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# Briefing on the death of Jimmy Mubenga

**The restraint-related death of Jimmy Mubenga during deportation by a private security firm: the call for a parliamentary inquiry and scrutiny by human rights mechanisms**

April 2011

## 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 Following his death INQUEST were put in touch with his family through a journalist and were able to arrange specialist lawyers to assist them in the complex investigation processes that follow contentious deaths. INQUEST is working closely with his family and lawyers to ensure proper scrutiny of Jimmy Mubenga's death and the wider issues this death raises about the treatment of people in immigration detention. The investigations being conducted into specific circumstances of Mr Mubenga's death are likely to be lengthy and there will inevitably be significant delay before any public scrutiny of the surrounding events. On 19 November 2010, INQUEST and Medical Justice[1] organised a joint public parliamentary meeting chaired by Lord Ramsbotham. The meeting concluded there needed to be an urgent parliamentary inquiry into the use of force during deportations.

1.3 The inquiry call has been given added impetus in light of the recent revelations in *The Guardian* newspaper[2] by G4S whistleblowers who state that concerns over the use of force had been raised with senior management on a number of occasions prior to the death of Jimmy Mubenga. This contradicts evidence by UKBA given to parliament and INQUEST is of the view that a parliamentary inquiry is now of the utmost importance in order to safeguard lives and to prevent further deaths and injuries.

## 2. CASE SUMMARY

2.2 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 is contracted by UKBA to escort deportees on flights until the end of April 2011.

2.3 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."[4]

2.4 Mr Mubenga leaves behind a widow and five children aged one to 17 years.

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[1] www.medicaljustice.org.uk
[2] *The Guardian* 8 February 2011.
[3] G4S receives more than £600 million from the government for services including the running of four prisons, three immigration removal centres and 675 court and prison cells. It is the second largest private employer in the world and has a £7 billion turnover.
[4] *The Guardian* 15 October 2010.

## 3. RESTRAINT-RELATED DEATHS

3.1 INQUEST has worked since 1990 on a number of 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.[5] 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.*
>
> *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.*[6]

*3.3* 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.

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[5] INQUEST submission to the Joint Committee of Human Rights, *JCHR Deaths in Custody: Interim Report and Findings*, 2003, p105.
[6] *Ibid.* p107.

## 4. ALLEGATIONS OF ILL-TREATMENT AND EXCESSIVE FORCE

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 In April 2004 Gareth Myatt, a 15 year old mixed race boy, died in Rainsbrook Secure Training Centre (STC).[7] 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.

4.3 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.

4.4 According to recent 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 guards were spotted using an unauthorised form of restraint.[8] It is unclear what remedial action was taken by G4S following this.

4.5 Complaints of excessive force by immigration detainees were documented in 2008 in the *Outsourcing Abuse* dossier[9] 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)

4.6 Following receipt of this dossier, Baroness Nuala O'Loan conducted an independent review[10] and made a number of recommendations for the improvement of removals and the complaints investigation process including:

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

[8] *The Guardian* 8 February 2011.

[9] *Outsourcing Abuse, A report by Birnberg Peirce & Partners, Medical Justice and the National Coalition of Anti-Deportation Campaigns*, July 2008.

[10] Report to the United Kingdom Border Agency on 'Outsourcing Abuse' by Baroness Nuala O'Loan, March 2010.

> *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)

4.7 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[11] and Bienvenue Mbombo.[12]

4.8 It appears that an evidence base existed within UKBA and G4S about allegations of ill treatment and excessive and dangerous restraint. The question this begs is what action was taken as a result of these serious concerns.

## 5. THE HOME AFFAIRS COMMITTEE INQUIRY

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 Vaz, held two evidence sessions into the work of the UKBA which also heard evidence on the use of restraint in deportations.[13]

5.2 Of significant importance is the detailed testimony sent to the HAC of four whistleblowers within G4S that a banned restraint technique referred to within the company as 'carpet karaoke' continued to be used in immigration removals. This technique involves the forceful holding down of a person's head between their legs.

5.3 The evidence of Mr Small and Mr Banks, two G4S managing directors, to the HAC is that no such technique is employed by their staff. In fact, Mr Small stated:

> *There is no training in pushing the head downwards. There is training in trying to keep the deportee upwards. There's no neck holds or head holds used.* [14]

5.4 The oral evidence given to the committee by Mr Small and Mr Banks is that they do not employ techniques involving head holds and that they have never been contacted by any G4S staff members raising concerns about any aspects of the removal process, the use of excessive force, or illegal restraint

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[11] *The Guardian* 21 October 2010.
[12] *The Guardian* 13 January 2011.
[13] 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.
[14] House of Commons Home Affairs Committee, *Uncorrected Transcript of Oral Evidence. HC 563-I*, 2 November 2010.

techniques.[15] The whistleblowers went on to add that G4S offered financial incentives to remove people from the UK. This was repudiated by Mr Banks, who stated:

> *No, there is no bonus incentive in that way. We are remunerated under the contract on the basis of the work we do, not the achievement of a successful removal.* [16]

5.5 This is in stark contrast to the submissions of the G4S whistleblowers/employees to the HAC.

5.6 Lin Homer's evidence to the HAC on 9 November 2010 regarding the use of restraint in deportation cases is that guidance is provided to contractors and that: "We have requirements within our contracts that contractors train their employees appropriately, that they follow the guidelines for force."[17]

5.7 In their conclusions to the short inquiry, the HAC found they:

> *...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.*[18]

5.8 Such discrepancies of knowledge and understanding of restraint techniques within an organisation responsible for the transportation of often vulnerable people gives cause for concern over the legality of such techniques and the lack of training.

5.9 INQUEST understands through a Parliamentary answer that there was a temporary ban on the use of restraint in deportation cases, but following a UKBA review the use of restraint was re-instigated. No details of the review, its terms of reference, evidence gathering or its conclusions have been made public. In any event an internal review is inadequate to satisfy the public interest that the techniques employed are appropriate, safe and lawful.

5.10 Reliance Security Task Management Limited has been awarded the contract to oversee forced removals from the UK, replacing G4S as of 1 May 2011. However, the use of a further private security firm continues to be a cause of concern particularly as the Independent Police Complaints Commission (IPCC) severely criticised the manner in which Reliance treated people in custody.[19]

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[15] *Ibid.* Q16 to Q24.
[16] *Ibid*. Q39.
[17] House of Commons Home Affairs Committee, *The Work of the UK Border Agency. 4th Report of Session 2010-11*, 21 December 2010.
[18] *Ibid.*
[19] *Ibid.* Q46 to Q51.

5.11 Consideration needs to be given to whether Reliance will inherit former G4S employees, what training will be provided to their staff and how have Reliance addressed the IPCC complaints. It is essential that the UKBA effectively monitors the training provided by its contractors in the use of restraint as highlighted by the HAC above. An independent enquiry would be pertinent at this stage given the change in and concerns over the new contracted security firm.

## 6. NON-DISCLOSURE OF RESTRAINT MANUAL

6.1 Lin Homer informed the committee that G4S were no longer contracted to UKBA. However, she also stated that she was satisfied that where there had been complaints, G4S had taken action and made improvements.[20] Yet UKBA have refused to disclose the current restraint guidance to INQUEST and have cited security concerns for non-disclosure.[21] It is not possible to scrutinise the current restraint process or to be satisfied that the current process is in fact any different to that employed at the time of Mr Mubenga's death without access to the full unredacted document.

## 7. PARLIAMENTARY COMMITTEE INQUIRY

7.1 INQUEST therefore calls for a parliamentary committee inquiry into use of restraint and force in deportation cases.

7.2 The terms of reference for such an inquiry should include:

I. The use of private companies in the removal process and the training such companies provide in control and restraint methods.
II. What are the approved control and restraint methods used by the UKBA and its contractors.
III. The current process for investigating complaints, injuries or deaths arising from restraint during deportation.

7.3 The latest UNCAT report[22] raised specific concerns around "allegations and complaints against immigration staff, including complaints of excessive use of force in the removal of denied asylum seekers." Their concerns were raised as far back as 2005 and are of immediate relevance in view of the death of Jimmy Mubenga and the numerous complaints raised by other deportees cited above.

7.4 INQUEST has also reported its concerns about the death of Jimmy Mubenga to the relevant United Nations Special Rapporteurs on Extra Judicial, Summary

[20] *Ibid*. Q.52.
[21] On 9 December 2010 INQUEST requested a full unredacted copy of the current guidance covering the use of force and restraint provided to UK Border Agency escorting contractors. On 7 February 2011 UKBA informed inquest a full unredacted copy would not be provided. INQUEST submitted a request for an internal review of this decision on 6 April 2011 and expect to receive a substantive from response from UKBA by 8 May 2011.
[22] United Nations *Report of the Committee Against Torture*, 3 October 2005, para 39 (i).

or Arbitrary Executions; on Torture; and on Contemporary Forms of Racism; as well as to the Council of Europe's Committee on the Prevention of Torture.

7.5 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 proper oversight and monitoring, and the lack of training and supervision of their staff. It is imperative that a parliamentary committee inquiry is held to ensure there are no further deaths. Quite apart from 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, which warrants separate investigation.

## 8 ABOUT INQUEST

8.1 INQUEST has a proven track record in delivering an award-winning, free in-depth specialist casework service on deaths in state detention or involving state agents[23]. It works on other cases that also engage article 2, the right to life, of the European Convention on Human Rights and/or raise wider issues of state and corporate accountability. It monitors public interest inquests and inquiries into contentious deaths to ensure the issues arising inform our strategic policy and legal work. INQUEST undertakes research and develops policy proposals to campaign for changes to the inquest and investigation process. Its overall aim is to secure an investigative process that treats bereaved families with dignity and respect; holds those responsible to account and disseminates the lessons learned from the investigation process in order to prevent further deaths occuring. Our casework service informs our research, parliamentary and policy work and we are widely consulted by government ministers and departments, MPs, lawyers, academics, policy makers, the media and the general public.

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[23] This includes deaths in prison, in police custody, following police contact, fatal shootings by police, deaths in immigration detention, of detained patients and in secure training centres.