facilitate delivery as expeditiously as possible. Third, in the event the detainee agrees to attend a visit after reading the note, JTF-GTMO will assess whether it is logistically possible to move the detainee for the originally-scheduled meeting time and if not, JTF-GTMO will attempt to schedule a meeting during the next available visit slot of the attorney's visit, logistics permitting. For example, in the case of a full-day scheduled visit where the detainee initially refuses to attend the morning session, but changes his mind after receiving the unprivileged note, JTF-GTMO would evaluate whether a morning meeting was still feasible and, if not, attempt to arrange to move the detainee in time for the scheduled afternoon visit session. In the event a detainee decides to attend an attorney-client meeting after an initial refusal where the attorney has scheduled only a half-day meeting with the detainee, JTF-GTMO would evaluate whether a meeting during the half-day session was still feasible and, if not, work with the attorney to assess whether there is time in the attorney's remaining schedule to meet with the detainee, JTF-GTMO logistics permitting.

JTF-GTMO is committed to ensuring that detainees at the Guantanamo Bay detention facility have meaningful access to counsel to pursue their habeas rights.

Best regards,

Andrew I. Warden

U.S. Department of Justice
Civil Division, Federal Programs Branch
Tel: (202) 616-5084

THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ABU WA'EL (JIHAD) DHIAB,

Petitioner,

v.

BARACK H. OBAMA, *et al.,*

Respondents.

Civil Action No. 05-CV-1457 (GK)

[PROPOSED] ORDER

Upon consideration of Petitioner's Application for Preliminary Injunction And An Immediate Order For Disclosure of Protocols Forthwith, as well as Respondents' Opposition, Petitioner's motion is hereby **DENIED.**

SO ORDERED.

Dated: _____

_____
UNITED STATES DISTRICT JUDGE