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April 28, 2009

The Hon. Emmet Sullivan
United States District Court for the District of Columbia
333 Constitution Avenue, N.W.
Washington, D.C. 20001

Re: ***Zuhair v Obama, et al***
Civ. No. 08-0864 (EGS)
United States District Court for the District of Columbia

Dear Judge Sullivan:

Please find attached my final report in the above-referenced matter. I apologize for the delay in completing this report, which was caused by my unexpectedly long involvement in another habeas matter.

Should you have additional questions related to Mr. Zuhair's medical or psychiatric status, I would be happy to provide you with a supplemental report.

Thank you again for referring this matter to me for evaluation and report.

Sincerely,

/s/

Emily A. Keram, MD

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Dear Judge Sullivan:

As noted in my initial report, pursuant to your order of January 16, 2009, I conducted a comprehensive medical and psychiatric evaluation of Ahmed Zaid Salim Zuhair, a Saudi Arabian male who estimated his age as 44 or 45 years old. The evaluation took place at the Joint Task Force Guantanamo (JTF GTMO) Detention Center, US Naval Station GTMO from January 17-24, 2009. Professor Charles Schmitz served as the Court's independent translator during the evaluation and assisted me in the conduct of JTF staff interviews and the review of certain documents. The following report contains my findings and recommendations.

ORGANIZATION OF REPORT

The contents of this report are outlined below. I have included an appendix to orient the reader to the JTF GTMO command structure for detainee operations and to the detention facility.

1. Summary of opinions and recommendations regarding Mr. Zuhair (see body of report for full discussion)
    a. Hunger strike and enteral feedings
    b. Medical status
    c. Psychiatric status
    d. Competency to participate in habeas proceedings
    e. Additional recommendations
2. Sources of information in conducting the evaluation
3. Informed consent
4. Findings and recommendations
    a. Hunger strike and enteral feeding
    b. Medical status
    c. Psychiatric status
    d. Competency to participate in habeas proceedings
5. Appendix A: Detention Operations
    a. Command Structure
    b. Detention facility environment

Please note that much of the content of the report reflects recollections and opinions stated by Mr. Zuhair and GTMO medical and guard staff. On occasion these statements conflicted. Many of the concerns that Mr. Zuhair expressed regarding the conditions of his confinement and his treatment by medical and guard staff cannot be verified. In general I have simply reported all parties' statements to me in the appropriate sections. This is not meant to convey my endorsement or lack thereof regarding any specific statement. Conflicts in the information provided to me did not affect the formation of my opinions.

SUMMARY OF OPINIONS AND RECOMMENDATIONS

Hunger strike and enteral feedings

Opinion regarding Mr. Zuhair's enteral feedings

Mr. Zuhair's medical and psychiatric health were adversely affected by the use of a restraint chair for enteral feedings. His medical record indicates that he has coccydynia (tailbone pain) and hemorrhoids that are exacerbated by his placement in the chair. Additionally, Mr. Zuhair stated to me that the restraint chair makes him feel that he is being treated like an animal and that it erodes his honor and dignity. Mr. Zuhair was transferred to the Detention Hospital in early February 2009 and has subsequently been transferred to the Behavioral Health Unit (BHU). Since his transfer he has received enteral feedings in a hospital bed. However, his weight has not changed appreciably since the time of my visit in late January 2009.

Recommendations regarding Mr. Zuhair's enteral feedings and nutrition

1. In order to provide the Court with appropriate recommendations regarding the management of Mr. Zuhair's hunger strike, I request that I be allowed to consult with the experts whom JTF had originally relied upon for management of the GTMO hunger strikers for the reasons described below.
2. Consideration should be given to videotaping all of Mr. Zuhair's enteral feedings. This would provide an objective record of the conduct of those involved in the feedings, including Mr. Zuhair, and would likely decrease concerns about the process from all parties.
3. Mr. Zuhair is currently located in the BHU where he is receiving enteral feedings while he is in a hospital bed. I have not interviewed him since the restraint chair was discontinued. It is likely that the use of a hospital bed, even with two or four point restraints, has decreased his sense that his honor and dignity are degraded. He stated that the restraint chair caused him physical pain and discomfort, as well as anxiety and worry. Being fed in a hospital bed may have caused him to feel that he is being treated in a more humane manner. I recommend that, to the extent possible, given the security concerns of the detention facility, it would be helpful if Mr. Zuhair could continue to be fed in a hospital bed to decrease pain, discomfort, anxiety, worry, and his sense that his honor and dignity are being degraded.
4. In the event that enteral feedings occur in the restraint chair in the future, consistent availability and appropriate placement of hemorrhoid pillow should be ensured.
5. If Mr. Zuhair should decide to try eating again in the future, it may be helpful for behavioral health clinicians to offer to assist him in identifying and addressing factors that might make it difficult for him to resume oral alimentation. These factors may include the possibility that he may feel that stopping his hunger strike would disappoint other detainees or that he may feel that he is abandoning other detainees.

He may feel that the hunger strike allows him to oppose Joint Medical Group (JMG) and Joint Detention Group (JDG) staff in a manner that does not constitute a rule violation. He may also feel that the hunger strike in some way creates a bargaining chip in his interactions with JTF staff, especially given his expressed belief that the JTF would like the detainees to stop their hunger strike. Aspects of his sense of self-esteem and self-worth may at this point be based on his long term involvement in his hunger strike, which may have become a source of a sense of autonomy and self-determination. If this is the case, Mr. Zuhair may feel increased depression and anxiety if he were to stop. Mental health clinicians may assist him in working through these issues should they arise and should he accept their help.

6. In the event that Mr. Zuhair accepts a meal in the future, the Hunger Strike SOP should be followed, in that Mr. Zuhair should be offered a bland and easily digestible diet.

Limitations in the scope of my recommendations regarding enteral feedings and nutrition

In order to provide the Court with recommendations regarding Mr. Zuhair's medical and mental health status and treatment that balance his needs with the safety of the institution, I sought information regarding the management of hunger strikers in US federal and state prisons. I consulted three experts in correctional mental health, behavioral management, and conditions of confinement. Although their input was helpful, none of them had ever been directly involved in the management of hunger strikers, or in the use of restraint chairs for enteral feedings.

After this consultation I made the determination that it would be most helpful for me to speak to the experts upon whom the JTF had originally relied on for advice in managing the GTMO hunger strikers. The result of JTF's original consultation with these experts was to implement the use of the restraint chair in administering enteral feedings. As noted in the original Respondent's Opposition filed in response to Mr. Zuhair's petition for emergency medical relief, these experts had direct experience in the management of hunger strikers in US prisons, whereas my consultants did not.

I contacted the Staff Judge Advocate's (SJA) office and requested contact information for the consultants JTF had previously relied upon. I was referred to Scott Levin, who subsequently denied my request as falling outside the scope of my evaluation and interfering with Department of Defense's (DoD) deliberative process. I believe consulting with these experts would allow me to provide the Court with recommendations that are medically appropriate and that take into account institutional safety, as such consultations would allow me to discuss the considerations that led to the current restraint chair protocol and allow me to present Mr. Zuhair's situation to experts in the field and ask them for their recommendations for managing Mr. Zuhair's enteral feedings in light of his medical and psychiatric concerns, and his inability to gain weight on enteral feedings.

This consultation would be especially helpful given the fact that Mr. Zuhair's weight has not changed appreciably since the time of my visit, despite his transfer to the Detention Hospital and subsequently to the BHU, where, presumably, he is more closely observed and enteral feedings take place in a hospital bed. An additional point of concern is the question of where Mr. Zuhair's enteral feedings should take place (restraint chair versus hospital bed) once he is discharged from the BHU.

Medical status

Opinion regarding Mr. Zuhair's medical status

As noted below, Mr. Zuhair's nutritional status remains adequate. His weight on April 19, 2009 was 114.8 pounds, 2.4 pounds higher than at the time of my visit. His body mass index (BMI) at 114.8 pounds is 18.2. This continues to place him in the Underweight (mild thinness) classification based on World Health Organization's standards. His medical evaluation to date, including laboratory and x-ray studies, has been normal.

Although the cause of Mr. Zuhair's GI symptoms and inability to gain weight despite enteral feedings remains unknown, he appears to be complying in an appropriate evaluation of their cause. Medical evaluation to date has been appropriate as per the gastroenterologist with whom I have consulted. This gastroenterologist suggested that if the GTMO GI consultant continues to be delayed, JMG clinicians consider obtaining a small bowel study to rule out distal obstruction. This study can be done in GTMO by JMG staff.

Mr. Zuhair has a long-standing mistrust of JMG clinicians that may be difficult to ameliorate. He ascribed this mistrust to reports by other detainees that previous JMG clinicians had been involved in interrogations and disciplinary processes; frustration over clinicians' not explaining the rationale for recommended treatment and evaluation; his perception that some requests for medical attention have not been addressed; his perception that some physician orders have not been carried out; and concerns that he is in some way being used as a guinea pig.

Mr. Zuhair has been intermittently non-compliant with recommended evaluation and treatment directed at a variety of medical concerns. In addition to mistrust, his non-compliance is likely rooted in a number of factors. These include an expression of autonomy during his indefinite detention (throughout the course of which he has had little control of any aspect of his life); an attempt to create a bargaining position; and, as he stated, an attempt to elicit concern on the part of clinicians that will bring him to the attention of more senior staff.

Recommendations regarding Mr. Zuhair's medical status

1. Mr. Zuhair was scheduled to see the gastroenterologist last week. Results of endoscopy and any other studies should be forwarded to me for review. Should this consultation continue to be delayed, consideration should be given to ordering a small bowel study to rule out distal obstruction.
2. As noted above, should Mr. Zuhair be recommended to receive future enteral feedings in a restraint chair, a hemorrhoid pillow should be available to him at all times which should be placed appropriately in the chair (the pillow was not used properly during my observation of enteral feeding.) Hemorrhoid medication will likely need to be re-ordered.
3. Chest x-ray should be repeated in approximately July 2009 for follow-up of the abnormality of his xyphoid process noted below.
4. Mr. Zuhair complained of a deformity of his left wrist. This should be evaluated if he has not brought this to the attention of his clinicians.
5. Improvement in Mr. Zuhair's mistrust of JMG clinicians will be difficult. However, JMG clinicians may wish to consider a few interventions designed at improving his compliance with recommended evaluation and treatment.
    a. If time and resources allow, JMG clinicians may consider scheduling future appointments with Mr. Zuhair on a regular (time-contingent) rather than

symptom-contingent basis. This is a common intervention directed at improving clinician-patient relationships, increasing compliance, and decreasing escalating patient reports of symptoms in an effort to come to clinician attention. Visits may be kept brief, with a defined number of complaints addressed at each visit.

b. JMG clinicians may wish to engage in a frank discussion with Mr. Zuhair about his assertion that he has not been informed as to the rationale for recommended evaluation and treatment of concerns that have arisen over the years. Mr. Zuhair identified this as a major source of his mistrust of medical staff. Clinicians should merely accept this concern, rather than engaging in a discussion of whether it is well-founded, as consensus regarding past events is unlikely to be reached. The focus of the discussion should be on their future interactions with Mr. Zuhair. JMG clinicians may wish to reassure Mr. Zuhair that they will respond to his future questions and concerns. In return, they may reasonably ask Mr. Zuhair to communicate these concerns to them, rather than avoiding contact with clinicians with subsequent complaints that he is not been educated about their treatment plans.

c. Clinicians should not become frustrated should these interventions not result in the desired outcome. Mr. Zuhair may continue to be non-compliant and to complain about aspects of medical care and his interactions with clinicians. Given the length of his indefinite incarceration, lack of autonomy, and tendency to focus on health concerns (see psychiatric status section below), improvements in Mr. Zuhair's attitude toward JMG staff and medical treatment may happen slowly, if at all.

Psychiatric status

Opinion regarding Mr. Zuhair's psychiatric status

As noted below, Mr. Zuhair complains of symptoms consistent with depression and anxiety. These symptoms are expected given his prolonged indefinite confinement, the conditions of his confinement, and his lack of autonomy. He is particularly disturbed by the process of receiving enteral feedings in a restraint chair. As noted below, he perceives the procedure of being restrained in the chair during feeding as degrading his honor and dignity He feels that animals are treated better and that he is being treated as a criminal. Mr. Zuhair is currently diagnosed with an Adjustment Disorder with Depressed Mood. He meets many diagnostic criteria for Posttraumatic Stress Disorder (PTSD), although it is likely that he is not able to experience the full panoply of symptoms given limitations in his current environment. Mr. Zuhair may have a tendency to focus on somatic complaints as a way of managing symptoms of depression and anxiety, as well.

Mr. Zuhair described many coping strategies he developed to manage the depression and anxiety that stem from the factors noted below. He stated that he fights against internal negative emotions and seeks out social support and interaction with other detainees. He uses conversation, reading, and recreation time to distract himself from psychiatric symptoms, preferring to rely on these methods and not seek out mental health treatment. His success in using these coping strategies likely explains the discrepancy between his report of his emotional state and the observations made by guard staff.

Recommendations regarding Mr. Zuhair's psychiatric status

Mr. Zuhair has not accepted mental health treatment aimed at targeting his symptoms, preferring to rely on the coping mechanisms he has developed. Nonetheless, regular contact with mental health clinicians should continue after his discharge from the BHU for symptom review and monitoring and to determine if he changes his mind about accepting treatment.

Competency to participate in habeas proceedings

Mr. Zuhair was competent to participate in the habeas proceedings when I evaluated him in January 2009. The information I have received regarding Mr. Zuhair's medical and mental health since the time of my evaluation does not suggest that his competency has changed. I would need to interview him again to determine his current competency to a reasonable degree of medical certainty.

Additional recommendations

1. The Court may wish to consider having Professor Schmitz and I reassess Mr. Zuhair in GTMO in the near future. All information regarding his medical and psychiatric status since the time of our visit was provided in the form of medical records and one government filing. Mr. Zuhair may have unmet medical and psychiatric concerns he wishes to have addressed.
2. I recommend that I continue to receive weekly updates of Mr. Zuhair's medical and mental health records to monitor his ongoing medical and psychiatric status.

SOURCES OF INFORMATION

Interviews

1. Interviews of Mr. Zuhair totaling 20.5 hours
2. Interview of Captain Bruce Meneley, MD, Commander, Joint Medical Group (JMG), JTF GTMO
3. Interviews of Mr. Zuhair's internist (the Senior Medical Officer or SMO), nutritionist [redacted] nurse administering his enteral feedings, and a Corpsman from [redacted] Mr. Zuhair's housing block at the time of the evaluation
4. Interview of [redacted] a psychiatrist currently serving in the JMG
5. Interview of Commander Jeff Hayhurst, Deputy Commander, Joint Detention Group (JDG), JTF GTMO
6. Interviews of the current [redacted] guard staff including [redacted] Officer in Charge of Delta Camps I-III [redacted] the Assistant Watch Commander; the Non-commissioned Officer, [redacted] and a guard, [redacted]

Observation of Procedures

1. Observation of enteral feeding in a restraint chair at the Detention Hospital, [redacted] January 22, 2009

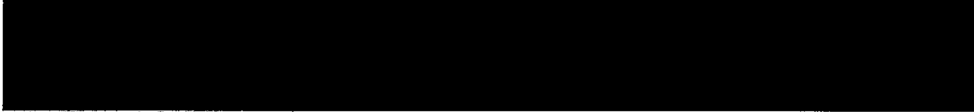
Record and Videotape Review

1. Review of Mr. Zuhair's medical record from August 2008 to April 19, 2009
2. Initial review of Mr. Zuhair's Detainee Information Management System (DIMS) record
3. Review of videotapes of four forced cell extractions (FCE's) of Mr. Zuhair that were done for the purposes of placing him in a restraint chair for enteral feedings in August 2008

4. Respondents' Notice of Filing Two Declarations Regarding Petitioner's February 11 and 12 Meeting with Counsel and His Current Medical Status, dated February 19, 2009

Policy Review

1. Medical Management of Detainees on Hunger Strike, Standard Operating Procedure (SOP) No. JTF-JMG #001



4. Forced Cell Extraction Procedures

Additional Information

1. Emergency Restraint Chair instruction manual, E.R.C. Inc.
2. At my request Mr. Zuhair's internist provided me with a plan for evaluating Mr. Zuhair's current medical conditions and complaints.
3. Tour of the Detention Hospital and Behavioral Health Unit

Consultations

I consulted with several experts during the course of the evaluation.

1. Douglas Drossman, MD, Professor of Medicine and Psychiatry, University of North Carolina Chapel Hill School of Medicine. Dr. Drossman is a gastroenterologist with expertise in psychiatric issues in gastrointestinal (GI) illnesses.
2. Sally Johnson, MD, Professor of Psychiatry, University of North Carolina Chapel Hill School of Medicine; Senior Lecturer in Law, Duke University School of Law; Captain, United States Public Health Service (retired). Dr. Johnson is a forensic psychiatrist and recently retired from the Federal Bureau of Prisons. She is an expert in prisoner mental health and conditions of confinement.
3. Jeffrey Metzner, MD, Clinical Professor of Psychiatry, University of Colorado School of Medicine. Dr. Metzner is a forensic psychiatrist and an expert in prisoner mental health and conditions of confinement.
4. Joel Dvoskin, Ph.D., Clinical Assistant Professor of Psychiatry, University of Arizona College of Medicine. Dr. Dvoskin is a forensic psychologist and former Acting Commissioner, New York State Office of Mental Health. Dr. Dvoskin is an expert in prisoner mental health and conditions of confinement.

Although these experts provided valuable information to me, the conclusions and recommendations contained in this report are my own.

Outstanding information

1. Mr. Zuhair requested that I interview two JTF service members whom he felt could provide more information about his health concerns. He identified one by service branch, rank, and job assignment. The second was identified by service branch, rank, job assignment and a name. I was informed that former had left GTMO. Staff Judge Advocate (SJA) staff stated they were unable to identify the latter based on the information Mr. Zuhair provided.
2. As noted above, I would like to consult with the experts upon whom JTF GTMO initially relied when developing policies and procedures for managing hunger striking detainees.

INFORMED CONSENT

At the outset of the interview, I notified Mr. Zuhair that I am a forensic psychiatrist who was ordered by the Court to evaluate his medical and psychiatric condition and make recommendations regarding his health status. I informed Mr. Zuhair that I would not be his treating physician but would be preparing a report summarizing the results of my evaluation. I informed Mr. Zuhair that any information he might provide me could be included in this report. I explained that I would send a copy of the report to the Court and that a copy would be provided to his attorney as well as the government's attorney. I informed Mr. Zuhair that I might be called to testify should there be a hearing in this matter. Mr. Zuhair demonstrated an adequate understanding of the purpose of the evaluation and the limits of confidentiality. He agreed to proceed with the interview.

At the outset of JTF personnel interviews I informed them of the information above. [redacted] of the SJA's office was present for interviews of all JTF personnel.

FINDINGS AND RECOMMENDATIONS

Hunger strike and enteral feedings

Mr. Zuhair's decision to hunger strike

Mr. Zuhair began a hunger strike in April 2005 to protest "the assault against our religion." This included his Koran being searched (non-Muslims should not touch a Koran written in Arabic), having his beard shaved every 15 days as a form of punishment, "insulting" body searches, and his indefinite confinement, which he views as a form of religious oppression. At times he had responded to the "assault" on the Koran by refusing it, even though he wanted to have one.

Although some of the initial reasons for his hunger strike have been resolved, he has continued as a means of continuing to protest his current conditions of confinement, including (at the time of my interview) the use of the restraint chair, being shackled for every move out of his cell, and the frequency and manner of searches. Although full body cavity searches have stopped, some guards look down his pants during searches. He also continues to protest his indefinite detention. He states the goal of his hunger strike is simply to engage in a "peaceful protest."

Mr. Zuhair's description of enteral feedings in 2005 and early 2006

From the time of his first enteral feedings until January 2006 Mr. Zuhair was administered feedings in the Detention Hospital while in two or four point restraints in a hospital bed. Mr. Zuhair described the conditions of enteral feedings in the hospital as "good." Feeding tubes were small bore (12 French) and were placed by physicians. Feeding tubes were coated with a topical anesthetic and lubricant prior to insertion. He was provided with honey, lozenges, and cough syrup for feeding tube discomfort. Tubes were left in place for approximately 20 days, obviating the need for daily insertion and removal.

In January 2006 restraint chairs were introduced and detainees receiving enteral feedings were moved from the Detention Hospital to dedicated residential "feeding blocks." Mr. Zuhair received enteral feedings in a restraint chair from that time until his admission to the Detention Hospital on February 9, 2009 (see medical status section below.) Feeding tube insertion was initially done by Corpsmen and is now done by nurses. Feeding tube placement was more

forceful when done by Corpsmen. Larger bore (14 to 16 French) tubes were used then and caused more discomfort. Topical anesthesia was used for the first month only. Each of Mr. Zuhair's enteral feedings was videotaped for the first month that the restraint chair was used. His treatment during enteral feedings in the restraint chair was "the best" during the time that feedings were videotaped.

When the restraint chairs were first introduced Mr. Zuhair was kept in the restraint chair for two hours after feeding ended. His requests to use the bathroom were refused. He soiled himself with urine and feces. Guards started putting diapers on Mr. Zuhair, refusing to allow him to do this himself. Some detainees ended their hunger strike. Mr. Zuhair was once kept in a restraint chair for six hours, exceeding the two hour maximum time limit recommended for the detainee's safety. When the restraint chairs were first introduced Mr. Zuhair was refused a change of clothing when he returned to his cell, despite being covered with vomit, urine, and feces. The temperature on the residential block was cold. Mr. Zuhair expressed his conviction that the restraint chairs were introduced as a means of punishing hunger striking detainees and forcing them to end their hunger strikes.

Mr. Zuhair's description of enteral feedings at the time of the evaluation

At the time of the evaluation Mr. Zuhair was housed [redacted] in Camp I within Camp Delta, with 23 other detainees who were on hunger strike. Twenty detainees were receiving enteral feedings in restraint chairs. Four were allowed to lie on a bed in the hallway during feedings. Two of these detainees have had back surgery and two were awaiting back surgery. Their orthopedic condition precluded the use of restraint chairs.

On [redacted] all detainees received enteral feedings at the same time. Detainees were first offered a meal. If they declined they received enteral feedings. Mr. Zuhair had the option to leave his cell voluntarily. If he did so, he was first placed in handcuffs and a waist chain. He then walked to his restraint chair, which was kept in the corridor outside of his cell. On the rare occasions that he refused to leave his cell for enteral feedings, the FCE team entered his cell. He did not resist FCE team members, who carried him to the restraint chair. FCE movements are videotaped. Enteral feedings are not videotaped.

Mr. Zuhair last refused to leave his cell for feeding one month prior to the evaluation. He stated that he would refuse when he felt too ill to go out of his cell, when he wanted the contents of his enteral feeding to be changed, or when he wanted to get the attention of medical staff in order to obtain treatment. In general he was fearful that the FCE team would hurt him during movement and avoided FCE movements.

Once Mr. Zuhair was in the chair, restraints at the ankles, waist, wrists, and a shoulder harness were placed by guards. The restraints are made of material similar to an airline seat belt. The feeding tubes used at the time of the evaluation were 10 French (small bore.) The nurse dipped the tube in olive oil prior to insertion as the lubricant gel caused Mr. Zuhair discomfort. Insertion of the tube "hurts" at times. Tube placement was checked with a stethoscope using air and confirmed with a small water bolus. A bag containing the feeding solution was attached to the feeding tube. The rate of delivery was controlled by a stopcock mechanism. Mr. Zuhair would tell the nurse when the rate needed to be adjusted for comfort. He would be kept in the restraint chair for 15-30 minutes after the solution was administered to facilitate absorption. There was a

two hour recommended maximum limit on how long a person could be in the restraint chair. Mr. Zuhair would be removed from the chair earlier if the entire solution had been administered.

Mr. Zuhair seemed to tolerate feedings of regular Ensure, a common nutritional supplement. He reported his concern that on at least two occasions an incorrect solution was placed in the bag. This was corrected when he pointed out the error.

Mr. Zuhair's description of medical consequences of enteral feeding as of January 2009
Mr. Zuhair stated that he experienced pain and discomfort from the restraint chair and the enteral feeding process. He was diagnosed with coccydynia (tailbone pain) and hemorrhoids. The restraint chair kept the occupant's back reclined at an angle. The position of his body in the restraint chair caused and exacerbated coccyx and hemorrhoid pain. "It seems to put all of the pressure on your tail bone and buttocks." The waist restraint precluded him from being able to move enough to alleviate this pressure. The pain persisted when he was no longer in the chair. When the shoulder harness was tightly applied he could not lean over to vomit into a receptacle or scratch an itch. The restraints chafed at times.

Mr. Zuhair stated that some guards fastened the restraints too tightly and would intentionally bump his restraint chair while he was being fed, increasing his discomfort. The nurse was sometimes rough when inserting the tube, and did not respond to his complaints of discomfort.

Mr. Zuhair denied forcing himself to vomit or changing the rate of feeding in an attempt to manipulate the perception of his physical health.

Mr. Zuhair's description of psychiatric consequences of enteral feeding as of January 2009
Mr. Zuhair stated that the restraint chair caused him to feel as though he was being treated "like an animal." He felt powerless to do anything to change this. Restraint chairs were used for all detainees' enteral feedings, regardless of their disciplinary history, unless there was a medical contraindication to restraint chair use. There was no behavioral reward system by which a detainee could work his way up to another venue for enteral feeding. Mr. Zuhair stated that this loss of autonomy and arbitrary policy "Is the core issue."

Mr. Zuhair stated that the use of the restraint chair was degrading. "The treatment of animals is better. I feel as though I'm not being treated like a person." He felt humiliated by the use of the restraint chair. "They treat me like a criminal. It takes away from my honor, it reduces my dignity. When your honor is reduced you are less than a person. It's like I'm weak." I asked Mr. Zuhair to help me understand what he meant by a loss of honor. He explained, "I'm a person. I have my honor, my dignity, my humanity. When I began my hunger strike, my peaceful protest, everyone should respect peaceful protest. They should not take away my dignity."

I asked Mr. Zuhair how the use of the restraint chair took away his honor and dignity. He explained, "The chair takes away my free will. It does not kill my soul or my spirit, I love life, but they've taken my free will away from me. They killed my freedom [through indefinite detention] and now I've lost my free will."

Mr. Zuhair stated that the restraint chair also caused him anxiety and worry. The chair had a label (which he brought me) that stated that its improper use may lead to injury or death. He

worried that persistent use of the chair might cause him harm or that he could lose the ability to walk. "If I die in the chair that's one thing, but to be an invalid is another."

Mr. Zuhair denied a history of attempted physical assaults on JDG or JMG staff throughout the entire history of his enteral feedings. He did use profanity and called them names. He believed the restraint chairs were introduced and were being used as punishment. He understood that an assaultive detainee should be fed in a restraint chair. "That's fair. But why go in the chair when you haven't done anything wrong? It's punishment."

Mr. Zuhair's statements regarding continuing to engage in a hunger strike
Mr. Zuhair had a phone call with his family the week prior to my evaluation. His wives and children expressed concern for his health and asked him to begin eating again. Most importantly, his elderly mother expressed extreme distress and worry as a result of his hunger strike. Mr. Zuhair promised her that he would stop his hunger strike and begin eating again. He accepted food that day and was brought "severely boiled chicken." He failed at his attempt to eat secondary to nausea on exposure to the smell of food. He did not try to eat a meal after that. [I note that Mr. Zuhair's being given chicken is not supported by the Hunger Strike SOP, which states that a detainee should receive the BRAT diet (bananas, rice, apples, and tea) when ending a hunger strike, to increase the likelihood of successful transition to oral feeding.] Mr. Zuhair stated that the younger detainees on [redacted] also wanted him to end his hunger strike as they worried about his health. Mr. Zuhair stated that he would stop his hunger strike if he were moved to Camp 4.

Mr. Zuhair stated that he would never refuse enteral feeding if he were allowed to be fed in a hospital bed. He would not object to being in two or four point restraints were enteral feeding to take place in a bed. Shortly after my evaluation, on February 9, 2009, Mr. Zuhair was transferred to the Detainee Hospital. He is currently housed in the BHU. It is my understanding that Mr. Zuhair's enteral feedings have taken place in a hospital bed since his transfer to the Detainee Hospital and BHU.

Observation of enteral feeding January 22, 2009
Observation of morning enteral feeding took place in the Detention Hospital. The observed procedure was generally consistent with Mr. Zuhair's report as noted above. The observed procedure was consistent with the SOP regarding the Medical Management of Detainees on Hunger Strike.

Summary of JDG guard staff interviews regarding enteral feedings
Interviews were conducted with guard staff from [redacted] who were directly involved in escorting Mr. Zuhair from his cell to the restraint chair and placing him in restraints in the chair. Guards also observed detainees during enteral feedings to ensure the physical safety of medical staff and detainees.

All guards interviewed from [redacted] had received training in FCE procedures and were members of the FCE team on [redacted] Guards stated that some detainees routinely declined to walk voluntarily to their restraint chairs, as they perceived this to be a violation of their "peaceful protest." The FCE team brought those detainees to their chairs. Guards stated that at this late point in the hunger strike, it was rare for a detainee who refused to walk to his chairs to resist the FCE team. When the FCE team approached his cell the detainee would lie on his

stomach either on the floor or in his bed and allow the FCE team to place him in restraints. The FCE team then carried him to his restraint chair. Mr. Zuhair rarely refused to walk to his chair voluntarily.

Guards described Mr. Zuhair's behavior during enteral feedings. He interacted well with other detainees, guards, and medical staff during enteral feedings. At times the detainees would sing during enteral feedings. A song by Akon, "Locked Up," was a favorite.

Guard staff denied harassing Mr. Zuhair during enteral feedings. They specifically denied bumping his chair. One guard stated that the guards appreciated Mr. Zuhair's ability to assist them in maintaining order on the block due to the respect he received from the other detainees. Guards would not want to do anything to irritate Mr. Zuhair. One guard stated, "To be honest, he's the guy you want to go to for help."

Detainees were allowed to bring a blanket, towel, sheet, or t-shirt to the restraint chair to decrease discomfort "all the time." Guard staff are aware of the two hour time limit on use of the restraint chair. They stated that they did their best to adhere to this policy. On occasion a detainee might be left in the chair for two and a half hours if guards were busy escorting many detainees who had all completed their enteral feedings at the same time.

All JDG staff interviewed stated that JTF GTMO had not implemented any SOP or informal policy aimed at stopping the detainee hunger strike. They denied withholding comfort items, access to medical care, or taking any other steps to pressure a detainee to stop their hunger strike. One guard summarized what appeared to be the prevailing sentiment on the part of the JDG staff, "It's their decision. It's like smoking." Guard staff did not know why detainees were fed in restraint chairs as opposed to hospital beds. Several detainees on [REDACTED] received enteral feedings in hospital beds due to medical conditions.

I interviewed a guard who was present when Mr. Zuhair returned to [REDACTED] after speaking with his mother. The guard stated that Mr. Zuhair indicated that he wanted to try to eat and was given a regular meal. [As noted above, this is not in accordance with the JTF Hunger Strike SOP. A detainee who decides to eat after being on hunger strike should receive a BRAT diet.] Mr. Zuhair was offered a different type of meal, but declined. He had not requested a meal since that time.

I interviewed Commander Jeff Hayhurst, the Deputy Commander of JDG. He also denied that JDG had implemented procedures designed to end the hunger strike. In fact, the JTF had made a conscious decision to allow the hunger strike to continue. Hunger strike management policy had been developed with consultation from outside experts in the fields of corrections and hunger strikes.

Commander Hayhurst stated that when the number of hunger strikers increased, JTF moved them to dedicated hunger strike blocks that provided the same conditions of confinement as in the general population. Steps were taken to increase the comfort of hunger strikers, for example, by adding padding to the restraint chairs. Commander Hayhurst did not know why there was no ability for hunger strikers to demonstrate their ability to be safely fed outside of a restraint chair. He did state that "the blocks aren't set up to do bed feeds."

Opinion regarding Mr. Zuhair's enteral feedings
Mr. Zuhair's medical and psychiatric health were adversely affected by the use of a restraint chair for enteral feedings. His medical record indicates that he has coccydynia (tailbone pain) and hemorrhoids that are exacerbated by his placement in the chair. Additionally, Mr. Zuhair stated to me that the restraint chair makes him feel that he is being treated like an animal and that it erodes his honor and dignity. Mr. Zuhair was transferred to the Detention Hospital in early February 2009 and has subsequently been transferred to the Behavioral Health Unit (BHU). Since his transfer he has received enteral feedings in a hospital bed. However, his weight has not changed appreciably since the time of my visit in late January 2009.

Recommendations regarding Mr. Zuhair's enteral feedings and nutrition

1. In order to provide the Court with appropriate recommendations regarding the management of Mr. Zuhair's hunger strike, I request that I be allowed to consult with the experts whom JTF had originally relied upon for management of the GTMO hunger strikers for the reasons described below.
2. Consideration should be given to videotaping all of Mr. Zuhair's enteral feedings. This would provide an objective record of the conduct of those involved in the feedings, including Mr. Zuhair, and would likely decrease concerns about the process from all parties.
3. Mr. Zuhair is currently located in the BHU where he is receiving enteral feedings while he is in a hospital bed. I have not interviewed him since the restraint chair was discontinued. It is likely that the use of a hospital bed, even with two or four point restraints, has decreased his sense that his honor and dignity are degraded. He stated that the restraint chair caused him physical pain and discomfort, as well as anxiety and worry. Being fed in a hospital bed may have caused him to feel that he is being treated in a more humane manner. I recommend that, to the extent possible, given the security concerns of the detention facility, it would be helpful if Mr. Zuhair could continue to be fed in a hospital bed to decrease pain, discomfort, anxiety, worry, and his sense that his honor and dignity are being degraded.
4. In the event that enteral feedings occur in the restraint chair in the future, consistent availability and appropriate placement of hemorrhoid pillow should be ensured.
5. If Mr. Zuhair should decide to try eating again in the future, it may be helpful for behavioral health clinicians to offer to assist him in identifying and addressing factors that might make it difficult for him to resume oral alimentation. These factors may include the possibility that he may feel that stopping his hunger strike would disappoint other detainees or that he may feel that he is abandoning other detainees. He may feel that the hunger strike allows him to oppose Joint Medical Group (JMG) and Joint Detention Group (JDG) staff in a manner that does not constitute a rule violation. He may also feel that the hunger strike in some way creates a bargaining chip in his interactions with JTF staff, especially given his expressed belief that the JTF would like the detainees to stop their hunger strike. Aspects of his sense of self-esteem and self-worth may at this point be based on his long term involvement in his hunger strike, which may have become a source of a sense of autonomy and self-determination. If this is the case, Mr. Zuhair may feel increased depression and anxiety if he were to stop. Mental health clinicians may assist him in working through these issues should they arise and should he accept their help.

6. In the event that Mr. Zuhair accepts a meal in the future, the Hunger Strike SOP should be followed, in that Mr. Zuhair should be offered a bland and easily digestible diet.

Limitations in the scope of my recommendations regarding enteral feedings and nutrition

In order to provide the Court with recommendations regarding Mr. Zuhair's medical and mental health status and treatment that balance his needs with the safety of the institution, I sought information regarding the management of hunger strikers in US federal and state prisons. I consulted three experts in correctional mental health, behavioral management, and conditions of confinement. Although their input was helpful, none of them had ever been directly involved in the management of hunger strikers, or in the use of restraint chairs for enteral feedings.

After this consultation I made the determination that it would be most helpful for me to speak to the experts upon whom the JTF had originally relied on for advice in managing the GTMO hunger strikers. The result of JTF's original consultation with these experts was to implement the use of the restraint chair in administering enteral feedings. As noted in the original Respondent's Opposition filed in response to Mr. Zuhair's petition for emergency medical relief, these experts had direct experience in the management of hunger strikers in US prisons, whereas my consultants did not.

I contacted the Staff Judge Advocate's (SJA) office and requested contact information for the consultants JTF had previously relied upon. I was referred to Scott Levin, who subsequently denied my request as falling outside the scope of my evaluation and interfering with Department of Defense's (DoD) deliberative process. I believe consulting with these experts would allow me to provide the Court with recommendations that are medically appropriate and that take into account institutional safety, as such consultations would allow me to discuss the considerations that led to the current restraint chair protocol and allow me to present Mr. Zuhair's situation to experts in the field and ask them for their recommendations for managing Mr. Zuhair's enteral feedings in light of his medical and psychiatric concerns, and his inability to gain weight on enteral feedings.

This consultation would be especially helpful given the fact that Mr. Zuhair's weight has not changed appreciably since the time of my visit, despite his transfer to the Detention Hospital and subsequently to the BHU, where, presumably, he is more closely observed and enteral feedings take place in a hospital bed. An additional point of concern is the question of where Mr. Zuhair's enteral feedings should take place (restraint chair versus hospital bed) once he is discharged from the BHU.

Medical status

Nutritional status and GI symptoms

Mr. Zuhair has been on hunger strike since April 2005. He has been receiving enteral feedings since meeting threshold criteria that summer. Recently received records indicate that he continues on his hunger strike at the present time.

Based on Mr. Zuhair's medical record through April 19, 2009, his nutritional status, although of obvious concern, has remained adequate since the time I saw him in January. His height is 66.5 inches. His weight on April 19, 2009 was 114.8 pounds, 2.4 pounds higher than at the time of my

visit. His weight over the prior month ranged between 114.2 to 119 pounds. This represents only a slight gain since my visit three months ago. As recently as March 14 he weighed 112 pounds, 0.4 pounds higher than at the time of my visit. His body mass index (BMI) at 114.8 pounds is 18.2. This continues to place him in the Underweight (mild thinness) classification based on World Health Organization's standards. The normal range of BMI is 18.5 to 24.99.

As of April 19, 2009 Mr. Zuhair is ordered 3 cans of regular Ensure (one can equals 250 calories in 237 ml or 8 ounces) and 3 cans of Ensure Plus (one can equals 350 calories in 237 ml or 8 ounces) per day, administered over two enteral feedings. Each feeding equals 711 ml or 3 cups. At the time of my visit and for some time afterward he was inconsistent in his ability to tolerate the total amount of Ensure prescribed to him. However, over the past several weeks his medical record indicates he has tolerated the full amount of Ensure given to him. His medical record suggests that for lengthy periods prior to my visit he had tolerated Ensure without difficulty. Of note, his current orders indicate that "Ensure Plus" is not to be written on the bag containing his enteral feeding, presumably because he has objected to it in the past. As he appears to be tolerating the combination of Ensure and Ensure Plus at this time, this unconventional approach of not fully labeling the bag containing his feedings may be justified by his need to gain weight.

Mr. Zuhair has longstanding complaints of nausea, vomiting, and abdominal pain. His medical record indicates that clinicians have been concerned that at times he appears to force himself to vomit intentionally. This was most recently documented in a nursing note dated February 8, 2009, "visibly appears to be making himself vomit, feed slowed, meds offered, Milk of Magnesia given." The record also indicates clinicians' concern that the frequency and severity of his GI symptoms and other medical concerns appeared to correlate with visits related to his legal case. This is most recently documented in a doctor's note dated February 10, 2009. Regardless of the cause of his nausea and vomiting, his ability to gain weight on enteral feedings appears to be directly related to the amount of Ensure he tolerates during feeding, which is related to these symptoms.

Previous evaluation for presence of food allergy

Mr. Zuhair expressed concern that he is allergic to the various nutritional solutions used in the enteral feedings. He based his concern on results of RAST testing performed in 2003 and 2005. A RAST (radioallergosorbent test) detects the presence of a certain type of antibody to various proteins in a blood sample, indicating the presence of an allergy to the protein. Mr. Zuhair reports that a JMG clinician told him in 2003 that based on his RAST results he is allergic to rice and corn. His diet was subsequently modified to avoid these foods. He believes that he is allergic to the nutritional solutions because they contain corn syrup. However, the corn syrup in nutritional supplements, including those used in enteral feedings at GTMO, contains little or no corn protein and would not be expected to cause a reaction in a person with a corn allergy.

Mr. Zuhair's RAST results from 2003 indicate an equivocal (no to mild allergy) response to peanuts, a Class I (mild allergy) response to egg whites and soybeans, and a Class II (moderate allergy) response to corn and rice. RAST results from 2005 indicate an equivocal response to peanuts and soybeans and a Class I response to corn. However, it is difficult to correlate RAST Class results to clinical symptoms. Mr. Zuhair has undergone trials of a variety of nutritional solutions. He has evidenced a pattern of tolerating solutions for lengthy periods and then having nausea and vomiting for periods of time on these same solutions.

In November 2008 the SMO, who has additional training and experience in allergy medicine, consulted with an allergist regarding Mr. Zuhair's concerns. The allergist indicated that based on the results of RAST testing and clinical history, Mr. Zuhair does not have a food allergy. Repeat RAST testing was last performed on February 13, 2009. Results yielded absent or undetectable levels of response to corn, rice, and soybeans, supporting the opinion that Mr. Zuhair does not have an allergy to these foods. The gastroenterologist with whom I consulted and shared results of all RAST testing, concurs with this opinion.

Current evaluation of nutritional status and GI symptoms

As previously reported, with the exception of an abdominal ultrasound done in October 2008 (with normal results) Mr. Zuhair had largely refused to undergo evaluation to determine the cause of his GI symptoms. After a lengthy discussion with me and Professor Schmitz on January 19, 2009, Mr. Zuhair agreed to accept the medical work-up.

At my request, the SMO provided me with her plans to evaluate Mr. Zuhair's current medical condition and determine the cause of his symptoms in order to formulate an appropriate treatment plan. In addition to the tests performed while I was in GTMO (see below), these recommendations included urinalysis, tuberculosis quantiferron, repeat RAST test for food allergies, and gastrointestinal consult with endoscopy. All of the laboratory tests have now been completed and yielded normal results. Mr. Zuhair understands that additional tests may be ordered depending on the results of initial findings. A review of recently received medical records through April 19, 2009 indicates that Mr. Zuhair appears to have remained complaint with participating in tests and consults ordered by JMG clinicians.

Basic laboratory tests were performed on January 21, 2009 and repeated as indicated thereafter. Results on all dates included normal serum albumin and total protein levels, gross measures of nutritional status. Liver function tests, amylase and lipase (measures of pancreatic function,) electrolytes, BUN and creatinine (measures of kidney function) were also within normal limits. These results demonstrate that Mr. Zuhair is not experiencing a metabolic disturbance consistent with starvation or gross organ dysfunction. Serum glucose, while below normal in January (although not to the point of causing serious symptoms,) was normal on repeat testing in February. Results of complete blood count (CBC) tests obtained in January and February 2009 demonstrate mild anemia, consistent with Mr. Zuhair's diagnosis of β-thallasemia, a genetically transmitted anemia found in Mediterranean countries, North Africa, the Middle East, India, Central Asia, and Southeast Asia.

As previously reported, testing of a stool sample for *H. pylori* antigen was negative. *H. pylori* is a bacteria that can cause stomach ulcers and gastritis, a potential cause of nausea, vomiting, and pain. Serum prealbumin was also normal. Prealbumin is a more sensitive test of malnutrition than albumin and total protein. Chest x-ray performed January 21, 2009 showed no acute cardiopulmonary process. Mr. Zuhair was on the schedule to see the gastroenterologist on the specialist's next visit to GTMO, which was anticipated to occur last week.

Additional medical concerns

At the time of my visit Mr. Zuhair had several medical concerns in addition to his nutritional status. Subsequent to my visit Mr. Zuhair was admitted to the Detention Hospital after a fall. He was since transferred to the BHU where he is currently housed. The following are medical concerns not related to Mr. Zuhair's nutrition and GI status.

1. The medical record indicates that on February 9, 2009, Mr. Zuhair reported that he fell when he stood up from his bunk. He complained of worsening right hip and knee pain, which the notes indicate had been present since the day before when he reportedly fell during recreation time. After the February 9 fall Mr. Zuhair also complained of right rib pain.

   On February 9, 2009 Mr. Zuhair was admitted to the Detention Hospital for evaluation and treatment of pain and for nutritional support. Inpatient admission for ongoing nutritional issues was under active consideration at the time of the reported fall. X-rays of Mr. Zuhair's right hip, knee, and chest were negative for fracture or dislocation. X-rays of the right hip and abdomen done on February 17, 2009 were reportedly also normal with respect to orthopedic concerns. Laboratory testing was normal.

   Mr. Zuhair had an orthopedic consult on February 13, 2009. There was no evidence of swelling or bruising on physical exam and no evidence of significant injury. The orthopedist concluded that there were no medical or structural reasons why Mr. Zuhair could or should not walk. Physical therapy consultation was completed on February 19, 2009 with the observation that Mr. Zuhair may have sustained a soft tissue injury and possible muscle spasm in the right hip area. Mr. Zuhair was recommended to do specific stretching exercises several times a day.

   Mr. Zuhair has continued to complain of pain. JMG physicians believe that that his pain complaints were out of proportion to the mechanism of his injury and physical findings. Nonetheless, because pain is subjective, it is JMG policy to "take these complaints of pain at face value and offer treatment." Mr. Zuhair has continued to be prescribed pain medication as noted below.

   Of note, while in the Detention Hospital Mr. Zuhair was observed to sit up without back support and to lean forward while lying on his bed without difficulty. This would be expected to cause some discomfort in a patient with hip pain. Additionally, he was observed to ambulate with a walker without difficulty.

2. Mr. Zuhair stated that the restraint chair causes pain at the base of his spine and exacerbates hemorrhoids. On January 25, 2009 his doctor wrote a memo indicating that it was medically necessary to have a hemorrhoid pillow while in the restraint chair secondary to coccydynia (tailbone pain.) At the current time Mr. Zuhair's feedings take place in a hospital bed. This is not an active issue currently, but may resurface if enteral feedings resume in a restraint chair.

3. Mr. Zuhair complained to me that he has had rib pain that has not responded to medications. This issue may have been subsumed by attention to pain management during his hospitalization.

4. Mr. Zuhair expressed concern to me about an apparently bony deformity that arose to the right of his sternum several months prior to my evaluation. He insisted upon showing this to me despite knowing that I would not do a physical exam. The deformity is readily apparent on visual inspection. Chest x-ray done on January 21, 2009 revealed a relatively

prominent and outward-angled xiphoid process (the bony attachment to the bottom of the sternum) which caused a bulge in the overlying muscle and skin.

I communicated with the SMO about this concern via the SJA's office. The SMO responded, "The skeletal abnormality does not have any other concerning features, and would classify as benign. It has no effect on his pulmonary status, and has no malignant features. Recent Normal Calcium and ALT/AST levels reinforce the observation of no malignant features. Recent AP CHEST, (AP) 09 Feb 2009 also did not see any concerning features. A conservative reassessment could include a follow up chest Xray - would not recommend earlier than 6 month interval. Case discussed with Orthopedics as well, who agrees with above plan."

5. Mr. Zuhair expressed concern about a deformity on his left wrist. He stated he would discuss this with his physician. There is no mention of this complaint in subsequent medical records.

6. I note that x-ray reports from chest, right knee, and right hip films apparently done on February 9, 2009 list the reason for the examination as "pain after forced cell extraction." Forced cell extraction for enteral feeding is noted in the medical record on February 8, 2009. Treating physician notes indicate that x-rays were ordered to evaluate pain from the reported fall. The radiologist may be mistaken in the reason for referral. The source of Mr. Zuhair's pain may be clarified should it become an issue in the future.

Current medications

Standing medications for GI symptoms

1. Aciphex, 40 mg po bid (for acid reflux symptoms and heartburn)

Standing pain medications

1. Lidoderm patch, one patch at 8 am, two patches at 10 pm

Other standing medications

1. Colace, 100 mg po bid (for constipation)
2. Metamucil, 2 packets po or via tube q pm (for constipation)
3. Multivitamin, one po or via tube every other day
4. Thiamine, 200 mg po or via tube once weekly
5. Calcium/vit D tab po or via tube bid

Medications taken as needed

For constipation

1. Magnesium Citrate, 60 ml po or via NG tube q d prn
2. Milk of magnesia, 15-30 cc po bid prn

Other medications taken as needed

1. Mylanta, 15-30 cc po q 6 hours prn (heartburn)
2. Percocet, 5/325 mg, two tabs po qid prn (pain)
3. Motrin, 400-800 mg po tid prn (pain)
4. Cepacol lozenge q 4-6 hours po (sore throat)
5. Sensodyne toothpaste prn (dental pain)
6. Zofran, 8 mg po bid prn (nausea and vomiting)

In addition, Mr. Zuhair receives honey and saline nasal spray with bacitracin for help with lubricating his feeding tube. He is prescribed other medications on an as needed basis, but recently has not been using them often. These include hydrocortisone cream, an analgesic balm, Eucerin cream, Claritin, Zantac, and Tyelenol.

Of note, medications prescribed for treatment of hemorrhoids have been discontinued since Mr. Zuhair has been receiving enteral feeding in a hospital bed and not a restraint chair, presumably because he has not needed them.

Mr. Zuhair's explanation of his previous refusal to participate in medical evaluation
Mr. Zuhair stated that several factors led him to refuse to participate in medical evaluation of his GI symptoms and to refuse medical care in general as he lost trust and confidence in JMG health care professionals.

Historical
Mr. Zuhair heard from other detainees that JMG medical staff were involved in their interrogations and the detainee disciplinary process. For example, in the past he was told that if a detainee refused medical treatment, privileges would be withheld from them until they complied.

Mr. Zuhair maintained that when the hunger strike first started routine medical care was withheld when he refused to eat. For example, he was not given Tylenol for headache. He stated that he was told that if he ate, his medical concerns would be addressed. He did state that withholding of medical care for hunger strikers does not occur at present.

Mr. Zuhair also expressed long-standing frustration over interactions with JMG clinicians whom he felt did not explain the purpose of recommended tests, their results, his diagnoses, subsequent recommended treatment, and side effects of medications. This lack of communication made him anxious. "They don't tell me anything. When they were taking my blood I began to worry, 'What am I, an experiment? Am I a mouse? Are they using me for teaching purposes?'"

Mr. Zuhair gave several examples of interactions that caused him concern. Two and a half years ago he asked why blood was being drawn and was told simply that the doctor had ordered it. His uncertainty over whether or not he has a food allergy and subsequent conflicting statements made by clinicians has left him confused over which clinician to believe. While he was housed in Camp Six last fall he was given a new medication for nausea that caused him to sleep for several hours. Due to mistrust of medical staff he feared that the medication was causing serious complications.

Current concerns
Mr. Zuhair does not trust current clinicians because of interactions that occurred proximate to my evaluation. For example, he did not trust that his requests to the nurse to see the nutritionist or SMO because of vomiting or pain from the restraint chair were communicated because "no one ever comes." He had asked a Corpsman to refer him to the SMO for evaluation of his chest wall abnormality, but had not seen her at the time of my evaluation. He stressed that this was a major source of concern and mistrust.

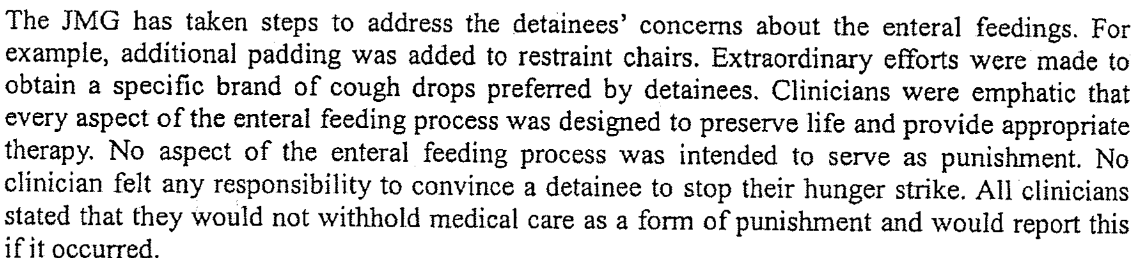
He does not trust that clinicians care about his symptoms. For example, when he told the nutritionist about his GI symptoms, she often increased the volume of his food. At times he

waived away the nutritionist during her rounds because "she wouldn't do anything anyway I thought." Additionally some physician orders are never followed. A good example of this is the fact that a hemorrhoid pillow was ordered for him, but he never received it.

Mr. Zuhair stated that no clinician had ever asked him why he refused evaluation and treatment. He stated that the goal of his non-participation was to bring himself to the attention of more senior JMG staff.

Summary of interviews of JMG clinicians

JMG clinicians emphasized their desire to provide Mr. Zuhair with appropriate medical and psychiatric evaluation and treatment. They expressed their frustration over his refusal to participate in the recommended evaluation of his GI symptoms and inability to gain weight. They were concerned that he might be forcing himself to vomit, as his complaints of nausea and vomiting often occur proximate to visits from his attorney and flared with the approach of our visit. His complaints of nausea and vomiting fluctuate over time.



The JMG has taken steps to address the detainees' concerns about the enteral feedings. For example, additional padding was added to restraint chairs. Extraordinary efforts were made to obtain a specific brand of cough drops preferred by detainees. Clinicians were emphatic that every aspect of the enteral feeding process was designed to preserve life and provide appropriate therapy. No aspect of the enteral feeding process was intended to serve as punishment. No clinician felt any responsibility to convince a detainee to stop their hunger strike. All clinicians stated that they would not withhold medical care as a form of punishment and would report this if it occurred.

With respect to Mr. Zuhair's enteral feedings, the nurse and Corpsman who administered and monitored the feedings stated that Mr. Zuhair frequently asked that his rate of feedings be slowed due to complaints of nausea, abdominal pain, cramping, and fullness. As a result of the two hour time limit on feedings Mr. Zuhair often did not receive the entire amount prescribed to him. At the time of the evaluation Mr. Zuhair was prescribed 24 ounces of Ensure twice daily. Mr. Zuhair generally went to the feeding chair voluntarily, not requiring the FCE team to bring him out of his cell. During feedings he interacted with the other detainees.

Mr. Zuhair was not felt to exhibit signs or symptoms of mental illness. He was usually polite and appropriate in his interactions with medical staff. When frustrated he occasionally used profanity. He never threatened to harm medical staff, although he occasionally threatened to "cause problems" when upset.

JMG clinicians described Mr. Zuhair's medical condition as difficult to assess given his non-compliance with recommended evaluation. They felt his nutritional status was at least adequate given his weight and ability to tolerate a minimally acceptable amount of nutritional intake. He

was not felt to have any significant co-morbid conditions. His last TB test was two years prior to the current evaluation. His immunizations were current. They noted that he had a history of β-thallasemia, asymptomatic diverticulosis, and past history of nephrolithiasis (kidney stones) which may have been due to his prolonged hunger strike.

Mr. Zuhair's internist was not aware that, as he maintained, he had requested that she evaluate his chest wall abnormality. She had seen him in the past, but had not examined him as he had refused to let her do so.

JMG clinicians did not know why Mr. Zuhair was refusing evaluation and treatment for his GI symptoms and inability to gain weight. They had considered whether it was based in his mistrust of the medical system or his occasional oppositional behavior. They also considered the possibility that he somehow did not want the issue addressed or was aware that there was nothing wrong.

I also interviewed the JMG psychiatrist, although Mr. Zuhair was not in mental health treatment at the time of my evaluation. She stated that Mr. Zuhair is monitored weekly by psychiatric technicians, as are all detainees on hunger strike. He had never asked to be referred to her. She conducts rounds on his block two to three times a week. Mr. Zuhair had not asked to see her when she was there.

JMG clinicians, including the psychiatrist, did not think that receiving enteral feedings in the restraint chair caused Mr. Zuhair emotional distress or harm. They did acknowledge that the restraint chair was a likely cause of his hemorrhoid symptoms.

Opinion regarding Mr. Zuhair's medical status

As noted above, Mr. Zuhair's nutritional status remains adequate. His weight on April 19, 2009 was 114.8 pounds, 2.4 pounds higher than at the time of my visit. His body mass index (BMI) at 114.8 pounds is 18.2. This continues to place him in the Underweight (mild thinness) classification based on World Health Organization's standards. His medical evaluation to date, including laboratory and x-ray studies, has been normal.

Although the cause of Mr. Zuhair's GI symptoms and inability to gain weight despite enteral feedings remains unknown, he appears to be complying in an appropriate evaluation of their cause. Medical evaluation to date has been appropriate as per the gastroenterologist with whom I have consulted. This gastroenterologist suggested that if the GTMO GI consultant continues to be delayed, JMG clinicians consider obtaining a small bowel study to rule out distal obstruction. This study can be done in GTMO by JMG staff.

Mr. Zuhair has a long-standing mistrust of JMG clinicians that may be difficult to ameliorate. He ascribed this mistrust to reports by other detainees that previous JMG clinicians had been involved in interrogations and disciplinary processes; frustration over clinicians' not explaining the rationale for recommended treatment and evaluation; his perception that some requests for medical attention have not been addressed; his perception that some physician orders have not been carried out; and concerns that he is in some way being used as a guinea pig.

Mr. Zuhair has been intermittently non-compliant with recommended evaluation and treatment directed at a variety of medical concerns. In addition to mistrust, his non-compliance is likely

rooted in a number of factors. These include an expression of autonomy during his indefinite detention (throughout the course of which he has had little control of any aspect of his life); an attempt to create a bargaining position; and, as he stated, an attempt to elicit concern on the part of clinicians that will bring him to the attention of more senior staff.

Recommendations regarding Mr. Zuhair's medical status

1. Mr. Zuhair was scheduled to see the gastroenterologist last week. Results of endoscopy and any other studies should be forwarded to me for review. Should this consultation continue to be delayed, consideration should be given to ordering a small bowel study to rule out distal obstruction.
2. As noted above, should Mr. Zuhair be recommended to receive future enteral feedings in a restraint chair, a hemorrhoid pillow should be available to him at all times which should be placed appropriately in the chair (the pillow was not used properly during my observation of enteral feeding.) Hemorrhoid medication will likely need to be re-ordered.
3. Chest x-ray should be repeated in approximately July 2009 for follow-up of the abnormality of his xyphoid process.
4. Mr. Zuhair complained of a deformity of his left wrist. This should be evaluated if he has not brought this to the attention of his clinicians.
5. Improvement in Mr. Zuhair's mistrust of JMG clinicians will be difficult. However, JMG clinicians may wish to consider a few interventions designed at improving his compliance with recommended evaluation and treatment.
    a. If time and resources allow, JMG clinicians may consider scheduling future appointments with Mr. Zuhair on a regular (time-contingent), rather than symptom-contingent basis. This is a common intervention directed at improving clinician-patient relationships, increasing compliance, and decreasing escalating patient reports of symptoms in an effort to come to clinician attention. Visits may be kept brief, with a defined number of complaints addressed at each visit.
    b. JMG clinicians may wish to engage in a frank discussion with Mr. Zuhair about his assertion that he has not been informed as to the rationale for recommended evaluation and treatment of concerns that have arisen over the years. Mr. Zuhair identified this as a major source of his mistrust of medical staff. Clinicians should merely accept this concern, rather than engaging in a discussion of whether it is well-founded, as consensus regarding past events is unlikely to be reached. The focus of the discussion should be on their future interactions with Mr. Zuhair. JMG clinicians may wish to reassure Mr. Zuhair that they will respond to his future questions and concerns. In return, they may reasonably ask Mr. Zuhair to communicate these concerns to them, rather than avoiding contact with clinicians with subsequent complaints that he is not been educated about their treatment plans.
    d. Clinicians should not become frustrated should these interventions not result in the desired outcome. Mr. Zuhair may continue to be non-compliant and to complain about aspects of medical care and his interactions with clinicians. Given the length of his indefinite incarceration, lack of autonomy, and tendency to focus on health concerns (see psychiatric status section below), improvements in Mr. Zuhair's attitude toward JMG staff and medical treatment may happen slowly, if at all.

Psychiatric status

Mood symptoms

At the time of the interview Mr. Zuhair reported experiencing intermittent depressed mood and daily anxiety. He described episodic crying spells. He endorsed difficulty falling asleep due to anxiety and noise from guard staff activity. He denied middle insomnia when it is quiet. He denied feeling hungry at his rate of caloric intake. He reported occasional difficulties with concentration and memory. He had episodic low energy. He denied anhedonia (inability to experience interest or pleasure in activities), stating, "I can always lift my spirits up. I'm older and more mature; it's harder for the younger detainees." He denied psychomotor agitation or retardation. He did not feel worthless. He had thoughts of death at times. He worried about what would happen to him if he died and how his family would manage. He denied suicidal ideation, intent, or plan. At times these symptoms were distressing and kept him from engaging in activities, but he could usually overcome negative feelings (see below.)

General anxiety symptoms

When asked about anxiety, Mr. Zuhair explained, "I worry all day and I worry at night." The worry was an anxious expectation or fear that he would again be subjected to having his Koran searched, his beard shaved, or to being touched disrespectfully. He was concerned that he might be seriously ill and die in GTMO. He was fearful that one of his teen-aged sons, who lives in the United States, might be harassed by the FBI or brought to Guantanamo. He was somewhat less worried about his family in Saudi Arabia as they were with his brothers and extended family. He was saddened by the lengthy separation from his children. "I will see my children and they will be grown. My wife is older. My mother is now over 70. What will she be like? I've missed a lot."

Uncertainty about his future also weighed on Mr. Zuhair. "If they move me to the US or to another country it is against my will. I still have chains on my feet. All of my freedoms are taken from me. And if I do leave here, what is there for me? I am sick, old, and have nothing in my hands. I'm going to be a burden on my family. I need treatment. I need to be in a hospital. I'm not going to be able to work right away, and now I'm an old guy. I don't have the same prospects now. I think about this all the time. Should I take money from my brothers or sons? What's going to happen after I leave? Am I going to keep driving from city to city as a merchant? Open a supermarket and sit in it? Maybe people have changed. Seven years is not a little time."

Posttraumatic stress disorder (PTSD) symptoms

Mr. Zuhair reported four events in which he experienced events that involved actual or threatened death, serious injury, or threat to his physical integrity, to which he responded with intense fear. The first occurred just after being taken into custody in Pakistan when he was beaten over a twenty-four hour period. He could not breathe at times and he thought he was going to die, "I wished they would kill me the pain was so great." The second occurred in American custody, midair on the plane from Bagram to Kandahar. The detainees were bound and blindfolded. The door of the plane was opened and he heard someone shout in Arabic, "They're throwing me from the plane! They're throwing me from the plane." Guards grabbed and beat him. Mr. Zuhair thought he would be the next to be thrown from the plane. The next traumatic event occurred in American custody in Bagram during an interrogation. He was threatened with being turned over to the Egyptians who would rape him if he did not admit to being involved in the Cole bombing. He felt this was a credible threat because he had heard the Egyptians

employed that form of physical abuse. The fourth and last event needs to be understood in the context of his faith and culture. He reported being traumatized by body cavity searches, which he perceived as a threat to his physical integrity.

The diagnostic criteria for PTSD require that, in addition to experiencing a traumatic event, three types of symptoms must also be present; re-experiencing; avoidance and numbing; and arousal. With respect to re-experiencing symptoms, Mr. Zuhair reported having nightmares every one to three months and intrusive thoughts, memories, and images of the traumas he experienced. He reported anxiety on exposure to reminders of traumatic experiences. With respect to the avoidance and numbing symptoms of PTSD, Mr. Zuhair stated he took care to avoid thoughts, feelings, and conversations that reminded him of traumatic events when possible. He also described a sense of having a foreshortened future. He is unlikely to experience many of the other avoidance and numbing symptoms due to restrictions in his environment. Mr. Zuhair reported having arousal symptoms consistent with those common in patients with PTSD. These included initial and middle insomnia, poor concentration, hypervigilence, and an exaggerated startle response, which has decreased over the period of his confinement.

Psychological sequelae of enteral feeding

Please refer to the "Hunger strike and enteral feeding" section above for a discussion of Mr. Zuhair's report of mental health consequences of enteral feeding.

Coping strategies

Mr. Zuhair stated that when he experienced fear, anxiety, or depression, "I get myself moving. I say, 'C'mon, let's laugh,' I get some activity going for distraction. Life needs this." He felt strongly that it is important to fight against internal negative emotions. "I try to sing, laugh, play, and talk to the brothers (other detainees). I try to push this sadness away. I tell the others that they have to push to do things. When you sit and think about things it wears you down. But even in the middle of all of this at Guantanamo, you have to push sadness away. So far we have patience or we would all be crazy just after the first six or twelve months."

Mr. Zuhair has memorized the Koran. He learned additional interventions from other detainees that were helpful in "keeping the sadness away." The detainees read to each other in pairs and shared their life stories. He valued these relationships. "Now all the people I'm with have become like my family. All the years next to the same person, one becomes sick, the other is sad, and vice versa. In spite of all that has happened, that has helped the seven years go by."

Mr. Zuhair stated that the 24 detainees on [redacted] recreated for three hours each day in groups of eight. During recreation time he usually sat in the sun and read the paper. He stated that he did not play soccer, unlike many of the other detainees.

Summary of JDG guard staff regarding observations of his mental state

I asked JDG guard staff to describe their observations of Mr. Zuhair's behavior and to share their perceptions of his emotional well-being. Guard staff reported that Mr. Zuhair was generally in a good mood. He frequently smiled and joked appropriately with guard staff. Guard staff did not think Mr. Zuhair exhibited signs or symptoms of depression or anxiety.

During recreation, Mr. Zuhair was usually observed reading Arabic newspapers and USA Today. He frequently talked with the other detainees in the recreation yard. Mr. Zuhair also played

soccer. He was observed playing soccer the day prior to my interview of guard staff. He was observed to be one of the better players. One guard commented, "He's quick!"

Guard staff also noted that Mr. Zuhair was well-respected by the other detainees and often functioned as an intermediary between guard staff and detainees. For example, if the detainees had a concern about something on the block they would discuss it with Mr. Zuhair, who would bring it to the attention of the guards. Mr. Zuhair generally made up the list of times during which specific detainees wanted to take their recreation time and gave it to the guards. For example, detainees who wanted to play soccer usually preferred to go out early in the day when it was still relatively cool. Guard staff relied on Mr. Zuhair's relationship with the other detainees to assist them in maintaining order on the block. One guard stated, "What he says goes on the block. We can ask him to calm things down if the detainees have a complaint that's being worked out but hasn't been resolved yet." Guards appreciated that Mr. Zuhair usually did not complain about insignificant issues. One guard stated, "If he has a complaint, it's almost always legitimate."

Guard staff stated that Mr. Zuhair was usually appropriate in his interactions with them. He had never threatened to harm a guard on the block. He had not engaged in assaultive behavior to guard or medical staff on the block.

Mental health treatment at the time of the evaluation

Mr. Zuhair reported that he was visited weekly by a Behavioral Health Unit Corpsman who would ask if he would like additional assessment or any treatment. Mr. Zuhair had consistently declined, as he felt he does not need mental health treatment for his psychiatric symptoms.

Review of mental health records

Mental health records provided at the time of my evaluation indicated that, as above, Mr. Zuhair was seen for a brief assessment each week by a Behavioral Health Unit Corpsman, and declined mental health treatment. He was not noted to have psychiatric symptoms.

Following Mr. Zuhair's admission to the Detention Hospital in February 2009 he was discharged to the BHU, where he remains at the present time. Records provided were not specific regarding the reason for this transfer. Mr. Zuhair has been diagnosed with an Adjustment Disorder with depressed mood. He is not currently taking psychotropic medication. He briefly took Cymbalta, an antidepressant that may also be useful for pain. Treatment notes through April 19, 2009 indicate that Mr. Zuhair has consistently denied suicidal ideation, intent, or plan. In general he has stated that he is doing "good." He has remained on twice daily enteral feedings in the BHU. It appears that these are administered to him while he is in a hospital bed.

Mental status examination

Appearance:	Mr. Zuhair was interviewed in Camp Echo. He presented as a well groomed man in standard detainee attire and appeared his stated age. One ankle remained in a restraint attached to a floor bolt throughout interviews. He was obviously very thin, but did not have signs of temporal wasting. He did not appear listless. His skin turgor and texture appeared normal, as did the texture of his hair. Mucous membranes appeared moist. His respirations were

even, unlabored, and of normal rate. He did not have lower extremity edema. These last observations were made at an approximately three foot distance, not by medical examination. They indicated the appearance of at least grossly adequate hydration and nutritional status, which was later confirmed by laboratory report.

Behavior: Mr. Zuhair was cooperative with the examination. He made good eye contact throughout and related easily. He preferred to sit on a mat on the floor over the course of the interviews for comfort. There was no evidence of psychomotor agitation or retardation.

Speech: Mr. Zuhair's speech was normal with respect to rate, rhythm, emotional tone, and articulation.

Mood: Mr. Zuhair evidenced a full range of mood that was appropriate to the content of our discussion. He appeared sad when discussing his family, painful experiences at GTMO, and his indefinite detention. His mood visibly improved when discussing the importance of the relationships he has made with other detainees.

Thought Process: Mr. Zuhair's thought process was linear and goal oriented throughout the interview.

Thought Content: Mr. Zuhair denied hallucinations. There was no evidence of delusional thinking. He denied current homicidal or suicidal ideation, intent, or plan.

Mr. Zuhair scored 30/30 on the Mini Mental Status Examination, indicating normal orientation, and normal functioning of short term memory (both retention and recall), attention, and language.

Opinion regarding Mr. Zuhair's psychiatric status

As noted above, Mr. Zuhair complains of symptoms consistent with depression and anxiety. These symptoms are expected given his prolonged indefinite confinement, the conditions of his confinement, and his lack of autonomy. He is particularly disturbed by the process of receiving enteral feedings in a restraint chair. As noted above, he perceives the procedure of being restrained in the chair during feeding as degrading his honor and dignity He feels that animals are treated better and that he is being treated as a criminal. Mr. Zuhair is currently diagnosed with an Adjustment Disorder with Depressed Mood. He meets many diagnostic criteria for PTSD, although it is likely that he is not able to experience the full panoply of symptoms given limitations in his current environment. Mr. Zuhair may have a tendency to focus on somatic complaints as a way of managing symptoms of depression and anxiety, as well.

Mr. Zuhair described many coping strategies he developed to manage the depression and anxiety that stem from the factors noted above. He stated that he fights against internal negative

emotions and seeks out social support and interaction with other detainees. He uses conversation, reading, and recreation time to distract himself from psychiatric symptoms, preferring to rely on these methods and not seek out mental health treatment. His success in using these coping strategies likely explains the discrepancy between his report of his emotional state and the observations made by guard staff.

Recommendations regarding Mr. Zuhair's psychiatric status

Mr. Zuhair has not accepted mental health treatment aimed at targeting his symptoms, preferring to rely on the coping mechanisms he has developed. Nonetheless, regular contact with mental health clinicians should continue after his discharge from the BHU for symptom review and monitoring and to determine if he changes his mind about accepting treatment.

Competency to participate in habeas proceedings

At the time of my evaluation Mr. Zuahir was competent to participate in the habeas proceedings. He demonstrated an adequate knowledge of the unclassified accusations against him. He was aware of the potential consequences and implications of prevailing in or losing the habeas petition. Mr. Zuhair adequately described the roles of the judge, his attorney, and the respondent's attorney. He correctly described the role of witnesses, the meaning of evidence, and the concepts of sworn testimony, and direct and cross examination. Mr. Zuhair stated that he trusted that his attorney, whom he correctly identified, was working hard on his behalf. He could not identify any reason that he would not be able to assist in his petition, nor did I observe any. Although he was not physically present for hearings in his habeas case, he accurately described appropriate courtroom behavior.

The information I have received regarding Mr. Zuhair's medical and mental health since the time of my evaluation does not suggest that his competency has changed. I would need to interview him again to determine his current competency to a reasonable degree of medical certainty.

Thank you for referring this matter to me for evaluation and report.

Sincerely,

/s/

Emily A. Keram, MD

Appendix A

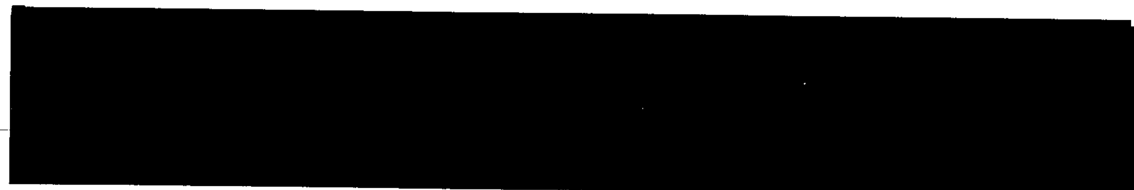
Detention Operations

COMMAND STRUCTURE

Commander, Joint Task Force-Guantánamo
The detention facility is located on the U.S. Navy Station-Guantanamo (NAVSTA GTMO). Two operationally independent command structures exist at Guantanamo. All operations not related to the detention facility fall under the command of the Commanding Officer, NAVSTA GTMO. The Commander, Joint Task Force-Guantánamo (JTF-GTMO or JTF) is the operational commander of detainee operations in Guantánamo. The JTF Commander reports to the Commander of the U.S. Southern Command (USSOUTHCOM), one of ten combat commands within the DoD.

The JTF is divided into three entities; Joint Detention Group (JDG), Joint Medical Group (JMG), and Joint Intelligence Group (JIG). The Detention Group and Medical Group Commanders, and the Director of the Intelligence Group report to the JTF Commander. Legal support is provided to the JTF Command and Groups by the JTF-Guantanamo Office of the Staff Judge Advocate (SJA.)

Joint Detention Group
The JDG is responsible for the safe custody of the detainees in various camps located throughout the detention facility. In the camps I have visited, the guard staff has been drawn from Military Police (generally from the National Guard) and Master at Arms (Navy). The chain of command within a camp block generally includes a Watch Commander who may be responsible for overseeing one or more camps; an Assistant Watch Commander assists the Watch Commander in the running of one camp; a Non-commissioned Officer (NCO) who supervises the guards on the block; and block guards whose number is determined by the detainee population on the block. Guard duties include enforcing camp rules; transporting detainees to the recreation yard, showers, and appointments; delivering meals; and clothing and linen exchange.



Joint Medical Group
The JMG provides medical, dental, and mental health care to the detainees. A detainee may self-refer for evaluation and treatment for concerns in these areas by contacting medical staff during their rounds in the camps or by requesting referral from guard staff. JDG staff may also make a

referral based on concerns raised during contact with detainees. Medical staff are always available for emergency evaluation and care.

General medical care
Medical care is provided on both an inpatient and outpatient basis [redacted] stand alone 17-30 bed Detainee Hospital, which includes an operating room, X-ray equipment, pharmacy, dental suite, and separate areas for physical therapy, optometry, audiology, and procedures.

The medical staff includes approximately five physicians, one physician assistant, two dentists, 17 nurses, and 85 Corpsmen. Nurses and Corpsmen are always present in the Detainee Hospital. Physicians are in the hospital during normal working hours and are available on call after hours. In the event of an emergency a Corpsman or nurse can reach each camp within minutes. The JDG has three ambulances, kept at Camp 6, Camp 7, and at the Detainee hospital, should emergency transportation be required.

Outpatient care can be delivered in camps [redacted] which relies on visits to the Detainee Hospital for care. Camp 5 has a small medical treatment room with a Corpsman on duty 24 hours a day. Camp 6 has a larger treatment area that includes a dental facility. Camp 6 has a significant medical staff. A physician is available during normal working hours and on call after hours. At least one nurse and five Corpsmen are on duty 24 hours a day to provide medical care to Camps 5, 6, and Echo. Camp 7 has a medical treatment room and dental chair. A physician is present during normal working hours and on call after hours. A corpsman is on duty in Camp 7 24 hours a day.

In addition to the treatment areas in Camps 5, 6, and 7, a Corpsman or nurse makes daily rounds in each camp to dispense prescribed and over-the-counter medications.

The NAVSTA Hospital, located in the main area of the Naval Station, provides services that exceed the Detainee Hospital's capabilities. A Computerized Tomography (CT) Scanner and other specialized services are available in this facility. Specialty and sub-specialty care are provided by visiting military physicians in quarterly or semiannual clinics, or on an as-needed basis.

The JMG staff provide preventative health care to detainees who have the option to have a basic immunization series and flu vaccine. The JMG offers age-appropriate screenings such as colonoscopy and Prostate Screening Antigen.

At the time of the evaluation, Mr. Zuhair's internist was identified as the Senior Medical Officer or SMO. One JDG physician, [redacted] is responsible for addressing the nutritional needs of all hunger striking detainees. Responsibility for general medical care and nutritional care was separated to relieve the internists of the large volume of work created in managing the hunger striking population and to allow a physician with expertise in nutrition to work with each hunger striker.

Mental health care
Mental health care is also provided on an inpatient and outpatient basis. The Behavioral Health Unit (BHU), [redacted] houses a 12 bed inpatient unit.

The BHU staff of 17 personnel includes a psychiatrist, a psychologist, behavioral health nurses and psychiatric technicians. The BHU is always staffed with at least one nurse and two psychiatric technicians. At the time of the evaluation it appeared that detainees who are on a hunger strike are seen at least weekly by a member of the BHU staff, usually a psychiatric technician, to monitor the possible need for BHU services.

Joint Intelligence Group

The JIG is run by a civilian director who is an employee of the Defense Intelligence Agency, with a military officer (rank of Colonel or Captain) as deputy director. Interrogators at GTMO work in the Interrogation Control Element (ICE). The Walsh Report noted that currently all interrogations are voluntary and that given the length of time that most detainees have spent at Guantánamo, the primary focus of interrogations is to gather security and force protection information related to the operations of the detention camps. The current nature of the intelligence mission lends itself to the use of direct approaches and small incentive items to encourage detainees to volunteer information.

DETENTION FACILITY

History

The detention camps [redacted] Visitors and personnel clear a main road gate when entering the detention facility area. When the JTF began receiving detainees in January 2002 housing was limited to Camp X-ray, which had open air housing and is no longer in use. Camp X-ray provided temporary housing during the construction [redacted] which opened in April 2002 and remains operational. [redacted] as well as the Detainee Hospital and the BHU. My understanding is that the ICE, which I have not visited, [redacted] As the detainee population expanded Camps 5 and 6 were opened in April 2004 and December 2006 respectively, [redacted]

[redacted]

The current detention facility for detainees in the general population at GTMO is limited to only two types of housing; one communal living camp (Camp 4) and several maximum security facilities (Camps 1-3, Camps 5-7, Camp Echo.) Camp Iguana is also a communal living camp, available to some non-general population by virtue of their legal status.

Communal living camp (Camp 4)

Camp 4 became operational in February 2003 and most closely resembles a Prisoner of War camp as set forth in Geneva Convention III, Relative to the Treatment of Prisoners of War (Article 25.) Detainees considered to be at lowest risk for dangerous or problematic behavior may be transferred to Camp 4 based on their compliance with camp rules in the maximum security camps.

Detainees live in open bay barracks and have access to a large recreation area and other communal facilities throughout the day. The recreation area has a basketball court, volleyball court, and soccer area. Camp 4 detainees also have access to educational and intellectual stimulation via the camp's media center which has a satellite television, bench seating, and a classroom used to teach literacy and art. Detainees participate in meal preparation and eat in a communal setting.

Two past incidents that took place in Camp 4 are cited by JTF to demonstrate the need for careful risk assessment in determining appropriate housing for detainees. JTF states that in 2004 some Camp 4 detainees plotted to take control of a food truck they planned to use to kill guards. More than ten detainees attacked guards before they were subdued by a Forced Cell Extraction (FCE) team using less than lethal weapons. JTF states that in 2006, Camp 4 detainees attacked guards with broken fan blades and light fixtures as well as other weapons, destroying much of the camp. JTF states the attack was a protest against indefinite confinement. Detainees have maintained that the incident was provoked by mistreatment by guards.

Maximum Security

The maximum security camps at GTMO are similar to federal and state maximum security prisons within the United States. Detainees are housed in single cells and are shackled for every move out of their cell. While the cells in Camps 1-3 are made of steel mesh, cells in Camps 5-7 are closed wall with cell doors that typically have a small clear window and food slot ("bean hole") through which detainees receive meals, medications, etc. Detainees remain alone in their cells except for recreation, showers, and appointments. Detainees are offered a minimum of two hours each day for recreation and opportunities for showering.

I do note the following report to me by a detainee whom I previously evaluated. In the summer of 2008, while he was housed in Camp 5, the detainee told me that due to limitations on the number of detainees allowed in the shower and recreation areas at a time and limitations on the availability of guard staff to move detainees to and from these areas, detainees were offered shower and recreation time at any hour of the day or night. The detainee cited many occasions in which he had been awoken at night by guard staff offering shower or recreation time. The detainee stated that he and other detainees frequently declined shower and recreation time when offered at odd hours, in order to sleep. The detainee's allegations were subsequently substantiated by JTF personnel. When a detainee declined a shower or recreation it was logged as a "refusal" in the DIMS records. Additionally, JTF maintains that the conditions of confinement in the maximum security camps do not constitute solitary confinement, citing the ability of detainees to communicate with each other by talking through their food slot and during recreation. However, the above-mentioned detainee also alleged that although he was able to communicate with other detainees by shouting through his food slot, guards would intermittently and arbitrarily cite such behavior as a rule infraction that resulted in disciplinary action. This allegation was substantiated by review of the detainee's DIMS file.

Camp 1

Camp 1, [redacted] opened in April 2002. The camp has approximately 200 steel mesh single cells that face each other, arranged in rows, with an equal number of cells on each side of the block. Camp 1 includes an outdoor exercise area for each block, equipped with a treadmill or elliptical machine.

Camp 2 and Camp 3
Camps 2 and 3, adjoining facilities [redacted] opened in October 2002. The camps have a total capacity of 400 detainees. Each camp has 10 adjoining blocks of 24 to 48 cells each. Detainees are housed in steel mesh single cells similar to those in Camp 1. The recreation area is similar to that in Camp 1 as well. Two cells in Camp 3 can be used as a movie room for detainees.

Camp 5
Camp 5 is a stand alone maximum-security facility that became operational in April 2004. [redacted] Camp 5 has the capacity to house 100 detainees in climate-controlled single cells that have clear windows and food slots. Camp 5 cells are organized into four 2 story wings surrounding a central automated control center. All operations throughout the building are controlled through this center. Each wing contains two rows of adjoining cells that face each other. One wing is devoted to administrative offices. There are three recreation areas accessible from each of the three cell wings. Each tier contains a room where detainees can watch movies at specified times. Additional rooms are available for attorney visits. Detainees are shackled to the floor during these visits via an ankle restraint.

Camp 5 Echo (part of Camp 5),
Camp 5 Echo, first occupied by detainees in April 2008, is similar to Camp 1 in its layout. The camp has the capacity to house 24 detainees in individual adjoining steel mesh cells arranged in two parallel and equal rows. The recreation facilities are similar to those in Camps 1, 2, and 3 and contain four adjacent yards with treadmills, elliptical machines and soccer balls.

Camp 6
Camp 6 became operational in December 2006. It is unique in that it was designed with the capacity to be converted easily between maximum and medium housing depending on the needs of the detention facility. However it has been continuously operated in its maximum security housing mode since its opening. Camp 6 is organized into eight 2 story wings of 22 cells each, 11 climate-controlled cells to each story. The wings have skylights that transmit natural light and are organized around an automated control center, as in Camp 5. Each wing has a communal area with tables, chairs, and recreation and entertainment equipment which could be used if the camp or individual wings were functioning as a medium security facility. Two outdoor recreation areas are subdivided into 11 areas that can accommodate one or two detainees. Two additional recreation areas hold five areas that can accommodate one or two detainees. A recently constructed outdoor recreation area can accommodate up to 22 detainees in a yard used for sports, exercise, reading, relaxation, prayer and meals. I do not know whether this area is currently in operation. Camp 6 also houses a newly constructed media building that has a television and DVD player, and can accommodate up to 20 detainees for entertainment or classroom activities. I do not know if this media center is currently in operation. The JTF has stated that in their effort to convert part of Camp 6 to medium security housing construction has started to transform some of the housing areas to provide detainees free access to communal and recreation areas throughout most of the day, in a manner similar to Camp 4.

Camp 7
Camp 7 opened in September 2006 and houses the HVD's. Detainees are housed in single climate-controlled cells with walls and doors similar to those in Camps 5 and 6. The camp is

organized into tiers that include a dual-cell recreation yard divided into two areas by a chain link fence. Recreation is offered for a minimum of four hours each day. The recreation yards contain elliptical machines, stationary bicycles, soccer balls, and racquetballs. Media rooms are available three times weekly for each detainee to watch movies of their choice, read newspapers, magazines, books and play hand-held electronic games.

Pre-Release Facility (Camp Iguana)
Camp Iguana houses detainees who are not in the general population by virtue of their legal status. [redacted] Detainees in Camp Iguana live communally and move freely within a fenced area that contains several wooden, hut-like buildings that are used for sleeping, recreation, meals, and prayer. Living quarters include a bed, dresser, desk, table, and chair. The camp contains an outdoor recreation facility with a treadmill, elliptical trainer, picnic table, and planted garden with garden hose. One building in the camp is designated for religious worship. A second building includes a library with books in native languages and a reading area. Residents have access to satellite television, newspapers, art supplies, hand-held games, puzzles, and Sudoku. Another building has a washer and dryer for detainee use. The camp has a shower and hygiene building with running hot and cold water, sinks, mirror, toilets, and showers.

Limited Use Facility (Camp Echo)
Camp Echo became operational in October 2004. It was originally used to house pre-trial detainees who had been charged in the original Military Commissions. It is currently used to house detainees and for attorney meetings. Each detainee resides alone in a hut-like wooden structure that is divided by a floor to ceiling steel mesh wall into two areas. The meeting area contains a table and chairs. Detainees are shackled to the floor during attorney visits via an ankle restraint. The living area contains a bed, sink, and toilet. If I recall correctly, the living area contains a shower as well. If the door, located on the meeting room side, is kept open, the detainee may see outside and have access to fresh air and natural light at that distance.