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Updated briefing on the death of Jimmy Mubenga

May 2013

1. INTRODUCTION

1.1 On 12 October 2010, Mr Mubenga died whilst being restrained during a removal from the UK. He was being escorted by three private security guards working for Group 4 Services (G4S) contracted by the UK Border Agency (UKBA).

1.2 INQUEST has been working with his family since his death and arranged specialist lawyers to assist them in the complex investigation processes that follow contentious deaths[1]. We are working to ensure proper scrutiny of Jimmy Mubenga's death and the wider issues this death raises about the treatment of people in immigration detention.

1.3 The inquest is listed from 13 May to 5 July 2013 before Karon Monaghan QC at Isleworth Crown Court.[2]

1.4 This briefing covers:

- a case summary;
- background information on restraint-related deaths;
- key issues regarding the use of force during removals such as:
    - parliamentary concerns about the use of excessive force in other cases;
    - details about INQUEST's push for greater transparency and scrutiny of the techniques used including our support for Liberty's legal challenge to the UKBA's policy on the use of force on immigration detainees on aircraft.

2. CASE SUMMARY

2.1 Jimmy Mubenga, a healthy 46 year old Angolan man, died on 12 October 2010 whilst being restrained by three G4S security guards on a flight from Heathrow airport to Angola. G4S[3] is a private security firm which was contracted by UKBA to escort deportees on flights at the time of Mr Mubenga's death.[4]

2.2 According to newspaper reports eyewitnesses on board the flight reported that the guards used excessive force when restraining Mr Mubenga, despite the fact that he showed no signs of violence or aggression. Mr Mubenga was heard complaining that he could not breathe and that "they are going to kill me."[5]

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[1] Jimmy Mubenga's widow Adrienne Makenda Kambana is represented by INQUEST Lawyers' Group members Mark Scott of Bhatt Murphy solicitors and barristers Henry Blaxland QC of Garden Court Chambers and Fiona Murphy of Doughty Street Chambers.

[2] A press release on the inquest is available on the INQUEST website.

[3] G4S is the world's largest private security company, with headquarters in the UK and operations in 125 countries. It operates police services, public surveillance, schools, hospitals as well as prisons, immigration removal centres and court and prison cells. The company reported that its UK Government contracts were worth £1 billion in 2012 (of which the Olympics contract accounted for around £284 million).

[4] The contract with UKBA to escort deportees on flights was taken over by Reliance Security Services in April 2011.

[5] The Guardian 15 October 2010.

2.3 Mr Mubenga left behind a widow and five children who were aged one to 17 years at the time of his death.

2.4 Following his death, there was a police investigation, which was subsequently passed to the Crown Prosecution Service (CPS). In July 2012 the CPS made the decision not to prosecute the guards involved[6]. Gaon Hart, Senior Crown Advocate, stated that there was "insufficient evidence to bring any charges for Mr Mubenga's death.[7]

3. RESTRAINT-RELATED DEATHS

3.1 Since 1990, INQUEST has worked on restraint-related deaths in police, prison and psychiatric custody, many of which have generated high profile media coverage and parliamentary and public disquiet. A disproportionate number of these deaths have involved people from Black and Minority Ethnic communities, raising concerns about racism and discrimination by state agents. A number of these cases resulted in unlawful killing and other critical inquest findings and led to coroners' recommendations to prevent future similar deaths. They have also generated significant parliamentary debate and inquiry. These deaths have resulted in enhanced awareness of the dangers of asphyxia associated with particular methods of restraint and led to changes in policy and practice.

3.2 In 2003, INQUEST gave detailed written evidence to the Parliamentary Joint Committee on Human Rights Inquiry into Deaths in Custody.[8] In evidence we raised our concerns about restraint-related deaths and the lack of joined-up thinking and learning between government agencies:

> *Evidence of dangerous practice and culture has emerged but the lessons to be learned have not been applied to the range of organisations that are increasingly involved in restraining people:*
> - *police and prison officers and those working in psychiatric custody;*
> - *immigration officers;*
> - *private security firms detaining asylum seekers;*
> - *security guards;*
> - *and those working in care homes for children, people with learning disabilities and older people.*

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[6] CPS decision on death of Jimmy Mubenga, 17 July 2012. https://www.cps.gov.uk/news/latest_news/cps_decision_on_death_of_jimmy_mubenga/.

[7] This decision was widely questioned, for example by the former Chief Inspector of Prisons, Lord Ramsbotham, who told the House of Lords that he found the decision not to prosecute "perverse". Lords Hansard, 19 July 2012: Column 392.http://www.publications.parliament.uk/pa/ld201213/ldhansrd/text/120719-0002.htm#12071967000662. INQUEST also issued a press release: http://www.inquest.org.uk/press-releases/press-releases-2012/inquest-response-to-cps-decision-not-to-prosecute-g4s-security-guards-involved-in-death-of-jimmy-mubenga

[8] INQUEST submission to the Joint Committee of Human Rights, JCHR Deaths in Custody: Interim Report and Findings, 2003, p105.

> *In the majority of restraint-related deaths, coroners have reiterated their concerns about restraint training and made recommendations but there is no mechanism for monitoring such recommendations and their communication and subsequent implementation across relevant government departments. In our view this failure to act and ensure inter-agency communication and collaboration in terms of policy and practice around restraint has resulted in more deaths and serious injury.*[9]

3.3 In April 2004 Gareth Myatt, a 15 year old mixed race boy, died in Rainsbrook Secure Training Centre (STC).[10] Attention focused on the use of restraint by privately-contracted G4S who ran the centre. Gareth was the first child to have died in a STC and the first to die following the use of force. Custody staff used a method of restraint called the 'seated double embrace.' This involved two guards holding down his upper body whilst another guard held Gareth's head pushing it down towards his knees. Despite Gareth saying that he could not breathe staff, continued to restrain him until he went limp. He died from asphyxia as a direct result of the restraint used against him. Following Gareth's death and medical concerns about asphyxia, this technique was withdrawn from use.

3.4 Gareth Myatt's death highlighted the dangers of restraint in the seated position. It also raised concerns over inter-agency communication and cross-sector learning from the fatal use of certain restraint techniques.

3.5 While the number of restraint-related deaths are a small minority of the total numbers of deaths in custody, they have been the most controversial because of what they have revealed about the excessive use of force by functionaries of the state, lack of proper training and/or awareness of the risks associated with some restraint techniques and the inadequacy of oversight mechanisms.

4. ALLEGATIONS OF ILL-TREATMENT AND EXCESSIVE FORCE ON IMMIGRATION DETAINEES

4.1 INQUEST is extremely concerned about the issues arising from Mr Mubenga's death and, in particular, the legality of the restraint used. His is the first restraint-related death of an immigration detainee since the death of Joy Gardner in 1993 when excessive and brutal restraint, including her being bound with thirteen feet of masking tape and body belts, resulted in Ms Gardner's death.

4. 2 According to newspaper reports, in 2006 the Home Office warned G4S that restraint techniques used by its guards potentially impeded breathing and could result in a fatality. It is understood that a letter titled 'positional asphyxia' was circulated to all G4S staff in 2006 after

[9] Ibid. p107.
[10] INQUEST's *Briefing on the Death of Gareth Myatt*, February 2007- available from www.inquest.org.uk.

guards were spotted using an unauthorised form of restraint.[11] It is unclear what remedial action was taken by G4S following this.

4.3 Complaints of excessive force by immigration detainees were documented in 2008 in the Outsourcing Abuse dossier[12] which made ten key findings, including "what may have started off as reasonable force turned into what we consider to be excessive force. Sometimes, however, force was used when the officers had no power to use force at all."(p.13)

4.4 Following receipt of this dossier, Baroness Nuala O'Loan conducted an independent review[13] and made a number of recommendations for the improvement of removals and the complaints investigation process including:

> *12. There should be a review of the training provided for the use of force, and of the annual retraining, to ensure that, in any case in which force is used, officers are trained to consider constantly the legality, necessity and proportionality of that use of force. (p11)*

4.5 That report was issued in March 2010, seven months before Mr Mubenga's death. Other press reports have highlighted complaints by people of excessive force being used by G4S during attempted removals, including Mr Jose Gutierrez[14], Ludovic Paykong[15] and Bienvenue Mbombo.[16]

4.6 Reliance Security Task Management Limited took over the contract to oversee forced removals from the UK from G4S in May 2011[17]. The guards involved in the removal that led to Mr Mubenga's death were apparently re-employed by Reliance. Furthermore, the Independent Police Complaints Commission (IPCC) has severely criticised the manner in which Reliance treated people in custody.[18] Consideration needs to be given, therefore, to whether Reliance has addressed the IPCC complaints.

5. HOME AFFAIRS COMMITTEE INQUIRY AND REPORT ON THE UKBA

5.1 The Home Affairs Committee (HAC) is appointed by the House of Commons to examine the expenditure, administration and policy of the Home Office and its associated public bodies. The HAC, chaired by Keith

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[11] The Guardian 8 February 2011.
[12] Outsourcing Abuse, A report by Birnberg Peirce & Partners, Medical Justice and the National Coalition of Anti-Deportation Campaigns, July 2008.
[13] Report to the United Kingdom Border Agency on 'Outsourcing Abuse' by Baroness Nuala O'Loan, March 2010.
[14] The Guardian 21 October 2010.
[15] The Guardian 1 November 2010.
[16] The Guardian 13 January 2011.
[17] On 14 January 2013, Reliance was re-named Tascor: www.tascor.co.uk/news/
[18] House of Commons Home Affairs Committee, The Work of the UK Border agency, 4th Report of Session 2010-11, 21 December 2010. Q46 to Q51.

Vaz, conducted an inquiry and produced a report on the rules governing enforced removals from the UK, published in January 2012. [19]

5.2 During the course of the inquiry, the Committee held two evidence sessions into the work of the UKBA which also heard evidence on the use of restraint during deportations.[20] The evidence given by Lin Homer, then Chief Executive of UKBA, is that guidance is given to contractors and that: "We have requirements within our contracts that contractors train their employees appropriately, that they follow the guidelines for force." In response to this evidence, the Committee said:

> *we are not at all convinced that the UK Border Agency is being effective in making sure that its contractors provide adequate training and supervision of their employees in respect of the use of force. This is a fundamental responsibility of the Agency and is not simply a matter of clauses in contracts or formal procedural requirements.* [21]

5.3 Four whistleblowers from within G4S sent detailed testimony to the HAC during the course of its investigation, alleging that a banned restraint technique referred to within the company as 'carpet karaoke' continued to be used in immigration removals. The technique involves the forceful holding down of a person's head between their legs.

5.4 The oral evidence of Mr Small and Mr Banks, two G4S managing directors is that no such technique is employed by their staff. They stated that they have never been contacted by any G4S staff members raising concerns about any aspect of the removal process or illegal restraint techniques.

5.5 In its final report, the Committee found evidence of:

- Inappropriate use of physical restraint, and the possible use of unauthorised and potentially dangerous restraint techniques;
- Weaknesses in passing on information about detainees' medical conditions to all the relevant staff;
- Use of racist language by contractors, which was not challenged;
- Use of excessive numbers of contractor staff.

6. THE UKBA'S USE OF FORCE POLICY

6.1 The United Nations Report of the Committee Against Torture (UNCAT) has also raised concerns over the use of private contractors for enforced removals, and noted specific concerns about the use of head-down

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[19] House of Commons Home Affairs Committee, *Eighteenth Report: Rules governing enforced removals from the UK*, January 2012.
http://www.publications.parliament.uk/pa/cm201012/cmselect/cmhaff/563/56302.htm

[20] House of Commons Home Affairs Committee, *Uncorrected Transcript of Oral Evidence,* HC 563-I 2 November 2010; and House of Commons Home Affairs Committee, The *Work of the UK Border agency, 4th Report of Session 2010-11*, 21 December 2010.
http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhaff/587/58702.htm

[21] Ibid, para 11

restraint techniques.[22] Concerns about the use of excessive force against detainees were raised by UNCAT as far back as 2005,[23] and remain unresolved eight years on.

6.2 A judicial review claim challenging the lawfulness of the UK Border Agency's use of force policy in relation to immigration detainees was heard by the High Court in February 2013. The case was brought by lawyers at the human rights and civil liberties organisation Liberty[24], and supported by INQUEST, who provided a witness statement documenting the importance of transparency, publication and scrutiny of the use of force in the context of children in custody and the significance of this learning in the context of immigration detainees.[25]

6.3 The judicial review brought by Liberty focused on the adequacy of the framework for restraint of those subject to removal from the UK when on board an aircraft, and argued that the current framework breaches Article 3 of the European Convention on Human Rights and potentially Article 2. It also highlighted the importance of transparency and availability of information on the policies and techniques used in order to understand risk and take protective preventative measures to safeguard lives.

6.4 The challenge was rejected by Mr Justice Foskett, but Liberty has lodged an appeal with the Court of Appeal. These proceedings are likely to take place in late 2013.

6.5 A key passage in the judgment[26] records the evidence heard in court that UKBA had commissioned their own internal report regarding the use of restraint on aircraft in 2008, and that this had made a series of recommendations included that "[no] seated restraint is to use the head support position from the front" (recommendation 9)[27]. Other recommendations of significance in the July 2008 report were:

> *1. That a facility be sought to provide training in … realistic scenarios. More specifically this would involve an aircraft with centre [aisle] and passenger seats on both sides which replicates the chartered aircraft currently being used.*
> *…*
> *4. Develop a system for use of mechanical restraints, this to include handcuffs, leg restraints, spit hoods and body restraints.*

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[22] EHRC Submission to the UN Committee Against Torture: response to list of issues on the UK's 5th periodic report, April 2013. INQUEST's April 2011 Briefing on the death of Jimmy Mubenga was submitted to UNCAT and other international human rights bodies.
[23] United Nations Report of the Committee Against Torture, 3 October 2005, para 39 (i).
[24] http://www.liberty-human-rights.org.uk
[25] For more details of INQUEST's work on the deaths of children in custody following restraint and our expert evidence in support of CRAE's Information Tribunal challenge to the Youth Justice Board's decision not to publish the "Physical Control in Care" restraint manual see: http://inquest.gn.apc.org/website/press-releases/press-releases-2010/youth-justice-board-climbdown-child-restraint-manual-to-be-released
[26] *Z, R (on the application of) v Secretary of State for the Home Department* [2013] EWHC 498 (Admin) (12 March 2013) http://www.bailii.org/ew/cases/EWHC/Admin/2013/498.html
[27] See paragraph 23, *Z* judgment

Re-assess the current type of handcuffs being used for escort procedures.
5. Techniques are developed that are applicable when fewer than three staff are present. This to include restraint techniques in a seated position.

6.6 The UKBA commissioned report was never published and there is no evidence that the recommendations were properly followed up by the UKBA or other government bodies – either at the time of the report or at any time subsequently[28].

6.7 However, the UKBA was aware that the use of restraint on an aircraft was a significant problem. Minutes of a meeting attended by various UKBA and NOMS representatives on 5 October 2010 recorded: "On a separate issue the difficulties being experienced by the overseas escort team was discussed. At present they are trained in C&R and PCC, however this presents numerous concerns when it comes to physical restraint on an aeroplane or in the back of an escort vehicle on the road"[29]. A week later Mr Mubenga died.

7. NON-DISCLOSURE OF THE USE OF FORCE MANUAL

7.1 Following Mr Mubenga's death, INQUEST requested a full unredacted copy of the guidance covering the use of force and restraint provided to UK Border Agency escorting contractors. The request was refused by UKBA, which cited security concerns for non-disclosure. INQUEST submitted a request for an internal review of the decision, but the request was finally rejected by the Home Office in May 2011. In September 2011, INQUEST lodged a complaint with the Information Commissioner who, in March 2012 ordered UKBA to release more pages of the current manual, but not the full unredacted version[30].

7.2 INQUEST maintains that without access to the full unredacted document it is not possible to properly scrutinise and monitor the safety of the use of restraint or to be satisfied that current techniques in use are any safer than those employed at the time of Mr Mubenga's death.

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[28] See paragraphs 22-26, *Z* judgment. Following the UKBA's July 2008 report the escorting contractor G4S issued an instruction to their staff in September 2008 pointing out that: "An immediate recommendation from this review is that there must be no use of the head support position. This is not a position that we have shown in our training but it is worth re-emphasising the point to ensure that there is no misunderstanding. The head support position is where the detainee's head is controlled by pushing it into their lap, similar to the "crash position". Medical advice suggests that use of the head support position in a confined space can increase the likelihood of positional asphyxia. The risk is heightened when the detainee is in an excited or distressed state."

[29] See paragraph 26, *Z* judgment

[30] The full ICO decision notice can be found via: http://ico.org.uk/~/media/documents/decisionnotices/2012/fs_50419564.ashx

8. CONCLUSION

8.1 As well as the investigation into the acts of individual custody staff, this case raises significant issues about corporate accountability and the culture of responsibility of G4S in dealing with restraint and their oversight by the UKBA.

8.2 INQUEST continues to support the family of Jimmy Mubenga and to highlight the risk to life arising from the use of contracted companies, the lack of oversight and monitoring, and the lack of training and supervision of their staff. It appears that an evidence base existed within UKBA and G4S about allegations of ill treatment and excessive and dangerous restraint prior to Mr Mubenga's death. The question of what action was taken as a result of these serious concerns remains unanswered.