Annex A (Medical SOP), to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

1. (U) Purpose. To provide guidance regarding delivery of medical care for all detainees being held as Unlawful Enemy Combatants (ECs) in the Combined Joint Operations Area (CJOA) from their capture to release or transfer to other detainee facilities or authorities.

2. (U) References.

a. (U) CJTF-101 Detention Operations Policy Memorandum, (S//NF) May 2007.

b. (U) Army Regulation 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 October 1997.

c. (U) Army Regulation 40-66, Medical Records Administration and Health Care Documentation, 21 June 2006.

d. (U) Army Regulation 40-400, Patient Administration, 13 October 2006.

e. (U) Department of Defense Instruction Number 2310.08E, Medical Program Support for Detainee Operations, 6 June 2006.

f. (U) Department of Defense Directive Number 2310.01E, The Department of Defense Detainee Program, 5 September 2006.

g. (U) Special Text (ST) 4-02.46, Medical Support to Detainee Operations, 30 September 2005.

h. (U) World Health Organization (WHO), Tuberculosis Control In Prisons: A Manual for Programme Managers, 2000.

i. (U) U.S. Army Field Manual 2-23.3, Human Intelligence Collector Operations, (S//NF) 6 September 2006.

j. (U) Multi-National Force-Iraq Detainee Hunger Strike Standard Operating Procedure, 12 March 2007.

k. (U) CJTF-76 FRAGO 5 to OPORD 05-08, SIR Reporting, (S//NF) 140750ZAUG05

l. (U) Treatment of Tuberculosis, MMWR Recommendations and Reports; June 20, 2003/52(RR11);1-77.

3. Applicability. This Standing Operating Procedure applies to the provision of medical care for personnel detained in the Bagram Theater Internment Facility (BTIF) and in U.S. Field Detention Sites (FDS).

4. (U) Detainee Medical Guidance: Personnel will treat detainees humanely and in a manner consistent with the principles of the Geneva Conventions of 1949. Do not condone, actively or passively, the use of torture or other cruel, inhuman, or degrading treatment. Violence to life and person and outrages upon personal dignity, in particular, humiliating and degrading treatment are prohibited. Detainees will have the same access to primary and specialty care as US Forces in the CJTF101 area of operations. Soldiers and detainees will be treated based upon the principals of triage. Maintain only a professional relationship with Soldiers and detainees.

5. (U) Performed by Medic and Medical Officer

a. (U) An initial screening medical examination will be performed when a new detainee arrives to the facility by the medic on duty. Findings will be recorded on the *Medic Inprocessing Exam* Form (Appendix 1). The medic will ask that photographs be taken of significant injuries. The screening examination will not include body cavity exploration. All detainees will also undergo an initial mental health screening examination with findings recorded on the *Mental Health Initial Screening* Form (Appendix 2). A comprehensive medical examination will be performed by a medical officer (licensed health care provider) within 24 hours. Findings from this exam will be recorded on the *Detainee Health and Medical record inprocessing Examination Form* (Appendix 3). ALL detainees at the BTIF will undergo a chest x-ray examination during inprocessing.

b. (U) Tuberculosis (TB) Screening:

1) (U) All detainees will be screened for tuberculosis using the TB Screening Questionnaire on the *Medic Inprocessing Exam* Form (Appendix 1). All detainees receiving a score of 5 or greater on the questionnaire, who have received previous treatment for TB in the last 5 years, or who have a body mass index (BMI) less than 20 will be immediately put on TB precautions by placing a mask (surgical mask) over the detainees nose and mouth. National Institute for Occupational Safety and Health (NIOSH)-approved N95 masks may be used, but are not required in this instance. Detainees will then be placed in medical isolation cells with negative pressure, until cleared by a medical officer. They will always wear a mask when outside of the negative pressure room, until cleared by a medical officer. All personnel entering the cell of a detainee with suspected or proven TB will wear an N-95 mask (surgical mask NOT adequate in this instance) until detainee is determined to be no longer contagious as described below. If negative pressure cells are not available or are non-operative, detainees who pose a high risk for TB transmission (those with active cough and cavitary changes on chest x-ray) will be transferred to the Combat Support Hospital and confined to negative pressure rooms located on the Intermediate Care Ward, until TB disease is excluded.

2) (U) Detainees will remain in negative pressure medical isolation cells until it is determined that they do not have active TB lung disease based on a negative chest x-ray and/or a minimum of three sputum smears negative for

the organism *Mycobacterium tuberculosis*, commonly referred to as acid fast bacilli (AFB). Detainees who are started on tuberculosis treatment should remain in medical isolation with negative pressure according to the following guidelines:

(a) Until detainee has received standard multi-drug anti-TB (directly observed) therapy for 3 weeks (if sputum AFB smears are negative, threshold for treatment is 7 days) AND

(b) If symptomatic, has demonstrated clinical improvement in fever, cough, sputum production, night sweats or weight loss AND

(c) If sputum AFB smear positive, must have had three consecutive negative AFB-smears.

3) (U) Detainees who have a WHO score of 5 or greater (chronic cough, fever, night sweats, weight loss, hemoptysis) AND a chest x-ray suggestive of TB (infiltrates with or without cavitation in the upper lobes or the superior segments of the lower lobes) will provide a minimum of three early morning sputum specimens on consecutive days for direct microscopy and culture (Appendix 4). A detainee with minimal symptoms, but with a chest x-ray suggestive of TB, should also be considered for sputum AFB examination. The collections will be directly observed to reduce the risk of detainees providing false specimens. If the detainee is not able to produce sputum spontaneously, cough may be induced with nebulized hypertonic saline (Appendix 4).

4) (U) Detainees with symptoms or signs of TB lung disease and a chest x-ray suggestive of TB or with positive AFB sputum smears will, after appropriate counseling is provided to the detainee, be started on a standard four-drug treatment regimen of Isoniazid, Rifampin, Ethambutol and Pyrazinamide (Appendix 5). Medications given for TB treatment will be directly observed (DOT) per standard pharmacy procedures for the BTIF. Available drug regimens for culture-positive pulmonary tuberculosis are listed in Appendix 6. The appropriate doses of anti-tuberculosis drugs are listed in Appendix 7. Guidelines for monitoring detainees who are on anti-tuberculosis treatment are included in Appendix 8. Recommendations for managing adverse effects commonly seen with anti-tuberculosis drugs are discussed in Appendix 9. Detainees who are started on anti-tuberculosis treatment, but whose sputum cultures are negative, should be managed according to the treatment algorithm in Appendix 10.

5) (U) ALL detainees with active TB disease should be tested for the Human Immunodeficiency Virus -1 (HIV-1) by screening ELISA serology or rapid oral diagnostic tests for HIV-1. Positive screening tests for HIV-1 will be confirmed with the Western Blot test. The treatment of TB disease in detainees with HIV infection is essentially the same as for patients without HIV infection. There are two important exceptions: 1) once weekly INH-rifapentine should not be used in the continuation phase; and 2) twice weekly INH/RIF or rifabutin should not be used for detainees with CD4+ lymphocyte counts less than 100/mm3.

6. (U) Immunizations: Detainees in the BTIF will be immunized with Tetanus-diphtheria-acellular pertussis vaccine (Tdap) and, measles/mumps/rubella vaccine (MMR). During the fall and winter months, influenza vaccine will be offered to those who have not yet received the updated vaccine preparation. Centers for Disease Control Vaccine Information Statements (42 U.S.C. §300aa-26), annually updated for both the inactivated Influenza vaccine and the live, attenuated vaccine, will be translated into the detainees' native language (e.g. Pashtu). For illiterate detainees, a brief simple explanation of the vaccines purpose and risks will be presented, followed by an opportunity to ask questions. Detainees over the age of 60 will receive Pneumovax. Immunizations provided to detainees will be voluntary. Detainees will be informed of the known health risk (if any) of the immunizations before proceeding. In the unusual circumstance of an epidemic of a vaccine preventable disease, detainees may be immunized against their wishes upon approval by the TF Guardian Surgeon with the concurrence of the BTIF Commander or his designee.

7. (U) General Healthcare Delivery: Detainee sick call for a medical and dental problem is scheduled daily, and is conducted similarly to Soldier sick call. Soldiers and detainees will not be seen in the same location at the same time. Detainees with diabetes will have their blood glucose monitored regularly, documented and reviewed by a medical officer. Pregnancy tests will be performed on all female detainees upon arrival and as clinically indicated. Detainees with mental health problems will be referred to a mental health professional in the BTIF. Detainees on psychiatric medications will be evaluated by the psychiatrist at least quarterly. Optometry appointments will be available and eye glasses will be furnished as needed. Each sick call encounter will be documented on an SF600 or in AHLTA, the Department of Defense electronic medical record. Detainees may refuse routine examinations or parts of physical examinations. All cases of refusal should be properly documented in the detainee health record. The Medical Treatment Facility responsible for providing care to the detainee may authorize examination or treatment if it is deemed necessary to preserve the life, limb, or eyesight of the detainee or to preserve the health or safety of other detainees or any other persons.

a. (U) A log of detainees requesting a sick call visit will be maintained by Detainee Operations. Medics will evaluate detainees who request a sick call visit and will treat any complaints within their scope of clinical practice. Minor ailments, such as headache or musculoskeletal pain, can be treated with over the counter (OTC) type medications without prescription. Medical problems that are clearly beyond the medic's scope of practice will be referred to the medical officer for evaluation and treatment.

b. (U) Any complaints outside designated Sick Call hours will be screened by the medic on duty. Any life-threatening, limb-threatening or eye-sight emergencies, or other situations requiring immediate care (e.g., heart attack, stroke, seizure, serious injury, and emergency dental) will be referred to the licensed healthcare provider on duty.

c. (U) Security of Detainees while in Health Care Setting: Escorts are guards who bring a detainee from one place to another. Movement is routed through Escort Control. Each detainee has a "baseball card" that is used for tracking purposes and to verify identity.

Detainees are escorted to the BTIF Clinic under "eyes and ears" restraints. Escorts remain with the detainee at all times while outside of the cell.

d. (U) Body Cavity Searches: In-take (screening) and routine medical examinations will not include body cavity exams or hernia exams. Body cavity *examinations* may be performed for valid medical reasons with verbal consent of the detainee. Body cavity *searches* may only be performed when there is a reasonable belief that the detainee is concealing an item that could present a security risk and must be authorized by the DCG(S). Body cavity examinations or searches will be conducted by trained personnel of the same gender and with the utmost respect for the detainee's dignity and privacy.

e. (U) Experimental research will not be conducted on detainees.

8. (U) Medical Evacuation: Procedures and routine appointments at the Combat Support Hospital (CSH) will be scheduled through Detainee Operations. Emergency referrals to the CSH will be done using BTIF provider to CSH provider communication in coordination with Detainee Operations.

9. (U) Monthly Weigh-in and Evaluation: Detainees will be monitored monthly for their weight which will be recorded on DA Form 2664-R and general state of health, nutrition, cleanliness, and for communicable diseases, especially tuberculosis, venereal diseases and lice infestation (Appendix 11).

10. (U) Competent detainees may refuse any medical treatment to include immunizations, medications, blood tests, and physical examinations. Detainees will be informed that refusal may result in medical isolation when necessary to prevent spread of disease or for the safety of detainees or others. Involuntary treatments will be carried out under standards similar to those applied to US forces. In the event that involuntary treatment is necessary to prevent death or serious harm the provider must obtain approval from the BTIF Commander or his designee. Every instance of involuntary treatment will be discussed in the ethics portion of the providers' weekly staff meeting.

11. (U) Repatriation, release, or transfer to another facility: A thorough exit physical examination will be performed by a licensed health care provider and documented using the form *Detainee Health and Medical Record Outprocessing Examination* form (Appendix 12), whenever a detainee is discharged from the BTIF. A brief narrative summary of the detainee's medical and psychiatric care will be written, translated into the detainee's language, and given to the detainee (Appendix 13). The medical record will also be copied and given to the detainee after provider information is redacted (all proper names have been removed). Detainees on chronic medications will be provided with a one month's supply of their medications.

12. (U) Medical management of the mentally ill: Psychiatric isolation will be recommended for detainees who need clinical monitoring or treatment in a controlled environment. Recommendations by the provider to isolate a detainee are approved by Detainee Operations.

13. (U) Underage Detainees: Detainees who are suspected of being age 15 or less will have x-ray of wrists and teeth performed for age determination within 24 hours of in-processing. Underage detainees will be segregated from the general population.

14. (U) Detainee Pharmacy: Medications will be maintained in a secure cabinet. stockage will be replenished through medical logistics channels.

15. (U) Use of Restraints: Physical restraints will be used on detainees to the minimum extent necessary and only for security or safety reasons.

16. (U) Medical supply and resupply: Medical logisticians assigned to the BTIF are responsible for daily assessment of needed supplies by personally checking shelves and making inquiries among their customers (medical staff) on the supply status. A list of needed supplies is prepared and entered on the Supply Request form, followed by prompt submission of request to the 583rd MEDLOG. They are responsible for retrieving ordered supplies and restocking shelves at the BTIF. Receipts for incoming supplies will be filed for accounting purposes.

17. (U) Both medical and mental health care providers will be on call 24 hours a day in the BTIF. If a provider is not in the building when needed, they will be summoned by cell phone or by runner.

18. (U) Hunger Strike Management: A hunger strike is defined as having missed nine (9) consecutive meals (72 hours) or not drinking fluids for twenty-four (24) hours. All detainees who have met either one of these criteria, will have baseline laboratory testing done to include a complete blood cell count (CBC), serum electrolytes (sodium, potassium, chloride), carbon dioxide, glucose, Blood Urea Nitrogen (BUN), serum creatinine, minerals (calcium and magnesium), serum albumin or pre-albumin, urinalysis, and an Electrocardiogram (EKG). Weekly blood tests will be done as long as the hunger strike is maintained. Testing may be ordered more frequently at the discretion of the medical officer. Detainees on hunger strikes are medically isolated and are evaluated daily by the medical officer. Mental health evaluation will be conducted to ensure that there is no underlying psychiatric condition for the hunger strike. Detainees will not be allowed to commit suicide or irreparably compromise their health with a hunger strike. Detainees will be provided involuntary hydration and nutrition to preserve their health only after approval by the BTIF commander or his designee. Involuntary hydration and/or feeding will be considered if there is evidence of organ dysfunction resulting from the hunger strike. This decision may be aided by the use of established critical laboratory values for blood chemistries (Appendix 14) and hematology results (Appendix 15). Involuntary enteral (by mouth, via orogastric or nasagastric tube) feeding should be considered after fourteen days of hunger strike, or if the detainee has experienced significant weight loss (greater than 15%) from previously recorded or inprocessing weight. Detainees who require enteral nutrition to preserve life will be admitted to the CSH to initiate the feedings. Detailed instructions on enteral feedings are found in Appendix 16. Only authorized medical personnel may administer involuntary hydration and/or feeding. This requires approval from the Task Force Guardian Commander.

19. (U) Medical Photographs: Significant wounds and injuries should be photographed during inprocessing. Photographs of genitals will never be taken unless necessary to document injury to the genitals themselves or when absolutely necessary for identification. Approval will be obtained from Detainee Operations prior to taking any photographs.

20. (U) Suicide Risks and Prevention: Every effort will be taken to minimize the risk of suicide. Detainees who are determined to be a suicide risk will be placed in segregation and monitored on a regular basis. Mental Health will be consulted for treatment recommendations and follow-up. A list of all detainees with prior suicidal ideation or attempts will be provided to Detainee Operations for closer monitoring by the Guard Force to ensure safety of the detainees. Training on Suicide Prevention will be provided to the Guard Force by the mental health officer.

21. (U) Release of Detainee Health Information:

a. (U) Detained personnel will have access to the same standard of medical care as US Forces in the CJTF-101 CJOA, to include respect for their dignity and privacy. In general, the security of detainees' medical records and confidentiality of medical information will be managed the same way as for US and coalition forces. During detainee operations, the Patient Administration Division (PAD), the Criminal Investigation Division (CID), the International Committee of the Red Cross (ICRC), and medical chain of command can have access to detainee medical records besides the treating medical personnel. At no time will the military police (MP) or other detention facility personnel have access to medical records, and at no time will a detainee's medical information be used during interrogation.

b. (U) Under U.S. and International law and applicable medical practice standards, there is no absolute confidentiality of medical information for any person. Detainee medical information may be released for permissible purposes. Anyone desiring access to detainee medical records other than the detainee medical staff and the ICRC must obtain approval from the medical treatment facility Commander is consultation with Detainee Operations Judge Advocate.

c. (U) The Brigade Surgeon or his/her designee, usually the PAD, determines what information is appropriate for release. Only that specific medical information required to satisfy the terms of a legitimate request will be authorized for disclosure.

d. (U) When medical information is disclosed for purposes other than treatment, health care personnel will record the details of such disclosure on DA Form 4254, including the specific information disclosed, the person to whom it was disclosed, the purpose of the disclosure, and the name of the Detainee Operations Judge Advocate approving the disclosure in accordance with AR 40-66.

e. (U) If a medical officer suspects that the medical information to be disclosed may be misused, he should seek a senior command determination that the use of the information is consistent with applicable standards.

f. (U) The information disclosed to a health care provider (HCP) during the course of the relationship between the HCP and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the HCP in order that the HCP may most effectively provide needed services. The patient should be able to make this disclosure with the knowledge that the HCP will respect the confidential nature of the communication. The HCP should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law or regulation. The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the HCP should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities.

g. (U) Because the chain of command is ultimately responsible for the care and treatment of detainees, the internment facility chain of command requires some medical information. For example, detainees suspected of having infectious diseases such as tuberculosis (TB) should be isolated from other detainees. Guards and other personnel who come into contact with such patients should be informed about their health risks and how to mitigate those risks.

h. (U) Releasable medical information on detainees includes that which is necessary to supervise the general state of health, nutrition, and cleanliness of detainees, and to detect contagious diseases. Such information should be used to provide health care; to ensure health and safety of detainees, service members, employees, or others at the facility; to ensure law enforcement on the premises; and ensure the administration and maintenance of the safety, security, and good order of the facility.

22. (U) Detainee Records Management and Retirement.

a. (U) Detainees should be entitled to copies of their medical records upon release from detention. Copies of medical documentation provided to released detainees will have all US military unit designation, health care provider, and other medical support personnel information (for example, name or provider number) redacted. The discharge summary will not include any US military unit designation, health care provider, or other medical support personnel information.

b. (U) Detainee outpatient medical records will be given a final disposition upon release of the detainee from detention and retired to the Military Police Brigade to be integrated with the detainee release records. All retired detainee records will be maintained, safeguarded (at Prisoner Service Branch or PSB), and provided to Undersecretary of Defense (Policy) and other Department of Defense components as appropriate IAW DoD Directive 2310.01E, September 5, 2006..

23. (U) Interrogation.

a. (U) Medical personnel are prohibited from engaging in acts that are considered harmful to the enemy. Therefore, medical personnel providing direct patient care for detainees will not provide assistance to detainee interrogation teams. The medical officer on duty or the medics will evaluate detainees before and after each interrogation using the form at Appendix 17. If there are medical contraindications (e.g., a detainee has a medical condition which could deteriorate during interrogation) the detainee will not be permitted to undergo interrogation at that time. If released for interrogation, the detainee is re-evaluated following the interrogation process to identify any adverse sequelae.

b. (U) Both the Operations Office and Joint Interrogation Facility (JIF) will be informed immediately whenever a detainee is not released for interrogation because of physical or mental conditions. Medical staff will notify both the Detainee Operations and the JIF when the detainee is physically and mentally well enough to participate in the interrogation process.

c. (U) Health care professionals charged with any form of assistance with the interrogation process, to include interpretation of medical records and information will not be involved in any aspect of detainee health care. Health care providers charged with the care of detainees should not engage in any activities that would be inconsistent with the principles affording them protected status under the Geneva Conventions. Health care providers charged with the care of detainees should not be actively involved in interrogation, advise interrogators how to conduct interrogations, or interpret individual medical records/medical data for the purposes of interrogation or intelligence gathering. Health care providers who are asked to perform duties they feel are unethical should ask to be recused. Requests for recusal should first go to the health care provider's commander and chain of command. If the chain of command is unable to resolve the situation, providers should engage the technical chain by contacting the command surgeon. If these avenues are unfruitful, health care providers may contact their specialty consultants or the Inspector General (IG).

d. (U) A behavioral science consultation team (BSCT), (see Appendix 18) consisting of a psychologist, and/or other behavioral health specialist(s), may be assigned to detainee operations. The BSCT assists interrogators and the detention staff with interrogations and the management of detainees within the facility, and is not assigned a mission of patient care. The medical treatment team should not consult with the BSCT on issues of treatment. Behavioral science consultation team members will not have access to medical records or any information about a detainee's medical treatment except as needed to maintain safe, legal, and ethical interrogations. For example, it may be helpful to advise the BSCT that a detainee has diabetes, and should not be provided certain types of food during interrogation. The BSCT will not provide treatment, except in emergency, and will inform the medical treatment staff of any medical issues needing attention.

24. (U) Detainee Death Procedures: In the event of a detainee death, the following shall apply.

a. (U) The BTIF commander shall immediately report the death to the CJTF-101 Detainee Operations Commander, the CJTF-101 Detainee Operations Judge Advocate, and the Army Criminal Investigations Division (CID). The notification will be in SIR format and at a minimum include the following:

(1) (U) Full name.

(2) (U) ISN.

(3) (U) Date, place, and cause of death.

(4) (U) Statement that in his or her opinion death was, or was not, the result of the detainee's own misconduct.

(5) (U) When the cause of death is undetermined, the medical officer will make a statement to that effect.

(6) (U) When the cause of death is finally determined, a supplemental report will be made.

b. (U) COMCJTF-101 may appoint an AR 15-6 Investigation Officer to inquiry into the circumstances surrounding the detainee's death. At a minimum, the investigating officer will determine whether the death was caused by the guards, another detainee, any other person, or from unnatural or unknown causes.

c. (U) The detainee's remains will be placed in a clean body bag and secured awaiting instructions from CID or the appropriate investigating agency. The remains will not be washed and all items on or in the body will be left undisturbed except for weapons, ammunition, and other items that pose a security threat. The body will not be released from United States custody without written authorization from the Armed Forces Medical Examiner and CID

25. (U) Death Certificates: A death certificate will be completed by the attending medical officer and a copy will be provided to the CJTF-101 Surgeon's Office and the Office of the Staff Judge Advocate. A DA Form 2669-R is the only authorized form for detainee death certificates. For each detainee death, the attending medical officer and the responsible unit commander will complete the DA Form 2669-R. The BTIF commander is responsible for ensuring that a death certificate is completed.

26. (U) Autopsy: Upon notification of a detainee death, CID will contact the Office of the Armed Forces Medical Examiner (AFME) to determine if an autopsy is needed.

a. (U) AFME has primary jurisdiction and authority within DOD to determine the cause and manner of death of any detainee in the custody of the Armed Forces of the United States. It is

presumed that an autopsy shall be performed, unless an alternative determination is made by the AFME.

b. (U) Commanders who in their judgment believe that an autopsy of the detainee is unnecessary and would only serve to cause additional grief to the local community due to the community's strongly held religious and cultural beliefs may submit a written request to forgo the autopsy to CID and the Commander, Detainee Operations. This request will be forwarded to AFME for consideration.

27. (U) Disposition of remains: Commanders will be mindful of Islamic traditions concerning the care and disposition of remains and will attempt to honor religious and cultural tradition so long as it is not inconsistent with the requirements set forth in this guidance. For additional guidance concerning burial, record of internment, and cremation of detainee remains, commanders should consult AR 190-8.

28. (U) Preventive Medicine Operations and Support: Preventive medicine inspections will be performed weekly. Findings will be forwarded to the commander of the detainee facility and the CJTF-101 Chief of Force Health Protection. All deficiencies will be corrected within a 24-48 hour period whenever possible.

29. (U) Reporting Geneva Convention Violations: Medical personnel report abuse (physical, emotional or sexual) or torture to the Task Force Commander, Judge Advocate, Military Police and supporting Criminal Investigation Division through the Brigade Surgeon.

30. (U) Training: All healthcare personnel will receive training on applicable policies and procedures regarding care and treatment of detainees. Particular attention should focus on the following: 1) medical records, 2) treatment purposes, 3) medical information, 4) reporting possible violations, 5) scope of care, and 6) procedures for management of deceased detainees. Training should be done prior to deployment from CONUS. Personnel who have not received training to deployment will complete the training on site prior to providing care to detainees. Refresher training will be conducted at least every six months.

31. (U) RIP/TOA Procedures for the BTIF:

Day 1 - Arrive at Bagram Airfield, check in with BTIF personnel (person you will be replacing), acquire billeting, familiarization tour of base, to include dining and exercise facilities, post exchanges, latrines, showers, Sick Call, Combat Support Hospital, Moral Welfare and Recreation areas, Chapel, laundry drop-off)

Day 2 - Required "Day 2 Brief" at the main Chapel on Tuesday, Wednesday or Friday @ 0745 hrs. (for the Air Force this usually takes place on Thursday)

Day 3 - Begin inprocessing (BTIF badge, weapons card, ammunition, tour BTIF, meet medical staff, set up internet accounts for secure-SIPR and non-secure-NIPR communications)

Day 4 - Continue inprocessing; familiarization with duty station and clinic procedures, specialty area policies and procedures, review BTIF Medical Infirmary Continuity Binder and Training Binder (Medical Highlights)

Day 5 - Continue inprocessing; continue familiarization by shadowing counterpart

Day 6 - Complete inprocessing; continue familiarization by shadowing counterpart

Day 7 - Perform all duties and responsibilities pertinent to your position, under the supervision of your predecessor; opportunity for questions.

Day 8 - Perform all duties and responsibilities pertinent to your position, under the supervision of your predecessor; opportunity for questions.

Day 9 - Perform all duties and responsibilities pertinent to your position, under the supervision of your predecessor; opportunity for questions.

Day 10 – Assume all duties and responsibilities

32. (U) POC for this memorandum is the TF Guardian Brigade Surgeon at DSN 318-431-2614 or 318-431-3115.

Appendixes:

Appendix 1: Medic Inprocessing Form
Appendix 2: Mental Health Initial Screening
Appendix 3: Detainee Health and Medical Record Inprocessing Examintion
Appendix 4: Procedure for AFBS Sputum Specimen Collection
Appendix 5: Basic Principles for Treatment for Tuberculosis
Appendix 6: Drug Regimens for Culture-Positive Pulmonary Tuberculosis
Appendix 7: Dose of Anti-Tuberculosis Drugs for Adults
Appendix 8: Monitoring of Detainees on Anti-Tuberculosis Treatment
Appendix 9: Management of Common Adverse Effects of Anti-Tuberculosis Drugs
Appendix 10: Treatment Guidelines for Culture-Negative Pulmonary Tuberculosis and Inactive Tuberculosis
Appendix 11: Monthly Evaluation
Appendix 12: Detainee Health and Medical Record Screening Examination
Appendix 13: Detainee Health and Medical Record Summary
Appendix 14/15: Chemistry Critical Laboratory Results/Hemotology Critical Laboratory Results

Annex A (Medical SOP), to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Appendix 16: Hunger Strike
Appendix 17: Health Record
Appendix 18: Behavioral Science Consultation Team (BSCT))

Appendix 1 (Medic Inprocessing Exam) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

DATE

BTIF BAGRAM AB, AFGHANISTAN
MEDIC INPROCESSING EXAM

ISN: **DOB:** **SEX**

AGE: **HT:** **WT:** **BMI** **(BMI <20 RequiresTuberculosis [TB] precautions)**

PAST MEDICAL HISTORY:

CURRENT MEDICATIONS:

ALLERGIES: _____**MENTAL HEALTH PRESENT**

TB RISK SURVEY:

COUGH > 2 WEEKS	**YES (2) NO**		
SPUTUM PRODUCTION	**YES (2) NO**	**COUGHING UP BLOOD**	**YES / NO**
LOSS OF WEIGHT (3 MONTHS)	**YES (1) NO**	**NIGHTS SWEATS**	**YES / NO**
LOSS OF APPETITE RECENTLY	**YES (1) NO**	**FEVER >5 DAYS**	**YES / NO**
CHEST PAIN	**YES (1) NO**		

TOTAL SCORE: _____ (A score of ≥5 requires TB precautions)

PREVIOUS TB TREATMENT WITHIN PAST 5 YEARS) YES / NO (if yes, requires TB precautions)

****DETAINEES MUST HAVE PHYSICAL EXAM BY HEALTHCARE PROVIDER WITHIN 24 HOURS****

TB Precautions (Check): _ ☐ Mask to the patient ☐ Medical segregation/negative pressure

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*	RECORDS MAINTAINED AT:	
	PATIENT'S NAME *(Last, First, Middle Initial)*	SEX

Appendix 1 (Medic Inprocessing Exam) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

RELATIONSHIP TO SPONSOR:	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	

Appendix 2 (Mental Health Initial Screening) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

ISN #: _____ Date: _____ Time: _____

Do you have a history of mental illness? Yes / No (If yes, please explain):

Are you currently taking any medications? Yes / No (If yes, please explain):

Are you now, or have you ever been, suicidal or homicidal? Yes / No (If yes, please explain):

Do you have any current mental health complaints? Yes / No (If yes, please explain):

Do you have a history of drug abuse? Yes / No (If yes, please explain):

General Observations

Yes	No	Behavior	Yes	No	Behavior
		Poor hygiene			Crying/Tearful
		Angry			Unusually confused
		Assaultive/Violent			Uncooperative
		Loud/Obnoxious			Memory/Concentration
		Bizarre behavior			Significantly scared
		Unusual suspiciousness			Incoherent
		Alcohol/Drug Withdrawal			Embarrassed/Shy
		Observable signs of depression			Significant marks/Scars
		Not understanding			Observable injuries
		Sleeping difficulty (history)			Obvious pain or bleeding
		Unusual paranoia			Other:

Disposition of detainee: ☐ *Segregation* ☐ *Close Observation* Other:

_____ _____

Print Name, rank and credentials Signature

_____ _____

Reviewed by: Name, rank, and credentials Signature

Appendix 2 (Mental Health Initial Screening) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Appendix 4 (Procedure for AFBS Sputum Specimen Collection) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

1. It is preferable that a health care provider coaches and directly supervises the collection of sputum.

2. The best time to collect sputum is in the early, after lung secretions have pooled overnight and should be done on consecutive days at least 8-24 hours apart. A minimum of three (3) sputum specimens provides the greatest opportunity to make the diagnosis of tuberculosis.

3. Give the patient confidence by explaining to him the reason for sputum collection.

4. Instruct the patient to rinse his mouth with water before producing the specimen. This will help remove food and any contaminating bacteria in the mouth.

5. Instruct the patient to take two breaths, holding the breath for a few seconds after each inhalation and then exhaling slowly. Ask him to breathe in a third time and then forcefully blow the air out. Ask him to breathe in again and then cough. This should produce a specimen from deep in the lungs. Ask the detainee to hold the sputum container close to the lips and to spit into it gently after a productive cough. The color may be a dull white or a dull light green. Bloody specimens will be red or brown. Thin, clear saliva or nasopharyngeal discharge is not sputum and is of little diagnostic value for tuberculosis.

6. The amount of sputum required for staining and culture is five (5) milliliters (1 teaspoon) or greater for each container. If the sputum amount is insufficient, encourage the patient to cough again until a satisfactory specimen is obtained. This may require several minutes for some detainees.

7. For detainees unable to cough up sputum, deep coughing may be induced by inhalation of an aerosol of warm, sterile, hypertonic saline (3%-15%). Because induced sputum is very watery and resembles saliva, it should be labeled "induced" to ensure that the laboratory staff workers do not discard it. This procedure should be done in an isolated room or outside if possible, because of the potentially large amount of infectious material that may be produced. The health care provider should wear an N-95 mask at all times while this process is taking place.

8. Specimen containers should be tightly closed and properly labeled with detainee's ISN #, and transported to the laboratory as soon as possible.

Appendix 5 (Basic Principles of Treatment for Tuberculosis) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

1. Detainees in whom tuberculosis is proven (positive AFB smears) or strongly suspected (cavitary changes on CXR), should have treatment initiated with Isoniazid (INH), Rifampin (RIF), Pyrazinamide (PZA) and Ethambutol (EMB) for the initial 2 months.

2. Repeat smear after 2 months of treatment:

a. If cavities were seen on initial CXR or sputum remains AFB smear positive, continue treatment with INH and RIF daily or twice weekly for 4 months to complete a total of 6 months of treatment.

b. If cavities were seen on initial CXR and the culture at 2 months is positive, treatment with INH and RIF should be continued for 7 months (total of 9 months of treatment).

c. If no cavities were seen on initial CXR and AFB smears are negative after 2 months of treatment, continue treatment with daily or twice weekly INH and RIF for 4 months (total of 6 months of treatment)

3. If there is drug resistance reported, add AT LEAST two new drugs to which the AFB isolate is susceptible. NEVER add a single drug to a failing regimen.

Appendix 6 (Drug Regimens for Culture-Positive Pulmonary Tuberculosis Caused by Drug Susceptible Organisms) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Initial phase			Continuation phase		
Regimen	**Drugs**	**Interval**	**Regimen**	**Drugs**	**Interval**
1	INH RIF PZA EMB	Seven days per week for 56 doses (8 weeks) or 5 days per week for 40 doses (8 week)	**1a**	INH/RIF	Seven days per week for 126 doses (18 weeks) or 5 days per week for 90 doses (18 weeks)
			1b	INH/RIF	Twice weekly for 36 doses (18 wks)
2	INH RIF PZA EMB	Seven days per week for 14 doses (2 wk), then twice weekly for 12 doses (6 wk) or 5 days per week for 10 doses (2 wk), then twice weekly for 12 doses (6 wk)	**2a**	INH/RIF	Twice weekly for 36 doses (18 wk)
3	INH RIF PZA EMB	Three times weekly for 24 doses (8 wk)	**3a**	INH/RIF	Three times weekly for 54 doses (18 wk)

Appendix 7 (Doses of Anti-Tuberculosis Drugs for Adults) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Drug	Formulation available	Daily dose	Twice weekly dose
Isoniazid	Tablets (300 mg)	5 mg/kg (300 mg)	15 mg/kg (900 mg)
Rifampin	Capsule (300 mg)	10 mg/kg (600 mg)	10 mg/kg (600 mg)
Pyrazinamide	Tablet (500 mg)	* See below	* See below
Ethambutol	Tablet (400 mg)	** See below	** See below
Amikacin	Aqueous solution (500 mg and 1 gram vials)		
Ciprofloxacin	Tablet (500 mg)	750 mg	N/A
Levofloxacin	Tablet (500 mg)	750 mg	N/A

N/A = Not Applicable

***Suggested Pyrazinamide doses, using whole tablets, for adults weighing 40-90 kg**

	Weight (kg)		
Frequency	**40-55**	**56-75**	**76-90**
Daily	1,000 mg	1,500 mg	2,000 mg
Three (3) times weekly	1,500 mg	2,500	3,000 mg
Twice weekly	2,000 mg	3,000	4,000 mg

****Suggested Ethambutol doses, using whole tablets, for adults weighing 40-90 kg**

	Weight (kg)		
Frequency	**40-55**	**56-75**	**76-90**
Daily	800 mg	1,200 mg	1,600 mg
Three (3) times weekly	1,200 mg	2,000 mg	2,400 mg
Twice weekly	2,000 mg	2,800 mg	4,000 mg

Appendix 8 (Monitoring of Detainees on Anti-Tuberculosis Treatment) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Baseline Monitoring:

1. Serologic testing for hepatitis B and C (at high risk for infection).

2. Measurements of aminotransferases (i.e., AST, ALT), bilirubin, alkaline phosphatase, serum creatinine and platelet count.

3. Testing of visual acuity with the Snellen chart and color vision (Ishihara) should be performed when Ethambutol is to be used.

4. Measurement of serum uric acid if Pyrazinamide is to be used.

5. HIV serology.

Monitoring During Treatment:

1. Monthly clinical evaluations to identify possible adverse reactions to medications and to access adherence.

2. Routine monitoring of liver, renal function or platelet count NOT necessary unless there were baseline abnormalities or clinical indications based on symptoms.

3. Monthly repeat testing of visual acuity and color vision is recommended for detainees receiving an Ethambutol dose exceeding 15-20 mg/kg (the recommended range) and for patients receiving the drug for more than 2 months.

4. Detainees should be educated regarding changes in vision and instructed to report it promptly.

Appendix 9 (Management of Common Adverse Effects of Anti-Tuberculous Drugs) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Gastrointestinal upset: nausea, vomiting, poor appetite, abdominal pain

1. Check hepatic transaminases (serum AST, ALT) and bilirubin.

   a. If results <three times the upper limit of normal, symptoms assumed not due to hepatic toxicity.

   b. If results ≥three times the upper limit of normal→hepatic toxicity.

2. Change the hour of drug administration to coincide with meals or at bedtime.

Rash

1. All TB drugs can cause a rash.

2. If minor (limited area with only itching), treat symptomatically with antihistamines and continue all medications.

3. A petechial rash suggests thrombocytopenia associated with Rifampin.

   a. Check platelet count, if low →Rifampin hypersensitivity.

   b. Monitor platelet count; do not restart Rifampin.

   c. If there is a generalized rash, especially if associated with fever and/or mucous membrane involvement, ALL drugs should be stopped IMMEDIATELY.

      1) If detainee has severe tuberculosis, start three new drugs (aminoglycoside and two oral agents).

      2) If drugs are temporarily withheld, when the rash has resolved, restart Rifampin first (least likely to cause rash and is the most important agent), then proceed with the other agents.

Drug fever

1. Suggested by the recurrence of fever after several weeks on therapy, while the individual looks and feels well, especially with microbiological and radiological improvement.

2. There is no specific pattern and eosinophilia may or may not be present.

3. First rule out worsening TB disease and any other potential causes for fever.

4. If no cause identified, all drugs should be stopped. Drug-related fever usually resolves within 24 hours.

5. Detainee should be given at least three new drugs in the interim.

6. Once the fever has resolved, follow same protocol for restarting drugs as recommended for drug rash.

Hepatitis

1. Most commonly seen with INH, RIF and PZA.

2. If the AST is <5 times the upper limit of normal, toxicity considered mild.

   a. With no symptoms, continue drugs.

   b. Increase frequency of clinical and laboratory monitoring.

3. If the AST is ≥5 times upper limit of normal:

   a. With or without symptoms, STOP all hepatotoxic drugs immediately.

   b. Evaluate patient for other causes of hepatitis to include viral hepatitis A, B and C, biliary tract disease, other hepatotoxic drugs.

4. Give at least three nonhepatoxic anti-tuberculosis drugs until the specific cause of the hepatotoxicity can be determined.

5. Restart drugs after the AST has declined to <2 times upper limit of normal.

   a. Restart RIF first (less likely to cause hepatitis and is most effective agent).

   b. If AST has not increased after 1 week, then restart INH.

   c. If AST has not increased after 1 week of restarting INH, restart PZA.

   d. If AST increases after 1 week, assume PZA is the cause and discontinue it.

Appendix 10 (Treatment Guidelines for Culture-Negative Pulmonary Tuberculosis and Inactive Tuberculosis) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

1. If the clinical suspicion is high, multi-drug therapy should be initiated before acid-fast smear and culture results are known.

2. If initial cultures remain negative and treatment has consisted of multiple drugs for 2 months, there are two options:

a. If the detainee demonstrates symptomatic or radiographic improvement, without another apparent diagnosis, then a diagnosis of culture-negative tuberculosis can be inferred. Treatment should be continued with INH and RIF alone for an additional 2 months.

b. If the detainee demonstrates neither symptomatic nor radiographic improvement, then tuberculosis is unlikely and treatment is complete once treatment including at least two months of RIF and PZA has been administered.

3. In low-suspicion detainees not initially started on treatment, who remain asymptomatic with stable CXR and whose AFB sputum cultures remain negative, there are three treatment options:

a. INH for 9 months

b. RIF with or without INH for 4 months

c. RIF and PZA for 2 months

Appendix 11 (Monthly Evaluation) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
DATE	

BTIF BAGRAM AB, AFGHANISTAN
MEDIC MONTHLY EVALUATION

1. General State of health (Please encircle)	**EXCELLENT**	**GOOD**	**FAIR**	**P**
2. Cleanliness (Please encircle)	**EXCELLENT**	**GOOD**	**FAIR**	**P**
3. Evidence of possible communicable disease?		**YES**		**NO**
4. Evidence of lice infestation?		**YES**		**NO**
5. Evidence of unexplained physical injuries?		**YES**		**NO**

If yes, ask the detainee about the cause (i.e. burns, fractures, severe sprains, bruises)

Performed by:

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR:	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION

Appendix 11 (Monthly Evaluation) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Appendix 12 (Detainee Health and Medical Record Outprocessing Examination) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

DETAINEE HEALTH AND MEDICAL RECORD OUTPROCESSING EXAMINATION

DATE:

T____ P____ R____ BP____ Ht____ Wt____ BMI____

ISN #:	DOB:	SEX: ☐ Male ☐ Female		

ALLERGIES:

MEDICAL HISTORY: (Check all that apply)

		COMMENTS			COMMENTS
Asthma			STD or HIV/AIDS		
Cancer			Tuberculosis (TB)		
Diabetes			Alcohol or IV Drug use		
Epilepsy/Seizures			Tobacco products		
Hemophilia/Bleeding			Other:		
Heart Disease			Injuries if Any:		
Hypertension					
Surgeries					
Kidney Disease					
Mental problems					
Hepatitis (liver)			**MEDICATIONS:**		
Malaria					

CLINICAL EVALUATION: (Check each item in appropriate column; NE = Not Evaluated)

	NL	ABN	NE	State of nutrition: GOOD ☐ FAIR ☐ POOR ☐
GENERAL SURVEY				**COMMENTS**
1. Head				
2. Eyes				
3. Ears				
4. Nose				
5. Mouth/Dental/Throat				
6. Neck				
7. Heart				
8. Lungs				
9. Abdomen				
10. Upper Extremities				
11. Lower Extremities				
12. Feet				
13. Neurological				
14. Skin				
16. Anus/Genital				☐ **Declined**
17. Other				

CASE NO. _____ NAME _____

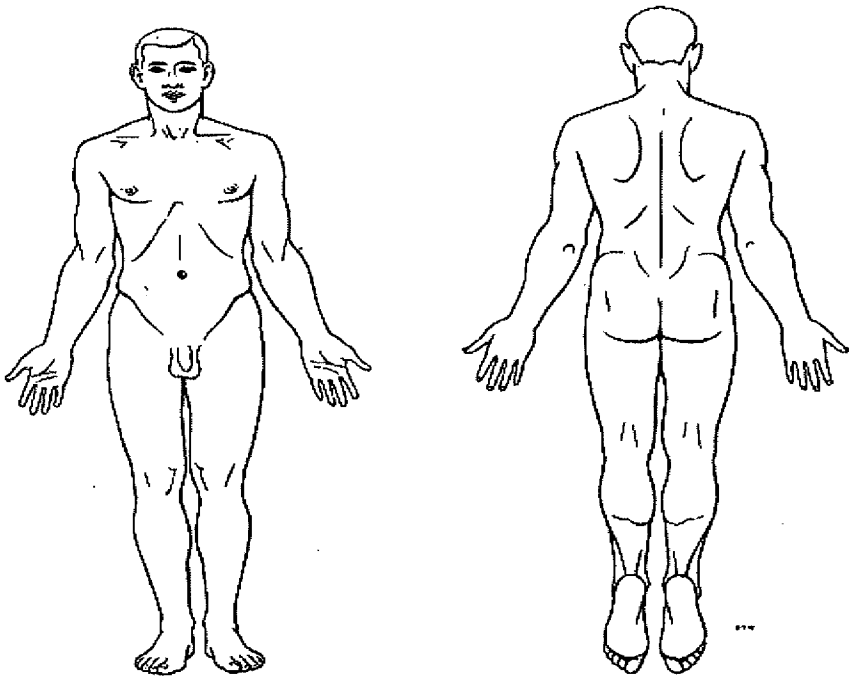

DIAGRAM A

Figure 21 (17)

Visual acuity screening Using "E" Chart _____

(Refer to Optometry if worse Than 20/40)

1. Is the detainee presently experiencing any problem with his eyes/vision?
   YES_____ NO_____
2. Does the detainee wear/need glasses?
   YES_____ NO_____
   If so, for what purpose? Are the glasses Present?
3. Does the detainee have any history of ocular disease, trauma, or surgery?
   YES_____ NO_____
4. Does the detainee require medications for eye related problems?
   YES_____ NO_____
   What are the names of the medications? Are they present?

Please indicate all findings: (Scars, tattoos, rashes, lacerations, bruises, injuries, etc.

Rev Sept 07 **BTIF Form 0001**

ASSESSMENT:	
1.	4.
2.	5.
PLAN:	
DISCHARGE MEDICATIONS:	
☐ Dental ☐ Ortho ☐ Mental Health ☐Surgery ☐ Int. Medicine ☐ Optometry/Ophthalmology	
Activity limitations: ☐ NO ☐ YES (Please explain:)	
Requires immediate referral to hospital If YES, please explain:	☐ YES ☐ NO
Medically cleared for Repatriation/Transfer to another facility If NO, please explain:	☐ YES ☐ NO
Required to ride on stretcher for medical or security reasons If YES, please explain:	☐ YES ☐ NO
Medically cleared to fly long distances If NO, please explain:	☐ YES ☐ NO
General Statement of Health for DRS: ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
PROVIDER'S PRINTED NAME AND SIGNATURE	**DATE**

Bagram Centcom 102

~~SECRET//NOFORN~~

Appendix 13 (Detainee Health and Medical Record Summary) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

DATE:

NAME:

ISN #: *US9AF-00xxxxDP*

CURRENT HEIGHT/WEIGHT:

PAST MEDICAL HISTORY:

CURRENT (ONGOING) MEDICAL PROBLEMS:

CURRENT MEDICATIONS:

MEDICATION ALLERGIES:

LAST MONTHLY MEDICAL EVALUATION: *Date; Excellent/Good/Fair/Poor Health*

د نظارت لاندې کس دروغتیا او درمل لنډیز

نښته :

نوم :

ISN

اوسنۍ قد او وزن

پخوانۍ د علاج او درملو تاریخچه

اوسنۍ دروغتیا ستونزې

اوسنۍ دوا او درمل

د درملو سره حساسیت

آخرځل چې په روغتون کښې ولیدل شو.

Appendix 14 (Chemistry Critical Laboratory Results) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Lab test	LESS THAN (<)	GREATER THAN (>)
Sodium (Na^+)	125	150 mmol/L
Potassium (K^+)	3.0	5.5 mmol/L
Chloride (Cl^-)	85	120 mmol/L
Carbon dioxide (CO^2)	16	35 mmol/L
Blood Urea Nitrogen (BUN)	N/A	60 mg/dL
Creatinine	N/A	1.5 mg/dL
Calcium (Ca^{++})	7.0	13 mg/dL
Magnesium (Mg^{++})	1.4	3.0 mg/dL

Appendix 15 (Hematology Critical Laboratory Results) to Annex A(Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedures (SOP)

Lab test	Adults	Pediatrics
White Blood Cell Count (WBC)	<3,000 or >25,000/mm3	<5,000 or >30,000/mm3
Hemoglobin (Hgb)	<7.0 or >19.0 grams	<7.0 or >15.0 grams
Hematocrit (Hct)	<24.0 or >58.0%	<21.0 or >45.0%
Platelets (Plt)	<50,000 or >750,000/mm3	<75,000 or >1,000,000

Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

1. Purpose: This appendix outlines the procedures for responding to any detainee or group of detainees who report or indicate their intention to begin a hunger strike at detainee holding and internment facilities in Iraq.

2. REFERENCES:

a. DoDI 2310.08, Medical Program Support to Detainee Operations, 6 June 2006.

b. DOD Policy Letter, Standard Operating Procedures for Involuntary Feeding of Detainees on Hunger Strike at Guantanamo Bay, 16 October 2006.

3. GENERAL: The Chief of Detention Operations ensures the health and well-being of all detainees in theater internment facilities is monitored and appropriate medical care/intervention is provided.

4. APPLICABILITY: The procedures of this policy apply to all units assigned, attached or OPCON/TACON to Task Force Guardian.

5. RESPONSIBILITIES:

a. Detainee Medical Task Force: Provide health care monitoring and medical assistance as clinically indicated for detainees on a hunger strike and provide updates to the TF Guardian Commander as the clinical situation changes. Provide medical treatment. Monitor, preserve, and protect the health and welfare of hunger striking detainees. Counsel detainees on the risks of the hunger strike and attempt to persuade the detainee to resume eating. Intervene to provide non-voluntary life-sustaining measures with the approval of the TF Guardian Commander. Terminate hunger strike procedures, when directed.

b. Detainee Mental Health Team: Evaluate the mental health status of detainee(s) on a hunger strike. Build profiles of the detainee's behavior and consult with medical and custodial staff. Conduct behavioral interventions to persuade the detainee to resume eating.

c. BTIF Commander: Ensure the welfare, security, and custodial control of detainee(s). Monitor and record all activities (food/water intake, statements, and behavior) of detainee(s) in a hunger strike. Provide a daily SITREP through the chain of command to the TF Guardian Commander.

6. DEFINITIONS:

a. Hunger Striker. A hunger striker is a detainee who communicates either directly or indirectly (e.g. repeated meal refusals) the intent to refuse to take nourishment. This may be done as a form of protest or to demand attention. A detainee will be officially classified as a hunger striker when he refuses to eat for 72 hours or after missing nine consecutive meals.

b. Meal. A meal is the combined or individual consumption of fluids and/or solid food required to maintain daily metabolic requirements. These requirements vary by individual. For the purpose of this document, any consumption of calories at or around 500Kcal is considered a regular meal.

7. PROCEDURES: Once it is determined that a hunger strike is in-progress / imminent, the following steps will be taken.

a. The Commander of the internment facility will immediately report the hunger strike through the chain of command to the TF Guardian Commander.

b. Notify medical and mental health staff. Medical and mental health staff will perform an initial evaluation.

(1) Examine the general physical condition of the detainee (Tab C). Measure and record vital signs, height and weight on the hunger strike matrix (Tab A).

(2) Perform urinalysis.

(3) Take a blood sample (complete chemistries, complete blood count) from the detainee; obtain an EKG, and record results on the hunger strike matrix (Tab A).

(4) If clinically indicated, perform radiographic and/or other laboratory studies.

(5) Conduct an initial mental health evaluation to determine if the detainee suffers from a mental disorder which renders him/her incapable of making a rational, reasonable decision concerning the hunger strike. If the mental health professional determines the detainee to be incompetent to make a rational decision about the hunger strike and/or be suffering from a mental disorder, the detainee will be referred to psychiatry for appropriate medical treatment of the disorder.

(6) During the mental health evaluation, attempt to determine the cause for the hunger strike. Inform the BTIF Commander of the findings.

(7) A medical provider will counsel the detainee who is on a hunger strike as to the medical hazards of a prolonged period without food and/or water. Tab B of this policy, *Refusal to Accept Food or Water/Fluids as Medical Treatment*, will be verbally translated at the initial assessment. The medical staff shall make a reasonable effort to persuade the detainee to resume eating and drinking. Medical risks faced by the detainee, if they do not eat and/or drink, will be explained. Tab B will be signed by the medical provider, witness and translator and placed in the detainee's outpatient medical record.

(8) Detainees refusing to participate in the initial and periodic medical examinations or treatments for a mental disorder may be forced to participate by order of the TF Guardian Commander.

c. Medical staff will conduct periodic evaluations of the detainee.

(1) Daily evaluations will include measuring and annotating the detainee's vital signs and weight on the hunger strike matrix (Tab A).

(2) Every three days, draw a blood sample (basic chemistries) from the detainee and annotate the results on the hunger strike matrix (Tab A).

(3) Every six days, draw a blood sample (complete chemistries) from the detainee and annotate the results on the hunger strike matrix (Tab A). Take a photograph of the detainee's stripped upper torso (front and side view). Include name, ISN, height, weight, date and time on the bottom of the photograph.

(4)Every month, draw a blood sample (Iron Panel) from the detainee, take a urine sample and conduct an electrocardiogram (12 lead ECG).

(5) These evaluations will be annotated in the detainee's medical records and reported through the chain of command to the TF Guardian Commander.

d. The mental health team will conduct regular examinations of the detainee and conduct appropriate interventions to induce the detainee to end the hunger strike. These interventions may include but are not limited to, offering to share tempting foods with detainee, including the detainee in small groups during meal times to create peer pressure to eat, and resolving the causes of the strike.

e. The commander of the BTIF will ensure the detainee is administratively segregated in a single occupancy cell. The cell should be equipped with the capability to turn-off the water ("Dry-Cell"). It should not be accessible by other detainees and should have good visibility for the guards and medical staff. The guards should search the cell and remove all food. Movement to other quarters, such as a medical facility, may be initiated at any time if medically indicated.

f. The guards will monitor the detainee's food and water intake and report this to the medical staff.

(1) The detainee will be given three meals per day, regardless of the detainee's refusal to eat. All meals will be pre-approved by the medical staff. Intake amounts will be carefully recorded after each meal and the remainder taken away.

(2) The detainee will be provided an adequate supply of drinking water and other beverages authorized by medical staff. Record the amount of fluids consumed.

g. The hunger strike procedures will be terminated when the all of the following occur:

(1) The detainee eats a meal or a portion of a meal (excluding liquids).

(2) After examining the detainee, a medical officer or physician's assistant recommends that the hunger strike procedures be terminated.

(3) The TF Guardian Commander terminates the hunger strike procedures.

h. The medical and mental health staff will continue follow-up as long as deemed necessary.

8. MEDICAL INTERVENTION:

a. Prior to medical intervention being initiated against the detainee's will, both the facility medical staff and the mental health team will make reasonable efforts to convince the detainee to voluntarily accept treatment. They must inform the detainee of the medical risks involved in a hunger strike and fully and completely document their efforts.

b. When the treating physician determines that the detainee's situation is deteriorating and an injury may result, or a life threatening situation exists, the medical staff will immediately notify the TF Guardian Commander. When medically indicated, the treating physician will consider and may recommend forced medical treatment of the detainee. The approval authority for forced medical treatment is the TF Guardian Commander.

c. Involuntary medical treatment should be considered if any of the following clinical criteria are met:

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

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

(3) There is a prolonged period of hunger strike (more than 21 days);

(4) The detainee is at a weight less than 85% of the calculated Ideal Body Weight (IBW);

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

d. Prior to medical treatment being administered, medical staff will make reasonable efforts to convince the detainee to voluntarily resume eating or accept treatment. Medical risks faced by the detainee if treatment is not accepted will be explained to the detainee. Involuntary medical treatment may include, but is not limited to, intravenous fluids, blood draws, weights, and/or administration of nutritional formulas or electrolyte solutions via an enteral feeding tube. When, after reasonable efforts, or in an emergency preventing such efforts, a medical necessity for treatment of a life or serious health-threatening situation exists, the Medical Officer may recommend that treatment be administered without the consent of the detainee. No direct action will be taken to involuntarily feed a detainee without the approval of the TF Guardian Commander, unless a medical emergency exists. Medical staff will fully and completely document all of their counseling efforts and treatments in the detainee's medical record. If involuntary enteral feeding is clinically indicated and authorized, Tab D, *Approval Authority for Initiation of Involuntary Enteral Feeding*, should be completed by the attending Medical Officer and placed in the detainee's inpatient medical record.

e. If a Medical Officer determines that the medical condition of a detainee on hunger strike dictates medical intervention to preserve life and health, the detainee will be admitted to the DH for resuscitation and, if needed, for involuntary enteral feeding. Clinical protocols for enteral feeding using a graduated continuous enteral feed infusion are found in Tab E, *Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike.* If a DH Medical Officer deems it medically safe (low risk of re-feeding syndrome) based on the duration of the detainee's fast or hunger strike, enteral feeding may be initiated with graduated intermittent feeds as opposed to a continuous infusion. Clinical protocols for enteral feeding using an intermittent infusion are found in Tab F, *Chair Restraint System Clinical Protocol for the Intermittent Enteral Feeding of Detainees on Hunger Strike. Medical Equations, Calculations And Definitions* (Tab G) may be used to calculate caloric goals/needs. *Management of Common Electrolyte Deficiencies* (Tab H) outlines means of correcting common electrolyte deficiencies seen in individuals on a hunger strike or prolonged fast.

f. If forced medical treatment is initiated, it will be continued until the detainee's life or permanent health is no longer threatened. Forced medical treatment normally consists of the following:

(1) Nasogastric tube (Dobhoff) for feeding.

(2) If a nasogastric tube is not medically appropriate or successful, then intravenous fluids and hyperalimenation intravenously may be necessary

(3) As a last resort, gastrostomy and tube feeding through the stomach may be required.

g. The following guidance will be used to remove a detainee from the hunger strike list:

(1) A detainee who has been declared a hunger striker, but has not required involuntary enteral feeding, will be removed from the hunger strike list when he has consumed a meal and a DH Medical Officer has declared his meal intake sufficiently adequate to be removed from the hunger strike list.

(2) A detainee who has been declared a hunger striker and who has been receiving enteral feeding will be removed from the hunger strike list when he has consumed a meal and a DH Medical Officer has declared his meal intake sufficiently adequate to be removed from the hunger strike list. He will continue to be closely monitored for a period of time as per Tab I. Detainees will be weighed monthly as per standard detention center protocols.

(3) *Medical Management of Enterally Fed Detainees Who Terminate Their Hunger Strike* (Tab I) outlines a proposed pathway to assist and monitor detainees in their transition from enteral feeding to a regular diet.

9. Each case will be evaluated on its own merits and individual circumstances. None of the above indicated procedures are meant to limit or override sound medical judgment by the physician responsible for the detainee's medical care.

ISN											
Hunger Strike Day					**4**	**5**	**6**	**7**	**8**	**9**	**10**
Meals Missed											
Weight (kg)											
Weight (lbs)											
% Body Weight Lost											
Blood Pressure											
Heart Rate											
Electrolytes					Sodium			Sodium			Sodium
					Potassium			Potassium			Potassium
					Chloride			Chloride			Chloride
					HCO3			HCO3			HCO3
					BUN			BUN			BUN
					Creatinine			Creatinine			Creatinine
					Glucose			Glucose			Glucose
					Calcium						Calcium
CBC					WBC			WBC			WBC
					Hemoglobin			Hemoglobin			Hemoglobin
					Hematocrit			Hematocrit			Hematocrit
					Platelets			Platelets			Platelets
Hepatic Enzymes					AST						AST
					ALT						ALT
					Alk Phos						Alk Phos
					Total protein						Total protein
					Albumin						Albumin
					T bili						T bili
Photos											
Behavioral Health											
12 Lead EKG											
Iron											

Tab B (Refusal to Accept Food or Water/Fluids as Medical Treatment) to Appendix 16 (Hunger Strike) to Annex B (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Detainee Number_____Age_____ Date_____

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

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

He understands the alternatives available to him including oral food and fluid, oral rehydration solutions, oral nutritional supplements, and intravenous fluid hydration.

He fully understands the risks to his health, if he does not accept food and water as directed above.

Translator/ Witness
Signature_____

Medical Provider Signature_____

Tab C (Hunger Striker Medical Evaluation Sheet) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Detainee Number:_____ Date of Evaluation:_____

Date of Onset:_____ Drinking Fluids: Yes No

Number of Meals Missed:_____

HPI:

MEDS:_____

ALLERGIES: NKDA or _____

PMH:

Reason for Hunger Strike?_____

Physical Assessment:

In processing Wt: _____lbs Pre Hunger Strike Wt: _____lbs/date:_____

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

Heart Rate: _____BP: ____/_____RR: _____T: _____
LOC: Yes No

Other Pertinent Physical Exam and Laboratory Findings:

Assessment: Hunger Striker

Plan:

1. Explained risks of inadequate intake of food and/or water to detainee. See *Refusal to Accept Food or Water/Fluids As Medical Treatment*, Tab B.
2. Continue follow-up as per Detainee Huger Strike Standard Operating Procedures (SOP).
3. Other:

Medical Provider: _____

Tab D (Chronological Record of Medical Care) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
Date Time	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION
	Detainee ISIN___has been on a hunger strike and is refusing to consume life sustaining nutrition and hydration. He meets the following clinical criteria for involuntary enternal feeding.
	_____There is evidence of deleterious health effects reflective of end organ involvement or damage to in clude but not limited to seizures, syncope or pre-syncope, significant metabolic derangements, arrhythmias, muscle wasting, or weakness such that activities of daily living are hampered.
	_____There is a pre-existing co-morbidity that might readily predispose to end organ damage (e.g. hypertension, coronary artery disease or any significant heart condition, renal insufficiency or failure, endocrinopathy,ect.).
	_____ There is a prolonged period of hunger strike (more than 21 days).
	_____The detainee is at a weight that is less than 85% of the calculated Ideal Body Weight (IBW)
	_____The detainee has experienced significant weight loss (greater than 15%) from previously recorded or in-processing weight.
	Involuntary feeding is required to prevent risk of death or serious harm to health. Written approval to initiate involuntary enteral feeding has been obtained from the Joint Task Force Commander as required per Standard Operating Procedure 001.
	Medical Officer

STANDARD FORM 600 (rev. 9/05)

DETAINEE'S IDENTIFICATION NUMBER:

Bagram Gentcom 115

Tab E (Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Once a detainee on hunger strike meets the criteria for enteral feeding, the following protocol will be followed:

Phase I: Admit to the Detention Hospital for Intravenous Fluid Resuscitation
Hospital Day #1:

Vital signs should be checked at admission and every four hours for the first eight hours, at which time the frequency can be decreased to every eight hours (if clinically stable).

If not drawn in the past two days, a complete blood count (CBC), basic metabolic panel, calcium (Ca^{++}), magnesium (Mg^{++}), phosphorous (phos), and creatine kinase (CK) should be obtained. A blood glucose reading (finger stick) should be documented in the Medication Administration Record (MAR).

A 12 lead EKG will be performed upon admit.

The detainee's admission weight should be recorded, with weights being recorded daily, thereafter.

Fluid resuscitation should begin with a 1-2-liter bolus of normal saline. The amount of the IV bolus will be decided after reviewing the detainee's medical history for any co-morbid diseases (This may be deferred if fluids were previously received in the SHU).

This should be followed by a standard formulation, which consists of one liter of D_5 ½ normal saline with 20 meq KCL, one vial of (water soluble) MVI, 500 mg of magnesium sulfate, one vial of trace elements, and 1 mg of folic acid. This IV formulation should be run @ 100 ml/hr for 10 hours.

Once the formulation has infused, maintenance fluids in the form of D_5 ½ normal saline with 20 meq KCL @ 100 ml/hr should be started and continued until at least 48 hours after admission (Hospital Day #3)

PRN medications during Phase I:

1) Thiamine 100 mg IV one time (Give prior to giving any Dextrose or D_5. This may have already been administered in the Clinic).

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

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

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

Tab E (Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Phase II: Initiation of Enteral Nutrition

Hospital Days #2 and #3.

Place a 10 French or 12 French feeding tube into the patient's *stomach* per standard medical practice. Viscous lidocaine should be offered for the nostril and the throat. The tube should be well lubricated prior to insertion. A linguist shall be present to assist with instructions. Once the feeding tube has been inserted, the placement needs to be confirmed. This confirmation can be achieved either by a standard chest x-ray or by air insufflations followed by a 10cc test dose of water.

The patient's head of the bed should be elevated at least 30-45 degrees while recumbent.

A blood glucose level (via finger stick) should be documented every 12 hours X 3.

A basic metabolic panel, calcium, magnesium, phosphorus, ALT, total bilirubin, amylase, and albumin should be ordered for the morning of Hospital Day #3.

Vital signs can be changed to daily (if patient is clinically stable).

Enteral Nutrition:

1. Place 360 ml of **Glucerna Select** in enteral nutrition (EN) bag. Mix three Tablespoons of 10 % oral potassium chloride solution (2340 mg of potassium), one teaspoon (8 packets) of table salt (2300 mg of sodium) and liquid MVI, and infuse via feeding tube at 30 ml/hr, for 12 hours.

2. After 12 hrs:
If tolerating EN, mix 360 ml of **Glucerna Select** with 240 ml water. Mix three Tablespoons of 10% oral potassium chloride solution and one teaspoon of table salt, and infuse via feeding tube at a rate of 50 ml/hr (*720 kcal/day + 480 kcal from IV fluids = 1200 kcal/day*).

3. After 24 hrs (start of Hospital Day #3):
If tolerating EN, mix 600ml of **Glucerna Select** with 400 ml water. Mix three Tablespoons of 10% of oral Potassium Chloride solution, one teaspoon of table salt and liquid MVI, and infuse at 60 ml/hr (*1296) kcal/day*). ***Kcals per day does not reflect any kcals from IV if IV is not d/c.*** Discontinue IV fluids and IV if fluid resuscitation is complete.

PRN medications during Phase II:

1) Tylenol 650 mg PO/enteral feeding tube Q 6 hrs PRN pain, headache.

2) Mylanta 15-30 ml PO/enteral feeding tube Q 4 hr PRN indigestion, heartburn.

3) Benadryl 25-50 mg PO/enteral feeding tube Q 6 hrs PRN rhinorhea, post-nasal drip, sneezing, itchy rash, watery eyes.

4) Saline Nasal Spray 2-3 puffs each nostril Q 4-6 hr PRN post-nasal drip or congestion.

5) Phenergan 12.5 – 25 mg PO/enteral feeding tube/PR/IM/IV Q 4-6 hrs PRN nausea.

6) Motrin (Ibuprofen) 600 mg PO/enteral feeding tube TID PRN pain (ONLY if nutrition is being tolerated at 20 cc/hr or more; avoid in any patient with concern for renal insufficiency).

7) Reglan 10 mg PO/enteral feeding tube Q 3 hr X 3 doses if nauseated or bloating after tube insertion.

Phase III: Achieving and Maintaining Goal Enteral Nutrition

Hospital Day #4-6:

1. After 48 hrs of EN: Discontinue **Glucerna Select**. Mix 750 ml of **Ensure Plus** with 250 ml water. Mix three Tablespoons of 10% of oral Potassium Chloride solution and one teaspoon of table salt and infuse via feeding tub at 60 ml/hr (*1620 kcal/day*).

2. After 72 hrs of EN: Increase above nutritional mixture to 80 ml/hr (*2160 kcal/day*).

3. After 96 hrs of EN: Increase above nutritional mixture to 100 ml/hr (*2700 kcal/day*) and discontinue table salt.

Phase IV: Intermittent Enteral Nutrition

If patient is clinically stable, nutritional supplementation can be given via intermittent feedings rather than continuous infusion.

This is usually accomplished using a BID or TID schedule, with approximately ½ or 1/3 of the daily calories being delivered at each feeding, respectively.

To enhance gastric motility, the following medication administration may be useful when using intermittent feeds.

1) Metoclopramide (Reglan) 10 mg via enteral feeding tube (place in feeding bag before nutritional supplement).

2) 30 ml magnesium citrate mixed in 500 ml water via enteral feeding tube.

Tab E (Clinical Protocol for the Evaluation, Resuscitation, and Feeding of Detainees on Hunger Strike) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

The *Minimum* recommended requirements to transition a patient to intermittent feeding are as follows:

1) 1500 total kcal/day.

2) Four cans of Ensure Plus or Boost Plus (or equivalent nutritional supplement). *If patient is not receiving at least 1000ml enteral formula per day, liquid Centrum (or equivalent) should be added daily until vitamin and mineral minimums can be achieved.*

3) Labs as needed to validate normal electrolyte status.

4) Stable clinical condition.

Phase V: Management of Enterally Fed Detainees Who Terminate Their Hunger Strike

When a hunger-striking detainee resumes eating, the Detention Hospital medical staff will medically manage these individuals to avoid complications associated with the resumption of oral nutrition. This medical management will consist of three phases as outlined in Tab I. The first phase will consist of slowly advancing the diet. The second phase will involve the transfer of the detainee to the Special Housing Unit for further monitoring. And the third phase will consist of the return of the detainee to the mainstream detention camp environment.

Warning: This Protocol is intended for guidance only. Changes in clinical course may necessitate variation from this protocol.

Tab F (Chair Restraint System Clinical Protocol for the Intermittent Enteral Feeding of Detainees on Hunger Strike) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Once the enteral feeding phases I through V as outlined in TAB E are completed, at the discretion of the attending Medical Officer, intermittent enteral feedings will be instituted on the feeding block. Detainees on the feeding block are evaluated daily by a medical provider. Intermittent enteral feedings are usually done two to three times a day. Medical restraints (e.g. chair restraint system) should be used for the safety of the detainee, medical staff, and guard force. The following describes the chair restraint system and feeding procedures used for intermittent enteral feeding.

1. Medical provider reviews missed meals logged from guards and medical staff to verify the detainee is still refusing regularly offered (breakfast, lunch, and dinner) meals.

2. Medical staff advises the detainee that hunger striking is detrimental to his health. He is offered a meal and given the chance to eat. If the detainee refuses to voluntarily eat a meal, the enteral feeds are initiated.

3. Medical provider signs medical restraint order to enterally feed the detainee the prescribed diet.

4. Guard force offers detainee restroom privileges (and encourages use of the restroom) before shackles are placed on detainee.

5. Guard force shackles detainee and a mask is placed over the detainee's mouth to safeguard staff from spitting and biting.

6. Detainee is escorted to the scale for daily weight.

7. Detainee is escorted to the chair restraint system and is appropriately restrained by the guard force in keeping with restraint use procedures and guidelines.

8. When the guard force advises it is safe, medical personnel initiate the medical restraint monitoring procedures; obtain vital signs, and document pulses and restraint placement. Using the restraint observation sheet, medical personnel will document circulation checks and detainee's condition every 15 minutes.

9. A feeding tube is placed in the stomach as follows:

a. Topical anesthesia (e.g. viscous lidocaine) will be applied to the appropriate nostril (unless detainee refuses) and the feeding tube OR.

b. Sterile surgical lubricant (may be substituted with viscous lidocaine, if desired by the detainee) is applied to the feeding tube.

c. The feeding tube is passed via the nasal passage into the stomach. Placement of the feeding tube in the stomach is confirmed using air insufflations with auscultation and a 10cc test dose of water.

d. The tube is secured to the nose with tape. The enteral nutrition and water that has been ordered is started and flow rate is adjusted according to detainee's condition and tolerance.

e. Typically, the feeding can be completed comfortably over 20 to 30 minutes.

f. After the feeding is completed, the medical staff removes the feeding tube.

10. Upon completion of the nutrient infusion and removal of the feeding tube, the detainee is removed from the restraint chair and placed in a "dry cell". The guard force will observe the detainee for 45-60 minutes for any indications of vomiting or attempts to induce vomiting.

11. If the detainee vomits or attempts to induce vomiting in the "dry cell" his participation in the dry cell protocol will be revoked and he will remain in the restraint chair for the entire observation time period during subsequent feedings to ensure nutrients infusion is not purged. This requirement to comply will be communicated to the detainee prior to each feeding.

12. Steps 10 and 11 are contingent upon adequate facility and staffing resources for the detainee census. The detainee will remain in the restraint chair for the feeding and observation periods if either resource is inadequate.
13. The total time the detainee is in the chair restraint system (to include the feeding process and the post-feeding observation) should not exceed 2 hours.

14. The "dry cell" may be the detainee's original housing cell with the water source turned off temporarily and only for the duration of the observation period. Documentation to include a feeding tube insertion note, restraint observation forms, and nursing notes are completed per restraint protocols.

Tab G (Medical Equations, Calculations and Definitions) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

Determination of Energy Requirements:

TOTAL CALORIES PER KILOGRAM METHOD

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

HARRIS-BENEDICT EQUATION

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

Women (kcal/day) = [655.1 + (9.56 x weight (kg)) + (1.85 x height (cm)) – (4.68 x age)] x activity factor x stress factor

Activity Description	Factor	Stress Description	Factor
Chair or bed bound	1.2xBEE	Elective surgery	1-1.1xBEE
Seated work with little movement	1.4-1.5xBEE	Multiple trauma	1.4xBEE
Seated work with little strenuous leisure activity	1.6-1.7xBEE	Severe infection	1.2-1.6xBEE
Standing work	1.8-1.9xBEE	Peritonitis	1.05-1.25xBEE
Strenuous work or highly active leisure activity	2-2.4xBEE	Multiple/long bone fractures	1.1-1.3xBEE
30-60 minutes strenuous leisure activity 4-5 times/week	2.3-2.7xBEE	Infection with trauma	1.3-1.55xBEE
		Sepsis	1.2-1.4xBEE
		Closed head injury	1.3xBEE
		Cancer	1.1-1.45xBEE
		Burns	1.5-2.1xBEE
		Fever	1.2xBEE(per1C>37C)

Determination of Protein Requirements:

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

Tab G (Medical Equations, Calculations and Definitions) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

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

Determination of Fluid Requirement:

Definitions:

a. Usual Body Weight (UBW) = The greater of the following:
   i. The weight of the detainee at in-processing physical exam.
   ii. The weight of the detainee before the hunger strike.
b. Ideal Body Weight (IBW) = [(Height in inches-60)x2.3+50]x2.2
c. % Ideal Body Weight (%IBW) = [Current Weight (pounds)/Ideal Body Weight (pounds)] x 100
d. % Weight Loss (%WL) = [Usual Body Weight (pounds)- Current Weight (pounds) / Usual Body Weight (pounds)] x 100
e. Body Mass Index (BMI) = [Current Weight (pounds) x 703 / Height2 (inches2)]

Tab H (Management of Common Electrolyte Deficiencies) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

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

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

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

Tab I (Medical Management of Enterally Fed Detainees Who Terminate Their Hunger Strike) to Appendix 16 (Hunger Strike) to Annex A (Medical SOP) to the CJTF-101 Detainee Operations Standard Operating Procedure (SOP)

When a hunger-striking detainee resumes eating, the Detention Hospital medical staff will medically manage these individuals to avoid complications associated with the resumption of oral nutrition in long-term hunger striking. This medical management will consist of three phases. The first phase will consist of slowly advancing the diet. The second phase will involve the transfer of the detainee to the Special Housing Unit for further monitoring. And the third phase will consist of the return of the detainee to the mainstream detention camp environment.

1. RETURN TO ORAL NUTRITION

a. During this phase of graduated oral intake, the medical staff will monitor the detainee for evidence of refeeding syndrome that is often characterized by decreased serum phosphorus, magnesium, and potassium levels, as well as peripheral edema.

b. When a hunger-striking detainee chooses to eat, he will first be offered a Bland diet. A Soft diet consists of soft, easily digestible, low fiber foods such as bread, fruit juice, rice, eggs, and can be supplemented with yogurt (if available) and liquid nutritional supplements such as Ensure Plus, and Enlive. The detainee should be encouraged to eat three consecutive soft meals before advancing to the next stage in the diet, which is a soft mechanical diet.

c. A mechanical soft diet consists of foods that are easy to chew or have been altered (blended, chopped or ground) to make them easier to chew and have increased calories, but still low in fiber. A mechanical soft diet typically consists of approximately 750 kilocalories per meal. All meals will be supplemented with yogurt (if available) and liquid nutritional supplements, as with the Bland diet. After consuming three mechanical soft diets, the detainee will be advanced to regular camp diet.

d. The detainees do not have menu choices for their regular diet. A regular diet consists of approximately 900 kilocalories per meal. Initially, all detainees coming off a hunger strike will be offered additional liquid nutritional supplementation.

e. After the detainee demonstrates a consistent behavior pattern of eating (approximately nine consecutive meals) the medical staff will perform a complete medical evaluation to include vital signs, weight, physical exam, and serum blood chemistries to include a basic metabolic panel, complete blood count, liver function tests, and serum magnesium, phosphorus, and calcium.

f. A representative from mental health will evaluate the detainee.

2. TRANSFER OF DETAINEE TO THE SPECIAL HOUSING UNIT

a. The detainee will be removed from the Hunger Strike list when he is transferred to the Special Housing Unit. The Special Housing Unit will serve as place for the former hunger-

striking detainee to begin to be re-assimilated back into the general population. He will be closely monitored for compliance with consumption of all of his meals.

b. The Medic assigned to the Special Housing Unit will visit the detainees daily to pass medications, assist in obtaining weights, conduct sick call, and to dispense supplemental liquid nutrition. The detainee can have up to two cans of vanilla flavored Ensure® two to three times a day. The Guard Force will facilitate the dispensing of the Ensure® using Styrofoam cups.

c. A Medical Officer will visit the detainee daily or as clinically indicated to monitor the former hunger striker.

d. The assigned Guard Force at the Special Housing Unit will take accurate daily weights on each former hunger striker and put this information in the Detainee Reporting System.

e. After a sufficient period of observation that satisfies the Medical Staff that the former hunger striker is tolerating a regular diet, the detainee will be transferred back into the main population.

f. Prior to transfer off the Special Housing Unit, a Medical Officer will perform a medical evaluation to include vital signs, weight, physical exam, and (if indicated) serum blood chemistries to include basic metabolic panel, complete blood count, liver function test, and serum magnesium, phosphorus, and calcium.

g. Prior to transfer, a member of the medical staff will counsel the detainee that a return to hunger striking would be extremely detrimental to his health.

3. RETURN OF DETAINEE TO THE MAINSTREAM DETENTION ENVIRONMENT

a. The hunger-striking detainee shall be placed into the mainstream detention environment. The detainee will now be given the same meals that all other detainees in the detention facility are given.

b. The guard-force members assigned to that post should be aware of the detainees previous medical condition and be observant of meal consumption. If guard-force member notices a hunger-strike may re-occur, that guar-force member should notify the Guard Force Commander and the medical section should be immediately notified.

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

(b)(1)1.4g applies.

2. (U) References.

a. (U) The Geneva Conventions of 1949.

b. (U) DoD Directive (DoDD) 2310.01E, Department of Defense Detainee Program, 5 September 2006.

c. (U) DoDD 2311.01E, Department of Defense Law of War Program, 9 May 2006.

d. (U) DoDD 3115.09, DoD Intelligence Interrogations, Detainee Debriefings, and Tactical Questioning, 9 October 2008.

e. (U) Health Affairs Policy 05-006, Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States, 3 June 2005.

f. (U) AR 190-8, OPNAVIST 3461.6, AFJI 31-304, MCO 3461.1, Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees, 1 October 1997.

g. (U) CJCSI 3290.01A, Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel (EPW/Detainee Policy), 15 October 2000.

h. (U) FM 3-19.40, Internment and Resettlement Operations, September 2007.

i. (U) FM 2-22-3, Human Intelligence Collector Operations, September 2006.

j. (U) FM 3-19.13, Law Enforcement Investigations, January 2005.

k. (U) Ethical Principles of Psychologists and Code of Conduct, American Psychological Association, 2002 edition.

l. (U) Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security, June 2005.

m. (U) Reaffirmation of the American Psychological Association Position Against Torture and Other Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined by the United States Code as Enemy Combatants, August 2007.

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

n. (U) DoDI 2310.08E, Medical Program Support for Detainee Operations, 6 June 2006.

o. (U) AR 190-45, Law Enforcement Reporting, 6 June 2005.

p. (U) AR 190-40, Serious Incident Report, 15 June 2005.

q. (U) CJTF-Detention Operations Policy Memo, October 2007.

r. (U) CJTF-101 Detainee Operations Standard Operating Procedures, 23 Sep 07.

s. (U) OTSG/MEDCOM Policy Memo 06-029, US Army Behavioral Science Consultation to Detainee Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning, 20 October 2006.

3. (U) Scope. This SOP applies to all personnel assigned to the BSCT.

4. (U) Mission. Provide psychological expertise and consultation in order to assist the command in conducting safe, legal, ethical, and effective detention operations, intelligence interrogations, and detainee debriefing operations for the CJTF-101.

5. (U) Objectives.

a. (U) To provide psychological expertise in monitoring, consultation and feedback regarding the whole of the detention environment in order to assist the CJTF-101 in ensuring the humane treatment of detainees, prevention of abuse, and safety of U.S. personnel.

b. (U) To provide psychological expertise to assess the individual detainee and his environment and to provide recommendations to improve the effectiveness of intelligence interrogations and detainee debriefing operations.

6. (U) Background. The BSCT provides consultation in the areas of detainee behavior and interrogation approach techniques in order to increase intelligence production. The BSCT does not conduct interrogations. The BSCT is designed to help obtain accurate and timely intelligence in a manner consistent with applicable laws.

7. (U) BSCT Personnel.

a. (U) Per U.S. policy, the BSCT functions as Special Staff to the Commander in charge of both detention and interrogation operations. Hence, at the Bagram Theater Internment Facility (BTIF), the BSCT is under Tactical Control of the CJTF-101 Chief of Detainee Operations (CDR, TF Guardian).

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

b. (U) The BSCT is comprised of two behavioral science consultants (BSCs, who are licensed clinical psychologists (USAF 42P3 or USA 73B) and two behavioral science technicians (BSTs, who are mental health service specialists, USAF 4C071 or USA 91X, performing under BSC supervision). The senior psychologist serves as the Team OIC. Technicians work under the direct supervision of the assigned psychologists and are should not be seen or perceived as independent practitioners.

c. (U) Where Air Force and Army policies conflict, the BSCT will actively pursue clarification with applicable leadership (TF Guardian, 755 AEG, Service BSCT Consultants) and implement accordingly.

8. (U) Mission Essential Tasks.

(b)(1)1.4g applies.

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

(b) (U) BSCT personnel **do not interrogate**.

(b)(1)1.4g applies.

b. (U) Monitors interrogations and other staff-detainee interactions; provides consultation on policies and strategies for ensuring the safety of detainees and BTIF personnel; provides direct feedback to command on issues involving psychological risk factors affecting detainee operations.

(b)(1)1.4g applies.

(2) (U) Provides feedback through the chain of command in verbal or written form, as appropriate, regarding potential risks to detainees and BTIF personnel.

c. (U) Environmental Setting Consultation. BSCs act as consultants to advise detention facility guards, military police, interrogators, military intelligence personnel and the command on aspects of the environment that will assist in all interrogation and detention operations. The detention environment includes physical aspects of the facilities as well as social and behavioral aspects of the detained population. BSCs can provide insight into the likely effects of this environment and how changes may affect detainees. This includes the social and behavioral aspects of the environment such as recreational and social activities, educational incentive programs, disciplinary plans and procedures and strategies for increasing positive behavior and compliance with facility rules. The goal is to ensure that the environment maximizes effective detention and interrogation/debriefing operations, while maintaining the safety of all personnel, to include detainees. BSCs can assist in ensuring that everything that a detainee sees, hears, and experiences is a part of the overall interrogation plan. The purpose of this consultation is to optimize the conditions and maximize the interventions that elicit accurate and reliable information.

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

d. BSCs are obligated to report any actual, suspected, or possible violations of applicable laws, regulations, and policies, to include allegations of abuse or inhumane treatment in accordance with DoDD 2311.01E, DoDD 3115.09, DoDD 2310.08E, AR 190-8, AR 190-45 and professional psychology ethical standards. BSCs shall report those circumstances to the chain of command. BSCs who believe that such a report has not been acted upon properly should also report the circumstances to the technical chain, including the Military Department Specialty Chain. As always, other reporting mechanisms, such as the Inspector General, criminal investigation organizations, or Judge Advocates, can also be used. BSCs shall make a written record of all reports of suspected or alleged violations in a reported incident log.

e. (U) Consults with BTIF Commander on detainee issues, personnel issues, and facility dynamics, and provides recommendations on ways to improve operations. The BSCT chief has full and direct access to the BTIF and TF Guardian commanders, if necessary, to consult on all aspects of the mission.

f. (U) Provides selected JIF, DAB, and BTIF personnel with training on behavioral, psychological, and cultural issues related to the detainee population. Periodic training sessions reiterate standards and reinforce awareness of the subject matter, as well as foster a culture conducive to behavioral correction, peer monitoring, and self-assessment. The concomitant healthy training environment can prevent "behavioral drift" that, in the long term, would be detrimental to the mission. "Behavioral drift" is the continual reestablishment of new, often unstated and unofficial standards in an unintended direction. In addition, BSCs provide training to other personnel regarding the cultural aspects of behavior that impact on interrogations.

g. BSCs also function as consultants to the Commander to ensure the guards and interrogators are regularly conducting training on SOPs. BSCs should identify and recommend to the chain of command areas of training that have either been neglected or are in need of review.

(b)(1)1.4g applies.

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

(b)(1)1.4g applies.

(b) (U) Provides input into the development of strategies for increasing positive behavior, such as implementation of incentive programs, reinforcement programs for positive behavior, and increasing access to recreational and/or social activities.

(b)(1)1.4g applies.

Appendix 18, Annex B (Behavioral Science Consultation Team (BSCT)), to the CJTF-101 Standard Operating Procedures (SOP)

(b)(1)1.4g applies.

m. (U) In the event that the BTIF detains juvenile personnel (any person below the age of 16), a BSCT member will be more actively involved in the consultation role in order to help ensure proper care for the juvenile.

9. (U) Mental Health Services. BSCT personnel shall not conduct clinical evaluations or provide mental health treatment to detainees or guard force personnel. BSCT personnel will take all reasonable steps to ensure that they are not perceived as healthcare providers.

a. (U) The health status of detainees, including mental health evaluation and treatment, is solely the responsibility of BTIF medical personnel. The BTIF Medical Clinic is responsible for advising JIF personnel (i.e., BSCT or TCA Operations) if there are any known physical, psychological, or medical conditions; limitations to functioning; or restrictions to usual activities that one is required to consider in order to ensure the safety of the detainee and staff personnel.

b. (U) In order to maintain the separation between medical care and intelligence-collection, neither BSCT personnel nor interrogation teams have access to the medical records of detainees.

c. (U) BSCT personnel may function as the Medical Liaison Officers for the intelligence unit based on procedures established in conjunction with the JIF OIC and MI Company Commander. When concerns about health status or medical condition of detainees are raised through observation by BSCT personnel, inquiries raised by interrogators or other reporting mechanisms, BSCT may convey these concerns to appropriate medical personnel for evaluation, treatment, and disposition. The kind of information shared will generally fall into two categories. The first is that of physical or medical conditions, or functional limitations, that one is required to consider in order to ensure the safety of the detainee and BTIF personnel (e.g., diabetes, heart condition, special diet, psychological instability, contagious conditions, etc.) The second kind of information shared is whether medical personnel were aware of the condition, if it had been evaluated and treated, or if an appointment is pending to address the concern.

d. (U) The BSCT will meet with appropriate personnel in the BTIF medical clinic and the Combat Stress Clinic (CSC) as needed in order to discuss and coordinate any issues related to policies and procedures.

10. (U) Other Operational Procedures.

a. (U) BSCT personnel will complete the JIF certification during in-processing.

b. (U) OPSEC. All operations of the BSCT must conform to guidance set forth in CJTF-101 and DoD policy.

(1) (U) Ensure that classified materials (files, papers, photos) are properly secured when not in use.

(2) (U) Do not discuss detainee operations or classified information over unclassified phone lines or over unclassified email.

(b)(2)High applies.

(4) (FOUO) Use a courier bag when transporting classified or sensitive documents. Do not use courier bags for transportation of unclassified or prohibited materials.

(5) (U) Do not discuss detainee operations in areas where individuals without appropriate clearance or need to know could overhear information.

(6) (U) Do not discuss operations, current events, or personal information in the presence of detainees.

(7) (U) All members of the BSCT must maintain a security clearance of Secret or higher.

c. (U) Uniforms. BSCT personnel will wear uniforms in accordance with CJTF-101 and USCENTCOM policies. The BSCT will not display recognizable patches or other designations on uniforms identifying them as healthcare providers or medical personnel while directly supporting interrogation and detention operations in order to avoid any misperception as being healthcare providers. Furthermore, sanitized uniforms shall be worn when in direct view of detainees (no name visible).

11. (U) Ethical and Legal Responsibilities. In addition to the other duties and qualifications noted in this document, it is the responsibility of all BSCT personnel to familiarize themselves with and adhere to the UCMJ, Geneva Conventions, applicable rules of engagement, local policies, as well as ethical standards and guidelines of psychological practice. All BSCT personnel will be expected to:

a. (U) Read and adhere to CJTF-101 Standard Operating Procedures for Detainee Operations, policy memoranda, and regulations.

b. (U) Immediately report any suspicions of abuse of detainees or misconduct by U.S. personnel (see 8.b.1).

c. (U) Consult with colleagues and the chain of command regarding any conflicts that may arise between professional requirements and duty performance. The BSCT may consult, at any time, with their specialty consultant designated by the Surgeon General. This includes consultation concerning the roles and responsibilities of the BSCT and procedures for reporting instances of suspected noncompliance with standards applicable to detention operations, as well as any other matters of concern.

12. (U) Battle Rhythm. Successful execution of day-to-day mission requirements requires BSCT personnel to be flexible, self-disciplined, and to have the ability to prioritize and multi-task. Assessments typically require a series of observations in different settings and hours of research. Many day-to-day activities are determined by response to requests for consultation and observation; often, rapid response is required. Every attempt is made to ensure the presence of BSCT personnel in the JIF during periods when interrogations take place.

a. (U) Committee Membership. BSCT personnel participate in the following committees, working groups, and meetings. Note: Some meetings may occur more frequently, but may not be attended every time by BSCT personnel.

(1) (FOUO) Detainee Process Action Team (DPAT) Meeting: bi-weekly.

(b)(2)High applies.

13. (U) Point of Contact. The point of contact for this SOP is the BSCT OIC at DSN: (b)(2)