REPORT BY THE ASSISTANT DEPUTY CORONER

Karon Monaghan QC

UNDER THE CORONER'S RULES 1984, Rule 43

INQUEST INTO THE DEATH OF JIMMY KELENDA MUBENGA

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Report by the Assistant Deputy Coroner, Karon Monaghan QC

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A. Introduction

1. This report is made pursuant to Rule 43 of the Coroner's Rules 1984, SI 1984/552 (as amended by The Coroner's (Amendment) Rules 2008, SI 2008/1652)[1] which provides as follows:

> *"(1) Where –*
>
> *(a) a coroner is holding an inquest into a person's death;*
>
> *(b) the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future; and*
>
> *(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,*
>
> *the coroner may report the circumstances to a person who the coroner believes may have power to take such action."*

2. In accordance with Rule 43(4), a copy of this report is being sent to the Lord Chancellor and all interested parties (within the meaning of Rules 19 and 20)[2] and to such persons as I consider appropriate on the basis that I consider that they may find it useful or of interest[3], in particular on the basis that they may have power to take some action to address the circumstances and risks identified. A full list of recipients is set out in Annex A.

[1] This Report was sent to the recipients after relevant provisions of the Coroners and Justice Act 2009 (Sch 5, para 7) were brought into force. However, the Inquest concluded before their coming into force and accordingly the new provisions do not apply (The Coroners (Investigations) Regulations 2013, Reg 3).

[2] To all of whom I am required to send this: Rule 43(4)(a), of the Coroner's Rules 1984 (as amended by the Coroner's (Amendment) Rules 2008). The Ministry of Justice is, in any event, an interested person.

[3] To whom I am permitted to send this report: Rule 43(4)(b).

3. Rule 43A(1) of the Coroner's Rules 1984 requires the recipients of this report under Rule 43(1) to give a written response within 56 days[4] of the report being sent to them. The responses are to contain details of any action that has been taken or which it is proposed will be taken whether in response to the report or otherwise, or an explanation as to why no action is proposed.[5] Copies of any responses will be sent to the Lord Chancellor.[6] The Lord Chancellor may publish any response, or a summary of it, and may send a copy of it to any person who the Lord Chancellor believes may find it useful or of interest.[7] Further, subject to any representations from a party providing a response,[8] any responses to the report will be shared with those to whom this report is being sent.[9] If, having considered any representations from a party providing a response, I consider that that response should not be shared with those or all of those to whom this report is being sent, I shall make (and publish) a decision to that effect and I will prepare a summary of that response and send a copy of that summary to all of those to whom this report is being sent, including the Lord Chancellor who may then publish that summary and send a copy of it to any person who the Lord Chancellor believes may find it useful or of interest.[10]

4. As to from whom a response to this report is required, those persons are listed in Annex B.

5. As to those persons to whom this report is being sent but from whom a response is not required, those persons are listed in Annex C.

B. The Inquest

6. An inquest into the death of Jimmy Kelenda Mubenga was conducted by me with a jury between 13th May 2013 and 9th July 2013. At the conclusion of the jury's deliberations, I announced that I would be making a report to the relevant

[4] By Rule 43B, I may extend the period of 56 days should an application for the same be made.
[5] Rule 43A(1)(a)-(b).
[6] Rule 43A(2)(a)(i).
[7] Rule 43A(3), subject to Rule 43A(6).
[8] Under Rule 43A(4).
[9] Rule 43A(2)(a)(ii) and (b).
[10] Rule 43A(6)-(7).

authorities, pursuant to Rule 43.[11] I decided to make such a report having regard to the evidence that I heard and the facts and matters set out below.

7. Mr Mubenga died on 12th October 2010 whilst in the custody of three Detention and Custody Officers (DCOs) employed by G4S. G4S, at that time, held a contract with the Home Office for the delivery of certain immigration-related services, including pertaining to the detention and removal of immigration detainees. Subject to what is said below at §27, the DCOs were empowered by statute to use reasonable force to effect a removal. All three DCOs had had training in the use of force and, in particular, in 'Control and Restraint' (C&R), as it was labelled. That training included training on various holds and locks and pain control techniques which could be applied to subdue a detainee pending the application of restraint. That training was contractually required to be delivered and was prescribed by the *"Use of Force"* training manual.

8. Mr Mubenga was an Angolan national. He arrived in the United Kingdom in 1994 with his wife, Mrs Kambana, from Angola. They applied for asylum but their applications were refused, though they were granted exceptional permission to stay in the UK, initially for four years. Mr Mubenga and Mrs Kambana had made a subsequent application for indefinite leave to remain in the UK, when on 24 March 2006 Mr Mubenga was convicted of assault occasioning actual bodily harm for which he was sentenced to 2 years imprisonment. On 13 March 2007, and because of that conviction, Mr Mubenga was notified that a decision had been taken to deport him back to Angola. After his release from prison, he was detained off and on pending his removal. Removal directions were ultimately set for 12th October 2010 by which time Mr Mubenga was detained pending deportation at Brooke House Immigration Removal Centre at Gatwick Airport.

9. The three DCOs in whose custody Mr Mubenga died were tasked with escorting Mr Mubenga to Angola for the purposes of ensuring his removal. For this purpose, all were booked on British Airways 077 on 12th October 2010 flying from Heathrow Airport and scheduled to depart at 20.00hrs.

[11] By Rule 43(3) it is provided that: *"a Coroner who intends to make a report under paragraph (1) [of rule 43] must announce this intention before the end of the inquest, but failure to do so will not prevent a report being made"*.

10. The three DCOs and a fourth (the driver) collected Mr Mubenga from Brooke House and, following an uneventful journey, boarded the plane approximately 10-15 minutes before the first of the other passengers. The driver left the plane shortly afterwards, leaving the three DCOs who were to travel with Mr Mubenga on the plane.

11. At some point after boarding, a struggle occurred between Mr Mubenga and the three DCOs and Mr Mubenga was in consequence handcuffed in the rear stack position and restrained in a seat by the DCOs. The restraint lasted, in all probability, between 30 and 40 minutes.[12] A significant number of witnesses reported that during that period Mr Mubenga shouted that he could not breathe. Witnesses also reported hearing Mr Mubenga say "they're killing me" or similar.

12. It appears that Mr Mubenga became quieter and was eventually found by the DCOs to be unresponsive some short time after *"push-back"* at 20.11. Cabin crew were made aware and the Captain was informed. Arrangements were made to return to the stand and at 20.24hrs, a call for emergency assistance was made. The London Ambulance Service (LAS), with response facilities at Heathrow, sent an emergency medical technician. He was at the stand and on the jetty before the plane arrived and boarded as soon as was possible, at around 20.38. Almost immediately afterwards, a paramedic and student paramedic arrived and between them they provided emergency care. However, Mr Mubenga had died by the time the LAS crew reached him. Accordingly, when a defibrillator was applied, Mr Mubenga was showing asystolic meaning he was in complete cardiac arrest. He was also found to be peripherally cyanosed. The LAS crew commenced cardiopulmonary resuscitation (CPR) and administered oxygen and atropine and adrenalin. Arrangements were made to take Mr Mubenga to Hillingdon Hospital and during the course of the journey resuscitation efforts continued. However, those resuscitation efforts proved unsuccessful and they were terminated at 21.49, shortly after Mr Mubenga's arrival at Hillingdon Hospital.

[12] The DCOs reported in the *"Use of Force Reports"* that it lasted approximately 35 minutes (that being the period during which handcuffs were applied).

13. The three DCOs were trained in first aid (including CPR), as were the BA cabin crew. No one sought to administer first aid to Mr Mubenga during the period after he was found to be unresponsive and before the arrival of the LAS crew.

14. It seems likely from the evidence heard at the Inquest that by the time the LAS crew arrived Mr Mubenga had not been breathing and had not had a pulse for some time. The jury's findings on this are addressed below. The evidence suggests that even if resuscitation had been started immediately after Mr Mubenga went into cardiac arrest, the chances of survival would have still been poor, probably in the region of about 10%. This is because any assistance would have been limited to basic life support and in the context of an out of hospital cardiac arrest the prognosis is poor even with CPR. On the other hand, if he was unconscious initially and went into cardiac arrest because of complications associated with unconsciousness, that is that his airway became obstructed at that stage, then clearing and supporting his airway during his unconsciousness would have meant that there was a reasonable chance of preventing cardiac arrest.

C. The Inquest

15. This Inquest was conducted in accordance with the obligations under Article 2, Schedule 1, Human Rights Act 1998 and it was intended that, along with this Report, it would discharge those obligations. With that in mind, I directed that the scope of the Inquest would be wide. Apart from the factual circumstances of Mr Mubenga's restraint and its aftermath and the cause of Mr Mubenga's death, the inquiries made at this Inquest explored;

(a) the methods of authorised restraint;

(b) the medical safety/reviews of restraints in particular in a seated position;

(c) training in restraints including handcuffing/medical safety/first aid by the Ministry of Justice and G4S;

(d) oversight and safeguards of escorting including contract monitoring, untoward incident reporting, complaints and inspections;

(e) actions taken following the death including reviews of restraint methods, medical reviews and reviews of training;

(f) the arrangements, procedures and standards put in place by the Home Office (and to the extent material, the Ministry of Justice) with respect to

the certification, training and deployment of detainee custody officers employed by private contractors;

(g) the use of force in general and control and restraint techniques in particular and the use and safety of restraint on deportations;

(h) the action taken by BA cabin crew and matters relevant to their response (including their training, instructions on the administering of first aid or medical care and whether that is affected by the location of the plane at material times);

(i) first-aid or medical equipment on board the BA flight and whether there were instructions in place as to its use in the circumstances that pertained about the time of the death;

(j) the response of the London Ambulance Service and the medical aid provided to Mr Mubenga on the plane and thereafter.

16. There were nine Properly Interested Persons[13]:

(i) Mr Mubenga's family;

(ii) The Home Office;

(iii) The Ministry of Justice;

(iv) G4S;

(v) Stuart Tribelnig (DCO[14]);

(vi) Terence Hughes (DCO[15]);

(vii) Colin Kaler (DCO);

(viii) British Airways; and

(ix) The London Ambulance Service.

17. The Inquest was heard over approximately 8 weeks. Evidence from 53 witnesses was heard live and statements from a further 39 witnesses were read into evidence.[16]

D. The Jury's Verdicts

18. By a majority (nine to one), the Jury found that the cause of Mr Mubenga's death was cardio respiratory collapse due to restraint. They also found that Mr Mubenga

[13] The Home Office and Ministry of Justice were represented by the same legal team and the three DCOs were also jointly represented.
[14] A Senior DCO at material times and the allocated Senior DCO for Mr Mubenga's removal.
[15] A Senior DCO at material times.
[16] Most of these were statements from witnesses on the plane who are now outside of the jurisdiction and whose attendance could not be secured.

died at approximately 20:24 hours on BA Flight 077 at Heathrow. As to the summary factual circumstances of Mr Mubenga's death, they found as follows:

> On 12th October 2010, Mr Jimmy Kelenda Mubenga was being deported to Angola from the UK, and was accompanied by three detention custody officers.
>
> After boarding British Airways flight 077 at approximately 19:10, Mr Mubenga was involved in a struggle with the detention custody officers after leaving the toilet. He was handcuffed to the rear in the backstack position, and sat into seat 40E. There was one guard either side of him, and another in the row ahead, facing Mr Mubenga and the rear of the plane.
>
> Based on the evidence we have heard, we find that Mr Mubenga was pushed or held down by one or more of the guards, causing his breathing to be impeded. We find that they were using unreasonable force and acting in an unlawful manner. The fact that Mr Mubenga was pushed or held down, or a combination of the two, was a significant, that is more than a minimal, cause of death. The guards, we believe, would have known that they would have caused Mr Mubenga harm in their actions, if not serious harm.
>
> We find that Mr Mubenga died in his seat at approximately 20:24, but before the paramedics boarded the aircraft at 20:38.

19. The jury, by a majority (nine to one) concluded that Mr Mubenga had been unlawfully killed (unlawful act killing).

E. The Rule 43 issues and this Report

20. The purpose of this report is not to apportion individual blame. The function of this report is to raise more general concerns flowing from the evidence, specifically where the evidence indicates that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future.

21. However, in formulating the recommendations below, I have been mindful of where the key responsibility for present conditions lies and, more particularly, where the

opportunity for change arises. As to the context for exercising escorting and custodial functions, recommendations directed at private contractors will be of limited impact since they enjoy the contract for fixed (relatively short) periods. Whilst generally the same personnel continue to provide the services or exercise the functions, their employers change and the chance to effect a real difference lies in addressing the standards imposed on contractors. For this reason, the bulk of the recommendations below are directed at the Home Office.

22. The Inquest heard much evidence pointing to steps that have been taken since the death of Mr Mubenga to review the approved methods in using force when carrying out detentions and removals. This will, in due course, affect the techniques adopted where force is to be used and consequentially the training provided. These are directed at introducing improvements. However, the outcome of the work being undertaken is still not known and no changes of any significance have yet been introduced (nearly three years after Mr Mubenga's death). It means that the concerns that arose from the evidence in this Inquest in relation to these matters have not been dispelled by any identifiable changes. This report is prepared on that basis.

23. It is important to note that it is not my function to identify or recommend solutions to the concerns that I have identified. Indeed, the Inquest process is not an adequate forum for exploring them. This is so even where Article 2, Schedule 1, Human Rights Act 1998 is acknowledged to be engaged and the Inquest conducted accordingly.

F. Report and Recommendations

(a) Detention and Custody Officers: Powers and Accreditation

24. Part VIII of the Immigration and Asylum Act 1999 makes provision for the certification of DCOs and with Schedule 11 prescribes their powers and duties. By section 154, it is provided that on an application made to her, the Secretary of State may certify that an applicant (a) is authorised to perform escort functions; or (b) is authorised to perform both escort functions and custodial functions. Such a certificate will not be issued unless she is satisfied that the applicant (a) is a fit and proper person to perform the functions to be authorised; and (b) has received

training to such standard as the Secretary of State considers appropriate for the performance of those functions. A certificate of authorisation continues in force until (as is material here) such date as may be specified in the certificate. As to what is meant by *"escort functions"* and *"custodial functions"*, these are functions under escort arrangements made by the Secretary of State[17] for the delivery of detained persons to premises in which they may lawfully be detained and the delivery of persons from any such premises for the purposes of their removal from the UK, and custodial functions at a removal centre, respectively. The power to perform those escort functions and custodial functions is dependent upon certification being granted under Section 154, Immigration and Asylum Act 1999.

25. By Schedule 11, Immigration and Asylum Act 1999, DCOs are provided with certain powers and made subject to certain duties. A DCO exercising custodial functions has the power to search any detained person in relation to whom he is exercising custodial functions and has powers arising from the duties prescribed which include the duty to prevent a detained person from escaping from lawful custody and, in respect of both these matters, the power to use reasonable force where necessary.[18] As the Explanatory Notes to section 154 state: *"This section sets out the arrangements for the appointment of detainee custody officers. It provides for the Secretary of State to issue certificates of authorisation <u>without which they will not be allowed to perform custodial or escort functions</u>"* (§411).

26. It goes without saying that the powers to detain and remove, by force if necessary, rank amongst the most coercive powers afforded by statute and that is no doubt why those upon whom such powers are conferred are closely circumscribed by the requirement to be certificated in accordance with the statutory scheme.[19]

27. It became apparent after the death of Mr Mubenga that one of the DCOs effecting the aborted removal of Mr Mubenga, was not certificated (or, as it was known, accredited) under the Act, his authorisation having expired on 9th June 2010 some four months beforehand. It is important to observe at once that there is no evidence that the DCO concerned was aware that his certificate having expired, no

[17] Under Section 156.
[18] Schedule 11, paragraph 2.
[19] As explained in evidence, accreditation was also required under the contract between G4S and the UKBA, although the statutory scheme would not have permitted otherwise.

further one had been issued and this matter did not form the subject of any issue put before the jury for determination.

28. However, it meant that that DCO had no power to escort Mr Mubenga for the purposes of removal from the UK, or to take any steps to keep him in custody pending removal or to use or threaten the use of force to secure the removal of Mr Mubenga. It became apparent during the course of the Inquest that this state of affairs did not result from individual oversight or administrative error, but formed part of a practice agreed between G4S and the UK Border Agency. [20] This practice had as its purpose and effect the informal authorisation of unaccredited G4S staff to carry out custodial functions and the removal of detainees from the UK (with threatened or actual force where necessary). According to the account given on behalf of Her Majesty's Government (the Home Office and Ministry of Justice, both interested persons), it was G4S who carried the responsibility for using unaccredited employees as DCOs and it was simply that the Home Office procedures were not sufficiently *"robust"* to identify where certificates had expired. However, the evidence points not to a mere lack of robustness either in the procedures of G4S or the Home Office but to an agreement to dispense with the need for accreditation, apparently to address delays within the UK Border Agency in processing applications for accreditation. The evidence provided to me following enquiries that I made about this practice indicates that in 2005 approximately 50% of DCOs (although not properly described since they had no extant accreditation) working in the Overseas operation for G4S were *"awaiting their accreditation letters to come through from UKBA"*. By a letter dated sometime in June 2006, the UK Border Agency provided a *"dispensation"* so that where G4S carried out an employment reference check; the employee concerned had satisfactory enhanced disclosure from the Criminal Records Bureau and a letter of accreditation had been applied for, employees were permitted to work as DCOs and undertake the duties of DCOs, notwithstanding the absence of accreditation under the Act. At this stage, it appears that the dispensation concerned employees awaiting first time accreditation (that is, newly appointed by G4S) and according to the evidence that I have seen, this *"dispensation"* was never withdrawn or amended.

[20] The evidence on this issue included a statement from an ex-employee of G4S produced by G4S addressing this issue which was not before the jury but read by me.

29. In 2009, following an informal (un-minuted) meeting between a G4S representative and UK Border Agency, it was agreed that where an initial accreditation had been granted and a renewal of that accreditation was sought, the accreditation was to be treated as valid whilst renewal of that accreditation was awaited. It appears that this informal agreement anticipated that the renewal criteria would be met before any dispensation would apply, but that it would permit the exercising of functions by an unaccredited DCO contrary to the requirements of the Act. In the case of the relevant DCO insofar as this Inquest is concerned, his last certification was granted on 14th August 2007 and it made clear that it would remain in force for (approximately) three years[21] (subject to it lapsing in the event of a cessation of employment in the role of DCO, suspension or revocation), at which point the training undertaken by this DCO would be reviewed and, subject to that and further clearance, it would be renewed. It was tentatively put on behalf of the Home Office during the course of the Inquest that the letter of accreditation could be read as granting accreditation without an end date (that is, not for a fixed period of three years). However, looking at the letter of accreditation overall, such a result would require a very strained interpretation and in any event, it was quite clearly understood by the Home Office, once the issue of this DCO's accreditation came to light, that his accreditation had indeed expired. It was plainly intended by the terms of the letter that accreditation would last for three years[22] and it was the dispensation granted by the UK Border Agency to G4S that permitted him to continue in his role.

30. It is, to say the least, extraordinary that an agreement was in place between G4S and the UK Border Agency permitting officers to exercise the functions of DCOs without the statutory accreditation necessary. A cursory enquiry would have revealed that permitting officers to carry out these functions, in particular where force (or the threat of force) was used, was impermissible under the Act. There is no evidence before me as to the number of occasions on which removals involving unaccredited DCOs took place and accordingly no evidence as to the occasions on which unaccredited DCOs used or threatened force to effect removals. A detainee, of

[21] Shortly before Mr Mubenga's death, the period of any certification was extended from 3 years to 5 but this did not affect the DCO in question since his expired after 3 years (that being the relevant period when his accreditation was authorised).

[22] The letter stated in terms that the certificate would not be valid after 9th June 2010 (when the DCO's Counter Terrorism Check clearance would expire), just short of three years and that a review of training would be required three years after the grant of accreditation.

course, would not be aware of the absence of accreditation (and nor, presumably, would their legal advisers if they had any) and the impact that might have on the legality of any detention or escorted removal.

31. Those representing the Home Office at this Inquest did endeavour to make some enquiries during the hearing to assist me in relation to this issue but key personnel have since left the UK Border Agency and, of course, time was limited. The Home Office, through their representatives, were also keen to assure me that the dispensation only operated where the DCO concerned met the conditions for accreditation.[23] However, this seems to me to be of limited significance since the purpose of the accreditation process is to check those very matters. It is the responsibility of the Home Office to ensure that DCOs exercising the coercive powers afforded by the Act are indeed accredited in accordance with the requirements of Section 156. It is not the duty of the contractor. The power to detain and expel persons from the UK based on nationality/immigration status lies exclusively in the hands of the State whether or not it chooses to exercise those functions through private providers. The duty of ensuring that those detentions and removals are carried out safely by properly qualified and accredited DCOs in accordance with the law falls on the Home Office. For at least a period of time, that duty was not discharged by the Home Office but instead was left to G4S.

32. It cannot be known now whether the *"dispensation"* did create a risk to the health and safety of detainees and deportees, not least because there appears to have been no enquiry (yet) into it. However, there is concern enough to justify this report. The minimum guarantees in the Act are intended to ensure the safe exercise of detention and removal functions and they were not respected for a significant period of time.

33. For completeness, the UK Border Agency had sought to implement an additional check against officers carrying out the functions of DCOs without the relevant accreditation. This was by ensuring that the certification team within the Home Office provided on a monthly basis a list of accredited DCOs to the travel agency

[23] Namely, where G4S were satisfied that the necessary training (pursuant to the arrangements for the grant of accreditation) had been undertaken by the employees concerned, either at initial stage or upon expiry and the awaiting of renewal of a certificate, and that the necessary CRB and other checks had been made.

Carlson Wagonlit. Carlson Wagonlit made the travel arrangements for deportees and their escorts. It appears following enquiries made after Mr Mubenga's death that that information was not in fact being properly passed on.

Recommendation 1: The Home Office should:

(i) **Conduct an inquiry into the circumstances in which a dispensation in relation to accreditation was granted by the UK Border Agency to G4S in or around 2006 (in the case of new recruits) and then in 2009 (in the case of DCOs requiring renewal of accreditation) and satisfy themselves that no such arrangements are currently in place and that they will not be reinstituted.**

(ii) **Review the arrangements for auditing compliance with section 154 and for ensuring that only accredited DCOs perform escorting and removal functions under the Immigration and Asylum Act 1999.**

(b) The provision of Overseas Escorting Services: The Contractual Arrangements

34. G4S held the contract for Overseas Escort Services from 1st May 2005. At midnight on 30th April 2011, the contract for the provision of these services (both in-country and overseas) passed from G4S to Reliance Secure Task Management Limited (*"Reliance"*). From Autumn 2012, Capita (under the trade name *"TASCOR"*) enjoy the benefit of that contract having purchased it from Reliance Secure Task Management Limited.

35. Under the contract with G4S (and there was no evidence before me indicating a significant change in later contracts) payment was largely by results. The fees payable under the contract were in large part based on the number and duration of the escorted movements (included removals), comprising an hourly rate in respect of escorts. Accordingly, if a job was aborted, payment would be made for the hours actually worked ending with the return of the escorts to the mustering location, not the anticipated hours that would have been worked on, for example, a lengthy overseas return journey.

36. Further, and in addition, service levels and performance measures were in place which were intended to incentivise successful removals. The contract operated a performance points system. Under this system, if the contractor failed against a *"performance measure,"* performance points would be incurred and these were given a monetary value which would be deducted from the invoices presented by G4S. The performance measures were determined by reference to (amongst other things) key service levels under the contract which included one that required that *"detainee[s] … leave UK on scheduled transportation on the first attempt"*. A failure to ensure the removal of a detainee on the first attempt, therefore, would result in an adverse financial consequence (the witness who dealt with this for the Home Office preferred not to use the word *"penalty"*). There was some evidence that in practice if removal did not go ahead for reasons other than the fault of the contractor (including because a deportee caused a disruption which meant he was required to disembark), then performance points would not be incurred. However, the default position was the allocation of performance points. This at least had the potential to encourage removals where they might not otherwise go ahead (especially when not set off by other risk – reducing incentives, such as rewards for a reduction in the use of force).

37. In the case of overseas escorting, the fact that G4S – and its predecessors - were paid only for the actual hours their DCOs worked no doubt led to the introduction of *"zero-hours"* contracts with DCOs. These are contracts under which DCOs are not guaranteed any work or any pay but instead are allocated work as needed, and then paid only for the hours actually worked.[24] It goes without saying that this arrangement between contractor and employee reflects that between the contractor and the Home Office. Both contracts incentivise the completion of a job. Newer contracts do provide for a (low) *"retainer"* salary but with hourly sums paid on top for work actually done, so having (whether intended or not) the same incentivising effect. Whilst some witnesses denied that these contractual arrangements created any sort of imperative to get a job completed even where deportees were disruptive or where there may be some other good reason to bring the job to an end, this seems inherently improbable and, in any event, there was other evidence pointing to the contrary.

[24] One of the DCOs escorting Mr Mubenga was employed on a zero hours contract.

38. It seems to me that incentivising the completion of removals by monetary award necessarily carries with it the risk that removals will go ahead in circumstances where otherwise they might be aborted. Having a financial interest in getting the job done does give rise to real concerns that inappropriate methods might be used to that end. Some dangerous practices have developed as I describe under §67 below with the specific purpose of ensuring that disruption by a deportee prior to take-off does not prevent removal. This may be symptomatic of the chosen arrangements for paying contractor and in turn employee. That is obviously very concerning indeed.

Recommendation 2: The Home Office should review its contractual arrangements to ensure that:

(i) **Any performance measures or other provisions directed at incentivising removals promote safe removals.**

(ii) **The contractors it engages for detention and escorting services adopt pay schemes for their DCOs which do not incentivise removal at the expense of safety.**

(c) Racism: Culture and Personnel

39. Following the death of Mr Mubenga, racist material was found on the private mobile phones of two of the DCOs[25] who were involved in the attempted removal of Mr Mubenga.

40. These comprised numerous text messages, the contents of which were explicitly racist. Most of these text messages had been sent to the mobile phones of the DCOs concerned by third persons. However, some were forwarded to others by these DCOs. Further, the text messages were not deleted notwithstanding their exceptionally offensive content.

41. Some of the messages referred to *"immigrants"* (or were referable to perceived immigration status) specifically. For example, one message read as follows:

> *"fuck off and go home you free-loading, benefit grabbing, kid producing, violent, non-English speaking cock suckers and take*

[25] The evidence showed that the third DCO had no involvement in the viewing or distribution of such materials.

those hairy faced, sandal wearing, bomb making, goat fucking, smelly rag head bastards with you."

42. Another, in the case of another of the DCOs read:

"just been sacked from my new job on the wines and spirits section at Asda. A Muslim came in and asked me to recommend a good Port. I said 'Dover, now fuck off'."

43. These texts were not evidence of a couple of *"rotten apples"* but rather seemed to evidence a more pervasive racism within G4S. Evidence provided in the run up to the Inquest about these texts from one of the DCOs was to the effect that *"lots"* of his work colleagues and acquaintances would send such material between themselves. Evidence at the hearing itself was that some of the texts were sent by other DCOs (that is, other than the three involved in the incident resulting in Mr Mubenga's death).

44. In addition, one of the DCOs accompanying Mr Mubenga on the attempted removal (and one of those found in possession of the text messages) posted a racially offensive picture and comment on his Facebook page. The significance of this was three – fold. Firstly, it was *after* the death of Mr Mubenga so demonstrated a complete lack of awareness on the part of the DCO or, worse, disregard for what at least could be perceived to be the significance of race in the events surrounding Mr Mubenga's death, in light of the text messages. Secondly, the comments posted in response to the posting included racially offensive remarks from other DCOs indicating, as with the text messages, that the sentiments expressed were not of an isolated DCO. Four DCOs were identified as being involved in the facebook incident, including the DCO who posted it, some of whom were employees of Reliance (to whom the contract previously held by G4S transferred) and/or ex-employees of G4S who worked, or had worked, as DCOs. The Facebook posting, and the comments made under it, were less explicitly racist than some of the text messages but nonetheless are illustrative of what appears likely to be a casual widespread racism. Thirdly, that this was after the transfer of the contract to Reliance means that it cannot be assumed that the mere change in contractor will eliminate these cultural problems. This is at least in large part because of the impact of the Transfer of

Undertakings (Protection of Employment) Regulations[26] which, in broad terms, have the effect that the employees will transfer from one contractor to another on transfer of the contract from one provider to another.

45. There was other evidence too of an unhealthy culture in G4S, and then Reliance, and it is difficult to see why that would have changed now that Tascor holds the contract, for the reasons just given. Evidence before the Inquest suggested problems with culture and behaviour more widely manifested by, as it was reported by one witness, *"loutish, ladish behaviour…… Inappropriate language, and peer pressure. Don't necessarily celebrate difference. Don't personalise the detainee. .."* The same witness reported evidence that Reliance was not a company where women, ethnic minorities and those of diverse religions felt comfortable.

46. It seems unlikely that endemic racism would not impact at all on service provision. It was not possible to explore at the Inquest the true extent of racist opinion or tolerance amongst DCOs or more widely. However, there was enough evidence to cause real concern, particularly at the possibility that such racism might find reflection in race - based antipathy towards detainees and deportees and that in turn might manifest itself in inappropriate treatment of them. As it was put by one witness, the potential impact on detainees of a racist culture is that detainees and deportees are not *"personalized."* This may, self-evidently, result in a lack of empathy and respect for their dignity and humanity potentially putting their safety at risk, especially if force is used against them. It is for that reason that the subject properly forms part of this Report.

47. As I have mentioned, the Inquest was unable to explore these issues fully but they do require scrutiny.

48. This would be important in any organisation but is most especially so here when the functions being performed by those providing detention and escorting services are necessarily targeted at groups defined by nationality or national origins and therefore *"race"*.[27] Further, because of the ties that link the UK to its colonial past

[26] 2006, SI 2006/246.
[27] Section 9, Equality Act 2010 (though, of course, exceptions in the Act ensure that lawful immigration control is not prohibited).

and global politics more generally, overwhelmingly, non-EEA immigrants (who will not be subject to full immigration control), will not be White. If the experience of being subject to immigration law is not to be felt as a mere experience in racism, considerable care needs to be taken to ensure that those subject to its adverse consequences do not feel the sting of racism in its application.

49. Further, an unhealthy and racist environment may be fostered by, or at least is less likely to be challenged in, a work force characterised by a lack of racial balance. The evidence before this Inquest showed that a small proportion of DCOs were not White. [28] In 2010, whilst the contract was held by G4S, 8.27% of the DCOs were recorded as being Black or Asian, as compared to White. This is as against [29] a non-White population of 14% in England and Wales and in London (which can properly be assumed to form part of the pool from which workers employed to service Heathrow and Gatwick are drawn), 40.2%.[30]

50. According to the evidence heard at the Inquest, the number of applicants from minority ethnic groups appointed to the position of DCO reflects their proportion amongst applicants for appointment. In other words, large numbers are not applying. It is not difficult to discern at least part of the reason for this. G4S (and it appears at least their predecessors if not their successors about which there was less evidence) advertised in publications directed at the uniformed services (the police and armed forces etc).[31] A glance at the monitoring data from these organisations shows that ethnic minorities are underrepresented in those services too[32]so targeting recruitment there will almost certainly result in an outcome reflecting that underrepresentation.

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[28] The monitoring data was unfortunately rudimentary but it was possible to deduce this.

[29] ONS: 2011 Census: Key Statistics for England and Wales, March 2011, December 2012: http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/stb-2011-census-key-statistics-for-england-and-wales.html. This census covers those of working and non-working age and so cannot be regarded as an accurate assessment of the composition of the working population but it will be a rough approximation.

[30] http://www.ons.gov.uk/ons/dcp171778_290685.pdf. The figures for Scotland and Northern Ireland are very considerably lower (Scotland: http://www.scotland.gov.uk/Topics/People/Equality/Equalities/DataGrid/Ethnicity/EthPopMig and Northern Ireland: http://www.nisra.gov.uk/Census/detailedcharacteristics_stats_bulletin_2_2011.pdf).

[31] There was some evidence too of historic *"word of mouth"* recruitment which would have contributed to the replication of the employee profile.

[32] See, by way of illustration; *"Statistics on Race and the Criminal Justice System 2010: A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991"* (Oct 2011) available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/219967/stats-race-cjs-2010.pdf; *"UK Defence Statistics 2012"* (Dec 2012) MoD, available at http://www.dasa.mod.uk/modintranet/UKDS/UKDS2012/pdf/ukds2012r1.pdf.

51. As I mentioned earlier in this Report, it is not for me to recommend solutions to the concerns I have identified. However, the absence of any performance measures or contractual requirements directed at securing or promoting equality and compliance with anti-discrimination law[33] and the limited provision in the contract addressing the issue at all is certainly noticeable. The contract with G4S (and I have no reason to believe that the more recent contracts with Reliance and then TASCOR are materially different) required G4S to comply with *"all [unspecified] legislation, statutory, regulatory and contractual requirements relevant to…..discrimination on grounds of race"* and to provide *"race relations and cultural awareness"* training (the contents of which are unspecified). Apart from that, there was no provision addressing equality, diversity or racism specifically.

52. It should be said that there is no shortage of legislative opportunity or policy tools available to assist in addressing a racist culture in a workplace or service environment or an underrepresentation of minority ethnic groups, including (and perhaps most especially) through the procurement process in the context of the contracting out of State functions.[34]

Recommendation 3: The Home Office should introduce detailed and specific measures requiring contractors to provide non-discriminatory escorting and custodial services and ensure that any cultural and staffing issues are addressed.

[33] And discrimination in the exercising of public functions has long since been unlawful: see now, section 29(6), Equality Act 2010 (there are numerous immigration related exemptions but none are material). The Public Sector Equality Duty (section 149, Equality Act 2010) would be of relevance during the procurement process but will also apply to the private contractors exercising escorting and custodial functions (both being public functions; see, section 149(2)).

[34] See, the Government's guidance in place at material times: Cabinet Office's Single Equality Scheme (2008–2011) (recognizing procurement as a relevant function; the review documentation identifies the *"desired outcome"* in this context as having systems in place that ensure that contractors comply with contract obligations relating to discrimination, and with the intentions of the equality duties (available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/83082/equality_scheme_review11.pdf). Further, the Office of Government Commerce (now part of the Cabinet Office) has promulgated guidance on mainstreaming equality considerations into the procurement process. *"Make Equality Count"* (2008) OGC, available at provided guidance on the impact of the Race, Disability and Gender Equality Duties, available at http://webarchive.nationalarchives.gov.uk/20110822131357/http://www.ogc.gov.uk/documents/Equality_Brochure.pdf. And for recent guidance from the Equality and Human rights commission, see *"Buying Better Outcomes: Mainstreaming Equality Considerations in Procurement: A Guide for Public Authorities in England"* (Mar 2013) EHRC, available at http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/buying_better_outcomes_final.pdf. See too, for the positive action provisions addressing the action that might be taken in the case of the recruitment of under-represented groups in section 158 and the *"tie-break"* provisions in section 159 of the Equality Act 2010.

(d) Use of Force

53. The use of force is not uncommon in escorted removals overseas. In the periods 2009 and 2012 between approximately 10% and 12% of escorted removals involved the use of force.[35] There was evidence that the vast majority of incidents involving the use of force on escorted removals occurred at or before the point of boarding, with only 20% on board. Certainly, there was a good deal of evidence indicating that disturbances on board shortly before the point of departure are not uncommon. The methods used to effect restraint in such circumstances are obviously very important indeed, therefore. Deportees are plainly in a particularly vulnerable position in such a situation since if removal is successfully effected, the opportunities for complaint, though they exist, will obviously be curtailed.

54. The contract between the Home Office and G4S (and apparently the successor contracts) contained provision requiring that DCOs were trained in *"Control and Restraint"* techniques and that at least 10% of them were trained in the *"Physical Control in Care"* (the latter being approved for use on children).

55. "*Control and restraint"* ("C&R") techniques are found within the *"Use of Force"* training manual. This is used for the delivery of training on C&R. It comprises guidance for instructors, setting out the physical and theory elements of the training. G4S trainers were taught C&R techniques within the *"Use of Force"* training manual and they in turn delivered C&R training to G4S DCOs. The techniques include various holds and locks and pain compliance.

56. I did not hear any evidence indicating that the techniques contained within the *"Use of Force"* training manual were inherently unsafe or dangerous.[36] It should be made clear that the finding by the jury of the pushing or holding down of Mr Mubenga was not said by anyone to have been authorised by the *"Use of Force"* manual or C&R (and nor does it appear in any of the instruction or training materials).

[35] In 2009, the figure was 12.6%; in 2010 the figure was 10.6%, in 2011 the figure was 11.3% and in the first quarter of 2012, 10.4% and the second quarter of 2012, 9.4%.

[36] Except in the case of the nose control technique which was withdrawn and replaced with the mandibular angle technique because of a high proportion of nose bleeds sustained by young people during a period in which it had been authorised as part of PCC.

57. However, I have identified five discrete areas of concern: (1) scenario based training; (2) use of C+R on an aircraft; (3) practice; (4) handcuffing to the rear and (5) restraint/positional asphyxia.

58. Firstly, the training provided by G4S trainers to DCOs was generally delivered in a wide - open space, in a gym or dojo, and although some *"dynamic"* scenarios were created (with trainees putting into practice the techniques learnt against instructors resisting to some degree), the environment in which the training took place did not replicate that of an aeroplane. There was a good deal of evidence indicating that the C&R techniques were capable of being applied in a confined space, as in an aircraft, and demonstrations to that effect were given during the course of the hearing. However, there was enough concern raised prior to the death of Mr Mubenga about the utility of these techniques in managing a restraint in an aircraft, and related inadequacies in the training, to question their suitability theoretically or in practice.

59. The "*Use of Force"* manual made provision for *"scenario based training"* which was intended to encourage the training of C&R in realistic environments. However, there was also a lack of clarity about the extent to which the contractual requirement to provide C&R training as provided for in the *"Use of Force"* training manual allowed for any departure from the strict terms of the manual by the provision of training directed at specific environments, such as on a plane.

60. It did appear to me that there was more flexibility permitted by the *"Use of Force"* training manual than was sometimes understood. However, there were also areas where a lack of clarity did genuinely create doubts about what training was permissible and the extent to which the adaption of techniques for an aircraft environment might constitute a departure from the *"Use of Force"* manual. Wherever the rights or wrongs lay in relation to this, this sort of lack of clarity was plainly undesirable and on any analysis the absence of training in an environment which reflected the context in which C&R might have to be used constituted a significant training gap. It was the subject of repeated complaint by DCO trainees and that by itself is a concern.

61. The need for scenario based training, in particular on an aircraft with a centre isle and passenger seats on both sides, had already been the subject of a recommendation following a review in 2008 by the National Tactical Response Group (NTRG)[37] for the UK Border Agency. This was not followed up by the provision of any such training. There remains such a deficiency in the training.

62. Secondly, there were many concerns raised during the course of the hearing, in particular by G4S trainers, as to the suitability of C&R for use in the confines of an aircraft at all. C&R was developed by the National Offender Management Service (NOMS) (an executive agency of the Ministry of Justice) primarily for use by prison officers in prison environments or in prison vehicles; that is, not for use on an aircraft. The *"Use of Force"* training manual did take account of the fact that in a prison environment force may have to be used in a confined space, such as where it is necessary to move a prisoner through a narrow doorway or up spiral staircases or within a vehicle. However, restraint on a scheduled flight with passengers and crew in very close proximity and in particularly narrow spaces, may present very specific challenges.

63. After the death of Mr Mubenga, an immediate review into the safety of C&R and whether the techniques were being properly taught concluded that there were no dangers inherent in the techniques themselves or in the means by which training was delivered. A more detailed report was conducted shortly afterwards recommending a review of the methods and techniques applied by overseas escorts more generally. This review comprised phase one of what was to become a three-phased project. Phase two began in April 2012 and this was concerned with the production of restraint techniques which were, amongst other things, fit for use on aircraft and the production of a new training manual and training materials. An Independent Advisory Panel was established to assess the quality and safety of the system of restraint and equipment proposed and is to operate as a *"critical friend"*. It is anticipated that at the end of Phase 2, the Panel will submit a final report with recommendations to Ministers. It is not expected that this will be until March 2014.

[37] The National Tactical Response Group (NTRG) within the National Offender Management Service was given specific responsibility for designing the methods and techniques relating to the use of force.

64. It is clear from the work being undertaken that there is a recognised need for improvements. However, nearly three years after Mr Mubenga's death no changes have yet been introduced. As mentioned Phase two is not expected to be concluded until the Spring of 2014 and thereafter Phase three will require the development of an implementation plan. These changes are still, therefore, a long way off and in the meantime C&R in its un-amended form is still the only authorised means by which a detainee might be restrained and the training is delivered in accordance with the *"Use of Force"* manual, notwithstanding the weaknesses that have already been identified.

65. It has to be said too, that some of the thinking around any new C&R methods give rise to a need to remind those engaged in this project about the need to show due respect for the dignity of those to whom these methods may be applied. It was indicated during the course of evidence that thought had been given at one time to applying a body-cuff to all deportees whether or not any risk of disruption/violence had been identified. It goes without saying that the use of a body-cuff would constitute a significant interference in the bodily integrity of any person to whom it is applied. Dignity and bodily integrity are matters to which close regard must be had in determining what new techniques are to be introduced.

66. In the meantime my recommendations below reflect the fact that there have been no changes yet introduced; the timeline for introducing any changes is extraordinarily long given that proposals for change were triggered by concerns centred on the death of Mr Mubenga, and there has been no opportunity at this Inquest to apply even superficial scrutiny to any proposed changes since they are at such an early stage in development.

67. Thirdly, the evidence at the Inquest revealed, distinct from concerns about the adequacy of C&R or its training, the existence of bad practice. In particular, the evidence disclosed the existence of a practice known as *"Carpet Karaoke."* This referred to a technique adopted for controlling disruptive deportees in an aircraft seat. It comprised pushing a deportee's head downwards so that any noise that he or she made would be projected towards the floor (*"singing to the carpet"*) and not through the plane upsetting the passengers or causing the captain to require

disembarkation (so aborting the removal). The practice originated in the methods adopted (it appears) by a much earlier contractor (and a company that, so far as the evidence before me indicated, no longer exists or at least has no further involvement in the provision of services to the Home Office). When G4S took over the contract, DCOs were notified that the practice would not be tolerated. However, in 2008 a notice was circulated by G4S to staff instructing them not to use the *"head support position"* described as *"where the detainee's head is controlled by pushing it into their lap, similar to the 'crash position'"*. This notice warned that the use of that position in a confined space could increase the risk of positional asphyxia. This at least raises the question whether *"Carpet Karoke,"* whether or not so labelled, was still in use, notwithstanding efforts to stamp it out. The findings of the jury in this Inquest give rise to similar concerns.

68. Fourthly, before Mr Mubenga's death there had been many warnings from various bodies about the dangers of handcuffing to the rear especially on an aircraft. I say nothing about its significance in Mr Mubenga's case but the evidence on this issue raises concerns more generally. The evidence indicated that there are dangers associated with rear handcuffing, as opposed to handcuffing to the front, on an aircraft in particular. These are: (i) in an emergency handcuffs to the front can be more easily released; (ii) a person will be better able to help themselves in an emergency (by managing an oxygen mask; using an emergency slide, for example) if cuffed to the front and (iii) handcuffing to the rear can restrict breathing if they cause a seated detainee to lean forward or make it difficult for him or her to sit upright. In consequence of the warnings given about handcuffing to the rear, an instruction was issued by G4S to all DCOs (and was included in the packs they were given for any overseas escorting) directing that they were not to leave a detainee handcuffed to the rear because of the dangers and that handcuffs were to be moved to the front as soon as possible. However, applying the guidance in practice might well have been confusing since there was no bar on handcuffing to the rear and additionally some independent monitors tasked with intermittent monitoring of removals had apparently provided positive reports on occasions where rear cuffing had been used.

69. It is obvious that there will be specific risks associated with handcuffing to the rear in flight given the disabling effect it may have in an emergency. It is of note that the evidence before the Inquest from cabin crew was that where restraint by cabin crew of a passenger was required inflight, rear cuffing was prohibited for the very reason that it would impede a passenger's ability to save themselves in an emergency. The lack of clarity about rear cuffing by DCOs, in flight in particular, must be a matter of some concern.

70. It is also important that when introducing any changes or replacement to C&R, the Home Office ensure that any independent monitors are fully acquainted with the policies in place and the approved methods of restraint. It is not possible to be certain in the case of the examples of apparent approval being given to rear handcuffing that the monitors were aware of the guidance and instruction promulgated in respect of it.

71. Fifthly, whilst there was a great deal of evidence that DCOs had been warned about the risks of positional or restraint asphyxia, the circumstances of Mr Mubenga's death means that there can be no complacency about this subject. DCOs need to be regularly reminded of the risk factors and the warning signs and these matters will need to inform the formulation of any new restraint techniques and training packages.

Recommendation 4: The Home Office and Ministry of Justice:

(i) **Rigorously review the approved methods of restraint, and specifically the use of force in overseas removals. Appropriate techniques and bespoke training packages, reflecting the environment in which restraint may need to be applied (aircraft), should be introduced expeditiously.**

(ii) **Ensure that any new use of force policy or approved techniques take account of the risks associated with handcuffing to the rear on an aircraft.**

(iii) **Give clear instruction and guidance to independent monitors on any new use of force policy and approved methods of restraint and ensure that they are aware of the standards imposed by them.**

(e) First aid

72. As referred to above, in the period between Mr Mubenga having been found unresponsive and the LAS crew arriving, no one administered first aid to him. This is significant because the three DCOs and all the cabin crew had first aid training. Unsurprisingly because of the risks posed by an emergency in flight, the cabin crew had very thorough and precise training and guidance as to the individual and team action required in the case of a medical emergency.

73. It became apparent during the Inquest that the fact that such assistance was not provided to Mr Mubenga was a matter of particular concern to the jury. The jury's very first question concerned the availability of a defibrillator (there was one on board), and they asked many other questions on the subject of first aid. This can be of no surprise to anyone. Mr Mubenga died in front of a number of people without anyone stepping in to see if he could be helped.

74. As is referred to above, it cannot be said that Mr Mubenga would have lived if first aid had been administered (including by the opening of airways and/or CPR) but such opportunity as there was, was lost by the inaction of those around him who were qualified to administer first aid but did not.

75. The reasons for the failure to intervene by the DCOs and the cabin crew are not entirely easy to understand but from the evidence appear to be influenced by two factors (i) disbelief and a consequential fear that Mr Mubenga would become disruptive and/or attempt escape if approached and (ii) in the case of the cabin crew, an assumption that it was the DCOs' responsibility to make any decisions on intervention.

76. As to the first, it seems that there was a general view amongst DCOs that deportees would feign illness and the like to avoid deportation. Warnings were given about this possibility to DCOs. It seems that cabin crew had absorbed this view and were influenced by this in their response to Mr Mubenga. That deportees had feigned illness to avoid removal is in all likelihood true, but it cannot be an answer to not intervening in the case of a person who may be genuinely ill (most specifically where

apparently unresponsive). It is plain that clearer guidance needs to be given to DCOs and cabin crew on this issue.

77. It seemed to me that there was also genuine confusion amongst cabin crew as to their role in the case of a deportee. The evidence from British Airways' witnesses was that deportees were to be treated in all respects like ordinary passengers (except that they were not to be given alcohol) but it is difficult to square this with the failure to provide any care to Mr Mubenga when he was found to be unresponsive. The evidence suggested that they in fact deferred to the DCOs and assumed that if there was something to be done, it was for the DCOs to do it. This was, in all probability, related to the anxiety about feigning illness and escape but was aggravated by the lack of any clear guidance as to their responsibilities in such a situation. The consequence of all of this was that Mr Mubenga was left unassisted.

78. The response of British Airways to the death of Mr Mubenga on board was to inform the Home Office that, notwithstanding their legal obligations,[38] they would not carry certain numbers and classes of deportee. This meant that though in 2008 they carried 1,394 deportees; in 2011, they carried only 68 (and in 2012, they carried 101 and as at the date of the Inquest, they carried 39 in 2013). Further, British Airways told the Home Office that they would no longer accept deportees with a history of violence or disturbance. Presumably these deportations are now being covered[39] by other scheduled airlines.

79. British Airways did not conduct any inquiry or review into the events on the plane and in particular into why there was no intervention from cabin crew. This was a surprise to me. It meant that they did not avail themselves of the opportunity to learn lessons, including by investigating the reasons for the response of the cabin crew. The evidence at the Inquest indicates that British Airways still do not consider such an inquiry necessary. I disagree. In my view simply refusing to carry deportees, either in certain numbers or classes, does not obviate the risk of a situation as occurred in Mr Mubenga's case reoccurring. Cabin crew need to fully understand

[38] All airlines are required to carry deportees if directed to do so by the Home Office and a failure to do so without reasonable excuse amounts to a criminal office (Immigration Act 1971, Schedule 3, paragraph 1 and section 27).

[39] At least in many cases: some may be managed through chartered flights but it is very doubtful that this would meet the need that is currently met by scheduled airlines.

their responsibilities, even in cases where escorts are failing to intervene to assist a deportee in medical danger. As I have mentioned, British Airways have refused to carry what would otherwise be expected to be large numbers of deportees despite their legal obligations. If they are able to persuade the Home Office to accede to this, they ought to be able to persuade them to participate in some discussion around their respective responsibilities. I have therefore made a recommendation concerning the same below.

80. Although there was little evidence on this issue, it seems likely that this is not an issue affecting British Airways only. For this reason, this report will be sent to the Civil Aviation Authority because of their broader responsibilities and the likely impact of these issues on other airlines.

81. Dr Deakin who was called by me as an expert in first aid and resuscitation raised a further concern. He suggested that there may be some weaknesses in the (approved) first aid training delivered by G4S to DCOs. These concerned certain of the written training materials and the guidance they gave as to when the recovery position should be adopted and the circumstances in which CPR should be commenced. The concerns of Dr Deakin were based upon the written materials alone (the trainers who delivered the training were not called) but given those concerns, it is important that the training is reviewed.

Recommendation 5: The Home Office should review:

(i) **The instruction and guidance given to DCOs concerning the need to administer first aid in cases where there is some evidence that there may be a medical emergency.**

(ii) **The first aid training delivered to DCOs in light of the concerns raised by Dr Deakin.**

(iii) **Their arrangements with scheduled airlines to ensure that the respective responsibilities of DCOs and cabin crew are clearly understood.**

Recommendation 6: British Airways should conduct a review into the actions of cabin crew at the time of Mr Mubenga's death, and in particular the failure to intervene to administer first aid, and address any issues that emerge.

G. Conclusion

82. Most of the recommendations in this report are directed to the Home Office. This reflects the fact that they have overall responsibility for detention, escorting and removal in the immigration sphere. Private providers hold contracts for limited periods and, as the history of the overseas escorting contract demonstrates, may be involved for a relatively short period of time. Ultimately, the Home Office carries responsibility for immigration law and policy and it is the Home Office that has ultimate responsibility for ensuring that any removals are carried out safely.

Karon Monaghan QC
Assistant Deputy Coroner
31 July 2013

Annex A

A Full List of Persons to whom this Report is being sent

Adrienne Makenda Kambana

The Home Office and the Secretary of State for the Home Department

The Ministry of Justice and the Secretary of State for Justice

G4S

Stuart Tribelnig

Terence Hughes

Colin Kaler

British Airways

London Ambulance Service

Independent Monitoring Board

Independent Panel on Deaths in Custody

Prisons and Probation Ombudsman

His Honour Judge Peter Thornton QC, Chief Coroner

Mrs Alison Thompson, West London Coroner

Lord Chancellor and Secretary of State for Justice

Civil Aviation Authority

Annex B

Persons from whom a Response is required

The Home Office

The Ministry of Justice

British Airways

Annex C

Persons from whom no Response is required

Adrienne Makenda Kambana

G4S

Stuart Tribelnig

Terence Hughes

Colin Kaler

London Ambulance Service

Independent Monitoring Board

Independent Panel on Deaths in Custody

Prisons and Probation Ombudsman

His Honour Judge Peter Thornton QC, Chief Coroner

Mrs Alison Thompson, West London Coroner

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Civil Aviation Authority