CHAPTER 13
COMBAT SERVICE SUPPORT

During urban operations (UO), the terrain and the nature of the operations create unique demands on the battalion combat service support (CSS) system. Increased ammunition consumption, casualties, transportation difficulties resulting from rubble, and the decentralized nature of operations all challenge the battalion CSS operators and planners. Solutions to these problems require innovative techniques and in-depth planning. This chapter focuses primarily on battalion-level CSS, but brigade- and company-level tactics, techniques, and procedures (TTP) have been inserted where applicable. All types of Infantry forces can use the TTP in this chapter, with modifications.

Section I. GENERAL

Although UO present a different set of problems, the supply and movement operations of the support platoon change little. The guidelines and principal functions of CSS are explained in this section.

13-1. GUIDELINES

Regardless of the conditions under which UO are conducted, there are some general guidelines for CSS.

- Preconfigure resupply loads and push them forward at every opportunity.
- Provide supplies to using units in required quantities as close as possible to the location where those supplies are needed.
- Protect supplies and CSS elements from the effects of enemy fire both by seeking cover and avoiding detection.
- Disperse and decentralize CSS elements with proper emphasis on communication, command and control, security, and proximity of main supply route (MSR) for resupply.
- Plan for carrying parties and litter bearers.
- Plan for and use host country support and civil resources when practical.
- Position support units as far forward as the tactical situation permits.
- Plan for requesting and distributing special equipment such as body armor, toggle ropes with grappling hooks, ladders, and hand tools.
- Position support units near drop or landing zones (DZ/LZ) for resupply from corps to forward units to reduce surface movement.

13-2. PRINCIPAL FUNCTIONS

The principal functions of CSS in urban areas are to arm, fuel, fix, and man the combat systems.

a. **Arm.** Urban combat is characterized by extremely high ammunition expenditure rates. Not only do individual soldiers fire more small arms ammunition, they use more munitions such as smoke, stun, concussion, and fragmentation grenades; LAWs; AT4s; Claymore mines; and explosives. The ammunition consumption rate for the first day of combat in an urban area can be up to four times the normal rate. Even though it decreases

during succeeding days, consumption remains high. Commanders and S4s must plan to meet these high consumption rates. The plan must include how ammunition and explosives are to be moved forward to the companies. Bradley fighting vehicles (BFVs) or armored personnel carriers (APCs) may have to be allocated for the movement of ammunition if rubble or glass prevents wheeled-vehicle traffic. Carrying parties may be used if streets are blocked by rubble.

b. **Fuel.** The amount of bulk fuel needed by a battalion or task force during combat in urban areas is usually reduced, due to the density of the terrain. Combat vehicles normally use less fuel in urban areas, because they travel shorter distances and perform less cross-country traveling. Engineer equipment and power generation equipment may use more fuel but requirements are small. The exception to this rule is a force equipped with M1 tanks. Because of the engine design, these tanks use fuel at a fairly steady rate whether they drive long distances or not. A unit may not use much fuel daily, but when it does need fuel, a problem exists in delivering bulk fuel to vehicles. In open terrain, a vehicle that has run out of fuel can be recovered later. But in urban areas, the same vehicle may be difficult to recover and could be lost quickly. Commanders and S4s must plan and provide the means of moving bulk fuel forward to combat units. They must pay special attention to any M1 tank units they have attached. These vehicles are not easily refueled by hand.

c. **Fix.** Maintenance teams must operate well forward to support units fighting in urban areas. Some maintenance operations may be consolidated in civilian facilities and many vehicles may have to be fixed near the fighting positions. Battle damage assessment and repair (BDAR) procedures allow mechanics to be inventive and make maximum use of battlefield damage, analysis, and repair techniques to return damaged vehicles to a serviceable condition (see applicable TMs). Other considerations include:

(1) Combat in urban areas generates a high demand for tires.

(2) The dust and rough handling characteristic of combat in urban areas also places great strains on communication and night observation devices.

(3) The unit armorer and their small-arms repair kits provide only limited maintenance. S4s should plan for increased weapon maintenance demands and coordinate maintenance support from higher headquarters. Based on recommendations from the staff (S3, S4, and motor officer), the commander may choose to consolidate and cross level major items of equipment and weapons.

NOTE: During recent experimentation, a higher number of M16A2 and M4 rifles were rendered unserviceable due to rounds impacting on the weapons as a result of close combat during precision and high intensity engagements. CSS planners must be prepared to replace a higher number of unserviceable weapons during urban combat.

d. **Man.** Units conducting combat in urban areas frequently experience higher casualty rates. Casualty feeder reports must be prepared and forwarded to the battalion personnel and administration center (PAC). Battalion S1s must be prepared to request replacements based on the OPTEMPO, realizing that assaulting units will probably sustain higher casualties than supporting units.

(1) ***MEDEVAC.*** The battalion surgeon (medical platoon leader), in coordination with the S1 and company first sergeants, must plan to expedite the evacuation of the wounded out of the urban area. Forward aid station locations and evacuation routes must be planned and disseminated to the lowest level. Higher casualty rates should be expected and may require stockpiling medical supplies and augmenting medical personnel and nonmedical personnel to serve as litter bearers.

(2) ***Replacements.*** The battalion PAC should process replacements quickly and transport them to their new unit. The battalion PAC is responsible for reviewing assignment orders, welcoming soldiers to the battalion, assigning soldiers IAW commanders priorities, obtaining personal information, and collecting medical records and forwarding them to the aid station. It is also responsible for adding names to the battle roster, preparing SIDPERS input, and processing the names into the servicing postal activity. The S1 and PAC should brief the new soldiers on the tactical situation, provide mess and medical support as needed, inspect for combat critical equipment shortages, and coordinate transportation to units. Company replacements should be brought forward from the field trains with the LOGPAC and linked up with their new unit's first sergeant. If replacements are brought forward at unscheduled times, the logistic release point (LRP) should still be used as the linkup point. The S1 must coordinate with the S3 or S4 to transport replacements over long distances and to issue missing individual combat equipment. At night, replacements may need to be sent to their new unit with guides. These groups may be used to carry critical supplies and ammunition forward.

(3) ***Personnel Accountability.*** Proper accountability of platoon personnel and accurate strength reporting are essential to support decision making by platoon leaders, company commanders, and the battalion commander. Using battle rosters, leaders in the platoon maintain accurate, up-to-date records of their personnel. At periodic intervals, they provide strength figures to the company CP. During combat, they provide hasty strength reports on request or when significant changes in strength occur.

(4) ***Casualty Reporting.*** By-name casualty information is reported by secure means to company headquarters during lulls in the tactical situation. Soldiers having direct knowledge of an incident complete a DA Form 1155 (Witness Statement on Individual) to report missing or captured soldiers, or casualties no longer under US control. DA Form 1156 (Casualty Feeder Report) is used to report soldiers who are killed or wounded. (See AR 600-8-1 for instructions on how to complete these forms.) After being collected and reviewed for accuracy by the platoon leader or platoon sergeant, these forms are forwarded to the company headquarters. These forms provide important casualty information and are also used to determine the platoon's replacement requirements.

(5) ***Stress Management.*** The surgeon, in coordination with the S1, must develop a flexible and comprehensive combat health support (CHS) plan to treat and or evacuate those with battle fatigue or combat stress. Medical personnel can provide training to unit leaders on recognizing stress and actions, which can be taken to mitigate its effect. (Refer to FM 22-51 for information on combat stress control for unit leaders.)

(a) Prolonged combat in urban areas generates incredible stress. Some soldiers show signs of inability to cope with such stress. Stress management is the responsibility of commanders at all levels. The surgeon coordinates for trained personnel, such as medical personnel and unit ministry team personnel, to support units when the situation dictates.

(b) The more intense the combat, the higher the casualties. The more extreme the weather, the longer the battle lasts, the more combat exhaustion and stress, the more casualties.

(c) The S1 should plan to provide the soldier with a short rest period along with warm food and hot liquids in a protected section of the battalion rear area. He should take this opportunity to give the soldier command information products (obtained through public affairs channels). These inform the soldier about the larger picture of the battle, the theater of operations, the Army, and the welfare of the nation as a whole. As a result of treating stress problems in the battalion area, a higher percentage of stress casualties can be returned to duty than if they had been evacuated farther to the rear. When recovered, they should be returned to their original units.

13-3. SUPPLY AND MOVEMENT FUNCTIONS

The S4, support platoon leader, and battalion motor officer share responsibility for coordinating supply and movement functions within the battalion. The use of preconfigured LOGPACs pushed forward to the elements in contact is the key to a successful resupply operations. The support platoon contains trucks and trained drivers to move supplies forward. Some classes of supply, and how they are moved, may assume greater importance during UO.

a. **Class I (Rations and Water).** The process of ordering and moving rations to the battalion's forward positions is complicated by the dispersed nature of UO and their increased caloric demands on soldiers. The battalion mess section must try to provide hot meals, whenever possible.

(1) Urban combat causes great stress on soldiers and requires great physical exertion. This combination of stress and exertion causes rapid dehydration. Unless potable water is continuously provided, soldiers will seek local sources, which are usually contaminated by POL runoff, sewage, bacteria, or unburied corpses. Soldiers who are not provided sufficient quantities of potable water become casualties due to drinking from contaminated sources or from dehydration. Waterborne contamination can quickly render entire units combat-ineffective.

(2) Water and other liquid supplements such as coffee, tea, or soup that must be brought forward to exposed positions may need to be backpacked there at night.

b. **Class II (General Supplies).** UO also places a great strain on uniforms and footgear. The battalion S4 should increase his on-hand stocks of uniforms, boots, and individual combat equipment such as protective masks and armored vests. Chemical protective overgarments (CPOGs) either tear or wear out quickly when worn in the rubble typical of combat in urban areas. Limited amounts of other Class II and IV items may be available locally. These should be gathered and used if authorized and practical. Local shops may provide such items as hand tools, nails, bolts, chains, and light construction equipment, which are useful in preparing a defense or reducing enemy-held positions. The unit's organic wire communications net may be augmented with locally obtained telephone wire and electrical wire.

c. **Class III (POL).** Bulk fuel may have to be brought forward from fuel tankers by 5-gallon cans. One man can carry a fuel can long distances, even over rubble, if it is lashed to a pack frame. Supplies of bulk Class III items and some prepackaged POL may be available at local gas stations and garages. These may be contaminated or poor quality.

The S4 should coordinate with the brigade S4 to have a fuel test performed by a qualified member of the supporting forward support battalion (FSB) or the forward support company (FSC).

d. **Class IV (Barrier Materials).** Barriers can be built from abandoned cars and buses, which are dragged into position, turned on their sides, and chained together through the axles. A unit defending an urban area may require less Class IV materials than in other areas because of local availability. After coordinating the effort with higher headquarters, the S4, support platoon leader, and supporting engineer officer can gather materials for use in strengthening a defense. Cargo trucks from the support platoon, wreckers or recovery vehicles from the maintenance platoon, and engineer construction equipment can be used to load and move barrier materials. Normally, division or corps-level assets bring Class IV materials forward. Defense of an urban area may require concertina wire and or barbed wire to restrict the enemy infantry's movements.

e. **Class V (Munitions).** Urban combat causes ammunition to be expended at extremely high rates. Commanders should plan for early resupply of explosives, grenades, and ammunition for small arms and direct/indirect fire weapons.

(1) In the defense, the S4 should prestock as much ammunition as practical in dispersed storage areas. These storage areas should be protected and have easy access from the forward defensive positions. In the offense, attacking troops should not be overburdened with excessive ammunition. Mobile distribution points may be set up as low as company level.

(2) Commanders and S4s must plan to deliver ammunition continuously to the leading elements as they advance. Armored vehicles may carry this close behind the advancing troops or by designated carrying parties. Modern ammunition is characterized by extensive amounts of packing material. The S4 must plan to have an element remove the ammunition depot's overpack before it is transported forward. Resupply by helicopter (prepackaged slingloads) may be feasible.

(3) Removing the outer packaging from large amounts of ammunition can be time-consuming. It may require the efforts of the entire support platoon, augmented by available soldiers. If carrying parties are used to move ammunition forward, an individual can carry about 75 to 90 pounds using a pack frame or rucksack. Carry the bulky and heavier loads by lashing them to litters and using carrying teams (two to four men). Loads up to 400 pounds can be carried moderate distances using four-man teams.

NOTE: Do not use medics to carry ammunition forward; it is a violation of the Geneva Accords. Consider using aid and litter teams to bring ammunition forward and then to back haul casualties.

f. **Class VIII (Medical Supplies).** Due to the decentralized nature of combat in urban areas, medical supplies should be dispersed throughout the battalion and not consolidated only with the aid station and the individual combat medic. Individual soldiers, especially trained combat lifesavers, should carry additional bandages, cravats, and intravenous sets. Companies should request additional splints and litters.

13-4. COMPANY RESUPPLY OPERATIONS

The company XO, first sergeant, and supply sergeant normally share the responsibility for coordinating all resupply and transportation requirements for the company. As stated previously, preconfigured LOGPACs are normally pushed forward to the companies in contact as the normal method of resupply operations. The support platoon contains the trucks and trained drivers needed to move supplies forward. The XO normally coordinates transportation requirements with the battalion S4. Generally, the priorities of resupply for infantry companies in urban combat are ammunition, medical supplies, water, and food. These priorities may change based on the factors of METT-TC; however, they will generally remain constant. This paragraph will discuss how infantry companies conduct resupply operations during UO.

a. **LOGPAC.** Resupply operations normally occur once a day. When possible, they should be conducted during periods of limited visibility. Company resupply is primarily a *push* system. This is accomplished through the reception of a LOGPAC from battalion. The contents of the LOGPAC are planned by the S4 based on mission requirements. The supplies are normally organized and assembled in the battalion field trains by the company supply sergeant under the supervision of the HHC commander and the support platoon leader. The LOGPAC should provide all supplies, equipment, and personnel needed to sustain the company for the next 24 hours or until the next scheduled LOGPAC delivery. Adjustments to the LOGPAC are sent to the battalion S4 by either the supply sergeant or the XO. These changes should be specific and based on the company commander's priorities. The company status reports usually serve as the basis for the LOGPAC and provide the necessary troop strength figures to determine resupply needs.

NOTE: Recent experimentation with different UO TTP has seen increased use of the company support team (CST) technique. The CST may consist of a squad or platoon (-) of soldiers that would come under the control of the company supply sergeant, XO, or 1SG. The soldiers come from the company headquarters section and organic platoons/sections. The CST fills magazines and canteens/camelbacks, removes packing material from ammunition, and generally prepares and delivers LOGPACs for immediate use by the rifle platoons. The CST also assists with CASEVAC by administering first aid and moving casualties from the point of injury to patient (casualty) collection points and/or battalion aid station.

b. **Distribution of Supplies.** Supplies are distributed as follows:

(1) ***Movement of LOGPACs.*** Once the LOGPAC is formed in the field trains, it is ready to move forward under the control of the supply sergeant. The support platoon leader normally organizes a convoy for moving the LOGPACs along a supply route to the logistics release point (LRP), where the first sergeant or XO takes control. The LRP is usually a covered and concealed position that offers protection to those distributing supplies (for example, a large enough building that can be secured locally).

(a) The LRP should be positioned close enough to the combat area so that LOGPACs can be off-loaded and carried to the platoons. LOGPACs should be broken down into 50- to 75-pound loads to be carried in rucksacks. Litters can be used to carry heavier loads,

when excess are available or evacuating wounded is not required. Companies should plan for carrying supplies and identify soldiers to do this.

(b) The platoon sergeant assumes control of the supplies once they arrive in the platoon area. Carrying parties should use covered and concealed routes through buildings to move from the LRP to the company sector. Carrying parties should be prepared to provide their own security to and from the LRP. When necessary, a security force (for example, a fire team) can accompany the carrying party.

(2) ***Pre-positioned Supplies.*** Based on METT-TC factors, LOGPACs may be pre-positioned in predetermined locations by the battalion S4. The LOGPAC would be placed in a covered and concealed location where the company retrieves the supplies. This system works best when the company is moving from one location within the urban area to another in a relatively secured area. Care should be exercised to ensure supplies are not left unprotected or pilfered through by the enemy or civilians. For example, the company can provide a two- to four-man security team to the S4 to guard the pre-positioned supplies until the company can recover them.

c. **Company Resupply Techniques**. Once the LOGPACS are brought to the company area, the XO or first sergeant has three options for resupplying the platoons: *in position*, *out of position*, and *pre-position*.

(1) ***In Position.*** This is the most common technique that will be used on urban terrain when the company is conducting operations that require platoons to maintain combat power forward (during contact or when contact is imminent). For example, this technique would probably be used during the consolidation and reorganization phase of an offensive operation where a counterattack is expected. Ammunition, medical supplies, and water would be brought forward by the support element and resupplied directly to the platoons in cleared buildings. All the assaulting platoons would remain in position.

(2) ***Out of Position.*** This technique is used when the situation does not require all combat power to be forward (contact is not likely). The XO or first sergeant would establish a resupply point in a covered and concealed position (a cleared building with overhead cover) to the rear of the platoon. Platoons would send selected personnel back to the resupply point, pick up the supplies, and move back to position.

(3) ***Pre-Position.*** This technique is most often used during defensive operations when supplies are often cached (pre-positioned and concealed) in buildings throughout the company sector or subsequent battle positions.

d. **Other Considerations.** Lessons learned from Operation Just Cause in Panama provide additional key points for company commanders to consider:

(1) LOGPAC vehicles must be prepared to back-haul captured enemy equipment and prisoners. Ensure drivers and company supply personnel are proficient in handling EPWs.

(2) Train and qualify supply personnel to configure and rig supplies for external helicopter lift.

(3) Consider deploying with airload slings and nets, and have procedures in place to expedite resupply operations.

(4) Train resupply personnel to receive container delivery system (CDS) bundles from a C-130 or C-141. This is a viable means of resupply in urban terrain when convoys and Army aviation are limited.

(5) Soldiers must deploy with extra sets of clothing. Uniforms deteriorate quickly in urban combat; especially in hot, humid conditions.

(6) Soldiers must deploy with sufficient toilet articles to sustain them for at least 15 days. Sundry packs are not maintained in the depot system and soldiers may not be resupplied with health and hygiene articles for up to 60 days after deployment.

(7) Soldiers may have compassion for disadvantaged people and may give away clothing and rations. Commanders and first sergeants must monitor this situation, and caution soldiers in austere conditions.

13-5. LOAD PLANNING AND MANAGEMENT

The soldier's load (what the soldier carries) is a crucial concern for leaders at all levels. This load is especially true during UO, where the demands of physical and mental stress are combined with the need to carry additional ammunition and water. (FM 7-10, Chapter 8, provides detailed information concerning load planning and management.) This paragraph highlights specific load management concerns for infantry company commanders during UO.

a. **Army Research.** Army research indicates that a soldier can carry an amount equal to 30 percent of his body weight and still retain a high percentage of his agility, stamina, alertness, and mobility (all of these are qualities that directly affect the ability of a soldier to fight on urban terrain). For the average soldier weighing 160 pounds this would be a 48-pound load. For each pound over 30 percent, the soldier loses a proportional amount of his functional ability. When his load exceeds 45 percent of his body weight, or 72 pounds, his functional ability drops rapidly and the chance of his becoming a casualty increases. The company commander must be directly involved in load planning and management. He must weigh the needs of the mission based on METT-TC against the physical reality of what a soldier can carry into the fight.

b. **Loads.** FM 7-10 divides loads into three major types: the combat, sustainment, and contingency loads. The combat load is defined as the minimum mission-essential equipment, as determined by the commander. This includes only what is needed to fight and survive immediate combat operations. The combat load is further broken down into two levels—the fighting load and the approach march load. The fighting load is defined as what the soldier carries once contact has been made with the enemy. It consists of only essential items the soldier needs to accomplish his task during the engagement. The remainder of this discussion will concentrate on describing the manner in which to manage a fighting load in urban combat. Company commanders must recognize that urban combat will place additional physical stress on soldiers. Part of this physical stress will be caused by the additional weight that soldiers will carry. The calculations in Table 13-1 are provided to assist in load planning and management.

COMMON ITEMS	POUNDS
BDUs and boots	8.2
Pistol belt, straps, and first aid kit	1.6
Canteen, cup and cover (with water)	3.3
Canteen, cover (with water)	2.4
Gloves	0.3
Socks	0.3
TOTAL	**16.1**
DUTY LOAD	**POUNDS**
M16A2 w/30-round magazine	8.2
Two ammunition pouches	1.8
Six magazines/180 rounds	6.3
Two fragmentation grenades	2.0
Two stun grenades	1.8
One smoke grenade	2.6
TOTAL	**22.7**
THREAT PROTECTION	**POUNDS**
M40 protective mask with cover	4.2
Knee and elbow pads (average weight)	1.5
Helmet	3.4
Eye protection	.3
Body armor	17.5
TOTAL	**26.9**
VARIABLES	**POUNDS**
Bayonet with scabbard	1.3
Rifle launched entry munition	1.9
TOTAL	**3.2**
TOTAL FIGHTING LOAD	**POUNDS**
Common items	16.1
Duty load	22.7
Threat protection	26.9
Variables	3.2
TOTAL	**68.9**

NOTE: All weights were rounded to the nearest tenth of a pound. Body armor was calculated with the front and back plates included. If a double basic load of ammunition (includes 2 more ammo pouches, 6 additional magazines and 180 additional rounds of ammunition) is added, an additional 8.10 pounds must be calculated, for a total of 77 pounds. If two additional quarts of water (a two-quart canteen with cover) are added, an additional 4.80 pounds must be calculated, for a total weight of 81.80 pounds.

Table 13-1. Load calculation.

c. **Load Management Techniques.** Based on the calculations, soldiers will probably carry more than the recommended 48-pound fighting load during urban combat, which will tax soldiers and create a greater amount of physical exertion. Commanders must be aware of this fact and manage loads accordingly. The following are key-load management techniques used during UO.

(1) Standardize the way items are carried within the unit. Soldiers should evenly distribute items on their load-carrying equipment (LCE) and the cargo pockets of their BDUs. Do not place anything on the firing side of the LCE that interferes with aiming the weapon.

(2) Distribute loads throughout the unit. Have the assault element only carry the items necessary to accomplish the mission, usually ammunition and water. Designate individuals in the support element to bring additional ammunition, medical supplies, and water forward as the tactical situation permits. Replace ammunition and water carried on the LCE as soon as possible. Medical personnel can only carry medical supplies; carrying ammunition is a violation of the Geneva Conventions.

(3) Designate individuals who will perform breaches and modify ammunition loads accordingly. Rotate these individuals when they tire, or after they have made numerous breaches.

(4) Rotate the assault element after each intermediate objective is secured, as the tactical situation permits. Try to maintain fresh assault troops to the maximum extent possible.

(5) Always consider the use of augmented transportation assets to carry loads. (For example, host nation or allied force vehicles, pack animals, civilian volunteers, wheelbarrows, and bicycles; however, do not procure them without authority.)

(6) Avoid unnecessary movement and displacements. To conserve the soldier's stamina, plan the mission as efficiently as possible.

(7) All leaders must supervise the soldier's load closely, through precombat inspections (PCIs), to ensure that soldiers carry only the items necessary.

13-6. OTHER COMBAT SERVICE SUPPORT TACTICS, TECHNIQUES, AND PROCEDURES

The following TTP are a result of lessons learned from combat training centers (CTCs) and different unit standing operating procedures (SOP).

a. **Soldier Top-Off Point.** This technique is primarily used at battalion or brigade level. A position is established that provides simple services to soldiers in a centralized location. The soldier top-off point can be as detailed as assets and time permit. These services are normally provided in a relatively secure location such as a lodgment area, the brigade support area, or the combat trains. Security considerations and mission requirements will determine the exact location of the soldier top-off point. Examples of activities and services at a soldier top-off point are:

- Distribution of mail and newspapers.
- Serving of hot food, to include fresh fruit and cold/hot drinks.
- Chaplain services/support.
- Showers.
- Combat health support, to include restocking of aid bags and combat lifesaver bags.
- Supply issue points for the distribution of water, MRE, ammunition, and so on.
- Distribution of A-bags.
- Sleep/rest area, which may include heated tents with cots.
- Briefing area.

b. **Resupply Techniques.** The following resupply techniques may be used in UO.

(1) ***Plastic Bags.*** This technique involves using double or triple stacked plastic bags to preconfigure soldier resupply. Resupply could include prefilled magazines, MREs, bottled water, and first aid dressing. Plastic bags are readily available and do not require back haul.

(2) ***Plastic Bladders***. Plastic bladders used in milk dispenser machines in most military dining facilities make excellent water containers. These bladders hold about five gallons of water, have a spout that permits canteens to be filled easily, and will fit into a rucksack or other container. These bladders have survived 60-foot drops from hovering helicopters when placed inside an empty MRE box. The bladder and MRE box are expendable. A box of 100 bladders is inexpensive and readily available through supply channels.

(3) ***Water Bottles.*** In many recent operations bottled water was the standard for supplying water to the soldier for individual consumption. During UO, this type of water distribution can be both a benefit and challenge. Although plastic water bottles are easy to transport and eliminate the need for back haul, they are expensive; usually require a contract with a commercial provider; and, in bulk, come in flimsy cardboard boxes. Regardless, this may be the best solution for water resupply in many situations.

(4) ***Speed Balls.*** This technique uses helicopters and preconfigured loads to resupply units. In urban areas, rooftops or secured drop-off points, such as small parking lots or playing fields, are used (Figure 13-1). CSS personnel prepackage supplies in aviation kit bags, duffle bags, or other suitable containers. Helicopters fly as close to the drop point as possible, reduce speed, drop supplies, and leave the area quickly in order to reduce exposure time. Supplies should be prepackaged in bubble wrap or other shock-absorbing material to minimize damage. This technique can work well where there is a minimal or no air defense threat and where the units receiving supplies are light infantry or other dismounted type forces.

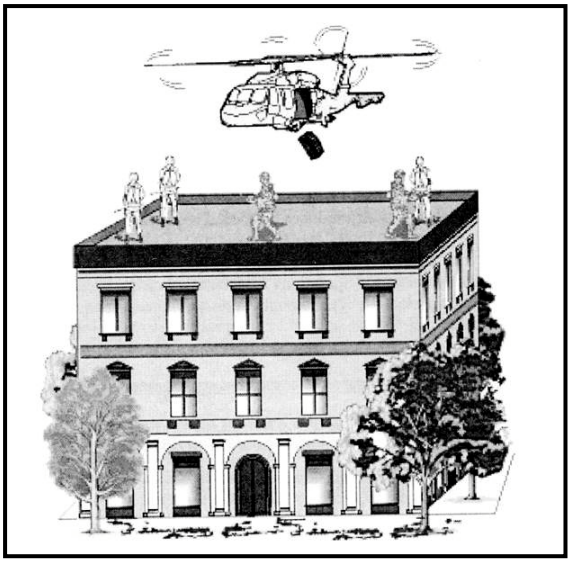

Figure 13-1. Speed ball delivery.

(5) ***Rope.*** A technique similar to *speed balls* is to lower water cans or supply containers from a rope. Water cans or containers are attached to the rope using a snap link and slid down. Once the supplies are received, the same rope can be used to back haul empty water cans or other items. Care must be taken to insure that a counterweight remains at the end of the rope to insure that it does not flap into the wind and catch the helicopter propellers. Heavy items can also quickly slide down the rope and damage the supplies, for example a five gallon water can weighs 40 pounds. Multiple water cans and/or "speed balls" can be linked together by means of a sling rope that has a snap link attached. To slow the rate of descent, a round turn can be applied to the snap link holding the supplies. Additionally, the rope can be belayed from the ground, which will also control the rate of descent.

(6) ***SKEDCO Litters.*** SKEDCO litters can be used effectively during UO at the squad and platoon level to move supplies and equipment. The litter can be used to move heavier items, such as mortar rounds, through difficult areas such as rubble. Additionally, SKEDCO litters can be used in conjunction with ropes and pulleys to haul supplies along the side of a building or through elevator shafts or destroyed stairwells.

(7) ***Body Bags.*** A “human remains bag” (NSN 9930-01-331-6244) Type 2 can be used to move supplies. The word “SUPPLIES” should be clearly stenciled in a bright color on the bag to avoid confusion. These bags are useful because they are durable, waterproof, have carrying handles, can hold a large number of items, and can be folded and carried in a rucksack. They are readily available through supply channels.

13-7. PERSONNEL SERVICES

The S1 plans for all personnel services supporting and sustaining the morale and fighting spirit of the battalion. Among the most important of these services are:

- Religious support.
- Postal services.
- Awards and decorations.
- Rest and recuperation.
- Replacement operations.
- Strength accounting.
- Casualty reporting.
- Finance support.
- Legal support and services.
- Public affairs activities.

A unit may encounter severe problems if it allows civilians to steal or destroy its equipment. Even friendly civilians may steal supplies or furnish intelligence to the enemy. Civilians should be evacuated to prevent pilferage, sabotage, and espionage. Military police and civil affairs units normally provide control of the civilian population. Collection points for noncombatants are established in rear areas. The S1 is the battalion’s link to the population control programs of the higher command.

13-8. DECEASED PERSONNEL

The commander is responsible for the evacuation of deceased personnel to the nearest mortuary affairs collection point, whether they are U.S., allied, enemy, or civilian. (See

FMs 10-63 and 10-497 for specific information on the handling of deceased personnel.) Some general considerations for handling deceased personnel include:

- The theater commander is the approval authority for hasty burial.
- The deceased's personal effects must remain with the body to assist in the identification of the body and to facilitate shipment of personal effects to the next of kin. Unauthorized retention of personal items is considered looting and is punishable by UCMJ.
- When operating under NBC conditions, the bodies of deceased personnel should be decontaminated before removal from contaminated areas to prevent further contamination and casualties.
- Care must be exercised when handling deceased personnel. Improper handling can result in a significant decrease in unit and civilian morale.

Section II. COMBAT HEALTH SUPPORT

"During the earlier years of our involvement in the Viet Nam War, it was a rare Medal of Honor list that failed to relate the story of some devoted, selfless medic. Wherever his infantry platoon, artillery battery, or tank troop went, the 'Doc' was always there, ready with skilled, competent hands to do his tasks."

Major Henry J. Waters
MS Medical Implications of Combat in Cities
Unpublished Research Paper, April 1974

13-9. MEDICAL CONSIDERATIONS FOR THE BATTALION STAFF

The battalion surgeon, in coordination with the battalion S1, physician's assistant, and field medical assistant, is responsible for planning and executing medical functions within the battalion. The most critical functions during urban combat include preventive medicine, trauma treatment, and evacuation. In addition, there should be a plan for treating, decontaminating, and evacuating NBC-related casualties that may occur in combat in urban areas.

a. **Disease.** Combat in urban areas exposes soldiers not only to combat wounds but to the diseases endemic to the area of operations. Commanders must enforce prevention measures against the spread of infectious diseases. The medical platoon advises the commander on how best to implement and use preventive measures.

b. **Medical Supplies.** Critical medical supplies should be planned for all operations and resupplied to the company as needed. (See paragraph 13-3f for more information.)

c. **Combat Medics.** Although the combat medic normally attached to each rifle platoon is the soldier best trained in the treatment of traumatic injury, he can quickly become overwhelmed by the number of casualties needing care. The commander must train selected soldiers within the platoons to administer enhanced first aid using the combat lifesaver program. The work of these combat lifesavers, plus the buddy-aid efforts of individual soldiers, eases the burden of the combat medic and allows him to concentrate on the seriously wounded. The medical platoon should plan to care for the mass casualties inherent in combat in urban areas. Combat medics and lifesavers should expect a higher incidence of crushing injuries, eye injuries, burns, and fractures due to

falling debris, spall from buildings, rubble, and fire hazards. Additional effects, such as concussive shock and hearing loss due to explosives, should be expected.

d. **Medical/Casualty Evacuation (MEDEVAC/CASEVAC).** The difficulties encountered when evacuating casualties from urban terrain are many and require innovative techniques and procedures (Figure 13-2). The planning for medical evacuation in urban terrain must include special equipment. For example, axes, ropes, pulleys, pitons, and other climbing equipment that will be used by litter teams; use of air ambulances and the rescue hoist, when feasible; use of the litter/ambulance shuttle system; and communications requirements and techniques for locating casualties.

Figure 13-2. Treatment of casualties.

(1) ***Casualty Collection Point (CCP).*** Although litter teams are labor intensive, they are required for evacuation from buildings, where casualties can occur on any level. Also, rubble in the streets, barricades, and demolition of roads impede the use of ground ambulances, requiring a heavy reliance on litter teams. Casualties are brought to the designated CCP and evacuated from there to the battalion aid station. The CCP is placed in a covered and concealed location that has overhead cover (usually a heavy-clad building that has not collapsed). The CCP should be located at a point where the field ambulances can reach them, yet close enough to the combat area so that casualties do not have to be carried great distances. It must be marked well enough that it is easy to find. By predesignating collection points, soldiers who are wounded but still ambulatory can walk to these points, hastening the CASEVAC effort.

(2) ***Air Ambulances/Shuttle System.*** When available, air ambulances equipped with the rescue hoist may be able to evacuate casualties from rooftops or insert medical personnel where they are needed. The vulnerability to enemy fire must be considered and weighed against probable success of the evacuation mission. Pilots must be familiar with over flying urban areas and the atmospheric conditions they may encounter. A litter/ambulance shuttle system with collection points, air exchange points (AXPs), and relay points can be established within the battalion area. The first sergeant or XO can coordinate with the S1 and S4 to determine the location of the AXPs within the urban

area in order to facilitate MEDEVAC for the company. By establishing an ambulance shuttle system, the distance required to carry casualties by litter teams is shortened. Air ambulances can also be used at secured ambulance exchange points to hasten evacuation time.

(3) ***Communications.*** Communications present one of the biggest obstacles to CASEVAC. Due to the terrain, line-of-sight radios probably will not be effective. Also, individual soldiers normally do not have access to radios. Therefore, wounded soldiers may be difficult to find and evacuate. The unit SOP should contain alternate forms of communications such as colored panels or other types of markers that can be displayed to hasten rescue when the battle is over. (See Appendix I for more information.) Also, a systematic search of the area after the battle may be required to recover casualties. Consideration may be given to marking the CCP so that it is visible to individuals trying to find it. Buildings and streets can cause confusion and disorient individuals trying to evacuate wounded.

(5) ***Special Equipment.*** Special equipment requirements include ropes, pulleys, SKEDCO litters and stokes litters, axes, crowbars, and other tools used to break through barriers.

d. **Use of Existing Medical Facilities.** The use of local medical facilities, hospitals, and medical supplies may be available during operations in large urban areas. The commander must adhere to the theater guidelines established for when and how these facilities can be used. A commander cannot confiscate civilian medical supplies unless he makes provisions to provide adequate replacements if civilians are wounded.

13-10. CONSIDERATIONS FOR THE COMBAT MEDIC (TRAUMA SPECIALIST)

The combat medic supporting Infantry companies and battalions during UO will be challenged physically, mentally, and professionally. He must be—

- Proficient in basic soldiering skills to survive on the battlefield and to accomplish his mission.
- Mentally agile to adjust and to adapt medical support as required by the changing battlefield environment.
- Well-versed in emergency medical treatment (EMT) procedures for trauma (especially to the head), burns, and blast, missile, and crush injuries.
- Knowledgeable in extraction techniques and procedures for extricating casualties from damaged aircraft, vehicles, and collapsed structures. The combat medic should request assistance from the supporting engineer unit to assist in freeing soldiers pinned down in collapsed structures. Using the correct techniques for extricating soldiers who are trapped by rubble may prevent doing further injury to the soldier.
- Proficient in locating and evacuating casualties from above, below, and at ground level.

Prior to the operation, the combat medic should ensure that all soldiers participating in the operation are proficient in first aid skills. He should conduct refresher training if any deficiencies are identified. He should also verify that combat lifesavers have all required medical supplies. The command surgeon may determine that it is feasible to train additional first aid skills for all soldiers to enhance their potential for survival, if

wounded. The combat medic must determine what specialized equipment will be required to extricate casualties (such as crowbars or extrication devices) and how this equipment will be carried into battle (such as on supporting helicopters).

a. **Acquiring Patients.** The first thing the combat medic must accomplish is to survive on the battlefield. He must be knowledgeable in basic soldier skills such as the techniques for crossing open areas, entering and exiting buildings, and recognizing and avoiding booby traps and mines. He must have the foresight and training not to needlessly expose himself to hostile fire. The combat medic who is wounded or killed cannot help his platoon and cannot accomplish his medical mission. He must also be proficient at and be prepared to defend himself and his patients in sudden, short-range engagements.

(1) If a soldier is wounded in an open area (for example, crossing a street), the first impulse of his fellow soldiers is to rush to his aid. However, since the casualty is located in an open area and probably exposed to sniper fire, soldiers (who are going out to rescue the wounded) are likely to become casualties. The combat medic should approach as closely as possible to the casualty, while still remaining under cover, and try to verbally determine the casualty's status.

(a) If the casualty is responsive to verbal stimulus, the combat medic should try to calm him and encourage him to try to crawl or drag himself out of the line of fire. If that is not possible, the combat medic should try throwing the casualty a rope which he could then hold or attach to his load-bearing equipment (LBE) and be dragged to safety. (The combat medic should carry a length of rope with a D-ring attached to one end for this purpose.)

(b) If the casualty is unresponsive, he may have to remain in the open until visibility can be reduced using smoke to obscure the area, or wait until he can be recovered under the cover of darkness.

NOTE: The use of smoke must be judiciously applied. During the battle for Hue, the enemy realized that U.S. Marines were using smoke on the battlefield and to cross open areas. Therefore, the enemy would blindly fire into the smoke in hopes of wounding U.S. forces crossing the street. The medic can coordinate with the maneuver platoon/company for covering fire and smoke obscuration to aid in rescuing the casualty.

(c) Another technique to provide cover to acquire a patient in an open area is to place a vehicle in between the casualty and the sniper and or hostile force. The rescuers move along the side of the vehicle until they reach the casualty, secure him, and continue to move along with the vehicle until appropriate cover is reached.

(2) The combat medic may be required to move a soldier before he has the opportunity to fully assess the potential for spinal injury. If the casualty is in imminent danger (such as near a burning vehicle or being exposed to gunfire), the combat medic or another soldier may be required to move him before the application of a cervical collar and or spine board can be accomplished. In this case, the combat medic should try to move the wounded soldier as efficiently and smoothly as possible. The rescuer can grasp the shoulders of the patient and use his forearms to temporarily stabilize the neck while the casualty is being dragged to safety.

(3) The combat medic must remain aware of his location when treating casualties as well as being familiar with information about urban construction and weapons effects to knowledgeably select effective cover for himself and his patients. Some building materials will not stop fragments or small arms. For example, casualties may be moved to a relatively safe area behind the wall of a building; however, if the wall is damaged and there are gaping holes, the medic and his patient may still be subjected to sniper fire through the openings. If the area is enclosed, they may be subject to ricochets, or if the wall is made of wood, depending upon its thickness and density (plywood versus oak), small arms fire will probably penetrate it. Another consideration is the type of building construction (for example, framed or massed), and the potential for collapse if hit by artillery or tank fire.

(4) If casualties are located above or below ground level, it may not be feasible to reach them until a lull in or cessation of the battle occurs. Special equipment, such as collapsible ladders or ropes and pulleys, may be required to reach these casualties. The time required and the complexity of erecting a means to reach the casualty may jeopardize the safety of the rescuers and the accomplishment of the mission.

NOTE: In this scenario, if the wounded soldier has medical supplies necessary to administer lifesaving first aid in his possession, such as a tourniquet for a traumatic or incomplete amputation, his chances for survival are improved while he has to wait to be rescued. This is another situation in which the combat medic can provide direction to the casualty who is responsive to verbal stimulus to calm him and reinforce the lifesaving steps the casualty can perform for himself.

CAUTION

The application of a tourniquet may result in the loss of the limb. All other methods of stopping a hemorrhage (direct pressure or pressure bandage), when practical should be tried first.

(5) The combat medic must guard against exhausting or seriously depleting his medical supplies on the initial casualties. The duration of the battle and or the number of patients may increase. Having each soldier carry the medical supplies for his own initial treatment enhances the combat medic's ability to conserve his medical supplies.

b. **Treating Patients.** During UO, the treatment of a patient is complicated by a number factors. As mentioned earlier, the patient may be experiencing some degree of dehydration; this in conjunction with blood loss from wounds or injuries may make the prognosis for certain injuries grim. Urban combat is often conducted within confined or limited space. The noise, smell, and confusion of battle may make it difficult for the combat medic to focus his energies and may eliminate some medical indicators (such as breath sounds) that he would normally rely on in assessing the patient.

(1) While the casualty and combat medic are still subject to hostile fire, there is little medical treatment that the combat medic can provide. If the casualty has a severe

hemorrhage, the combat medic may be able to place a tourniquet on it. The combat medic's first priority, however, is to survive and defend himself and his patient. Once the combat medic can move the casualty to a more secure location, such as under cover or behind a wall, he can more fully assess and treat the casualty. This is the same principle as used in emergency medicine—to remove the patient from the source of injury.

(2) One of hardest and most essential tasks the combat medic must accomplish is to quickly and accurately triage the patient conditions he is faced with. EXPECTANT category patients must be protected from further injury and, if possible, made comfortable, but the focus of the combat medic must be directed towards those patients whose chances of survival are greater.

(3) The combat medic ensures that each patient has an open airway, bleeding is controlled, and circulation maintained. Once this is completed, he must assess the mental status of the wounded soldiers. During UO, the outcome of the battle may hinge on the amount of firepower that can be concentrated at critical times. Patients that are wounded but still mentally alert may be able to contribute to the defense of the position. Further, depending upon the extent of injuries, the wounded soldier may still be able to function after being administered a low dose of pain medication.

CAUTION

If at any time the combat medic feels that a soldier has an altered mental state, the soldier should be disarmed regardless of the cause for that condition (injury/wound, dehydration, stress, medication, or other factors).

(4) The combat medic must effectively use all resources available to him; this includes other injured or wounded soldiers. A patient with an altered mental state may not be able to help defend the position, but he may be capable of applying direct pressure to another soldier's wounds. Another example would be for a relatively stable patient to observe a more critically wounded soldier and to alert the combat medic of any change in the patient's condition (such as the reappearance of bleeding or labored breathing).

(5) The patient conditions presenting and the likelihood of multiple traumas may tax the knowledge base of the combat medic, especially if he must sustain these patients for an extended period of time. If secure communications are available, the combat medic should avail himself of telemedicine support (advice) from the supporting battalion aid station (BAS) and or clearing station (forward support medical company [FSMC]).

(6) After providing initial treatment to all of the patients, the combat medic must continually reevaluate the patients' conditions until they can be evacuated. The length of evacuation to the BAS may not be that great. Treatment teams may be able to move closer than normal to the fight due to the available cover afforded by buildings. Urban structures can provide cover and concealment and facilitate light discipline. Engagement ranges are usually short and a few city blocks may provide a relatively secure area for the provision of advanced trauma management (ATM).

c. **Evacuating Patients.** Medical evacuation (MEDEVAC) during UO is a labor-intensive activity that may have to overcome significant and numerous obstacles. During UO, casualty evacuation (CASEVAC) may entail evacuation by litter, the expedient use of a vehicle of opportunity, or other military vehicle not dedicated for medical evacuation. CASEVAC occurs when medical personnel are not available to provide en route medical care to the casualty while being moved from the point of injury or wounding to a medical treatment facility (MTF). Field Manual 8-10-6 provides an in-depth discussion on the distinct differences between CASEVAC and MEDEVAC operations.

(1) ***Aeromedical Evacuation.*** Aeromedical evacuation is the preferred method; however, it may not be a feasible option. The threat from small arms fire, rocket-propelled grenades (RPG), and other shoulder-fired weapons may prohibit the employment of these resources. Aeromedical evacuation can also be hampered by the lack of landings zones (LZs) due to narrow streets and heavily-damaged buildings.

(2) ***Ground Ambulance.*** Evacuation by ground ambulance may have to surmount obstacles such as rubble, debris, barricades, mines and or booby traps, and wrecked or otherwise inoperable vehicles and or aircraft. If the employment of air ambulances is not feasible, a ground evacuation operation must be executed. Ground ambulances should be-

- Hardened to improve the survivability of the evacuation platform and the safety of the ambulance crew and patients.
- Field-sited as close to the operation as is tactically and physically possible.
- Maneuverable in tight spaces and narrow streets.

(3) ***Litter.*** The same obstacles that interfere with effective aeromedical and ground evacuation of patients will be factors in CASEVAC operations. Nonmedical vehicles and aircraft may not be feasible alternatives in MOUT and the only form of evacuation possible may be by litter carries. Litter evacuation is labor-intensive and the tactical commander may not be able to divert his soldiers to the task of performing litter evacuation until a lull in or a cessation of the battle occurs. Planners should push forward as many standard litters as are feasible.

(a) If litters are not available, the combat medic can improvise a litter from items such as blankets or ponchos and poles, doors, shutters, metal roofing materials, or other flat objects. The item selected to serve as a litter should be sturdy and as light as possible. Adding the weight of a soldier to an already heavy item (such as an oak door) increases the burden of the litter bearers. (Refer to FM 8-10-6 for additional information on improvising litters.)

(b) Depending on the distance the patients must be carried to reach the MTF or an area accessible by ground or air platforms, a litter shuttle system can be established. The litter shuttle system provides brief periods of rest for the litter bearers, and maintains the litter bearers' knowledgeable about the specific urban terrain in that area.

(4) ***Casualty Rates.*** Combat health support planners must take into consideration potentially higher casualty rates. The requirement for close combat by infantry will inevitably produce a higher patient workload in a shorter period of time than will operations where forces have more freedom of maneuver. Plans should address secure routes and marking structures for casualty/patient collection points and aid stations. Means of extracting casualties from damaged structures should be planned for, resourced, and, when possible, coordinated with the supporting engineer unit.

d. **Guidelines and Considerations.** Additional guidelines and considerations for the combat medic are as follows:

(1) ***Overall Health Status of Soldiers.*** In addition to rendering EMT to battlefield casualties, the combat medic is concerned with the overall health status of the soldiers he supports. Disease and nonbattle injuries generate significant combat ineffectiveness. The combat medic should be vigilant for the signs and symptoms of infectious diseases. Early recognition and reporting of diseases coupled with early treatment can avoid epidemic situations.

(2) ***Replacement of Combat Medic.*** The combat medic should designate one of the combat lifesavers to take his place in the event he is injured. Although the combat lifesaver only has advanced first aid skills, he can effectively coordinate for medical evacuation and treatment support.

(3) ***Disease and Nonbattle Injuries (DNBI).*** The prevention of DNBI is a significant responsibility for the combat medic. He must ensure that supported elements are proficient in and practice field hygiene and sanitation procedures. He must also ensure that supported personnel only consume food and drinks from approved sources.

(4) ***Mine and Booby Trap Awareness.*** Mine and booby trap awareness is a crucial consideration when operating in urban areas. The combat medic must be able to recognize mines and booby traps and take precautions as required. Additionally, the combat medic must be proficient in the skills and techniques to extract casualties from minefields. (Refer to FM 8-10-6 for additional information.)

(5) ***Manual Evacuation.*** Because MEDEVAC is a labor-intensive activity during UO, the combat medic must train his supported personnel in the techniques of manual evacuation. It is essential that those soldiers acting as litter bearers correctly handle the litter. Being proficient in using litters decreases the potential for injury to the litter bearers (muscle strains and back problems) and avoids further injury to the wounded soldier; for example, dropping the litter or tilting it so that the patient falls from the litter. (For information on litter-carrying techniques and manual evacuation, refer to FM 8-10-6.)

(6) ***Survivability.*** Soldier survivability is of the utmost importance and cannot be over emphasized. The combat medic should have his fellow Infantrymen train him in these skills.

(7) ***Navigation.*** Urban terrain is often difficult to navigate. The combat medic should have a city map available if at all possible. He should be familiar with possible routes from the battle site to the BAS. The routes do not necessarily have to only be established roads. If crossing gardens and yards or going through basements or battle-damaged buildings (holes in walls) is possible and these avenues provide better cover and concealment than is available on established road, then these routes should be used.

(8) ***Medical Materiel.*** Under the provision of the Geneva Conventions, medical materiel (supplies and equipment) are protected from intentional destruction. Should friendly units come across civilian or enemy medical supplies, medics and leaders must ensure that soldiers do not intentionally destroy these items. (For a discussion of the Geneva Conventions refer to FM 8-10.)

13-11. CONSIDERATIONS FOR THE BATTALION PHYSICIAN'S ASSISTANT AND COMMAND SURGEON

Routine operations in an urban environment performed numerous times without incident can suddenly become an intense battle. Medical personnel must be prepared to sustain casualties for longer periods of time in the event that MEDEVAC support is delayed. This paragraph provides considerations for the battalion physician's assistant (PA) and command surgeon during UO.

a. **Reliance on First-Aid Measures.** Due to decentralized control and the isolating nature of urban combat, each soldier must be proficient in administering first aid to himself and or his buddy. Further, units should have sufficient soldiers trained in advanced first aid (combat lifesaver skills) to assist the combat medic in stabilizing casualties. PAs and surgeons may determine that each individual soldier should carry sufficient medical supplies for his own initial care, if wounded or injured. These medical supply items may include tourniquets, carried in a designated location in the BDUs or rucksack; bandages; intravenous (IV) fluids, and IV starter kits.

b. **Specific Considerations.** Before entering an urban environment, PAs and surgeons must ensure that supporting medical personnel have the skills and knowledge to effectively perform their medical duties in a challenging and, often, adverse environment. They must first assess the skill level of the available medical personnel, provide refresher training to correct deficiencies, and develop treatment protocols/guidance for the care and treatment of patients while under fire and during lulls in the battle. PAs and surgeons must also ensure that they participate in the early planning for UO. To develop a comprehensive, effective, and synchronized combat health support (CHS) plan, the PA and surgeon must know and understand the tactical commander's guidance, intent, and concept of the operation. They can only accomplish this by participating in the planning process. Further, the PA and surgeon must be included in the combined arms rehearsal to ensure the CHS plan is synchronized with the tactical plan. PAs and surgeons should determine if each soldier should carry medical supplies for his own treatment into the battle. This decision is based on patient estimates, anticipated level of hostilities to be encountered, the expected duration of the operation, and any anticipated delays in evacuation. Specific considerations are:

(1) ***Wounds.*** The types and frequencies of wounds and injuries generated by urban combat should be monitored to ensure required specialty teams are available for medical care.

(2) ***Resupply.*** The PA and surgeon must ensure that prepackaged emergency medical resupply bundles are prepared prior to the operation in the event emergency resupply by airdrop is required. This may include complete medical equipment sets (MESs) or specific replacement for high use items, such as bandages.

(3) ***Preventive Medicine***. Preventive medicine (PVNTMED) policies and programs must receive command emphasis. This is particularly important with regards to water discipline. Dehydration is a significant threat in the urban environment. Increased water loss may be due in part to the effects of the weather, additional heat stress of body armor and or MOPP gear, and operating in poorly ventilated and confined spaces. Dehydration can affect mental functions and complicate medical treatment in the event of wounding or injury. Medical surveillance programs are essential for the following reasons:

- To ensure the health of the command during UO.

- To provide a baseline of diseases present in the AO in order to facilitate the identification and confirmation of potential use of biological warfare agents against U.S. forces.
- To identify what immunizations, prophylaxis, pretreatments, and barrier creams will be effective in the AO.

(4) ***Medical Intelligence.*** Current and comprehensive medical intelligence is a critical factor during UO. Medical intelligence can provide the CHS planner with the information needed to protect the fighting force from preventable diseases once engaged within the city confines. It also assists the tactical commander in evaluating the health status of enemy forces, which, if it is poor, may indicate a degradation of morale and will to fight.

(5) ***Remains.*** During UO, it is often difficult to clear the area of remains. Although U.S. forces have always quickly recovered their dead, the enemy may not. The unrecovered remains of enemy dead, civilian casualties, and animals can present serious complications in preventing the spread of infectious diseases. Coordination with supporting civil affairs (CA) units may be required.

(6) ***Disease.*** Food and waterborne diseases can quickly decimate a fighting force. Small-unit leaders must ensure that soldiers only eat and drink from approved water and food sources. Although the water system may be intact in an urban area, the water may still be contaminated. Food procured on the local market can contain infectious organisms or parasites. Food and waterborne diseases are preventable. Field hygiene and sanitation measures must be fully understood and enforced.

(7) ***Triage.*** The PA and surgeon must ensure triage categories and priorities are ingrained within all medical personnel. In mass casualty situations, the focus of health care delivery is to provide the greatest good for the greatest number. Mass casualty situations develop when the patient workload exceeds the capabilities of medical personnel/facilities available. During UO, this type of situation may develop when a single combat medic must treat, sustain, and manage three or four seriously wounded soldiers prior to evacuation. When a casualty has received massive wounds, making survival unlikely even if treated in a major trauma facility, he should be triaged as EXPECTANT. This permits the combat medic to use his medical skills and scarce resources to treat patients with a better chance of survival. (A description of triage categories is provided in FM 8-10-1.)

(8) ***Marking System.*** The PA and surgeon must ensure that a uniform marking system is used to indicate where casualties are located within buildings. This facilitates the quick retrieval and treatment of isolated casualties. The uniform system permits follow-on forces/reinforcements to identify locations where casualties can be found. These procedures should be included in the unit's tactical standing operating procedure (TACSOP). Most combat maneuver units have a system for marking the buildings and rooms as they are cleared. The CHS planner should coordinate with the supported maneuver unit to ensure the location of casualties is also indicated. (See Appendix I for more information on marking systems.)

(9) ***Mobility.*** The PA and surgeon must coordinate with supporting engineers to clear medical evacuation routes of rubble, debris, and barricades behind the fighting force. Due to isolated areas of resistance, this may not be possible in all urban scenarios.

(10) ***Communications.*** A viable communications capability is essential for successful UO. The PA and surgeon must ensure that medical elements have sufficient

communications resources to remain synchronized with the tactical force, locate casualties, and effect telemedicine activities, if required.

(11) ***Collateral Damage.*** Although every effort is made to limit collateral damage, some civilian casualties will inevitably occur. The PA and surgeon must develop a policy, in conjunction with the staff judge advocate (SJA), on the care and treatment of civilian casualties. Further, CHS planners will be required to coordinate with the local civilian government and health care community for the transfer of these patients to civilian facilities.

13-12. BATTALION AID STATION OPERATIONS

The following paragraphs discuss considerations for establishing and operating a battalion aid station (BAS).

a. **Site Selection.** As in all military operations, site selection is a crucial element in facilitating the accomplishment of the mission. This is particularly true in the urban environment. The BAS must be located close enough to the fight to reduce evacuation times, normally by litter, yet not interfere with ongoing tactical operations. Further, the site selected must be defensible. Progress during urban combat is often measured in feet and yards. Moving and fighting house-to-house and street-by-street is time consuming and often results in higher casualties. Since forward progress during UO may be slow, the BAS has the opportunity to more fully establish the medical treatment facility (MTF) and to fortify its position.

(1) ***Location***. Whenever possible, the BAS should establish the MTF in a location that is accessible to both ground or air ambulances. The location should permit ambulance turnaround, which facilitates the further evacuation of patients from the immediate combat area.

(2) ***Layout***. The actual layout of the BAS will depend upon the type of structure and the amount of space available. The anticipated duration of the operation determines the extent to which the BAS is established. If the BAS is expected to move frequently, only essential elements will be established. If an existing building will be used, the structural integrity of the building should be determined prior to establishing the facility for an extended period of time. Heavy-clad mass construction buildings with good roofing are preferred.

(3) ***Fortification***. The position of the BAS should be fortified when possible. Barricading windows, placing sandbags, or otherwise reducing the vulnerability to attack, provides the physician and PA a more secure location to provide advanced trauma management (ATM). While fortifying their positions, BAS personnel should ensure that observation/firing ports remain to observe the surrounding area and to permit the return of defensive fire, if required. Firing ports can be covered during night operations to facilitate light discipline. If the observation/firing ports are covered with a material that does not blend with the building facade, it must be removed during daylight hours to ensure it does not identify the structure as being in use. Chapter 3 provides information and techniques for fortifying positions; however, in evaluating this information it is important to consider medical requirements. Although it is advisable to move fighting positions away from the wall/window to afford more protection and to reduce the potential that the enemy would recognize the position, it may significantly limit the usable space available to care for patients. Space requirements include a treatment area

and a space to hold soldiers awaiting evacuation. Unless the BAS is reinforced/ augmented with cots and additional medical personnel, the BAS may not have a holding capability. During UO, however, wounded soldiers may have to be sustained for longer periods of time due to limitations and delays in evacuation. Further, the BAS must have sufficient space to establish a patient decontamination area, if required.

b. **Acquiring Patients.** The BAS may acquire patients from ground ambulances or from casualty/patient collection points.

(1) ***Ground Ambulances.*** The employment of ground ambulances forward of the BAS may not be possible due to rubble, debris, and other obstacles. Patients may arrive at the BAS by litter or other means of conveyance or, if ambulatory, they may arrive unassisted.

(2) ***Casualty/Patient Collection Points.*** Casualty/patient collection points are preplanned and included on the CHS overlays. Control devices, such as phase lines and check points, can be used as triggers for the movement of these facilities.

c. **Treating Patients.** The BAS is the first location on the battlefield where the wounded soldier can receive ATM. The BAS has both a physician and a PA assigned. It has the capability of forward-siting a treatment team closer to the fight if required.

(1) ***Triage***. As with the combat medic, the patient conditions presenting at the BAS must be triaged in order to provide the greatest good for the greatest number of patients. Higher casualty rates in UO can quickly attrit units engaged in combat operations. Those patients who can be treated and quickly returned to duty (minor wounds and illnesses-MINIMAL category) should be expeditiously managed. When evacuation capability is limited, patients in the IMMEDIATE category should be stabilized and further evacuated at the first opportunity. ROUTINE and EXPECTANT category patients should be evacuated after patients in the IMMEDIATE category. (FM 8-10-6 provides more information on categories of triage.)

(2) ***Delays***. If delays in evacuation are anticipated, the BAS may be reinforced with a limited holding capability (cots and additional medical personnel) and increased stockage of Class VIII materiel.

(3) ***Wounds***. The BAS must be prepared to treat an increased number of patients with head wounds; missile wounds (shrapnel and shards of brick, concrete, glass, metal, and wood); burns; and inhalation and crush injuries. Medical equipment sets may need to be reconfigured, with the advice of the command surgeon, prior to the mission to ensure adequate supplies to treat trauma injuries are included. When space is a limiting factor, those Class VIII items used for routine sick call may have to be replaced with trauma-related Class VIII items. Routine sick call service may have to be delegated to follow-on forces and coordinated with the supporting medical company.

NOTE: Recent experimentation has shown that most wounds from small arms occur in the front and back of the head and upper torso.

d. **Evacuating Patients.** Patients are evacuated from the BAS as follows:

(1) ***Litter Evacuation.*** If ground ambulances cannot go forward of the BAS due to rubble, obstacles, and barricades, evacuation by litter or manual carries to the BAS may be required. When developing plans for CHS during UO, the requirement for additional litter bearers should be considered and resourced as appropriate. Training in the safe

handling of litters should be provided to reduce the incidence of injuries to the litter bearers and patients.

(2) ***Evacuation Routes.*** Medical evacuation personnel should have the most up-to-date commercial maps available. Evacuation routes should be preplanned, reconnoitered, and, when possible, secured. If commercial maps are not available and strip maps must be used, an ambulance shuttle system should be established. The shuttle system allows the ambulance crews most familiar with the terrain surrounding the BAS to remain in that area, thereby limiting the chances of ambulance crews getting lost and straying into hostile territory. (An in-depth discussion of an ambulance shuttle system is provided in FM 8-10-6.)

(3) ***Aeromedical Evacuation.*** See paragraph 13-9c.

13-13. PRECOMBAT MEDICAL CHECKLISTS.

Tables 13-1 and 13-2 provide examples of precombat checklists for the combat medic during UO and for the BAS.

Map of the AO is available (military, commercial, strip maps, aerial imagery, as required.
Class VIII Supplies are on hand. • Medications and other time-sensitive supplies are current. • Has the command surgeon authorized the carrying of additional and or different Class VIII based upon the tactical scenario?
Is specialized equipment for the extrication of casualties from surface, supersurface, and subterranean levels available? • Ropes and pulleys. • Rope with attached D-ring. • Collapsible light weight ladders. • Picks, axes, crowbars, and shovels. • Mechanical/electrical extrication devices. • Heavy gloves. • Collapsible light-weight litters.
Do combat lifesavers have required Class VIII?
Are soldiers carrying bandages and IV fluids for their own initial care? (Where will they be carried on the uniform?)
How will MEDEVAC/CASEVAC be accomplished? • Are litter teams available? (How will they be requested? Where are the resources from? Supported unit? Medical augmentation?) • Locations of patient collecting points and AXP are preplanned. (What are the triggers for activation? • Will ground and or air ambulances be available? (If yes, how will medical evacuation requests be managed?)

Table 13-2. Example precombat checklist for the combat medic during UO.

Is specialized military equipment available? • Flack jackets and/or other body armor. • Chemical Protective Overgarments (CPOG). • Night vision devices (NVDs). • Personnel locator devices. • Chemical lights. • Flares and colored smoke.
Is a marking system developed to mark buildings where casualties can be located?
Have troops been prescribed/issued pretreatments or chemoprophylaxis based on the anticipated threat?
Have personal protective measures (such as insect repellent) supplies/equipment been issued to unit members?
How will contaminated casualties be managed/evacuated?

Table 13-2. Example precombat checklist for the combat medic during UO (continued).

Map of the AO is available (military, commercial, strip maps, aerial imagery, as required).
Location of patient collecting points and AXP are preplanned. (What are the triggers for activation?)
All authorized shelters are on hand and serviceable.
All authorized collective protective equipment and shelters are on hand and serviceable.
Procedures for the management of medical waste are established.
Provisions for water supply are coordinated.
Patient protective measures are instituted (such as patient bunkers or sandbags placed in areas of patient care).
Ambulance turnaround is planned for and established.
Area for patient decontamination operations is planned for and established, when required.
Camouflage material is available if authorized for use.
Medical unit identification markers are on hand.
Class VIII. • Medical equipment is properly calibrated and serviceable. • Medications and other time-sensitive supplies are current. • All authorized MESs are on hand and complete. • Special medications and equipment authorized by the command surgeon for the operation are on hand and current. • Each MES has a packing list on hand. • Authorized number of days of supply are on hand. • Accountability of controlled substances is maintained. • Medical gases are on hand.

Table 13-3. Example precombat checklist for the BAS.

Ground ambulances. • Authorized MES are on hand and complete. • Medical equipment is calibrated and serviceable. • Authorized medical gases (oxygen) are on hand and serviceable. • Authorized medications are on hand and current. • Packing list is available. • Commercial city maps, strip maps, or road maps are available. • On-vehicle materiel (OVM) is on hand. • Situational awareness equipment (position locator) is on hand and serviceable. • Log book is present and current, if applicable. • Communications equipment is on hand, serviceable, and set to the correct frequency. • Medical unit identification markings (in accordance with the Geneva Conventions) are displayed.
Medical/refresher training for combat medics. • Has battalion surgeon initiated training program for combat medics? • Has refresher training been conducted for combat medics?

Refresher training for BAS personnel.
• Has battalion surgeon initiated a training program for BAS personnel?
• Have BAS personnel received refresher training in the care for—
  • Blast injuries?
  • Crush injuries?
  • Head injuries?
  • Complete/incomplete amputations?
  • Missile injuries?

Table 13-3. Example precombat checklist for the BAS (continued).

NOTE: Markings are a red cross on a white background; camouflaged or subdued markings are not authorized. If the unit is required to camouflage, the Geneva Conventions emblem is removed or covered. In accordance with North Atlantic Treaty Organization (NATO) Standardization Agreement 293-1, the Geneva Conventions emblem can be camouflaged (removed) IAW instructions of a brigade-level commander or higher when the tactical situation dictates.

Section III. LEGAL ASPECTS OF URBAN OPERATIONS

Commanders must be familiar with legal aspects of UO including the control of large groups of civilians, protection of key facilities, and civil affairs operations. While this section primarily addresses considerations for brigade and battalion commanders and staffs, many of the issues discussed will also affect company commanders. A judge advocate (JA) should be involved in the planning process and immediately available to commanders for advice during the conduct of UO.

13-14. CIVILIAN IMPACT IN THE BATTLE AREA

The presence of large concentrations of civilians can greatly impede tactical operations.

a. **Mobility.** Fleeing civilians, attempting to escape over roads, can block military movement. Commanders should plan routes to be used by civilians and should seek the assistance of the civil police in traffic control.

b. **Firepower.** The presence of civilians can restrict the use of potential firepower available. Areas may be designated no-fire areas to prevent civilian casualties. Other areas may be limited to small-arms fire and grenades with prohibitions on air strikes, artillery, mortars, and flame weapons. Target acquisition and the direction of fire missions are complicated by the requirement for positive target identification. Detailed guidance on the use of firepower in the presence of civilians will normally be provided to the battalion commander in the form of ROE. In the absence of guidance, the general rules of the law of land warfare apply. Commanders must ensure that all soldiers receive a copy of the written ROE and that soldiers are thoroughly briefed on its contents.

c. **Security.** Security should be increased to preclude:

- Civilians being used as cover by enemy forces or agents.
- Civilians wandering around defensive areas.
- Pilferage of equipment.
- Sabotage.

d. **Obstacle Employment.** The presence of local civilians and movement of refugees influence the location and type of obstacles employed. Minefields may not be allowed on designated refugee routes or, if allowed, must be guarded until the passage of refugees is completed. Booby traps and flame obstacles cannot be emplaced.

13-15. LIMITS OF AUTHORITY

The limits of authority of commanders at all levels over civilian government officials and the civilian populace must be established and understood. A commander must have that degree of authority necessary to accomplish his mission. However, the host government's responsibility for its populace and territory can affect the commander's authority in civil-military matters. In less secure areas, where the host government may be only partly effective, the commander may be called upon to assume greater responsibility for the safety and well being of the civilian populace. Again, depending on the nature of the operation, the brigade and battalion staff will coordinate concerning the limits of command authority and for any non-organic assets needed to accomplish the mission.

13-16. DIVERSION OF MILITARY RESOURCES

Conducting operations in highly populated areas may require the diversion of men, time, equipment, and supplies from combat tasks to accomplish stability and support tasks. If host government agencies collapse, the impact on military resources could be substantial. Battalion TFs and brigades can be given a wide range of stability and support missions that will tax the logistical capabilities of the unit. Commanders must clarify the limits of their authority concerning the commandeering of civilian supplies or equipment in order to facilitate mission accomplishment.

13-17. HEALTH AND WELFARE

The disruption of civilian health and sanitary services sharply increases the risk of disease among both civilian and military personnel. Commanders should minimize contact with the civilian population, unless contact is specifically required for mission accomplishment.

13-18. LAW AND ORDER

The host government may not be able to control mobs. Brigades and battalion TFs may have to augment civilian forces to protect life and property and to restore order, by controlling civil disturbances. The Provost Marshal/brigade MP has the responsibility of coordinating with host nation police to quell civil disturbances. Brigades and battalion TFs may also have to secure vital government facilities for the host nation (see Chapter 5). (See FM 19-15 for more information on how to control civilians violating civil law.)

13-19. PUBLIC AFFAIRS OFFICER AND MEDIA RELATIONS

It is very likely that there will be media representatives in the brigade and battalion's operational area. Brigade and battalion commanders must be prepared to receive and possibly escort journalists in their respective area of operations. Generally, the best way to deal with the media is to receive them and allow them access to soldiers IAW guidance from higher headquarters. While free access to units in the field is desirable, operational security, existing guidelines, and or ROE considerations will take priority and may limit access. All members of the media visiting the field should have an escort officer. This officer may be detailed from line units due to the shortage of trained public affairs personnel. Ensuring the media follows the established guidelines or ROE will help prevent negative publicity that could jeopardize the mission. Media access will be coordinated through the S1, who may be assisted by a public affairs officer.

13-20. CIVIL AFFAIRS UNITS AND PSYCHOLOGICAL OPERATIONS

Civil affairs (CA) units and psychological operations (PSYOP) have essential roles during UO. They are critical force multipliers that can save lives. The battle in urban terrain is won through effective application of necessary combat power, but CA and PSYOP can help facilitate mission accomplishment. CA and PSYOP offer the possibility of mission accomplishment in urban terrain without the destruction, suffering, and horror of battle. These units may become key factors in shaping the urban battlefield and facilitating movement from shaping directly to transition, thus minimizing the amount of close combat conducted by companies, platoons, and squads (see Chapter 4, Sections IV and V).

a. **Evacuation of Civilians.** If the brigade or battalion TF is tasked to facilitate the evacuation of civilians from the AO, the unit is normally augmented by CA personnel. Infantry units may provide security and command and control for the execution of this operation, which is accomplished in two separate but supporting actions.

(1) CA personnel coordinate with the military police and local police officials for evacuation planning. They plan for establishing evacuation routes and thoroughfare crossing control, and for removing civilians from the military supply routes (MSRs).

(2) CA personnel coordinate with U.S. Army PSYOP assets, local government officials, radio and television stations, newspapers, and so on, to publicize the evacuation plan.

b. **Health and Welfare of Civilians.** CA assets will also conduct coordination for the health and well being of civilians. They can include the reestablishment of water systems; distribution of available food stocks and clothing; and establishment of displaced persons, refugee, and evacuee (DPRE) camps. Again, brigades and battalion

TFs may be tasked to provide security and command and control for some of these missions.

c. **Tactical PSYOP.** Tactical PSYOP in support of UO are planned and conducted to achieve immediate and short-term objectives. PSYOP are an integral and coordinated part of the overall tactical plan. They provide the tactical commander with a system that can weaken the enemy soldier's will to fight, thereby reducing his combat effectiveness. They can also help prevent civilian interference with military operations. PSYOP are designed to exploit individual and group weaknesses. For example, infantry units may be given the mission to clear a specific urban objective where it has been determined that a graduated response will be used. The PSYOP unit would be in support of the unit conducting this mission, and they use loudspeakers to broadcast warnings and or incentives not to resist.

e. **Other PSYOP.** PSYOP units also provide support during UO using television, radio, posters, leaflets, and loudspeakers to disseminate propaganda and information. Television, including videotapes, is one of the most effective media for persuasion. It offers many advantages for PSYOP and is appropriate for use during UO. In areas where television is not common, receivers may be distributed to public facilities and selected individuals.

NOTE: See FM 41-10 for further discussion on civil affairs.

13-21. PROVOST MARSHAL

The provost marshal has the responsibility of coordination with the host nation's law enforcement officials. The provost marshal recommends measures to control civilians and direct MP activities in support of refugee control operations. The provost marshal coordinates his activities with staff sections and supporting units in the area. Refugee control operations are the responsibility of the G5 or S5, host nation authorities, or both. MPs assist, direct, or deny the movement of civilians whose location, direction of movement, or actions may hinder operations. The host nation government is responsible for identifying routes for the safe movement of refugees out of an area of operations.

NOTE: Other military police responsibilities, regarding civil affairs and civilian control, are contained in FM 3-19.1(FM 19-1).

13-22. COMMANDERS' LEGAL AUTHORITY AND RESPONSIBILITIES

Commanders and leaders at all levels are responsible for protecting civilians and their property to the maximum extent allowed by military operations. Looting, vandalism, and brutal treatment of civilians are strictly prohibited, and individuals who commit such acts can be severely punished under the UCMJ. Civilians, along with their religions and customs, must be treated with respect. Women must be especially protected against any form of abuse. In urban combat, however, some situations are not always clear. Discussed below are those civilian-military situations most common during UO, and how an infantry commander might manage them to legally accomplish his mission.

a. **Control Measures.** Commanders may enforce control measures to conduct operations, maintain security, or ensure the safety and well being of the civilians.

(1) ***Curfew***. A commander may need to establish a curfew to maintain security or to aid in control of military traffic. (Curfews are not imposed as punishment. They are normally established to reduce noncombatant casualties and provide a measure of force protection.)

(2) ***Evacuation.*** A commander can require civilians to evacuate towns or buildings if the purpose of the evacuation is to use the town or building for imperative military purposes, to enhance security, or to safeguard those civilians being evacuated. If the commander takes this action, he must specify and safeguard the evacuation routes. Food, clothing, medical, and sanitary facilities should be provided or available at the destination until the evacuees can care for themselves. Evacuated civilians must be transferred back to their homes as soon as hostilities in the area have ceased. The staff must plan for and coordinate the movement and evacuation of civilians to ensure their actions do not interfere with the military operation. The S5, brigade JA, S3, S2, and supporting civil affairs units working with local officials coordinate the movements of civilians.

(3) ***Forced Labor.*** The Geneva Accords prohibit the use of civilians in combat. However, they may be used before the battle reaches the city. Commanders will be given guidelines for use of civilian labor. The brigade or battalion TF may force civilians over 18 years of age to work if the work does not oblige them to take part in military operations. Permitted jobs include maintenance of public utilities as long as those utilities are not used in the general conduct of the war. Jobs can also include services to local population such as care of the wounded and burials. Civilians can also be forced to help evacuate and care for military wounded, as long as doing so does not involve any physical danger. Prohibited jobs include digging entrenchments, constructing fortifications, transporting supplies or ammunition, or acting as guards. Volunteer civilians can be employed in such work. Brigade and battalion TF commanders normally will not order forced civilian labor. However, they may find themselves supervising such labor in their area of operations.

b. **Civilian Resistance Groups.** Units may encounter civilian resistance groups whose actions may range from lending supplies, services, and noncombat support to the enemy to actively fighting against friendly forces. Members of such resistance groups should be dealt with in accordance with applicable provisions of the law of war. Commanders should seek guidance from the JAG concerning the detention and disposition of persons participating in acts harmful to friendly forces. The S2, brigade JA, PSYOP, MP, and civil affairs units must work together to identify these threats and recommend, within the ROE, the appropriate preemptive action or response, when required. The activities of resistance groups may also benefit friendly forces. They may provide HUMINT; act as guides, liaisons or translators; and provide subject matter expertise on local public facilities such as refineries, power plants, and water works. They may also provide active resistance against the threat. Another situation that brigade and battalion commanders might encounter is combat with a civilian resistance group.

(1) ***Accompanying Civilians.*** Civilians who are accompanying their armed forces with an identity card authorizing them to do so are treated as enemy prisoners of war (EPWs). For example, when captured; civilian members of military aircraft crews, war correspondents, supply contractors, and members of labor units or service organizations responsible for the welfare of the armed forces.

(2) ***EPWs.*** Civilians are treated as EPWs when captured if they—

- Are from a nonoccupying territory and have taken up arms against an invading enemy without time to form regular armed forces.
- Wear a fixed, distinctive insignia that can be seen at a distance and carry their weapons openly.
- Operate according to the rules and customs of war.

Other civilians who provide assistance to such groups may not be entitled to status as combatants, depending upon whether they are actually members of the resistance group. Any person whose status is in question should be treated as an EPW and be accorded all corresponding protections, rights, and privileges. Consult the JA.

(3) ***Armed Civilian Groups.*** Armed civilian groups that do not meet the criteria of a legal resistance (civilians accompanying their armed forces and mass conscription) or individuals caught in the act of sabotage, terrorism, or espionage are not legal combatants. If captured, they must be considered criminals under the provisions of the law of land warfare. They should be detained in a facility separate from EPWs and should be quickly transferred to the military police. Reprisals, mass punishments, taking of hostages, corporal punishment, pillage, and destruction of property are prohibited punishments. However, any person whose status is in question should be treated as an EPW and be accorded all corresponding protections, rights, and privileges. Consult the JA.

(4) ***Civilian Control.*** The law of land warfare lets a commander control the civil population under the conditions already described using his own resources. However, because of language and cultural differences between U.S. and foreign personnel, it is advised to use native authorities, such as the police, for such purposes. Use of the police does not relieve a commander of his responsibility to safeguard civilians in his area. Infantry units may be required to engage in these type of operations as part of a joint task force.

c. **Protection of Property.** Like civilian personnel, buildings and towns normally have a protected status—specifically, they are not legal targets. Buildings and towns lose their protected status if authorities determine that the enemy is using them for military purposes. If doubt exists as to whether a town or building is defended, that doubt should be settled by reconnaissance, not by fire.

(1) ***Legal Targets.*** If the enemy is using a building or a portion of the town for military purposes—for example, as a supply point or a strongpoint—that building or that portion of the town is a legal target. Before engaging the target, the commander must decide if fire on the target is necessary. Only such destruction as is required for military purposes is justified.

(2) ***Restricted Facilities/Objects.*** Normally, religious, historical, and cultural facilities/objects and buildings are not legal targets. They are sometimes marked with symbols to signify their cultural status. Medical facilities, personnel, and equipment are protected under provisions listed in Article 39 (GWS) and shall bear one of the following emblems on a white background: the internationally recognized Red Cross, Red Crescent, Red Lion, or Red Star of David. The fact that such symbols are absent does not relieve a commander of his responsibility to protect objects he recognizes as having religious, cultural, medical, or historical value.

(3) ***Misuse of Restricted Facilities/Objects.*** The misuse of such facilities/objects by the enemy is grounds to disregard their protected status. Whenever possible, a demand should be made for the enemy to stop his misuse of the protected object within a reasonable time. If an enemy forward observer uses a church for an OP, for example, a commander would be justified in destroying it immediately because a delay would allow the enemy to continue the misuse of the church. If a religious shrine were used as a telephone switchboard, a warning would be appropriate, since it would take some time to dismantle the wires. Once the decision to order fires on those objects is reached, destruction should be limited to the least necessary in order to neutralize the enemy installations.

(4) ***Destruction or Damage to Property.*** The destruction, demolition, or military use of other buildings is permitted under the law of land warfare, if required by clear military necessity. Thus, destroying a house to obtain a better field of fire would be a legal act—destroying it as a reprisal would not be. Likewise, firing on any houses that are occupied or defended by an enemy force is legal.