UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

MOHAMMED ABDULLAH MOHAMMED BA ODAH, *et al.*,	:	
Petitioners,	:	
	:	Civil Action No. 06-1668 (TFH)
v.	:	
BARACK H. OBAMA, *et al.*,	:	
Respondents.	:	

REPLY IN SUPPORT OF PETITIONER'S MOTION TO REINSTATE HIS HABEAS PETITION AND FOR JUDGMENT ON THE RECORD

PRELIMINARY STATEMENT

The government confirms that Mr. Ba Odah remains at a "dangerously low" weight of 75 pounds and it presents no argument or medical assessment refuting Petitioner's claim that he is gravely sick, at risk of disability and even death, and unlikely to be cured within one year. The record is thus clear that Mr. Ba Odah meets the medical requirements set forth in Army Regulation 190-8 that render him eligible for release. Nevertheless, the government presses for unreviewable authority to detain Mr. Ba Odah, now imprisoned for over thirteen years and cleared for transfer for five, all so it may persist in force-feeding him to prolong his detention even more. The sweeping – and senseless – claim of unchecked power is an attack on this Court's constitutional authority and contravenes the humanitarian principles of the laws of war.

First, the government's brief proceeds as if the Supreme Court decrees in *Hamdi v. Rumsfeld*, 542 U.S. 507 (2004) and *Boumediene v. Bush*, 553 U.S. 723 (2008) never occurred, by suggesting that medical repatriation decisions under the law-of-war are categorically beyond judicial authority precisely as it once argued that detention decisions themselves must be

categorically shielded from judicial review. But, the government cannot roll back the judicial clock. *Boumediene* guarantees Mr. Ba Odah a constitutional right to "meaningful" review of the legal and factual bases for executive detention. Likewise, *Hamdi* – in rejecting a variation of a political question defense the government resuscitates here – confirmed that the government's detention authority is subject to judicially imposed constraints.

The primary constraint, *Hamdi* holds, is the law of war, which authorizes the executive to detain in order to prevent a return to the battlefield, *Hamdi*, 542 U.S. at 518, but imposes bounds on that detention authority, including where a prisoner is gravely sick or wounded. The government cannot embrace law-of-war detention authority – in justifying Mr. Ba Odah's interminable imprisonment – in the same breath that it chooses to discard the law's corresponding limitations. It is the Court's duty – not the Executive's prerogative – to reconcile the law that authorizes and limits detention.

Second, the government revives the harshly-discredited Combatant Status Review Tribunals (CSRTs) "enemy combatant" determinations to argue that Mr. Ba Odah has no legally recognized status under the governing Army Regulation. But, the CSRTs are not competent authorities and cannot dislodge Mr. Ba Odah from the protections of international humanitarian law. Setting aside their irremediable procedural defects, *see Boumediene*, 533 U.S. at 729, by their own terms, CSRTs were never empowered to adjudicate the specific status determinations required by Army Reg. 190-8. Thus, contrary to the government's construction, Army Reg. 190-8 (like the Geneva Convention provisions that it incorporates) resolves any ambiguity about a prisoner's status by enhancing international humanitarian law protections, not withholding them.

Finally, the government argues that Mr. Ba Odah's debility is "self-inflicted," and that granting the writ in this case would incentivize other detainees to orchestrate their own hunger

strike in order to game their release. Putting aside the dubious nature of this perceived incentive structure,[1] the argument presents no bar to relief as it turns on a Geneva Convention provision not applicable here. Petitioner grounds relief in Army Reg. 190-8, based on *Article 110* of the Geneva Conventions that governs "sickness;" the government's argument relies on *Article 114* of the Conventions which covers a categorically different phenomenon not contemplated by the Army Regulation – "Injury" from "Accidents." *See* Convention Relative to the Treatment of Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees art. 114, Aug. 12, 1949, 6. U.S.T. 3316, 75 U.N.T.S. 135 (hereinafter "Third Geneva Convention"). Even if Mr. Ba Odah's sickness could somehow be classified as accidental injury, there is no "clearly established" proof (a requirement the government elides) that, by maintaining a hunger-strike – where the government nonetheless enterally feeds him 2600 calories a day – he willfully intends to inflict on himself debilitating "injuries" such as organ depletion, psycho-neurological deterioration, let alone the cellular decomposition likely causing malabsorption. As three medical experts attest, something dangerous is happening to Mr. Ba Odah that is now likely beyond his control.

ARGUMENT

I. The Supreme Court Confirms this Court's Authority to Determine the Legality of the Government's Continuing Detention of Mr. Ba Odah Under the Laws of War.

Without so much as acknowledging the Supreme Court's directives in *Boumediene* and *Hamdi*, the government contends that Mr. Ba Odah's claim for habeas relief "would require the Court to make determinations that are not within the province of the Judiciary." *See* Resp'ts' Opp'n 3. There is no longer a question about this Court's power to determine whether Mr. Ba

[1] *See* Joseph Margulies, *The Fear of Too Much Justice: Tariq Ba Odah and the Department of Defense*, Verdict, Aug. 10, 2015, available: https://verdict.justia.com/2015/08/10/the-fear-of-too-much-justice (calling DoD's professed concern about hunger-strike copy-cats "morally bankrupt").

Odah's continuing detention is lawful. *See Boumediene v. Bush*, 553 U.S. 723, 781-82 (2008) (for the "writ [to] be effective…[t]he habeas court must have sufficient authority to conduct a meaningful review of…the Executive's power to detain"); *Hamdi v. Rumsfeld*, 542 U.S. 507 (2004) (laws of war authorize detention for the limited purpose of preventing a return to conflict, but courts are constitutionally compelled to review the legal and factual grounds for detention). The Court's jurisdiction is not diminished because Mr. Ba Odah's challenge to the government's detention authority turns on his ill-health – not when the laws of war expressly contemplate release for the sick.

In the face of *Boumediene* and *Hamdi*, the government expends considerable energy discussing elements of the Geneva Convention it contends preclude judicial resolution of Mr. Ba Odah's case. *See* Resp'ts' Opp'n 30-31. Its arguments are so strained as to be perplexing; but in any event, they are pointless. While Army Reg. 190-8 incorporates (with modification) the substantive guidelines of the Third Geneva Convention, Art. 110, *see* Pet'r' Br. 14-15, Mr. Ba Odah does not invoke the provision as the rule of decision or the authority upon which habeas relief should be granted. *See* Military Commissions Act of 2006, Pub. L. 109-366, § 5(a), Oct. 17, 2006, 120 Stat. 2631. Thus, whatever the government's reading of Art. 110 may be, it does not undercut the Court's authority to apply Army Reg. 190-8 to the facts Mr. Ba Odah presents here. *See Al-Warafi v. Obama*, 716 F.3d 627, 629 (D.C. Cir. 2013) (holding that Army Reg. 190-8 is binding domestic law and properly invoked in habeas proceedings).

To sidestep *Al-Warafi*'s clear holding, the government turns to the "framework" of Geneva Conventions Art. 110, which describes how state parties can, of their own accord, conclude agreements for medical repatriation. On that thin reed, the government asserts – without analysis – that therefore it would be inappropriate for the Court to resolve Mr. Ba

Odah's motion. *See* Resp'ts' Opp'n 30. Yet, whatever support can be drawn from Art. 110 for deference to the Executive, the framework is silent on this Court's power, confirmed in *Hamdi* and *Boumediene*, to resolve Mr. Ba Odah's habeas action – based as it is on a separate domestic statute which binds the U.S. military.[2]

Casting farther afield for its claim to deference, the government recalls "Operation Little Switch" – a multilateral prisoner-swap concluded at the end of the Korean War. Yet, resolving this motion does not require the Court to wade into sensitive international affairs; if it did, *Boumediene* and *Hamdi* would have been decided differently. Notably, Mr. Ba Odah has now been detained well over *four times* the duration of the Korean War. After over thirteen years of imprisonment, the judiciary can (and must) review whether the exercise of Executive discretion comports with the law.[3]

---

[2] The government's offering of *Ludecke v. Watkins*, 335 U.S. 160 (1948) helps confirm that the President guides U.S. foreign affairs. That point is undisputed and irrelevant.

[3] The government makes the remarkable assertion that "because the relief requested involves transfer to a foreign country," it is politically sensitive and not appropriate for the court to hear. Resp'ts' Opp'n 33, n.21. Of course, *all* Guantanamo habeas petitions implicate potential transfer to a foreign country. If the prospect of a foreign transfer divests the Court of its authority to hear this case, then habeas review is meaningless. *But see Boumediene*, 553 U.S. at 781-82. Regardless, resolving this motion requires the Court to answer only the narrow legal question of whether the AUMF authorizes Mr. Ba Odah's current detention, not the propriety or obligation to release him to a particular country. It bears noting, however, that ruling in Mr. Ba Odah's favor would exempt him from the very NDAA transfer restrictions the government cites as an obstacle to releases, *see* Resp'ts' Opp'n 33, n.21. This begs the question of why this litigation has become necessary given the parties' aligned interests. *See* Resp'ts' Opp'n 1 ("The United States Government remains committed to securing an appropriate transfer location for [Mr. Ba Odah], who is approved for transfer…."). *See* Charlie Savage, *Guantanamo Hunger Strike Petition Divides Officials*, NY Times, Aug. 7, 2015 (reporting the Justice and Defense Departments' insistence on litigating this case over the objection of the State Department, which preferred not to oppose due to Mr. Ba Odah's "medical condition and the incongruity of sending diplomats to ask other countries to take in such detainees even as the Justice Department fights in court to prolong their detention.").

II. THE RECORD DEMONSTATES THAT MR. BA ODAH IS SUFFERING FROM A GRAVE, CHRONIC ILLNESS UNDER ARMY REGULATION 190-8, WHICH CANNOT BE REMEDIATED AT GUANTANAMO.

A. The Record is Clear that Mr. Ba Odah is in a Grave, Chronic Medical Condition that Has Not Been Cured in One Year.

The government's Senior Medical Officer (SMO) cannot dispute – and ultimately supports – the central and obvious conclusion of Petitioner's three independent medical experts: that Mr. Ba Odah is in a crisis medical situation, owing primarily to the clinically shocking fact of his 74-pound weight; he risks the underlying destructive effects of starvation; and he exhibits predictable distrust of Guantanamo medical staff requiring urgent intervention by *independent* medical professionals. His condition is chronic, life-threatening and potentially irreversible. As a "sick" detainee who is unlikely to recover within one year, he conclusively meets the standard for medical repatriation under Army Reg. 190-8.

The SMO's assertion that Mr. Ba Odah is "clinically stable" is alarming as a matter of medical procedure and substantive judgment. As a matter of medical procedure, a physician cannot responsibly opine that a patient at Mr. Ba Odah's weight – and with the symptoms he reports – is "stable" based on the "evidence" the SMO cites: primarily second-hand observations and anecdotes from medical and non-medical staff about Mr. Ba Odah's behavior. *See infra* Section II(A)(2). As a matter of substance, the SMO's conclusion is controverted by the unanimous assessment of Petitioner's three medical experts who say that anyone facing the chronic and potentially fatal consequences of severe malnutrition cannot be considered "stable."

1. The SMO Declaration Largely Corroborates that Mr. Ba Odah Has a Grave, Chronic Illness.

First, the SMO confirms that as of mid-July, Mr. Ba Odah weighed 74 pounds, just 56% of his ideal body weight. SMO Decl. ¶14. As Petitioner's medical experts explain, this fact

alone demonstrates that Mr. Ba Odah is in a medical-psychological crisis.[4] The SMO also catalogs the systematic depletion of his weight since 2007 (when he weighed 133.5 pounds), resulting in his present precarious state – a degeneration that prevailed despite medical staff's attempt to maintain his weight through its force-feeding treatment regimen. *Id*. n. 2.[5] From this, the SMO rightly concedes that Mr. Ba Odah's weight "is certainly at a very low and dangerous point," SMO Decl. ¶22 and remarks that, "Mr. Ba Odah is presently in poor health, primarily due to his non-religious fast [sic][6] and subsequent weight loss." SMO Decl. ¶14; *see also id*. ¶27 ("His weight remains an active concern for the JMG."). He notes Mr. Ba Odah's expression of "despair regarding his situation." SMO Decl. at ¶16. The SMO also recognizes the emergent dangerousness associated with any *further* weight loss, even while failing to consider Drs.

---

[4] *See* Declaration of Dr. Mohammed Rami Bailony, dated June 18, 2014 ("Bailony Decl.") ¶6 ("This is a shocking medical fact that alone indicates the presence of a crisis-level medical condition presaging organ failure, neurological damage and, inevitably, death."); Declaration of Dr. Sondra Crosby dated June 22, 2014 ("Crosby Decl.") ¶5 (based on his weight and reported symptoms, "I can confidently say that Mr. Ba Odah is suffering from severe malnutrition and that . . . such a state of starvation will, without medical intervention, lead inevitably to death, possibly in a period of months." Declaration of Dr. Jess Ghannam dated June 21, 2014 ("Ghannam Decl.") ¶20 ("a weight of 75 pounds for an adult male is a phenomenon rarely, if ever encountered by the medical profession. It is a level of physical deterioration typically seen in a late-stage cancer or AIDS patient.").

[5] Notably, in prior years, Mr. Ba Odah's weight fluctuated widely from 90 to 105 pounds in 2012, from 90 to 122 pounds in 2013, and 74.5 to 110 pounds in 2014. Yet, for nearly a full year – from September 2014 to the present, his weight stayed consistently below 80 pounds. This status and inability to gain any substantial weight during an entire year supports the assessments of Dr. Bailony and Dr. Crosby that he may be suffering from a chronic physical debility – be it nutritional, gastrointestinal or organ-related – that is preventing his absorption of calories and may be the product of long-term or permanent harm. *See* Bailony Decl. ¶¶ 15-18, 30; Crosby Decl. ¶ 30. It is concerning that the SMO did not account for this possibility in concluding that Mr. Ba Odah is stable. *See infra* at Section I(A)(2).

[6] In referring to Mr. Ba Odah's long-term hunger strike as a "non-religious fast," the SMO parrots the Orwellian parlance of the Defense Department, adopted in 2013 in response to the wave of hunger striking among detainees at Guantanamo. *See* Phil Stewart, *U.S. Calls Guantanamo hunger strikes 'non-religious fasting*,' Reuters, Mar. 12, 2014. Outside of Guantanamo, "non-religious fast" is not a medically valid or recognized term. The appropriate clinical term, as derived from medical literature and common understanding, describes Mr. Ba Odah's actions as a "hunger strike." Crosby Suppl. Decl. ¶20.

Crosby and Bailony's concern that, because Mr. Ba Odah's may have bottomed at 74 pounds, death or debility may occur even without a further decline in body weight. *See* SMO Decl. ¶26.

The SMO further confirms Mr. Ba Odah's grave and chronic condition by cataloging additional symptomology beyond that raised by Petitioner. The SMO reports, for example, that Mr. Ba Odah is consistently cold, and that he has been given cushions to alleviate a "pressure ulcer, SMO Decl.¶25" – *i.e.*, "bed sores," a dangerous signal of degradation that stems from the inability of Mr. Ba Odah's skin-and-bones to absorb the pressure from his own weight because he is sedentary, frail, or both. *See* Exhibit 2, Supplemental Declaration of Dr. Jess Ghannam, dated September 9, 2015 ("Suppl. Ghannam Decl.") at ¶20. The SMO confirms that Mr. Ba Odah vomits after force-feedings, though refers to the reflex as "purging," without explanation or detail. SMO Decl.¶19.[7] The SMO reports that in August 2014, when returning from a feeding, Mr. Ba Odah felt fatigued and "slid down to the floor," SMO Decl.¶22 – *i.e.* he collapsed.[8] He also reports that Mr. Ba Odah has "latent tuberculosis" SMO Decl. ¶25, a condition that could develop into full-borne disease given Mr. Ba Odah's highly vulnerable state. *See* Exhibit 4, Supplemental Declaration of Dr. Sondra Crosby dated September 9, 2015 ("Crosby Suppl. Decl.") ¶15.

[7] As Dr. Ghannam explains, the assessment of "purging" to "limit caloric intake" lacks sufficient detail to be "of clinical value" because what appears to be purging "to an untrained attendant could just as easily be the result of an involuntary physiological process caused by pain, gastrointestinal dysfunction…." Ghannam Suppl. Decl. ¶9. Moreover, Dr. Ghannam concludes that in a case such as this where malnourishment is central, any report of purging should incorporate significant detail. *Id*.

[8] As Dr. Ghannam explains, this event and Mr. Ba Odah's general unwillingness or inability to use recreation time are clinically significant. "The times when Mr. Ba Odah is at his most compromised are critical clinical moments and are important in making a differential diagnosis. These moments reveal the depth of the medical crisis Mr. Ba Odah is facing." Ghannam Suppl. Decl. ¶12.

2. Because the SMO's Assessment that Mr. Ba Odah is "Clinically Stable" is Conclusory, Anecdotal and Unresponsive to Mr. Ba Odah's Existing Symptomology and the Known Medical Risks Associated with Starvation, it is Entitled to No Weight.

Despite acknowledging the medical "danger" facing an adult man withered to 74 pounds, the SMO nevertheless attempts to reassure the Court that it is in control of Mr. Ba Odah's health by declaring him "clinically stable," SMO Decl. ¶22, and by asserting "that the current manner of managing his non-religious fast remains appropriate." SMO Decl. ¶26. The conclusions are offered devoid of analysis in the sentences that follow or precede them sufficient to support such a consequential medical assessment.[9]

However, in paragraph 26, the SMO makes this extraordinary statement:

> [T]he fact that he has maintained a consistent weight range since September 2014 and is functioning normally in his daily life leads me to believe that the current manner of managing his non-religious fast [sic] remains appropriate.

This assessment is "impossible to accept" and "medically naive," Bailony Suppl. Decl. ¶¶ 4, 11 and, even accounting for difficulties in treating hunger strikers, not clinically defensible, Crosby Suppl. Decl. ¶¶2, 21. As detailed below, this judgment has been made without following necessary medical protocols; and, substantively, it is unacceptable insofar as it cannot be squared with expected illnesses, the problem of caloric malabsorption and current, serious symptomology. *See* Ghannam Suppl. Decl. ¶3 ("The SMO's course of treatment, as reported in his declaration, departs from basic tenants of diagnosis, preventative and remedial care,

[9] As Dr. Bailony explains, the term "clinically stable," when properly used, signifies that the physician "has satisfactorily performed certain common, threshold diagnostic tests . . . evaluated the results of those tests and found them to be within normal ranges, further considered and ruled out the risks associated with manifest symptomology, likely illnesses and injury," but the SMO declaration evidences a failure to undertake the predicate clinical work necessary to make such an assessment. *See* Exhibit 3, Supplemental Declaration of Dr. Mohammed Rami Bailony, dated September 9, 2015 ("Bailony Suppl. Decl.") at ¶ 5.

particularly for a patient who is so abnormally malnourished and underweight as Mr. Ba Odah.").

"Functioning Normally in His Daily Life"

One basis for the SMO's confidence in Mr. Ba Odah's stability is his reported ability to "function [ ] normally" in his "daily life," despite being 74 pounds. SMO Decl. ¶ 26. That claim, in turn, appears grounded on undated, second-hand reports that, on some unspecified occasions, Mr. Ba Odah "*has been* observed" walking "without difficulty," and "speaking clearly and fluently," and engaged in activities such as "grooming," "cleaning" "going to the bathroom," "*sleeping*," "praying," "singing," and "reading." SMO Decl. ¶ 27 (emphasis added).[10]

First, no responsible medical professional would make such a prognosis on visual observations alone – let alone indirect, undated, unspecified visual observations. Crosby Suppl. Decl. ¶2, 5-6; Bailony Decl. ¶6 (as with "patients with severe, undiagnosed heart disease" who regularly engage in such "normal" activities "until the moment they collapse and expire," the fact that "Mr. Ba Odah is able to talk on occasion to a neighboring prisoner, does not rule out the presence of potentially permanent, even fatal, vitamin deficiency."). Given Mr. Ba Odah's precarious condition, a credible evaluation would have to be based on more reliable data not considered by the SMO, including: full metabolic blood tests, physical exam including blood pressure check and EKG, and follow up tests to evaluate the symptomology described. Crosby Suppl. Decl. ¶5; Bailony Suppl. Decl. ¶11 ("[U]nder no circumstance, would a doctor declare the patient clinically stable before those tests were performed."); Ghannam Suppl. Decl. ¶6 ("Failing to undertake basic diagnostic testing for a patient in Mr. Ba Odah's obvious state of ill health,

[10] Drs. Crosby and Ghannam each stress that these observations lack documentation of dates, times, durations or qualifications of observers, in a way that could make them "useful and reliable from a clinical standpoint." *See* Crosby Suppl. Decl. ¶7, Ghannam Suppl. Decl. ¶10.

but electing to declare him clinically stable all the same, invites an intolerable level of risk of his decline and, in the worst case, his death.").[11]

Second, the set of observations from which the SMO bases his conclusion is, on its own terms, unreliable. The SMO extrapolates a finding of clinical stability from anecdotal reports of episodic functioning in daily life while downplaying (or discounting altogether) obvious contrary indications suggesting Mr. Ba Odah's ill-health, such as: the constellation of symptoms reported to Mr. Ba Odah's counsel; his despairing comments; the majority of occasions where his functioning is diminished, evidenced by his unwillingness or inability to leave his cell and his reported collapse. The SMO's selective reliance on certain helpful aspects of Mr. Ba Odah's behavior is a form cherry picking that is not clinically responsible. *See* Ghannam Suppl. Decl. ¶12 (stressing the limited value of isolated appearances of mobility, because the "times when Mr. Ba Odah is at his most compromised are critical clinical moments").[12]

Even fatally ill patients exhibit the common clinical phenomenon of "waxing and waning" – that is, they exhibit moments of "alertness" and "apparent good health" despite an otherwise debilitating medical situation particularly as it relates to performance of "overlearned, reflexive" behavior such as grooming, walking or praying. Ghannam Suppl. Decl. ¶11. This phenomenon can itself be "a hallmark of progressive deterioration" and "waning periods" are "most revealing because they indicate . . . the extent of a patient's deterioration." *Id*. A doctor

---

[11] Of course behavioral observation, particularly if undertaken by the treating physician (which was not done in this case), can be a piece of relevant information, but it "can never replace the 'hands-on' clinical examination and diagnostic testing." Ghannam Suppl. Decl. ¶7. *See also* Crosby Suppl. Decl. ¶7.

[12] As another example, the SMO admits that Mr. Ba Odah suffers from "pressure ulcers," commonly known as "bed sores." Yet as Dr. Ghannam stresses, "bed sores" are fundamentally incompatible with an assessment that someone is "functioning normally in their daily life" and are often an indication that a patient's system is degraded and their level of incapacitation severe. In a hospice setting, "the onset of bed sores is typically viewed as a possible indication of below standard of care." Ghannam Suppl. Decl. ¶20.

would not extrapolate based on observed grooming or praying that a patient with advanced heart disease was clinically stable. *See* Bailony Suppl. Decl. ¶ 6.

Third, the SMO's analysis ignores any of the severe symptoms and other red flags identified by Petitioner or the known chronic and acute risks to someone suffering from severe malnutrition. *See, e.g.* Bailony Decl. ¶35 (describing serious risks from presence of leg edema); *see also* Bailony Suppl. Decl. ¶¶8-9 (describing consistency in Mr. Ba Odah's reported symptoms and Wernicke-encephalopathy).

Finally, that Mr. Ba Odah understandably failed to directly report his serious symptoms to the very doctors he does not trust, SMO Decl. ¶23, or verbally insulted staff ("comparatively modestly" in Dr. Crosby's view) does not make those symptoms less real or serious and certainly does not make Mr. Ba Odah unique among patients in a prison setting. *See* Crosby Suppl. Decl. ¶19. Indeed, it may be evidence of deterioration. *Id.*, *see also* Bailony Suppl. Decl. ¶10. Yet for a doctor to simply ignore them in concluding a patient is clinically stable, calls into question the credibility of that medical assessment. Ghannam Suppl. Decl. ¶¶14-17. As Dr. Crosby stressed, while caring for hunger strikers is "complex and challenging, even for experienced, senior physicians" the care proposed for Mr. Ba Odah "is not consistent with good medical practice." Crosby Suppl. Decl. ¶21.

"Maintained a Consistent Weight Range"

The other basis for the SMO's judgment that Mr. Ba Odah is clinically stable and receiving appropriate care is that his weight has consistently held around 74 pounds for almost a year. To begin, the assumed correlation between consistent *weight* and stable *condition* is categorically false. *See* Ghannam Suppl. Decl. ¶13 ("Consistent body weight is merely one isolated piece of data . . . and is insufficient to assess the quality of health in a man otherwise so

degraded."); *see also* Crosby Suppl. Decl. ¶6. The SMO cannot say if Mr. Ba Odah is suffering from metabolic problems (as his symptomology and the course of malnutrition would indicate, *see* Bailony Decl. ¶¶28-31) or cardiac problems (*see* Crosby Decl. ¶31) or respiratory problems or gastrointestinal problems (of which Mr. Ba Odah is also symptomatic, *see* Crosby Decl. ¶37, Bailony Decl. ¶30(h)), all of which would render him at risk despite consistent weight. *See also* Ghannam Suppl. Decl. ¶13. Indeed, all three of Petitioner's medical experts explained in detail that Mr. Ba Odah is malnourished and cannot responsibly be considered "clinically stable." *See e.g.*, Bailony Decl. ¶6 ("His body is in a state of persistent, inevitable morbid decline and is at every moment presenting a latent but severe risk of death from infection."). The SMO does not attempt to answer these conclusions.

Second, the SMO's assessment misapprehends the lethal risks associated with severe malnutrition. As Dr. Bailony explained (but the SMO ignores), given the mass associated with Mr. Ba Odah's basic skeletal frame and (depleted) organs and blood, he simply may have no more weight to lose; viewed properly, the 74-pound floor is cause for *alarm*, not reassurance. Dr. Bailony explains:

> 16. . . . [I]n a classic case of malnutrition such as this, where a patient is already at approximately 50% of his normal body weight, *the caloric deficiency he is enduring may not manifest in continued weight loss; instead, it may manifest as further and progressively life-threatening symptomology*.
>
> 17. *This is why no responsible doctor would take comfort in the fact that his weight is unchanging especially when at least some of his reported symptoms have progressed*. In Mr. Ba Odah's severe state of malnutrition, the effects of his systemic calorie deficiency will continue to manifest as additional injury to his body.

Bailony Decl. ¶¶16-17 (emphasis added); Bailony Suppl. Decl. ¶14; Crosby Decl. ¶30 ("anything below 70% of ideal body weight [is] considered medically dangerous because of increased risk of multiorgan dysfunction, life-threatening medical complications, and sudden death.").

Third, the SMO does not meaningfully defend his medical standard of care. In other words, he does not attempt to explain why a daily force-feeding regimen of 2600 calories cannot increase Mr. Ba Odah's weight. *See* Bailony Suppl. Decl. ¶13 (calling the lack of analysis of caloric absorption, as opposed to intake, "striking" when that is "the indispensable piece of clinical data" for treatment of someone so diminished). The likely explanation, common to malnourished patients, is that Mr. Ba Odah is suffering from an underlying metabolic, gastrointestinal or micro-nutrient deficiency that frustrates his caloric *absorption*, regardless of his *intake*. *See* Bailony Decl. ¶¶13-16; Bailony Suppl. Decl. ¶14 (inability to absorb calories "is a clear and alarming indication that his gastrointestinal tract likely does not function correctly.").

Given this predominant explanation, it is clinically implausible that Mr. Ba Odah's "condition is the consequence *purely* of his own effort," SMO Decl. at ¶26 (emphasis added) – when the SMO supports that absolute statement with only undated, unspecified, and indirectly reported anecdotes of attempts to circumvent force-feedings. *See* Crosby Suppl. Decl. ¶¶11-12; Bailony Suppl. Decl. ¶15 (given other likely clinical explanations, the evidence is "insufficient to support a clinical determination that Mr. Ba Odah's malnourishment is explained by behavior and not physiology."). Mr. Ba Odah is likely suffering from as yet undiagnosed, underlying chronic conditions that cannot be remediated by his prison doctors.

3. The Proposed Medical Intervention is Clinically Inappropriate

The SMO also proposes the following medical intervention should things get worse:

> 26. In the event of a significant change in his weight for the worse, I am prepared to admit him into the Detainee Acute Care Unit (DACU) where he would be placed on a continuous enteral feed and restricted to a bed with a scale under him.

This is an unelaborated proposal but, as articulated, clinically inadequate.

First, to the extent that he would await further weight loss from Mr. Ba Odah prior to hospitalization, the SMO fails to appreciate the appropriate trigger for acute medical intervention. As previously explained, Mr. Ba Odah quite likely has no more weight to lose and "people who die from malnutrition . . . die precisely at the level of lost body mass Mr. Ba Odah is at now – or even at a greater percentage body weight – from the effects of malnutrition on the body's functioning." Bailony Decl. ¶18; *see also* Crosby Decl. ¶ 30; Bailony Suppl. Decl. ¶¶14, 18. He is already past the threshold requiring acute and independent medical intervention.

Second, the proposed course of intervention – continual nasal intubation and feeding with commercial formula is not clinically appropriate. The SMO offers no "medical basis" to conclude that "feeding Mr. Ba Odah more slowly will enhance his ability to efficiently absorb those additional nutrients." Bailony Suppl. Decl. ¶18. Indeed, "as an emergency intervention plan, continuing enteral feeding is shockingly inadequate and finds no support in the medical literature that I am aware of." *Id.* As Dr. Bailony explained:

> Due to the varied position of the NG tube, delayed gastric emptying, and high gastric residuals (high amount of content left in stomach without passing to the intestines), adequate nutritional support over the long-term with gastric feedings is impossible. (This has been documented in numerous clinical studies). There is not one clinical study that I am aware of that demonstrates that adequate long-term nutritional support can be delivered via nasogastric enteral nutrition. There is likewise no responsible physician or health care facility in the country that would ever use a protocol that attempted to provide long-term nutritional support through NG enteral feeding.

Bailony Decl. ¶36. Dr. Bailony stresses that, particularly in an acute care setting, clinical protocol requires alternative enteral feeding methods:

> Successful enteral nutrition requires placement of jejunal feeding access (i.e. directly through the belly into the small intestine), which is what is routinely done for cancer patients, chronically, debilitated patients, and patients in chronic vegetative state.

Bailony Decl. ¶36. *See also* Bailony Suppl. Decl. ¶19 ("At this stage – although only sound diagnostic testing can determine – he likely needs micronutrients introduced into his system intravenously to support healing of his gastrointestinal tract among other treatments.").

B. Mr. Ba Odah's Understandable Distrust of the Guantanamo Medical Staff Only Demonstrates that, Consistent with Governing Medical Ethics, He Should be Transferred for Treatment to Another Country.

The SMO devotes a large portion of his declaration to chastising Mr. Ba Odah for a perspective he willingly admits: he does not trust the medical staff at Guantanamo. Thus, it is no criticism of Mr. Ba Odah, who has been detained without charge for over 13 years and force-fed by medical staff for over eight, that he refused the SMO's frequent visits in the days immediately preceding and following Petitioner's filing, *see* SMO Decl. ¶18 (describing attempts to visit Mr. Ba Odah on June 19, 20, 21 and July 20 and 24 and noting that Mr. Ba Odah cursed at him and told "to go away."); or that, despite Mr. Ba Odah's "sense of despair regarding his situation," he refused to meet with a BHU technician. *Id*. at ¶16.

That a prisoner in Mr. Ba Odah's situation would exhibit distrust toward prison doctors is, "as a psychological phenomenon . . . not at all surprising; on the contrary, it is common." Ghannam Decl. ¶38. *See also* Crosby Decl. ¶43 (across the world "this phenomenon of mistrust is widely observed and understood."); Crosby Suppl. Decl. ¶¶17-18. In penal settings, trust is frequently lost if, as here, physicians are viewed as part of the prison apparatus. Ghannam Decl. ¶39; Ghannam Suppl. Decl. ¶14; Crosby Decl. ¶43. In Guantanamo, the medical staff orders and performs forcible feeding (and forced cell extractions), against Mr. Ba Odah's will, requiring immobilization in a restraint chair "in a manner he finds painful and coercive" and which is "extremely invasive" and "humiliating." Ghannam Decl. ¶38; Crosby Decl. ¶43. And, as an understandable result of this mistrust, "patients will often not accept appropriate medical recommendations" from assigned medical staff. Ghannam Decl. ¶40; *see also* Ghannam Suppl.

Decl. ¶16 ("Revisiting a patient day after day to renew the offer of treatment can re-traumatize and intimidate patients, often eliciting precisely the 'vigorous' reactions the SMO declaration attributes to Mr. Ba Odah.").

Indeed, his expressions of displeasure may stem from "cognitive issues related to his malnutrition" or "other undiagnosed psychological conditions," Crosby Decl. ¶19, and are actually "hallmark indicators of Wernicke-Korsakoff syndrome." Bailony Suppl. Decl. ¶¶9-10 ("Clinical literature is replete with examples of anorexic patients" and other patients with serious undernourishment who "cycle through periods of overreaction, seemingly unprovoked outbursts, noncompliance and agitation.").[13]

Because "a trust-based doctor-patient relationship is of paramount importance for treatment and recovery," Crosby Decl. ¶43, Ghannam Decl. ¶40, the medical profession has developed ethical standards to ensure the appropriate care of patients in custodial settings who distrust medical staff. Crosby Decl. ¶44. Those standards are codified in the "World Medical Association Declaration of Malta on Hunger Strikers," which is "the authoritative source for medical ethical guidance as it relates to the treatment of hunger striking patients." Under the Malta Declaration, clear evidence of a breach of doctor-patient trust – as present here – dictates that the hunger-striking prisoner "should be granted access to an outside independent physician of confidence." Crosby Decl. ¶44. *See also* Ghannam Suppl. Decl. ¶¶15-16.

Mr. Ba Odah cannot be treated effectively at Guantanamo. The medical ethical guidelines are intended to prevent his suffering (or worse) in light of his understandable distrust

[13] The SMO notes that Mr. Ba Odah has accepted some medical attention, for over-the-counter palliatives and in agreeing to remove a cyst. SMO Decl. ¶¶23, 25. These instances cannot call into question the intensity – and legitimacy – of his distrust of medical staff. Consistent with "common and clinically predictable phenomenon," a prisoner will often "negotiate that mistrust and his acute medical needs as he sees fit" and "accept care they determine is essential despite their overriding aversion to cooperating." Ghannam Suppl. Decl. ¶17.

of doctors there. At this late stage, transfer out of Guantanamo – which the government authorized years ago when it cleared him – is required to preserve Mr. Ba Odah's health. It is within the power of this Court to order that necessary relief.

C. At a Minimum, An Independent Medical Examination Should be Ordered.

The record conclusively demonstrates that Mr. Ba Odah is gravely and chronically ill so as to meet the Army Reg. 190-8 standard for medical repatriation. The government's demand that the court simply trust its diagnosis and treatment – unsubstantiated and medically inappropriate as it is – is insufficient grounds to deny Mr. Ba Odah's petition. Thus, if the court has questions about his condition, it should order an independent medical examination by one or more of Petitioner's experts. Mr. Ba Odah has communicated directly to counsel that he would be willing to meet with independent doctors, such as Dr. Crosby and Dr. Ghannam, in person and undergo blood testing and any other necessary medical exams. *See* Exhibit 1, Supplemental Declaration of Omar Farah, dated September 10, 2015, ¶7. The court is empowered to order such an evaluation as part of its inherent power to resolve habeas petitions. *See Aamer v. Obama*, 58 F. Supp. 3d 16, 29 (D.D.C. 2014).

III. THE LIMITATIONS ON DETENTION AUTHORITY PRESCRIBED IN ARMY REGULATION 190-8 ENTITLE MR. BA ODAH TO RELEASE.

In spite of the evidence that Mr. Ba Odah meets the threshold medical repatriation standards of Army Reg. 190-8, the government nevertheless argues that medical repatriation is otherwise prohibited by the Geneva Conventions or Army Regulation. None of the arguments preclude this Court from granting Mr. Ba Odah's habeas petition.

A. Mr. Ba Odah Is Entitled to Humanitarian Law Protection Based on His Legal Status as an "Other Detainee," Regardless of the CSRT's Determination that He is an "Enemy Combatant."

Under the terms of Army Reg. 190-8, Mr. Ba Odah is an "Other Detainee" because his "legal status" has not been "ascertained by a competent authority" and therefore he is entitled to certain protections as if he were an Enemy Prisoner of War. Army Reg. 190-8, App. B, §II. Unable to escape the regulation's plain meaning, the government revives the long-discredited CSRT experiment, arguing that those ad hoc administrative proceedings constituted a "competent authority," and its determination that Mr. Ba Odah was an "enemy combatant" dislodges him from the humanitarian-law protections codified in Army Reg. 190-8. The argument has already been rejected. *See Aamer*, 58 F. Supp. 3d at 29 (D.D.C. 20014)("In light of . . . precedents, Respondents put more weight on 'enemy combatant' than the term can bear.").

First, under Army Reg. 190-8, a "competent tribunal" is one constituted for the purpose of conferring on a captive one of four recognized status determinations: Enemy Prisoners of War, Retained Personnel, Innocent Civilian, or a Civilian Internee. Army Reg. 190-8 at ch.1 §6(e)(10). Until a captive's status has been so determined, or for as long as their status remains in doubt, they are – by operation of statute – an "Other Detainee," entitled to the protections of an Enemy Prisoner of War, including eligibility for direct repatriation for medical reasons. *See* Army Reg. 190-8, Glossary, Section II-Terms.

The CSRTs, by contrast, were empowered to perform only a narrow, binary determination: whether it should "confirm" the President's determination that a detainee is an "enemy combatant" – "yes" or "no." *See* Mem. From Deputy Secretary of Defense Paul Wolfowitz re: Order Establishing Combatant Status Review Tribunal §1-3 (July 7, 2004). Neither Army Reg. 190-8, nor the Geneva Conventions on which it is premised, even recognizes "enemy combatant" or what the government now refers to as "detained former combatant," as a

category of prisoner. As such, the CSRTs cannot be "competent" as understood by Army Reg. 190-8 when they were precluded from performing the very function for which competent tribunals are constituted.[14]

Second, the CSRTs are not competent tribunals due to their "myriad" procedural defects. *See Boumediene*, 533 U.S. at 729. For example, Army Reg. 190-8 requires that captives be permitted to call witnesses. Army Reg. 190-8 at ch.1 §6(e)(6). Yet, in concluding that the CSRTs were not an "adequate substitute" for habeas review, the Court concluded that detainees had only "limited means to find or present evidence to challenge the Government's case against him." 553 U.S. at 783; *see also id*. at 784 (finding "the detainee's opportunity to questions witnesses is likely to be more theoretical than real"). In addition, because the CSRTs were "closed and accusatorial," there is "considerable risk of error in the tribunals' findings of fact." *Id.* at 785. Given its glaring procedural defects, it is unsurprising that the CSRTs found Mr. Ba Odah – and every other Guantanamo detainee – to be properly detained as an enemy combatant. But simply calling the CSRTs competent does not make them so. The government can make no argument sufficient to rehabilitate the discredited tribunals – certainly not when it publically turned its back on the designation "enemy combatant." *See Al Warafi*, 716 F.3d at 629.[15]

---

[14] The government notes that Mr. Ba Odah's CSRT was comprised of commissioned officers, *see* Resp'ts' Opp'n 23. But, the number and rank of officers comprising the CSRT means little if those officers were precluded from determining Mr. Ba Odah's status in a manner consistent with domestic and international law of war norms.

[15] Moreover, the government fails to distinguish governing D.C. Circuit precedent. As the government acknowledges, in *Al-Warafi*, the D.C. Circuit remanded to the district court with instructions to resolve the predicate factual matter of whether petitioner was indeed a Retained Personnel. *See* Resp'ts' Opp'n 21. Ultimately, the district court concluded he was not, but that has no bearing here. What is relevant is that the Court of Appeals found the judicial inquiry to be necessary in the first place. If the government is correct that CSRT "enemy combatant" determinations conclusively establish the legal status of Guantanamo detainees, it would have been unnecessary for the Court of Appeals to order fact-finding to determine the petitioner's status (after all, Mr. Al-Warafi, like Mr. Ba Odah, had been deemed an "enemy combatant"). *See Aamer*, 58 F. Supp. 3d at 29. The D.C. Circuit ordered the inquiry because it was necessary to resolve the petitioner's motion for release, concluding that Guantanamo detainees may

By its very terms, Army Reg. 190-8 categorizes Mr. Ba Odah to be an "Other Detainee." To that interim status attends certain humanitarian protections, including eligibility for release owing to his grave medical condition.[16]

B. Article 114 of the Geneva Convention's Prohibition on Release for Self-Inflicted Accidents Does Not Preclude Mr. Ba Odah's Release Based on His Severe, Undisputed Sickness.

The government argues that Mr. Ba Odah's medical repatriation is barred because the Third Geneva Convention, Art. 114 creates an exception for "injuries" that are "self-inflicted." But the government fails to acknowledge that the provision is categorically inapplicable here. Mr. Ba Odah grounds his claim for release, not due to "injury" as covered by *Art. 114*, but on Army Reg. 190-8 (the domestic analogue of *Art. 110*), which governs potential release for prisoners who are seriously "sick."

Art. 114's intentionally narrow provision covers the facially distinct phenomenon involving "Prisoners Who Meet With *Accidents*."[17] (emphasis added). Mr. Ba Odah has not "met with [an] accident" at Guantanamo; he is gravely and chronically *sick*.

---

invoke the regulation as legal justification for their release in habeas corpus proceedings. *See Al Warafi*, 716 F.3d at 629.

[16] The government characterizes its conflict with the Taliban and Al-Qaida as a non-international armed conflict and argues – on the strength of a Department of Defense Directive – that Mr. Ba Odah is therefore entitled to only "minimum" standards of protections under Common Article 3 of the Geneva Conventions. *See* Resp'ts' Opp'n 24. Whether that argument has merit or not, Common Article 3 provides robust protections that mirror those enshrined in the Third Geneva Convention itself, including release on medical grounds. *See Prosecutor v. Mile Mrkšić,* IT-95-13/1-A, Judgment (May 5, 2009), para. 70, *available at* http://www.icty.org/x/cases/mrksic/acjug/en/090505.pdf; *see also* Sean D. Murphy, *Evolving Geneva Convention Paradigms in the War on Terrorism: Applying the Core Rules to the Release of Persons Deemed Unprivileged Combatants,* 75 Geo. Wash L. Review 1105, 1162-63 (2006-07) (arguing that Article 110's medical repatriation requirement is the benchmark for humane treatment contemplated by Common Article 3).

[17] It reads: "Prisoners of war who *meet with accidents* shall, unless the injury is self-inflicted, have the benefit of the provisions of this Convention as regards repatriation or accommodation in a neutral country. Third Geneva Convention, Art 114 (emphasis added). The commentary the government cites

Even if Article 114's limited self-inflicted injury bar could be shoehorned into Article 110, or stranger still, imported afresh into Army Reg. 190-8, Mr. Ba Odah's underlying debilitation cannot be said to have been "*willfully* inflict[ed]" – and let alone by the "clearly established" burden of proof that the government bears, but willfully excises in quoting the relevant commentary. *Compare* Resp'ts' Opp'n 25 *with* Third Geneva Convention Commentary at 534.[18] As a result of Mr. Ba Odah's malnutrition, he likely suffers from a variety of ailments, including organ depletion, neuro-cognitive debilitation, potentially irreversible gastrointestinal tract degradation and malabsorption produced by intra-cellular decomposition that may forever frustrate his ability to absorb necessary nutrients – voluntarily or otherwise. *See infra* Section II(A). Despite the government's reference to a broad "course of conduct" (a standard nowhere referenced in the actual regulation) the court cannot construe each of these specific, potentially fatal manifestations of his illness – or the unique factual circumstances here – as having been *willfully* self-inflicted. There is no proof – "clearly established" or otherwise – that maintaining a hunger strike as a "course of conduct," despite being forced-fed 2600 calories per day, would result in this abnormal level of debilitation. Indeed, three independent medical experts have attested that something unexplained and dangerous is happening to Mr. Ba Odah. It is implausible that the humanitarian provisions of the Geneva Conventions – promulgated as they

---

explains that Art. 114 is derived from Art. 71 of the 1929 Convention and expanded its previously narrow category of injury occurring as a result of work-place accidents. *See* GCIII, Commentary Art. 114.

[18] Indeed, the government has still not explained why Mr. Ba Odah's weighs only 74 pounds despite the military's force-feeding regime, where its suggested attribution to "purging" or hiding food is implausible as a clinical matter, given the degree of malnutrition. *See* Crosby Suppl. Decl. ¶¶11-12; Bailony Suppl. Decl. ¶15.

were to alleviate the unnecessary suffering of prisoners in war settings – incorporate the government's narrow, retributive view of Mr. Ba Odah's suffering. [19]

C. Mr. Ba Odah's Refusal to Accept Additional Medical Intervention from Guantanamo Staff Does Not Preclude Reliance on Army Regulation 190-8.

The government contends that Mr. Ba Odah is ineligible for relief under Army Reg. 190-8 because he has refused various medical interventions from Guantanamo staff. Resp'ts' Opp'n 28. Yet it simultaneously touts its force-feeding regime as an appropriate medical response to Mr. Ba Odah's chronic, grave malnourishment. These irreconcilable assertions cannot preclude relief. The SMO describes the government's "treatment" protocol, which involves monitoring Mr. Ba Odah's calorie intake and weight loss, followed by medical intervention in the form of forcible enteral feeding through NG tube; it has employed this treatment on Mr. Ba Odah for 8.5 years. *See* SMO Decl. ¶10. The treatment protocol includes a contingency plan should Mr. Ba Odah deteriorate further, to admit him to the Detainee Acute Care Unit for still more (if slower and continuous) nasal tube-feedings. SMO Decl. ¶26. Indeed, the SMO concludes the military's treatment is proper: "the current manner of managing Mr. Ba Odah's non-religious fast is appropriate." *Id.*[20] Thus, under the government's own view, his condition persists "in spite of the treatment" the government gives him and he satisfies Army Regulation 190-8.

---

[19] Art. 114 is primarily written to ensure that prisoners injured by accidents obtain the benefit of medical repatriation, except in the limited circumstances of self-infliction – an exception designed to eliminate the incentive towards self-harm as a means to hasten release. But a ruling in Mr. Ba Odah's favor would not undercut the premise of Art. 114 or encourage other prisoners to strike in order obtain similar relief. First, Art. 114's prohibition on self-harm is meant to discourage manufactured, self-injurious accidents as a path to release. It bears no relationship to the facts presented here. In any event, Mr. Ba Odah's hunger strike at Guantanamo does not lend itself easily to copycats; it is unique, both in its nearly decade-long duration and its devastating and as yet-undiagnosed physical consequences. The likelihood that another prisoner would (or could manage) to manufacture the fact pattern presented here to win his release is so remote that the government's professed concern appears disingenuous.

[20] The government points to the fact that Mr. Ba Odah's weight has been holding at 74 pounds for roughly one year as evidence that he is stable. But, the more sensible reading in conformity with Army

The government nevertheless imagines that because Mr. Ba Odah does not "fully cooperate" with Guantanamo medical staff, he should be ineligible for the protections of Army Reg. 190-8. *See* Resp'ts' Opp'n 28. First, the government reads into the regulation a requirement unsupported by the statute itself. Nothing in the regulation imposes an obligation on prisoners to accept *all* treatment their captors prescribe. Second, the government's argument purposefully overlooks Mr. Ba Odah's understandable mistrust of his caregivers, developed over 13.5 years of imprisonment at Guantanamo, during which time he has endured countless tube-feeding sessions and other humiliating interactions with medical staff there (or which may even be a manifestation of his illness). *See infra* Section I(B); Bailony Suppl. Decl. ¶10.

Army Reg. 190-8 and the humanitarian principles it incorporates are a *shield*, not a *sword*; they are meant to protect gravely ill prisoners and ameliorate their suffering, not penalize them for their clinically predicable mistrust in the doctors that are periodically sent to their prison doors. "Treatment" must likewise be read consistently with medical ethical standards; and it remains undisputed that mistrust of prison medical staff is a "widely observed and understood" medical phenomenon that triggers an ethical duty to provide care from a trusted physician. *See, e.g.*, Crosby Decl. ¶42; Ghannam Suppl. Decl. ¶15.

Neither should it be surprising that Mr. Ba Odah has described myriad, grave symptoms to counsel that he has withheld from Guantanamo medical staff. *See* Resp'ts' Opp'n 28. It should be self-evident: patients are forthcoming with trusted confidants but reticent with caregivers whose intentions they doubt – if for no other reason than to avoid further unwelcomed, and thus punitive, medical attention. Ghannam Suppl. Decl. ¶18. The

---

Reg. 190-8, is that Mr. Ba Odah has proven unable to recover "*in spite of*" the treatment he has been given at Guantanamo, rendering him eligible for immediate release.

Guantanamo medical staff's attempts to consult Mr. Ba Odah do not undercut his entitlement to the protections of Army Reg. 190-8.

D. Because Participation in a Mixed Medical Commission Would be Futile, It is No Prerequisite to Relief Pursuant to the Court's Broad Habeas Power.

The government's insistence on procedures governing the convening of a mixed medical commission is misplaced as the commission would be an exercise in futility. The record before the Court is clear (and confirmed by the SMO in material ways): at 74 pounds and 56% of his ideal body weight, Mr. Ba Odah is gravely and chronically ill from malnutrition, which will continue to proceed on a dangerous course, if acute injury or sickness does not overwhelm him first. The government has nevertheless refused either to accede to his petition or even permit an independent medical evaluation. The questions regarding the legality of Mr. Ba Odah's continued detention under the laws of war are properly before the court. Therefore, the Court has the evidence and the authority, consistent with its broad equitable habeas power, to resolve Mr. Ba Odah's petition.

CONCLUSION

Mr. Ba Odah's continuing detention is unlawful. His petition for a writ of habeas corpus should be granted.

Dated: September 11, 2015
New York, New York

Omar Farah
Baher Azmy
CENTER FOR CONSTITUTIONAL RIGHTS
666 Broadway, 7th Floor
New York, NY 10012
212.614.6485

By: /s/ *Omar Farah*

Attorneys for Petitioner, Tariq Ba Odah

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on September 11, 2015, he caused a true and correct copy of the foregoing Reply in Support of Petitioner's Motion for Reinstatement of Petitioner's Habeas Petition and for Judgment on the Record on all parties of record through this Court's ECF system.

/s/ *Omar Farah*
Omar Farah