Medical Officer / Preventive Medical Officer
INTERVIEW QUESTIONS

Rank (b)(6)-4 & (b)(7)(C)-4 **Branch** (b)(6)-4 & (b)(7)(C)-4 **Date** 10 Jun **Unit** (b)(6)-4 & (b)(7)(C)-4
Duty Position (b)(6)-4 & (b)(7)(C)-4 **How Long in Job** 8 yrs.
How Long in Current MOS 8 yrs. **Interviewer** (b)(6)-4 & (b)(7)(C)-4
How long have you been in Country 11 mos.

1. What medical requirements in support of the detainee program were identified in the medical annexes of relevant OPLANs, OPORDs, and other contingency planning documents? What identified requirements were actually allocated? What procedures were specified in these documents? **(Collect theater/local policies, SOPs, etc)** *(1.1, 1.2, 2.1, 4.1)* AR 190-8, paragraph 1-4 g (6): Combatant Commanders, Task Force Commanders and Joint Task Force Commanders will identify requirements and allocations for Army Medical units in support of the EPW, CI and RP Program, and ensure that the medical annex of OPLANs, OPORDs and contingency plans includes procedures for treatment of EPW, CI, RP, and ODs. Medical support will specifically include: (a) First aid and all sanitary aspects of food service including provisions for potable water, pest management, and entomological support. (b) Preventive medicine. (c) Professional medical services and medical supply. (d) Reviewing, recommending, and coordinating the use and assignment of medically trained EPW, CI, RP and OD personnel and medical material. (e) Establishing policy for medical repatriation of EPW, CI and RP and monitoring the actions of the Mixed Medical Commission.

SOP ~ medical section
ARTEP - I/R, EPW

2. What training, specific to detainee medical operations, did you receive prior to this deployment? What training have you received during this deployment? *(1.4)* DoDD 2310.1: The U.S. Military Services shall be given the necessary training to ensure they have knowledge of their obligations under the Geneva Conventions (references (b) through (e)) and as required by DoD Directive 5100.77 (reference (f)) before an assignment to a foreign area where capture or detention of enemy personnel is possible.) AR 350-1, para 4-14 c (2) and table G-1 Refresher training, dated 9 April 2003: Level B training is conducted in units for officers, warrant officers, NCOs and enlisted personnel commensurate with the missions of the unit. DoDD 5100.77, para 5.5.1: The Secretaries of the Military Departments shall provide directives, publications, instructions, and training so that the principles and rules of law of war will be known to members of their respective Departments, the extent of such knowledge to be commensurate with each individual's duties and responsibilities.

None - no fit-testing
Isolation of mask assets in non-medical chain of command - supplies difficult to acquire.
TB tng at annual Reserve tng. Briefings during mission.

3. What are the minimum medical care and field sanitation standards for collection points/internment facilities? What have you observed when detainees are received at collection points/internment facilities? **(Describe the process)** *(1.2, 1.4, 1.8)* AR 190-8, paragraph 2-1 a (1) (e): Prisoners will be humanely evacuated from the combat zone and into appropriate channels as quickly as possible. . . . The capturing unit may keep prisoners in the combat zone in cases where, due to wounds or sickness, prompt evacuation would be more dangerous to their survival than

(b)(2)-3

retention in the combat zone. Para 3-2 b: Prisoners will not normally be interned in unhealthy areas, or where the climate proves to be injurious to them. Transit camps or collecting points will operate under conditions similar to those prescribed for permanent prisoner of war camps, and the prisoners will receive the same treatment as in permanent EPW camps. Para 3-3 (3): Provide prisoners with humane treatment, health and welfare items, quarters, food, clothing, and medical care. Health Service Command (HSC) provides medical and dental care for EPW in federal or civilian health care facilities per HSC plans. (13) Provide the initial medical examination and monthly screening of prisoners. **AR 190-8, paragraph 3-4 e: EPW/RP will be quartered under conditions as favorable as those for the force of the detaining power billeted in the same area.** The conditions shall make allowance for the habits and customs of the prisoners and shall in no case be prejudicial to their health. The forgoing shall apply in particular to the dormitories of EPW/RP as it regards both total surface and minimum cubic space and the general installation of bedding and blankets. Quarters furnished to EPW/RP must be protected from dampness, must be adequately lit and heated (particularly between dusk and lights-out), and must have adequate precautions taken against the dangers of fire. In camps accommodating both sexes, EPW/RP will be provided with separate facilities for women. When possible consult the preventive medicine authority in theater for provisions of minimum living space and sanitary facilities. f. The daily food rations will be sufficient in quantity, quality, and variety to keep EPW/RP in good health and prevent loss of weight or development of nutritional deficiencies. (1) Account will be taken of the habitual diet of the prisoners. (2) EPW/RP who work may be given additional rations when required. (3) Sufficient drinking water will be supplied to EPW/RP. (4) The use of tobacco will be permitted in designated smoking areas. (5) EPW will, as far as possible, be associated with the preparation of their meals and may be employed for that purpose in the kitchens. Furthermore, they will be given means of preparing additional food in their possession. Food service handlers must have training in sanitary methods of food service. (6) Adequate premises will be provided for messing. (7) Collective disciplinary measures affecting food are prohibited. g. Clothing, underwear, and footwear will be supplied to EPW/ RP in sufficient quantities, and allowances will be made for the climate of the region where the prisoners are detained. Captured uniforms of enemy armed forces will, if suitable for the climate, be made available to clothe EPW/RP. The camp commander will ensure the regular replacement and repair of the above articles. EPW/RP who work will receive clothing appropriate to the nature or location of the work demands. Para 6-6, g: (1) Hygiene and sanitation measures will conform to those prescribed in AR 40-5 and related regulations. Camp commanders will conduct periodic and detailed sanitary inspections. (2) A detailed sanitary order meeting the specific needs of each CI camp or branch camp will be published by the CI camp commander. Copies will be reproduced in a language that the CI understands and will be posted in each compound. (3) Each CI will be provided with sanitary supplies, service, and facilities necessary for their personal cleanliness and sanitation. Separate sanitary facilities will be provided for each sex. (4) All CI will have at their disposal, day and night, latrine facilities conforming to sanitary rules of the Army.

Army MP

KBR did Vector control & med folks — No MP enforcement
Food allowed in tents/ → rats
garbage
Fed 2x/d 0700 & 1500 (so would have to Load food
Drinking H_2O next to sewage (to get thru night)
drain – feces around site)

4. How often are the collection points/internment facilities inspected **(PVNTMED inspections)**? Who performs the inspections **(field sanitation team, PVNTMED detachment)**? What do the inspections consist of? What do you do with the results of the inspections? Are the appropriate commanders taking the necessary actions to correct the shortcomings noted during your monthly medical inspections? Have you observed any recurring deficiencies during your inspections? **(Obtain copies of past inspection reports)** *(1.1, 1.2, 1.3, 1.7, 2.1, 4.1)* AR 190-8, paragraph 3-4 i (1): The United States is bound to take all sanitary measures necessary to ensure clean and healthy camps to prevent epidemics. EPW/RP will have access, day and night, to latrines that conform to the rules of hygiene and are maintained in a constant state of cleanliness. In any camps in which women EPW/RP are accommodated, separate latrines will be provided for them. EPW/RP will have sufficient water and soap

for their personal needs and laundry. The necessary facilities and time will be made available for those purposes. **AR 190-8, paragraph 3-4 e: EPW/RP will be quartered under conditions as favorable as those for the force of the detaining power billeted in the same area. [Thus, field prev med requirements outlined in AR 40-5, TB MEDs 530, 577, and 561 are applicable.]** FM 3-19.40, paragraph 2-11: Certain sanitation standards must be met to prevent disease and ensure cleanliness. These standards include—

- Ensuring that internees receive as much water as US soldiers.
- Providing adequate space within housing units to prevent overcrowding.
- Providing sufficient showers and latrines and ensuring that they are cleaned and sanitized daily.
- Teaching dining-facility workers the rules of good food sanitation and ensuring that they are observed and practiced.
- Disposing of human waste properly to protect the health of all individuals associated with the facility according to the guidelines established by preventive medicine (PVNTMED).
- Providing sufficient potable water for drinking, bathing, laundry, and food service.
- Providing materials for personal hygiene.
- Training personnel on proper garbage disposal to prevent insects and vermin that can contribute to health hazards.

Paragraph 2-43: The PVNTMED section provides limited PVNTMED services for the facility. Performs sanitary inspections of housing, food service operations, water supplies, waste disposal operations, and other operations that may present a medical nuisance or health hazard to personnel. Provides training and guidance to the staff, unit personnel, and others. Para 3-49: The division PVNTMED section supports the central CP by—

- Monitoring drinking water and advising on disinfection procedures.
- Controlling animals and insects that carry disease.
- Ensuring that captives help prevent illness by—
  - ?? Drinking enough water.
  - ?? Wearing clothing that is suited for the weather and the situation.
  - ?? Handling heating fuels carefully.
  - ?? Avoiding contact of exposed skin to cold metal.
  - ?? Using insect repellent, netting, and insecticides.
  - ?? Taking approved preventive medication.
  - ?? Using purification tablets when water quality is uncertain.
  - ?? Disposing of bodily wastes properly.
  - ?? Practicing personal hygiene.

Para 3-62: The CHA guards isolate wounded captives and captives suspected of having a communicable disease until medical personnel can examine them (see Chapter 2). Take necessary sanitary measures to ensure a clean, healthy CHA and to prevent epidemics. Request PVNTMED units to assist and advise unit field sanitation teams on—

- The survey and control of disease-carrying insects and rodents
- Sanitary engineering (water treatment and waste disposal)

Para 5-52 (CI): Proper sanitation and cleanliness of a facility prevents the spread of disease among the CI population and the US forces guarding them. The facility commander—

- Conducts periodic, detailed sanitary inspections.
- Publishes a detailed sanitary order in a language that CIs understand and posts it in each compound.
- Provides sanitary supplies, services, and facilities necessary for personal cleanliness and sanitation.
- Ensures that—
  - ?? Hygiene and sanitation measures conform to AR 40-5 and related regulations.
  - ?? Latrines are available 24 hours a day.
  - ?? Separate showers and latrines are available for males and females.
  - ?? Adequate space is allocated to prevent overcrowding within housing units, while maintaining proper segregation and family integrity.
  - ?? Good food sanitation and personal hygiene is observed by food service personnel.
  - ?? Waste is disposed of properly.
  - ?? Sufficient potable water is available for drinking, bathing, doing laundry, and preparing food.

KBR inspections as well

?? Materials are available for personal hygiene, including products for female hygiene and infant care.

Daily, than random to prevent prep, sent at least
twice 7 days (min of 5 x/wk)
Sewers daily
H2O testing 3 wk.
Hygiene checklist & food service from FN (3 lt o
Results briefed 3 night

5. How do you ensure that each unit has a field sanitation team and all necessary field sanitation supplies? What PVNTMED personnel are assigned to MP units responsible for detention operations? *(1.1, 1.2, 1.3, 1.4, 1.5, 1.7, 2.1, 4.1)* AR 40-5, paragraph 14-3 a: As a minimum, units deploying to the field will—(1) Before deployment, appoint a field sanitation team with responsibilities defined in b below. b. Field sanitation teams. (1) When organic or attached medical personnel are available, they will be appointed and will serve as the field sanitation team for the unit. . . . Company and battery-sized units deploying without organic or attached medical personnel will appoint a field sanitation team. (2) (a) Composition. Company aidmen (military occupational specialty 91A) organic or attached to deployed units will be trained and will function as the unit field sanitation team. If medical personnel are not available, two soldiers will be selected and trained, one of whom must be a noncommissioned officer.

Plus 5 inspectors
Only problem

FM 4-02.17, paragraph 3-13: Military Police Units. a. Preventive medicine personnel play a vital role in the oversight of health and sanitation standards in displaced persons assembly areas, enemy prisoner(s) of war (EPW) camps, and confinement facilities. To perform this mission, PVNTMED personnel are assigned to military police (MP) EPW detachments, MP EPW battalions, MP EPW brigades, MP EPW commands, and MP confinement battalions. b. The type and number of PVNTMED personnel assigned is dependent upon the assigned unit's mission. The PVNTMED element can range from a single PVNTMED noncommissioned officer (NCO) to a staff consisting of an environmental science officer, a sanitary engineer, and PVNTMED specialists. c. They serve as technical advisors to the command on PVNTMED issues associated with the supported population. Since the staff's role is advisory, it has no organic equipment and must coordinate for monitoring/testing support from PVNTMED detachments, ASMB or the Theater Army Medical Laboratory (TAML).

One 91S —
go Weekly - visit from PVNTMED det

6. How are detainees initially evaluated (screened) and treated for medical conditions **(same as US)**? Who performs the screening? What do you do if a detainee is suspected of having a communicable disease **(isolated)**? *(1.1, 1.2, 2.1, 4.1)* AR 190-8, paragraph 2-1 a (2): First aid and medical treatment will be provided to the same extent that the United States provides to its own forces. Sick and wounded prisoners will be evacuated separately, but in the same manner as U.S. and allied forces. Para 2-2 b: Ensure sick and wounded EPW and RP in their custody are classified, by qualified medical personnel, as either walking wounded or litter, or as non-walking wounded. Walking wounded or litter EPW will be evacuated through established evacuation channels. Non-walking wounded or sick EPW will be delivered to the nearest medical aid station and evacuated through medical channels. All detained personnel will remain physically segregated from U.S. and allied patients. Para 3-4 i (2): EPW/RP with a contagious disease, mental condition, or other illness, as determined by the medical officer, will be isolated from other patients. A list of endemic diseases of military importance can be obtained from the theater surgeon or preventive medicine officer. EPW/RP will be immunized and reimmunized against other diseases as recommended by the Theater Surgeon. EPW/RP suffering from serious disease, or whose condition necessitates special treatment, surgery, or

Sick call good
160/d for sick call

hospital care, must be admitted to any military or civilian medical unit where such treatment can be given. . . . EPW/RP will not be denied medical care. Para 6-6 d (2): Each CI will be given an initial radioscopic chest examination. If active disease is found, pulmonary disease consultation is indicated. If no active disease is found, the individual will be followed through routine periodic examinations. (3) For children up to 14 years of age, a tuberculin skin test (TST) will be administered. No chest x-ray is necessary if the TST is negative. The local medical officer will establish guidance for subsequent tests based on the tuberculosis experience of the population. Routine annual tuberculin testing of children is not warranted unless there is clear-cut evidence of high risk. (See AR 40-26, paragraph 8 f.) FM 3-19.40, paragraph 3-48: Prevent captives from incurring disease and nonbattle injuries (DNBI) (heat and cold injuries or communicable diseases) while in captivity. Isolate captives who exhibit obvious signs of disease (diarrhea, vomiting, or fever) until medical personnel make an evaluation. If a large number of captives appear ill, notify medical and command channels for immediate action/treatment. Tables 4-1 (EPW), 5-1 (CI) and 8-1 (US military). US Prisoners: 7-103: The facility commander establishes a close liaison with commanders of local medical and dental facilities to ensure their full support of the confinement facility. He ensures that prisoners receive the same medical and dental care as other soldiers. 7-104: Medical officers or other medically trained personnel conduct sick call, perform emergency medical treatment, and dispense medication. Hold sick call daily at a time that does not interfere with duties and training of prisoners. Medical examinations and treatment usually require using instruments and medications that can cause custody and control problems. Secure medications and equipment when they are not in use, and inventory them frequently. 7-105: Corrections NCOs dispense medication to prisoners in cellblocks, supervise the ingestion or application of the medication, and maintain a medication issue register. When possible, use qualified medical personnel to dispense prescription medication. No comm dz screen at IP.

NDRS is line for med tent –
No way to keep paper files – used electronic notes, then hand ents into NDRS
Not flowing up from other facilities ie records (Beef)
No record of immns or guidance on what to give (No immns anyway – no refrig)

7. How often do you or your staff conduct routine medical inspections (examinations) of detainees? What does the medical evaluation consist of? What is the purpose of the medical examination? How are the results recorded/reported? *(1.1, 1.2, 1.3, 1.7, 2.1, 4.1)* AR 190-8, paragraph 3-4 i (3): Medical inspections of EPW/RP will be held at least once a month, where each detainee will be weighed and the weight recorded on DA Form 2664-R (Weight Register). . . .The purpose of these inspections will be to monitor the general state of health, nutrition, and cleanliness of prisoners and to detect contagious diseases, especially tuberculosis, venereal disease, lice, louse-borne diseases and HIV. Para 3-3 a (22): Information will be posted to the individual's personal, medical, and financial records, and will be provided to the supporting PWIC and next higher headquarters, as required. FM 3-19.40, paragraph 2-10: A medical officer, a physician's assistant (PA), or a nurse practitioner examines each internee monthly. Para 6-6 a (2): A medical officer will examine each CI upon arrival at a camp and monthly thereafter. The CI will not be admitted into the general population until medical fitness is determined. These examinations will detect vermin infestation and communicable diseases especially tuberculosis, malaria, and venereal disease. They will also determine the state of health, nutrition, and cleanliness of each CI. During these examinations, each CI will be weighed, and the weight will be recorded on DA Form 2664-R. (3) Each CI will be immunized or reimmunized as prescribed by theater policy.

monthly screening & if sick call / refills.
or then weight-in (medic ?'s)
Tracked in NDRS

724th - med records & derogatory comments
c/o bad med care to 320th

8. Does every internment facility have an infirmary? If not, why not? How do detainees request medical care? What are the major reasons detainees require medical care? Have any detainees been denied medical treatment or has medical attention been delayed? If so, why? *(1.1, 1.2, 1.8, 2.1, 4.1)* AR 190-8, paragraph 3-4, i (2):Every camp will have an infirmary. EPW/RP with a contagious disease, mental condition, or other illness, as determine by the medical officer, will be isolated from other patients. . . . EPW/RP will not be denied medical care. Para 6-6 a (1): Dental, surgical, and medical treatment will be furnished free to the CI. d (1): Medical and dental care, including dentures, spectacles, and other required artificial appliances, will be provided the CI in accordance with AR 40-3. (5) Sick call for the CI desiring medical attention will be held each day. Emergency treatment will be provided at all times. FM 3-19.40, paragraph 6-19: Ensure that medical treatment is available for all internees.

Delays c/c security for convoy.

9. How do detainees obtain personal hygiene products? *(1.1, 1.2, 1.8, 4.1)* AR 190-8, paragraph 3-4 h: EPW/RP will be provided sundry/health and comfort packs, which may be supplemented with items tailored to their cultural needs, as a temporary substitute for establishing canteen operations. When directed by the Theater Area Provost Marshal or senior Military Police officer in the internment facilities' chain of command, canteens will be installed in all camps, where EPW/RP may procure foodstuffs, soap, tobacco and ordinary articles in daily use.

Issued-

10. What are the procedures for the transfer of custody of detainees to/from the infirmary for medical treatment? How is security maintained when a detainee is transferred to a medical facility? **(Database, form, etc)** *(1.1, 1.2, 1.7, 4.1)* AR 190-8, paragraph 3-3 (22): Establish and maintain complete and accurate accountability information regarding the location, physical and legal status, training, and employment of all individuals in the custody of, or assigned to, the EPW facility. Information will be posted to the individual's personnel, medical, and financial records, and will be provided to the supporting PWIC and next higher headquarters, as required. Para 2-1 a (1) (f): Accountability will be maintained for all evacuated prisoners regardless of the evacuation channel used. Units designated to receive the prisoners at the collection points or camps will prepare a receipt DD Form 629 (Receipt for Prisoner or Detained Person) with a list of each prisoner's name attached and provide a copy of the receipt to the escort. FM 3-19.40, paragraph 3-32: If medical personnel request MP to guard captives at a medical facility in the corps area and the corps commander chooses to delegate that responsibility to the MP, the PM allocates support on a case-by-case basis. The MP structure is not designed to provide MP to guard hospitalized captives on a continuous, uninterrupted basis.

11. What are the procedures for repatriation of sick and wounded detainees? Who is eligible for repatriation based on a medical condition? How do you interact with the Mixed Medical Commission (EPW/RP only)? *(1.1, 1.2, 4.1)* AR 190-8, paragraph 3-12 a: Sick and wounded prisoners will be processed and their eligibility determined for repatriation or accommodation in a neutral country during hostilities. Both will be according to the procedures set forth below. (1) Sick and wounded prisoners will not be repatriated against their will during hostilities. (2) Procedures for a Mixed Medical Commission will be established by HQDA, according to this regulation and Annex II of the GPW. The purpose of the Commission will be to determine cases eligible for repatriation. h: The EPW and RP noted below will be examined by the Mixed Medical Commission. (1) EPW and RP designated by a camp or hospital surgeon or a retained physician or surgeon who is exercising the functions of the surgeon in a camp. (2) EPW and RP whose applications are submitted by a prisoner representative. (3) EPW and RP recommended for examination by the power on which the EPW and RP depend or by an organization duly recognized by that power and that gives assistance to them. (4) EPW, RP who submit written requests. These EPW will not be examined until the EPW listed in (1), (2), and (3) above have been examined. i: An EPW or RP found ineligible by the Mixed Medical Commission may apply for reexamination 3 months after the last examination. l: The following EPW and RP are eligible for direct repatriation: (1) EPW and RP suffering from disabilities as a result of injury, loss of limb, paralysis, or other disabilities, when these disabilities are at least the loss of a hand or foot, or the equivalent. (2) Sick or wounded EPW and RP whose conditions have become chronic to the extent that prognosis appears to preclude recovery in spite of treatment within 1 year from inception of disease or date of injury.

Surg. Doc memo to BDE surg & SI to ICRC
"Compassionate release"

12. Who maintains medical records of detainees? How are these maintained and accessed? What is kept in the medical record? Who collects, analyzes, reports, and responds to detainee DNBI data? *(1.1, 1.2, 1.7, 4.1)* AR 190-8, paragraph 3-3 a (22): Information will be posted to the individual's personal, medical, and financial records, and will be provided to the supporting PWIC and next higher headquarters, as required. Paragraph 3-4 i (2): The detaining authorities shall, upon request, issue, to every EPW/RP who has undergone treatment, an official certificate indicating the nature of the illness or injury, and the duration and kind of treatment received. A duplicate of this certificate will be forwarded to the ICRC. The detaining authority will also ensure medical personnel properly complete the SF 88 (Report of Medical Examination), SF 600 (Chronological Record of Medical Care and DA Form 3444 (Treatment Record). Paragraph 6-6 f (1): General. The medical records and forms used for the hospitalization and treatment of U.S. Army personnel and for EPWs will be used for CI. The letters "CI" will be stamped at the top of the form. Medical and dental records will accompany the CI when they are transferred. (3) Certificate of medical treatment. Each CI who has undergone medical treatment will be given on request an official certificate indicating the nature of his or her illness or injury, and the duration and kind of treatment given. A duplicate of this certificate will be forwarded to the Branch PWIC. (4) Seriously ill report. When a CI is seriously ill because of injury or disease, the camp or hospital commander will notify the Branch PWIC without delay and provide a brief diagnosis of the case. Follow-up reports, including notification of removal from the seriously ill list, will be submitted each week thereafter during the period the CI remains critical.

Weekly DNBI report to BDE Surgeon

13. What are the standards for detainee working conditions? Who monitors and enforces them? Who administers the safety program? What is included in the safety program? How does a detainee apply for work-related disability compensation? *(1.1, 1.2, 1.7, 4.1)* AR 190-8, paragraph 3-17: A safety program for EPW and RP will be set up and administered in each EPW camp. Army regulations, circulars, and pamphlets in the 385-series may be used as guides for establishing an EPW and RP safety program. Accident injury forms used in the EPW and RP safety programs will be prepared, administered, and maintained separately from those prepared for other persons included under the Army Safety Program. Paragraph 4-5 a: Unhealthy or dangerous work. EPW and RP may not be employed in any job considered injurious to health or dangerous because of the inherent nature of the work, the conditions under which it is performed, or the person's physical unfitness or lack of technical skill. Paragraph 4-6: Preliminary job training will be given when necessary and; protective clothing and accessories will be provided as required (e.g., hard-toed shoes, goggles, and gloves). Such safety devices will be equal to safeguards provided for civilian labor. Commanders will make periodic inspections to ensure satisfactory conditions and safeguards are maintained at all times. Paragraph 4-8 a: The length of the workday for EPW, including the time for travel will not exceed that permitted for civilians in the locale who are employed in the same general type of work. b. Except as provided in subparagraph c below, the EPW will not be required to work more than 10 hours (in one day) exclusive of a one hour lunch and rest period. They will not be kept out of camp for more than 12 consecutive hours, including travel time. Rest cycles consistent with the wet bulb, black globe temperature will be monitored and followed. c. EPW may be required to work any number of hours for the efficient operation of the EPW compound messes. EPW are responsible for preparing food within these messes. Paragraph 4–9 a: Each EPW will be allowed a rest period of 24 consecutive hours every week. b. Each EPW who has worked for one full year will be given a rest of eight consecutive days during which the U.S. will give working pay to the EPW. Paragraph 4–20 a: An EPW may be injured or suffer a disability while working under circumstances that may be attributed to work. If so, DA Form 2675-R (Certificate of Work Incurred Injury or Disability) will be completed in four copies. The original will be given to the EPW; the second copy will be forwarded to the PWIC to be sent to the National Prisoner of War Information Center; and the third and fourth will be placed in the EPW's personnel file.

Detainees as interpreters (5) – 3 on release list, working on #4. 1/2 c MI (already in place from Berlin unit).

No real labor - all KBR

14. How are retained medical personnel identified? What special conditions apply to them? How are they employed in the care of detainees? How are they certified as proficient? Who supervises them? *(1.1, 1.2, 1.7, 4.1)* AR 190-8, paragraph 1-5 f: Medical Personnel. Retained medical personnel shall receive as a minimum the benefits and protection given to EPW and shall also be granted all facilities necessary to provide for the medical care of EPW. They shall continue to exercise their medical functions for the benefit of EPW, preferably those belonging to the armed forces upon which they depend, within the scope of the military laws and regulations of the United States Armed Forces. They shall be provided with necessary transport and allowed to periodically visit EPW situated in working detachments or in hospitals outside the EPW camp. Although subject to the internal discipline of the camp in which they are retained such personnel may not be compelled to carry out any work other than that concerned with their medical duties. The senior medical officer shall be responsible to the camp military authorities for everything connected with the activities of retained medical personnel. Paragraph 3-4 i (4): EPW who, though not attached to the medical service of the Armed Forces, are physicians, surgeons, dentists, nurses, or medical orderlies may be required to exercise their medical functions in the interests of prisoners of war dependent on the same power after being certified per Paragraph 3-15. They will continue to be classified as EPW, but will receive the same treatment as corresponding RP (medical personnel). They will be exempted from any other work. Paragraph 3-15 b. Enemy personnel who fall within any of the following categories, are eligible to be certified as RP: (1) Medical personnel who are members of the medical service of their armed forces. (2) Medical personnel

who are exclusively engaged in: (a) The search for or the collection, transport, or treatment of the wounded or sick. (b) The prevention of disease. (c) Staffs exclusively engaged in administering medical units and establishments. c. RP whose status is certified will not be considered as EPW; however, they will receive the benefits and protection of an EPW. . . . e. Certification of the retained status of personnel will be effected upon the decision that the special identity card held by each such person is valid and authentic. This certification will be decided, if possible, at the time of processing by the camp commander. f. The Theater Commander, or CINCUSACOM will confirm the certification of the technical proficiency of the persons described in paragraph 3-15d. Qualified U.S. Military medical and religious personnel must first confirm the medical or religious proficiency of each EPW. . . . i. Verifications of retained status and religious or medical proficiency will be recorded on the DA Form 4237-R of the person concerned. Denials of claims to retained status or certification of proficiency will also be recorded together with a brief statement of the reason. k. RP, who are members of the enemy's Armed Forces, will be assigned to EPW camps. If available, they will be assigned in the ratio of two physicians, two nurses, one chaplain, and seven enlisted medical personnel per 1,000 EPW. Economy of medical staffing may be achieved at higher levels per guidance from Commanding General, HSC. As much as possible, these RP will be assigned to camps containing EPW from the same Armed Forces upon which the RP depend. m. Subject to security requirements the theater commander will ensure: (1) Full use of enemy medical personnel for the treatment of sick and wounded EPW/RP. (2) Release of U.S. medical personnel, when possible, from caring for sick and wounded EPW except for supervision and training of enemy medical personnel. n. The senior medical officer in each camp will provide close and continuing supervision of the professional activities of the retained medical persons and report all improper activities. p. EPW camp surgeons or hospital commanders in which retained persons are used will verify: (1) Accuracy of the final diagnosis. (2) Adequacy of treatment. (3) Final disposition of patients treated by RP.

One MD, taken from I Hosp. Spoke English. Supervised closely by doc & medics

15. What measures are taken to protect US personnel from contracting diseases carried by detainees? Who monitors/enforces these procedures? *(1.1, 1.2, 1.5, 1.7, 4.1)* FM 3-19.40, paragraph 3-48, Prevent captives from incurring disease and nonbattle injuries (DNBI) (heat and cold injuries or communicable diseases) while in captivity. Isolate captives who exhibit obvious signs of disease (diarrhea, vomiting, or fever) until medical personnel make and evaluation. If a large number of captives appear ill, notify medical and command channels for immediate action/treatment. AR 40-5, paragraph 4-1b d. Preventive measures include personal protective measures (for example, personal hygiene, immunizations, prophylactic medications, and repellents) and environmental control measures (for example, disinfection of water supplies, proper food handling practices, area vector control, and other aspects of field sanitation). Effective implementation of preventive measures require command emphasis and command, unit, and individual soldier education on ways to prevent illnesses. AR 40-5, paragraph 4-1a a. Epidemic potentials include those diseases and injuries that can seriously compromise the ability of a military unit to carry out its mission. Preventive measures are essential. Exercise of command authority based on sound medical recommendations, troop discipline, and provision of PVNTMED services in both garrison and field settings is critical. AR 40-5, paragraph 4-2b b. PVNTMED services and teams will be familiar with disease prevention and control measures and will provide advice and guidance to commanders, units, and individuals on the prevention of communicable diseases. PVNTMED services and teams will also provide guidance to units on disease and environmental threats, specific preventive measures, and medical surveillance during and following deployments.

Education.
Searches/sweeps in tents by MPs & protection.
Φ masks & in medical (only a few N-95's)

16. What kind of stress counseling do you provide to Soldiers/Guards of detainees? *(1.1, 1.2, 2.1, 4.1)* FM 3-19.40, paragraph 2-48: Personnel assigned or attached to I/R facilities are trained on the care and control of housed personnel. They are fully cognizant of the provisions of the Geneva and UN Conventions and applicable regulations as they apply to the treatment of housed personnel. A formal training program should include stress management techniques. FM 8-51, Appendix D, D-2 f (3): Combat stress control units should provide routine mental health consultation to EPW confinement facilities. This should include: stress control advice to the command regarding the stressors of US Army MP personnel and any allied or coalition personnel working at the confinement facility; individual evaluation and intervention for guards or prisoners when indicated. AR 190-8, Paragraph 1-5, (4) The inhumane treatment of EPW, CI, RP is prohibited and is not justified by the stress of combat or with deep provocation. Inhumane treatment is a serious and punishable violation under international law and the Uniform Code of Military Justice (UCMJ).

Ø. Thru sick call (ASMB)

17. What are the procedures if a detainee in U.S. custody dies? *(1.1, 1.2, 4.1)* AR 190-8, paragraph 3-3a (20): Report allegations of criminal acts or war crimes committed by or against EPW/RP to the supporting element of the U.S. Army Criminal Investigation Command (USACIDC). Deaths resulting from other than natural causes will be investigated by USACIDC. Para 3-10 c: When an EPW or RP in US custody dies, the attending medical officer furnish the camp (or hospital) commander or other officer charged with their custody before death, the following information: (1) Full name of deceased. (2) ISN of deceased. (3) Date, place, and cause of death. (4) Statement that death was, or was not, the result of the deceased's own misconduct. (5) When the cause of death is undetermined, the attending medical officer will make a statement to that effect. When the cause of death is finally determined, a supplemental report will be made as soon as possible. e. The attending medical officer and the appropriate camp commander will complete a DA Form 2669-R (Certificate of Death). DA Form 2669-R will be reproduced locally on 8 1/2 by 11-inch paper. The form is located at the back of this regulation. This form is for the use of Army only. Enough copies of form will be made out to provide distribution as follows: (1) Original—information center. (2) Copy—information center (branch), if necessary. (3) Copy—The Surgeon General. (4) Copy—EPW or RP personal file. (5) The proper civil authorities responsible for recording deaths in the particular state if the EPW dies in the United States.

Call S4
Doc filled out Death cert. on NDRS

18. What do you perceive to be doctrinal medical shortcomings pertaining to detainee operations? How would you fix/incorporate into updated doctrine/accomplish differently? Does the current force structure of the Medical/MS/SP Corps support the successful accomplishment of detainee operations? What are the shortcomings, and how do we fix the problem at the Army level? *(1.1, 1.3, 1.5, 1.7, 2.1, 2.2, 3.1, 4.1)* AR 190-8g Combatant Commanders, Task Force Commanders and Joint Task Force Commanders . . . must ensure the proper force structure is included in any joint operational plans. Commanders at all levels will ensure that all EPW, CI, RP, and ODs are accounted for and humanely treated, and that collection, evacuation, internment, transfers, release, and repatriation operations are conducted per this regulation. Combatant Commanders, Task Force Commanders and Joint Task Force Commanders will- (6) Identify requirements and allocations for Army Medical units in support of EWP, CI, and RP Programs, and

ensure that the medical annex of OPLANs, OPORDs and contingency plans includes procedures for treatment of EPW, CI, RP, and ODs. Medical support will specifically include: (a) First aid and all sanitary aspects of food service including provisions for potable water, pest management, and entomological support. (b) Preventive medicine. (c) Professional medical services and medical supply. (d) Reviewing, recommending, and coordinating the use and assignment of medically trained EPW, CI, RP and OD personnel and medical material. (e) Establishing policy for medical repatriation of EPW, CI and RP and monitoring the actions of the Mixed Medical Commission.

20-30 medics PLT [redacted] Cleaners from ASMB & CO's) → 12 max.

Medical staff too small. Not enough vehicles (inside or outside camps) & no medical vehicles
Air compressor - nebs for asthmatics
Own set of radios

19. If you noticed any markings and/or injuries on a detainee that might lead you to believe the detainee was being abused, what would you do with the information? Do your subordinates know the reporting procedures if they observe or become aware of a detainee being abused? *(1.1, 1.2, 1.6, 4.1)* **(Serious Incident Report/Commander's Inquiry, etc)** AR 190-40 paragraph 2-1, Military and civilian personnel assigned to or accompanying a DoD Component know that they shall report reportable incidents through their chain of command and that such reports also may also be made through other channels, such as the military police, a judge advocate, or an Inspector General.) AR 190-8, paragraph 3-3a (20): Report allegations of criminal acts or war crimes committed by or against EPW/RP to the supporting element of the U.S. Army Criminal Investigation Command (USACIDC). Deaths resulting from other than natural causes will be investigated by USACIDC. Paragraph 2-1 a (1) (d): The use of physical or mental torture or any coercion to compel prisoners to provide information is prohibited. Paragraph 5-1 a (1): No form of physical torture or moral coercion will be exercised against the CI. AR 190-40, Paragraphs 2-1a and 2-1b. a. Incidents listed in appendix B and appendix C are reportable to HQDA as Category 1 and 2 serious incidents respectively. b. Submission of an SIR will not be delayed due to incomplete information. All pertinent information known at the time of SIR submission will be included. Additional required information will be provided in a subsequent add-on report. AR 190-40, Appendix B, Category 1 Reportable Serious Incidents, B–1. Actual or alleged incidents involving the following: b. War crimes, including mistreatment of enemy prisoners of war, violations of the Geneva Conventions, and atrocities. B–2. Any other incident the commander determines to be of immediate concern to HQDA based on the nature, gravity, potential for adverse publicity, or potential consequences of the incident.

NCOIC or AOC → S3 → XO → CDR

Full exam req'd
Sworn statements & medical record into NDRS

20. Overall, how do you feel detainees are being treated at the infirmary, collection points and/or detention facilities? What systemic weaknesses have you identified? **No standard. Personal observations.** *(1.1, 1.2, 2.1, 4.1)*

Non-lethal GSW - inside Wire - riots

(b)(2)-3

[redacted]

(Reported to S3 verbally)

21. What AARs or lessons learned have you written or received regarding detainee operations? Can I get a copy? (preferably on disk) *(2.2)* AR 350-1, paragraph 4-3 c: The after action review is a structured review process that allows military training participants to discover how and why certain events actually happened and how to improve future task performance. The reviews focus on military training objectives, on performance according to Army standards, and on discovering lesson learned for sustaining and improving collectives and individual task performance proficiency.

22. What do you perceive as the mission of your unit? Describe the importance of your role in that mission. **(Insight to the Soldier's understanding and attitude concerning unit mission and their role)** AR 600-20 Command Policy 2-1. Chain of Command *a.* The chain of command assists commanders at all levels to achieve their primary function of accomplishing the unit's assigned mission while caring for personnel and property in their charge. A simple and direct chain of command facilitates the transmittal of orders from the highest to the lowest levels in a minimum of time and with the least chance of misinterpretation. *b.* Commanders delegate sufficient authority to soldiers in the chain of command to accomplish their assigned duties, and commanders may hold these soldiers responsible for their actions.

IX of prisoners

23. Describe your working environment and living conditions since being in Theater. **(Identify physical and psychological impact on Soldier's attitude).** (1.2, 1.3, 1.4, 1.5, 1.6, 1.7) FM 10-1, Ch. 7, para. 3, "Tactical Vision. A primary QMC focus at the tactical level will continue to be on sustainment of the soldier. Each company-sized unit will have two cooks and a small, state-of-the-art field kitchen. This provides a limited capability to prepare or heat meals and supplements. An improved containerized capability for providing responsive laundry and shower support well forward on the battlefield must be developed. Frontline soldiers require brief respites from the rigors associated with combat. A facility complex (Force Provider) will be available in which they can shower, clean their clothes, eat hot meals, and rest in an environmentally controlled shelter.

Bad in beginning
CDR, E8/9 & refrig / cool H_2O / A/C & not for soldiers
Benefits for upper leadership. GI's eating local food &
no seat belts, heat casualties. (Failure to initiate HAS Loss)

24. Describe the unit command climate and Soldier morale. Has it changed or evolved since you have been in Theater? **(Identifies Soldier's perception of the chain of command and Soldier attitude. Does the Soldier feel supported? Do Soldiers feel the Command cares? Are they getting clear guidance?)** 1 AR 600–20 • 13 May 2002 1–5. Command, b. Elements of command. c. The commander is responsible for establishing leadership climate of the unit and developing disciplined and cohesive units. This sets the parameters within which command will be exercised and, therefore, sets the tone for social and duty relationships within the command. (1) Commanders and other leaders

committed to the professional Army ethic promote a positive environment. If leaders show loyalty to their soldiers, the Army, and the Nation, they earn the loyalty of their soldiers. If leaders consider their soldiers' needs and care for their well-being, and if they demonstrate genuine concern, these leaders build a positive command climate. (2) Duty is obedient and disciplined performance. Soldiers with a sense of duty accomplish tasks given them, seize opportunities for self-improvement, and accept responsibility from their superiors. Soldiers, leader and led alike, work together to accomplish the mission rather than feed their self-interest. .

Living arrangements - [redacted] for uppers, for lowers in one room, some in hallway.

(b)(2)-3

25. Are you aware of any incidences of detainee or other abuse in your unit? AR 190-8, 1-5. General protection policy *a.* U.S. policy, relative to the treatment of EPW, CI and RP in the custody of the U.S. Armed Forces, is as follows: (1) All persons captured, detained, interned, or otherwise held in U.S. Armed Forces custody during the course of conflict will be given humanitarian care and treatment from the moment they fall into the hands of U.S. forces until final release or repatriation. (2) All persons taken into custody by U.S. forces will be provided with the protections of the GPW until some other legal status is determined by competent authority. (3) The punishment of EPW, CI and RP known to have, or suspected of having, committed serious offenses will be administered IAW due process of law and under legally constituted authority per the GPW, GC, the Uniform Code of Military Justice and the Manual for Courts Martial. (4) The inhumane treatment of EPW, CI, RP is prohibited and is not justified by the stress of combat or with deep provocation. Inhumane treatment is a serious and punishable violation under international law and the Uniform Code of Military Justice (UCMJ). *b.* All prisoners will receive humane treatment without regard to race, nationality, religion, political opinion, sex, or other criteria. The following acts are prohibited: murder, torture, corporal punishment, mutilation, the taking of hostages, sensory deprivation, collective punishments, execution without trial by proper authority, and all cruel and degrading treatment. c. All persons will be respected as human beings. They will be protected against all acts of violence to include rape, forced prostitution, assault and theft, insults, public curiosity, bodily injury, and reprisals of any kind. They will not be subjected to medical or scientific experiments. This list is not exclusive. EPW/RP are to be protected from all threats or acts of violence. d. Photographing, filming, and video taping of individual EPW, CI and RP for other than internal Internment Facility administration or intelligence/counterintelligence purposes is strictly prohibited. No group, wide area or aerial photographs of EPW, CI and RP or facilities will be taken unless approved by the senior Military Police officer in the Internment Facility commander's chain of command. e. A neutral state or an international humanitarian organization, such as the ICRC, may be designated by the U.S. Government as a Protecting Power (PP) to monitor whether protected persons are receiving humane treatment as required by the Geneva Conventions. The text of the Geneva Convention, its annexes, and any special agreements, will be posted in each camp in the language of the EPW, CI and RP.

No.

ADVISEMENT OF RIGHTS (For military personnel)

The text of Article 31 provides as follows a. No person subject to this chapter may compel any person to incriminate himself or to answer any questions the answer to which may tend to incriminate him. b. No person subject to this chapter may interrogate or request any statement from an accused or a person suspected of an offense without first informing him of the nature of the accusation and advising him that he does not have to make any statement regarding the offense of which he is accused or suspected, and that any statement made by him may be used as evidence against him in a trial by court-martial. c. No

person subject to this chapter may compel any person to make a statement or produce evidence before any military tribunal if the statement or evidence is not material to the issue and may tend to degrade him. d. No statement obtained from any person in violation of this article, or through the use of coercion, unlawful influence, or unlawful inducement, may be received in evidence against him in a trial by court-martial. (1.2, 1.6)

I am _____(grade, if any, and name), a member of the (DAIG). I am part of a team inspecting detainee operations, this is not a criminal investigation. I am reading you your rights because of a statement you made causes me to suspect that you may have committed _____. (specify offense, i.e. aggravated assault, assault, murder). Under Article 31, you have the right to remain silent, that is, say nothing at all. Any statement you make, oral or written, may be used as evidence against you in a trial by courts-martial or in other judicial or administrative proceedings. You have the right to consult a lawyer and to have a lawyer present during this interview. You have the right to military legal counsel free of charge. In addition to military counsel, you are entitled to civilian counsel of your own choosing, at your own expense. You may request a lawyer at any time during this interview. If you decide to answer questions, you may stop the questioning at any time. Do you understand your rights? Do you want a lawyer? (If the answer is yes, cease all questions at this point). Are you willing to answer questions?

26. Describe what you understand happened leading up to and during the incident(s) of abuse. (No applicable standard)_____

27. Describe Soldier morale, feelings and emotional state prior to and after these incidents? **(Identifies unit and Soldier morale, atmosphere, mood, attitude, stress, retaliation, preemption, family crisis)** _____

28. Was this incident reported to the chain of command? How, when & what was done? What would you have done? **(Identifies compliance, procedure, timeliness, Soldier perception of action taken and effect on unit morale.)** (1.2, 1.6) (AR 190-40, Appendix B, Category 1 Reportable Serious Incidents, B–1. Actual or alleged incidents involving the following: *b.* War crimes, including mistreatment of enemy prisoners of war, violations of the Geneva Conventions, and atrocities. B–2. Any other incident the commander determines to be of immediate concern to HQDA based on the nature, gravity, potential for adverse publicity, or potential consequences of the incident. AR 190-40, Appendix C Category 2, Reportable Serious Incidents, C–1. Actual or alleged incidents involving the

following: *g.* Incidents involving prisoners or detainees of Army confinement or correctional facilities to include escape from confinement or custody, disturbances which require the use of force, wounding or serious injury to a prisoner, and all prisoner deaths. C–2. Any other incident that the commander determines to be of concern to HQDA based on the nature, gravity, potential for adverse publicity, or potential consequences of the incident. AR 190-8, 5–1. General protection policy—civilian internee, *a.* Treatment. (1) No form of physical torture or moral coercion will be exercised against the CI. This provision does not constitute a prohibition against the use of minimum force necessary to effect compliance with measures authorized or directed by these regulations. (2) In all circumstances, the CI will be treated with respect for their person, their honor, their family rights, their religious convictions and practices, and their manners and customs. At all times the CI will be humanely treated and protected against all acts of violence or threats and insults and public curiosity. In all official cases they will be entitled to a fair and regular trial as prescribed by this regulation. (3) The CI will be especially protected against all acts of violence, insults, public curiosity, bodily injury, reprisals of any kind, sexual attack such as rape, forced prostitution, or any form of indecent assault. (4) The CI will be treated with the same consideration and with-out adverse distinction based on race, religion, political opinion, sex, or age. AR 190-8, para 6-9, *e.* Any act or allegation of inhumane treatment or other violations of this regulation will be reported to HQDA (DAMO-ODL), WASH DC 20310-0400 as a Serious Incident Report. Reporting instructions in AR 190-40 will be used.)_____

29. How could the incident have been prevented? **(Identifies root cause and perceived solution)** (No applicable standard)_____

30. Describe any unit training or other programs that you are aware of that teach leaders and Soldiers how to recognize and resolve combat stress. FM 22-51, para 11-5. Prevention of Misconduct Stress Behaviors. The measures which reduce battle fatigue and prevent battle fatigue casualties should also help reduce the incidence of misconduct stress behaviors. However, additional actions also need to be practiced consistently by leadership at all echelons and by buddies at the small unit level. FM 22-51, para 1-3, Stress control requires special involvement from direct (small unit) leaders. The responsibility extends up through the organizational leaders and their staffs (both officers and noncommissioned officers [NCOs]) at all echelons. Appendix A describes combat stress risk factors and prescribes leaders' actions to control them. Leaders, staffs, and individual soldiers all receive assistance from the supporting chaplains, the medical personnel, and combat stress control/mental health personnel (see Appendix B for information pertaining to combat stress control units). If any link in the chain of responsibility is weak, it is the responsibility of the other members of the chain to strengthen it. FM 8-51, para 1-1, b. Responsibility For Stress Control. Control of stress is the commander's responsibility (see FM 22-51) at all echelons. The commander is aided in this responsibility by the noncommissioned officer (NCO) chain of support; the chaplaincy; unit medical personnel; general, principal, and special staff, and by specialized Army CSC units and mental health personnel.)_____

31. What measures are in place to boost morale or to relieve stress? **(Identifies perceived solution.)** FM 22-51, para 11-5. Prevention of Misconduct Stress Behaviors. The measures which reduce battle fatigue and prevent battle fatigue casualties should also help reduce the incidence of misconduct stress behaviors. However, additional actions also need to be practiced consistently by leadership at all echelons and by buddies at the small unit level. FM 22-51, para 1-3, Stress control requires special involvement from direct (small unit) leaders. The responsibility extends up through the organizational leaders and their staffs (both officers and noncommissioned officers [NCOs]) at all echelons. Appendix A describes combat stress risk factors and prescribes leaders' actions to control them. Leaders, staffs, and individual soldiers all receive assistance from the supporting chaplains, the medical personnel, and combat stress control/mental health personnel (see Appendix B for information pertaining to combat stress control units). If any link in the chain of responsibility is weak, it is the responsibility of the other members of the chain to strengthen it. FM 8-51, para 1-1, b. Responsibility For Stress Control. Control of stress is the commander's responsibility (see FM 22-51) at all echelons. The commander is aided in this responsibility by the noncommissioned officer (NCO) chain of support; the chaplaincy; unit medical personnel; general, principal, and special staff, and by specialized Army CSC units and mental health personnel.

32. What measures could the command enact to improve the morale and command climate of your unit? **(Identifies perceived solution.)** FM 22-103, Leadership and Command at Senior Levels, 21 Jun 1987, p. 6, - "Leadership. The process of influencing others to accomplish the mission by providing purpose, direction, and motivation." AR 600-100, Army Leadership, 17 Sep 1993, p. 8, 1987- "Senior-level leadership is the art of direct and indirect influence and the skill of creating the conditions for sustained organizational success to achieve the desired result. But, above all, it is the art of taking a vision of what must be done, communicating it in a way that the intent is clearly understood, and then being tough enough to ensure its execution."

Dental abscesses - ξ no dental whatsoever.

TB = triage outside
- under supply of PPD
- no CXR capability (CX at Brits)
- no TB meds

ϕ EKG ξ Propak

3 active cases in 90 d

all 1/3 dietetics

Hard to arrange to get dietetic meds

used non-medical isolation area.

DOT x 14 d then back to command (3-4 d meds at time)

Medevac - ground: too slow ξ too many people (security)

No lift inside vehicles - container.

No mental health (incl. Brits) Limited ϕ drugs. Brigs: repatriate