EXHIBIT 3

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.	:	

SUPPLEMENTAL DECLARATION OF DR. RAMI BAILONY IN SUPPORT OF PETITIONER TARIQ BA ODAH'S MOTION FOR HABEAS RELIEF

I, DR. MOHAMMED RAMI BAILONY, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I incorporate by reference my original declaration signed on June 18, 2015.

2. I have reviewed the declaration submitted by the Senior Medical Officer (SMO) at Guantanamo Bay, outlining his ongoing treatment and monitoring of Mr. Ba Odah and his conclusions about the state of Mr. Ba Odah's health.

3. The SMO's declaration does not lead me to modify my prior assessment of the nature of the medical crisis facing Mr. Ba Odah. In fact, in many important ways, it only confirms my initial analysis that Mr. Ba Odah's low weight evidences severe malnourishment that could lead to the onset of potentially grave illnesses if it has not done so already.

4. In light of the overwhelming indicators of Mr. Ba Odah's ill-health as reported by the SMO himself – for example, that Mr. Ba Odah's weight as of July 15 remained at only 74

pounds, his correct, if likely understated, assessment that Mr. Ba Odah's health is "poor," SMO Decl. ¶14, that his weight level poses a "danger," SMO Decl. ¶22, and reported symptomology such as the fact that Mr. Ba Odah has collapsed in his cell and has suffered from bed sores, SMO Decl. ¶25 – I find the SMO's summary conclusion that Mr. Ba Odah is nonetheless "clinically stable" impossible to accept.

Mr. Ba Odah's Apparent Physical Condition Defies the SMO's Conclusion that he is Clinically Stable

5. "Clinically Stable" is a term that carries significant medical implications. As used in the medical community, it typically communicates that a clinician has satisfactorily performed certain common, threshold diagnostic tests (i.e., full metabolic panels and blood-tests among others), 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, and concluded that the patient faces no imminent risk of further deterioration and death absent urgent remedial intervention. Nothing in the SMO's declaration indicates that he performed the predicate analysis that would justify his conclusion that Mr. Ba Odah is clinically stable, other than reportedly checking Mr. Ba Odah's vital signs on one occasion roughly four months before the SMO's declaration was signed. Indeed, the reported observations of Mr. Ba Odah point to precisely the opposite determination.

6. To be more direct, in my experience, a physician would not assess a patient to be clinically stable based merely on the outward appearance of "normal" behavior or functioning. There are numerous diseases – particularly in cases of chronic, severe malnourishment – that do not appear to interfere with normal human functioning until they progress to their final, lethal stages. This is why, for example, patients with severe, undiagnosed heart disease can perform

routine daily activities such as walking, talking, grooming – the very activities that have assured the SMO that Mr. Ba Odah is stable – right up until the moment they collapse and expire. That Mr. Ba Odah is able to talk on occasion to a neighboring prisoner, does not rule out the presence, for example, of potentially permanent, even fatal, vitamin deficiency (particularly thiamine or B-12) that would explain the numbness in his extremities as reported to his counsel, or protein deficiencies, imminent heart failure, kidney failure, or other serious illness.

7. And while it seems unlikely to me that an adult male at 74 pounds is functioning normally, the medical reality is that in his current state, Mr. Ba Odah could appear to function normally in most outward respects right up until the moment he dies. But no doctor charged with caring for Mr. Ba Odah could justify failing to intervene to avoid that outcome by pointing to episodic observations of the patient grooming, sleeping, or singing.

8. What is more, as I explained in my prior declaration, the connections between malnourishment and Thiamine Folate and Vitamin B12 deficiencies are well-established. See, e.g., June 18, 2015 Declaration of Rami Bailony, ¶30. As a result, in my view, no responsible clinician would say that Mr. Ba Odah is clinically stable at 74 pounds, irrespective of how much he is able to walk. The neuropathy and brain damage commonly accompanied by Mr. Ba Odah's level of malnourishment poses profound risks and is associated with the onset of Wernicke's encephalopathy – a debilitating neurological disorder the manifestation of which is gradual, but also irreversible. Its potential onset in Mr. Ba Odah's case cannot be ruled out without serious, purposeful consultation and lab work, a thorough psychological analysis and other testing.

9. This is particularly troubling in light of certain specific symptoms the SMO reports. Mr. Ba Odah's reported outbursts, episodic vigorous resistance to treatment, and despair are hallmark indicators of Wernicke-Korsakoff syndrome. These symptoms are commonplace to

doctors treating the elderly, for example. But should a 90-year old, frail, end-stage hospice patient become unduly agitated, curse and physically resist attending nurses, no doctor would take such behavior as indicative of stable health, precisely because latter stages Warnecke syndrome can produce just such types of reactions.

10. Clinical literature is replete with examples of anorexic patients or, for example, patients suffering from complications related to gastro-intestinal tract operations that caused dramatic undernourishment cycling through periods of overreaction, seemingly unprovoked outbursts, noncompliance, and agitation. Though the SMO points to Mr. Ba Odah's reported vigorous interactions with caregivers and guards at Guantanamo as indicia of his overall fitness, his symptoms lead me to precisely the opposite conclusion.

11. To illustrate the point with an example close to my own area of practice, if an extremely anorexic adult male patient presented in an emergency room or hospital at 74 pounds, it is unlikely that the attending physician would declare that patient stable, even were the patient able to perform each of the behaviors the SMO's attributes to Mr. Ba Odah. A robust, urgent evaluation would be necessary to ascertain the state of their gastro-intestinal tract – one of the most significant, but also vulnerable systems in patients who are chronically malnourished – whether cognitive function was still intact, and whether the patient suffered from any unrelated disease that nonetheless posed a risk in light of the patient's depleted weight. But under no circumstance would a doctor declare the patient clinically stable before those tests were performed. As such, the SMO's assessment strikes me as medically naïve.

12. The SMO also appears to attribute Mr. Ba Odah's current condition to his reported refusal to accept medical care. I must note, however, that he provides no assessment of Mr. Ba Odah's ability to make sound, fully-informed medical decisions. It is well known that

malnutrition frustrates thought processing, changes a patient's perceived values and priorities, and thus diminishes their decision-making ability and their competence to refuse treatment. Further, decision-making capacity improves and declines during the course of illness and treatment. Therefore, it should be monitored regularly. In my view, standards of medical care require a physician to seek a full psychiatric evaluation before declaring a 74-pound patient medically competent to refuse care. Studies show that in malnourished individuals standardized medical tests of competence are often insufficient and more exhaustive methods are required. In any event, clinical protocols do not contemplate blaming a patient with Mr. Ba Odah's advanced, severe malnourishment and related ill-health with frustrating their own rehabilitation because they continue to refuse care.

Insufficient Information Regarding Mr. Ba Odah's Caloric Absorption

13. The SMO's declaration is also striking in that it lacks any detailed assessment of what calories Mr. Ba Odah is absorbing (as opposed to what he is being provided). Where a patient is so dramatically underweight, the indispensable piece of clinical data is the amount of nutrients and calories the patient is absorbing and thus able to utilize towards furthering recovery.

14. Caloric intake, however, does not necessarily correlate to absorption as should be obvious in the case of an adult male who weighs 74 pounds, despite at times consuming up to 2600 calories in a day. The human heart, other vital organs, and the skeletal structure cannot continue to lose mass. The fact that Mr. Ba Odah's weight has bottomed at 74 pounds is likely evidence that his body has already consumed its fat reserves and therefore does not have much weight to lose. Minimally, however, it is evidence that he is not – and as a clinical matter,

cannot – be properly absorbing the calories that are fed to him at Guantanamo. This is a clear and alarming indication that his gastro-intestinal tract likely does not function correctly.

15. I do not credit the SMO's suggestion that Mr. Ba Odah's depleted weight is primarily the product of his reported efforts to circumvent the feeding protocol for hunger strikers at Guantanamo. I must reemphasize how alarmingly underweight Mr. Ba Odah is for an adult male. To achieve and maintain his current diminished weight for roughly the last year, despite the forcible enteral feeding protocol described in the SMO's declaration, which includes provision of 2600 calories per day, Mr. Ba Odah would have to go to considerable lengths to conceal, dispose of, or purge the vast majority of his allotted daily caloric intake. The SMO's declaration, however, recounts some instances where Mr. Ba Odah was observed attempting to limit his nutritional intake, but is insufficient to support a clinical determination that Mr. Ba Odah's malnourishment is explained by behavior and not physiology.

16. As a clinician, however, it is the SMO's professional responsibility to rule out all possible physiological causes for Mr. Ba Odah's observed symptoms before relying on an explanation that turns on his behavior. As I have outlined above, however, in this case, Mr. Ba Odah's behavior itself points to the likely presence of severe underlying illnesses that require urgent diagnosis and treatment.

Medical Impropriety of Anticipated Emergency Care

17. As I explained in my initial declaration, there is no medical support for delivering calories to a patient via nasogastric tubes for an extended period of time – certainly not for the over 8 years that Mr. Ba Odah has reportedly been on hunger strike. Likewise there is no evidence to support the SMO's plan of continual enteral feeding of Mr. Ba Odah should he lose more weight.

18. Frankly, as an emergency intervention plan, continual enteral feeding is inadequate and finds no support in the medical literature that I am aware of. First, as I indicated above, it may well be medically impossible for Mr. Ba Odah to lose much more weight – at least not without precipitating a total and fatal collapse of his system. Under the circumstances, therefore, monitoring Mr. Ba Odah for additional weight loss is akin to waiting by a patient's bedside for them to crash before initiating emergency intervention. Further, in the event that Mr. Ba Odah does begin to lose still more weight, there is no clinical evidence that continual enteral feeding will aid Mr. Ba Odah. 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.

19. I recognize that there is some logic in presuming that consuming nutrients more slowly increases absorption, but sound medical practice cannot proceed merely on the basis of logic or commonsense. If it is the case that Mr. Ba Odah suffers from an underlying illness that inhibits absorption – and as I recount in my initial declaration, all indications are that he does – feeding him more slowly will do nothing to avert his further decline and potential demise. Without more, delivering additional calories through nasogastric intubation will not likely help Mr. Ba Odah. At this stage – although only sound diagnostic testing can determine – he likely needs micronutrients introduced into his system intravenously to support healing of his gastro-intestinal tract among other treatments.

20. Doctors working in the field of nutrition would likely arrive at this conclusion on the basis of the SMO's declaration alone: If Mr. Ba Odah is receiving up to 2600 calories, but his weight is fixed at 74 pounds, a reasonable clinical conclusion is that he is not absorbing those calories, which may now depend first on healing his digestive and related physiological systems. More nutritional supplements, whether provided slowly or more rapidly, will not address this. In

conclusion, it bears emphasis that refeeding-syndrome was first discovered during World War II when prisoners of war who appeared stable – though frail – died precipitously as their systems were overwhelmed by well-meaning efforts to rehabilitate them through increasing their caloric intake. In my clinical opinion, Mr. Ba Odah's deterioration has long passed the point where merely upping his calories is an appropriate remedial course.

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

Dated: September 9, 2015
Belmont, California

Dr. Mohammed Rami Bailony