

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital in
October 2010, while in the custody of G4S**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of the investigation into the death of a man, who died at hospital in October 2010. He was 46 years old. He was an immigration detainee and died during an attempt to remove him from the United Kingdom. I offer my condolences to his family and friends.

The man was collected from Brook House immigration removal centre by G4S overseas escort staff in October. He did not want to be returned to Angola or be separated from his wife and children in the United Kingdom.

He and three accompanying escort staff boarded the flight to Angola at 7.20pm. About 20 minutes later, he apparently became non-compliant and the escort staff used force to restrain him. His hands were cuffed behind his back and he was manoeuvred into a seat at the very back of the plane. He allegedly continued to struggle until the plane began to taxi towards the runway at about 8.15pm. The escort officers then realised that he was unconscious and not responding. The plane returned to the stand. Paramedics attended and attempted to resuscitate him. He was transferred to hospital where his death was later confirmed. The post-mortem report concluded that he died from cardiorespiratory collapse, caused by restraint. Our report has been necessarily delayed by the lengthy police investigation which followed.

The investigation raises a number of serious questions about the actions of the escort staff in October: it does not appear they followed the guidance they had been given about the use of force techniques, they did not appear to consider that the man might be at risk of positional asphyxia until it was too late and they did not administer any immediate first aid when it was clear that he was unwell.

Underlying these apparent failures was a lack of adequate use of force training for escort staff. This is particularly disappointing, as the United Kingdom Border Agency (whose responsibilities have now reverted to the Home Office) acknowledged shortcomings in this training in 2009, in response to a previous investigation by this office. However, little progress had been made in addressing these issues by the time of the man's death. Indeed, the matter still remains under review and escort staff continue to receive the same training that has once again been highlighted as seriously inadequate by this investigation.

This final version of the report includes the Home Office response to the recommendations made and the verdict of the inquest into the man's death.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and detainees involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man, an Angolan national, arrived in the United Kingdom (UK) in 1994 and claimed asylum. His wife had already done so and, by the time of his death in October 2010 he had five children, all of whom were born in the UK. In 2006, he received a two year prison sentence for assault occasioning actual bodily harm. As a result of the conviction, he was to be deported to Angola after he had served his sentence.
2. He was released from prison in 2007 and spent the next three years appealing against his deportation, sometimes while detained in immigration detention centres and sometimes on bail. In August 2010, the courts decided that he had exhausted all of the available legal avenues to prevent his removal. On 27 September 2010, he was detained and taken to Brook House immigration removal centre. He was told that he would be removed from the UK in October. There were no serious concerns about his physical or mental health while he was at Brook House, although about an hour before he was due to leave he became tearful and told staff he did not want to return to Angola. He was monitored more closely by staff for the next hour.
3. He was to be accompanied on the flight to Angola by three G4S escort staff and an additional escort officer drove him and the escort staff to Heathrow Airport. The team left Brook House at 3.30pm and arrived at Heathrow Airport Terminal 5 at 4.40pm. The escort staff said he was calm and friendly during the journey.
4. Before boarding the flight to Angola, the G4S team leader briefed the British Airways captain and told him that the man was compliant. At 7.20pm, he and the escort staff boarded the flight. Because the team leader was confident that he posed no problems, he allowed the driver to leave.
5. At about 7.40pm, the man asked to use the aircraft toilet. As he left the toilet, he apparently became non-compliant and was restrained by the three escort staff. After a struggle, his hands were cuffed behind his back and he was manoeuvred into a seat at the back of the aircraft. It seems that he was restrained in his seat for about 30 minutes during which time some witnesses said they heard him complain that he could not breathe. At least for some of the time, he was bent forwards at the waist, with his head and chest towards his thighs.
6. At about 8.15pm, the aircraft began to taxi towards the runway in preparation for take off. The man then apparently stopped struggling and became unresponsive. The escort staff checked him for signs of life, and said that he was breathing and had a pulse. At about 8.20pm, the captain radioed air traffic control to say that he needed to return the aircraft to the stand as there was a medical emergency and that paramedics were needed. The escort staff continued to monitor him in his seat but no first aid was provided by the escort staff or cabin crew.

7. The first paramedic boarded the aircraft at 8.36pm and was soon joined by an ambulance crew. The paramedics checked the man and concluded that he was not breathing. They began cardiopulmonary resuscitation, which continued as he was transferred to hospital by ambulance. Sadly, he could not be resuscitated and his death was pronounced by hospital staff at 9.45pm.

8. We are concerned about aspects of the escort staff's response when the man became unresponsive. Underlying these concerns is serious disquiet about the standard of the use of force training that was delivered to escort staff in 2010. It is very worrying that UKBA were aware of the inadequacy of the training being delivered to escort staff before his death, yet two years after his death, the training has still not been adapted. We make nine recommendations as a result of our investigation.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was informed of the man's death on 12 October 2010. An investigator and another member of staff visited Brook House IRC on 19 October. During the visit, they met senior managers for the United Kingdom Border Agency (UKBA) and G4S.
10. In accordance with our procedures, the Ombudsman's investigation was suspended while the police carried out a criminal investigation into the man's death. An information sharing policy was agreed and the two investigation teams met regularly. We are grateful to the Metropolitan Police for sharing interview statements and other documents.
11. The investigator met the Coroner for West London in November 2010 to discuss the progress of the investigation. The report has been sent to the Coroner to assist with the inquest.
12. In December 2010, the investigator and one of the Ombudsman's family liaison officers visited Heathrow Airport to observe an accompanied deportation.
13. Notices of the investigation were displayed to staff and detainees at Brook House and on the G4S staff intranet inviting those with relevant information to contact the investigator. In February 2011, two former G4S employees provided general statements to us, the police and also the Home Affairs Select Committee.
14. While the PPO investigation was formally suspended, some tasks continued with the police's agreement. The investigator and an Assistant Ombudsman reviewed the man's immigration file and other relevant documents at the UKBA offices in London. In July 2011, they interviewed UKBA and G4S staff at Brook House. Further interviews were carried out in March 2012.
15. In July 2012, the Crown Prosecution Service (CPS) decided that the three escort staff responsible for the man in October 2010 would not face criminal charges over his death. In October 2012, the PPO and the police agreed that the PPO investigation could resume.
16. We asked to interview the three escort staff but, in December 2012, they declined to be interviewed on the basis that they had already been interviewed three times by the police and were cooperating fully with the Coroner's requests for further information. (The inquest into the man's death is scheduled to begin in May 2013). The PPO has no power to compel individuals to be interviewed. Reference in this report to the escort staff's evidence is based on the transcripts of their interviews with the police, as well as the use of force incident reports they completed shortly after his death and other relevant documentation.

17. The investigator and another member of the Ombudsman's staff conducted three further interviews in February 2013. In total, we interviewed ten members of UKBA, G4S and Tascor staff.
18. With the agreement of the Coroner, we obtained copies of the police files and have reviewed statements made by the passengers on board flight BA77 on 12 October 2010, the British Airways crew on duty that day, paramedics who attended and expert witnesses consulted after the man's death. We have also reviewed relevant UKBA and G4S policies and protocols. In December 2012, we asked UKBA for data on the use of force and restraints during overseas removals and for information on aspects of the contract between UKBA and the overseas escort provider. The Home Office provided the information after the draft report had been issued.
19. The investigator and the Assistant Ombudsman met a representative of Citizens UK in late 2012. Citizens UK kindly shared the draft report of their independent commission on forced removals. We have also read the report 'Report to the United Kingdom Border Agency on "Outsourcing Abuse"'.
20. The investigator and family liaison officer remained in contact with the solicitors acting for the man's family during the course of the investigation. The family reviewed the report at the draft stage and their comments have resulted in some minor changes.
21. The investigation had a wide scope and we have reviewed a great deal of information and evidence. In this report we have focused on what we considered to be the main issues raised by the man's death. Due to the contradictory witness evidence and the lack of closed circuit television footage of events on the aircraft, we have not attempted to provide a detailed description of what happened during the use of force incident. Accounts of these events will be subject to cross-examination during the inquest.

GLOSSARY

United Kingdom Border Agency

22. At the time of these events, the United Kingdom Border Agency (UKBA) was an agency of the Home Office responsible for controlling migration in the UK. UKBA's responsibilities included enforcing immigration and customs regulations and considering applications for permission to enter or stay in the UK, including citizenship and asylum applications.
23. The agency also had overall responsibility for the ten immigration removal centres across the UK. The day to day management of each individual centre is either contracted out to a private company or operated by HM Prison Service, under a service level agreement.
24. On 26 March 2013, the Home Secretary announced that UKBA would be abolished, with its work being divided into two areas (the visa system and immigration law enforcement) both to be delivered directly by the Home Office.

G4S

25. G4S is a multinational security services company founded in 2004, with headquarters in the UK. G4S operates six private prisons on behalf of the National Offender Management Service (NOMS). The company also carries out work for the government in the care and justice fields, including electronic monitoring, prisoner transportation and police support services.
26. The company currently operates three immigration removal centres (including Brook House). It is also responsible for escorting immigration detainees within the UK. Until the end of April 2011, G4S held the contract for escorting removed detainees to any overseas destination. In May 2011, that contract was won by Reliance (now Tascor). Under employment law, G4S staff involved in overseas escort duties were offered the chance to move to Reliance with the change of contract.

Brook House Immigration Removal Centre

27. Immigration removal centres are intended for the temporary detention of individuals who have no legal right to remain in the UK but have refused to leave voluntarily.
28. Brook House is a purpose-built immigration removal centre near Gatwick Airport, modelled on a prison design. It opened in March 2009 with capacity for up to 426 adult male detainees. It is run under a contract by G4S.

Her Majesty's Inspectorate of Prisons

Brook House

29. The centre was last inspected by Her Majesty's Inspectorate of Prisons (HMIP) in September 2011, following the first inspection of the centre in 2010. In his introduction, the Chief Inspector described substantial improvements at the centre, although significant concerns remained.
30. Inspectors criticised the excessive and often illegitimate use of the separation unit, noting that large numbers of detainees were moved to the separation unit, usually before removal. They also criticised the lack of systematic consideration of detainees' needs prior to removal.

Escorted removals

31. In 2009, the Inspectorate published a short thematic review to explore immigration detainees' experiences of escorts, focusing on those about to be removed. The Inspectorate described most removals as highly stressful and dramatic events for detainees, and for the staff who had to manage them. The review identified varied practice by escort staff. Most escort staff were described as appropriate, with examples of firm but sensitive handling, but some were said to be too concerned with swiftly resolving incidents rather than the detainee's wellbeing.
32. Incident reports completed when force had been used highlighted inconsistent and sometimes poor practice, although the one removal the Inspectorate observed where force was used seemed to be handled professionally.
33. In 2010, the Inspectorate inspected the arrangements for overseas removals from Heathrow Airport. Most detainees surveyed said that escort staff had been respectful. The inspection team observed detainees being escorted onto aircraft and reported that, in one case, the escort staff had been insufficiently discreet, causing embarrassment for the detainee. No force was used during any of the observed removals.

Independent Monitoring Board

34. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of centre life to help ensure that proper standards of care and decency are maintained. The 2010 IMB report for Brook House reflected the IMB's concern about the high use of Removal from Association under Detention Centre Rule 40 (and which we discuss in more detail later in this report). They suggested that, instead, a Departure Wing be set up to house detainees due for imminent removal from the UK.
35. In the most recent annual report for Brook House for 2011 – 2012, the Board continued to be concerned about the use of Removal from Association under Rule 40 for detainees about to be removed. The IMB were unhappy that

these detainees were prevented from using the centre's facilities, such as computers and fax machines, exactly when they might most need them. They noted that a new wing, specifically for use when removal directions have been served, was due to be opened.

Use of force

36. For use of force by immigration removal centre and escort staff to be lawful the following criteria must be met:
 - It is reasonable in the circumstances
 - It is necessary
 - No more force than necessary is used
 - It is proportionate to the seriousness of the circumstances.
37. UKBA contract holders, such as G4S, must be trained in and use recognised techniques, developed and accredited by NOMS. These techniques are called Control and Restraint and UKBA contract holders are trained in the same techniques as HM Prison Service staff.
38. Escort staff managing deportations carry rigid bar handcuffs, like those used by the police in England and Wales. The use of rigid bar handcuffs is not included in the NOMS use of force training or, therefore, in the training manual.

Positional asphyxia

39. Use of force and the application of restraints can have a number of adverse effects. One of the potentially most dangerous is positional asphyxia. Restraining someone in a position that compromises the airway or the expansion of the lungs can seriously impair the individual's ability to breathe, and can lead to asphyxiation. Restricting the neck, chest wall or diaphragm can be dangerous. The NOMS Use of Force Manual, the training text issued in 2006, covers positional asphyxia in some detail. According to the manual, forcing the head below the level of the heart, use of force and restraints where the person is seated and compression of the torso towards the thighs can increase the risk of positional asphyxia.
40. The manual notes that someone may be more predisposed to positional asphyxia and sudden death under restraint if they are physically exhausted, for example because of a physical struggle or anxiety, because this can increase the body's oxygen requirements.
41. The warning of signs of positional asphyxia noted in the manual include:
 - Struggling to breathe
 - Complaining of being unable to breathe
 - Evidence or report of the individual feeling sick or vomiting
 - Swelling, redness or bloodspots to the face or neck
 - Marked expansion of the veins in the neck

- Individual becoming limp or unresponsive
- Changes in behaviour
- Loss of, or reduced levels of, consciousness
- Respiratory or cardiac arrest

The training manual highlights that “it is a common misconception that if an individual can talk then they are able to breathe, this is NOT the case. An individual dying from positional asphyxia may well be able to speak or shout prior to collapse.” (Capitals used in the original text.) If staff involved in the restraint become aware of any of the listed warning signs, they are instructed to immediately release or modify the restraint as far as practicable to relieve pressure on the chest wall, and summon medical help.

CHRONOLOGY

42. The man was originally from Angola. In June 1994, he followed his wife to the United Kingdom (UK) and claimed asylum – which was refused. In 2001, he was granted exceptional leave to remain until 2004. He applied for further exceptional leave to remain in 2005. This application was not refused until 2008.
43. In April 2006, the man received a two year prison sentence for assault occasioning actual bodily harm. As a result of his conviction, the UK Border Agency (UKBA) told him that that he would be deported to Angola once he had served his sentence. He appealed against this decision.
44. The man was released from prison in 2007 and was detained at an immigration removal centre pending deportation. Over the next three years, he was sometimes held at immigration removal centres, but was also granted periods of bail. During this time, he was served with various removal directions, which were cancelled for legal reasons. In May 2010, the courts decided that he had exhausted all of his routes of appeal against deportation and should be removed from the country.
45. At various points during his periods of detention, the man's physical and mental health was assessed. In July 2009, he was prescribed antidepressants. He reported a family history of strokes and diabetes. In March 2010, he denied any family history of chronic illness and made no mention of any history of depression or mental illness. He complained of pain in his right knee and said he used a variety of pain relief medications, including paracetamol, ibuprofen and an ibuprofen gel. He did not mention any other health concerns.
46. On 21 September 2010, the man's UKBA case worker completed the IS91 Detention Authority form, which authorised staff to detain him when he next visited Becket House to report. (Becket House, near London Bridge, is the UKBA reporting and enforcement centre for South East London. It was run by G4S, on behalf of UKBA.) The IS91 includes a risk assessment. She recorded that he had committed a serious criminal offence involving violence and might require special monitoring or supervision. She also noted that he had refused to transfer between immigration removal centres in the past. His history of knee pain and use of pain relief medication was also recorded on the form.
47. At about 11.00am on 27 September 2010, the man was detained at Becket House and taken to Brook House Immigration Removal Centre (IRC). When he arrived, reception staff at Brook House recorded that he was fit and well.
48. At 5.39pm, UKBA faxed the man's removal directions to Brook House. He was due to be deported to Angola on a scheduled British Airways flight, leaving from Heathrow Airport at 8.00pm in October. The fax coversheet asked that the removal directions be served as soon as possible. They were served by G4S staff while he was still in the reception area at Brook House.

The member of staff serving the directions noted that he had been made aware of the instructions but said he was too tired to sign them.

49. No entries of note were made in the man's files over the next two weeks. At 8.15pm the day before he was to be deported, he was moved from his room and away from other detainees to the Removal from Association (RFA) Unit (under Rule 40 of the Detention Centre Rules, 2001, which allows detained persons to be removed from association with others in the interests of security or safety). Two managers authorised his removal from association on the grounds that it would "assist with the facilitation of his escorted removal directions" set for the following day. Staff kept an ongoing record of his time in the RFA unit, making entries at least once an hour.
50. According to these entries, the man slept well that night and came out of his room for exercise at 9.10am. He was visited by a UKBA representative, the centre's duty director and the most senior custody officer on duty. They recorded no concerns about him. He was given his lunch at 12.15pm.
51. At 2.10pm, Detention Custody Officer (DCO) 1 was concerned about the man and placed him on a Raised Awareness Support Plan (RASP)¹. The DCP noted that he had not eaten his lunch and was tearful. He told the DCO that he did not want to go back to Angola because he had nothing there and his wife and five children were staying in the UK.
52. The G4S overseas escort team responsible for taking the man to the airport and accompanying him on the flight met at Spectrum House (the central G4S office at Gatwick Airport). The team comprised a Senior Detention Custody Officer (SDCO), who was the team leader, and three DCOs. They arrived at Brook House at 3.00pm. During the journey to Brook House, the SDCO briefed the team about the man's risk assessment, which focused on his criminal offence.
53. DCO 1 made a number of entries in the RASP support record. At 2.30pm, he noted that the man had said his wife was upset about him being deported and that this had upset him. At 3.10pm, the DCO wrote that he had told him that he would be leaving soon and that he was okay about this. Five minutes later, he left the unit for the reception area.
54. The overseas escort team introduced themselves to the man. In a statement made after his death, the SDCO said that he had told the escort team about

¹ RASP was a G4S policy, only used at G4S-managed removal centres. It was implemented before the introduction of the Assessment, Care in Detention and Teamwork process (ACDT, which is a formal suicide and self-harm monitoring system used across the immigration estate). According to information received from UKBA in February 2013, G4S withdrew the RASP system as of 1 March 2013. The RASP process was designed as an intermediary step to provide additional support to detainees whose demeanour caused some concern but was not sufficiently concerning to lead to suicide or self-harm monitoring. Because RASP was a local policy, plans were closed automatically when the detainee left the removal centre and were not handed over to escort staff responsible for the detainee during transfer or removal.

the man's knee pains and he asked the reception staff to contact the Brook House healthcare department for further information. No one from the healthcare department answered the telephone so no further information was available. Reception staff told the escort team that he had been emotional that morning and had been monitored on a RASP. In his statement, the SDCO wrote that he had never heard of the RASP but was told that it was an internal process which would be closed when the man left Brook House.

55. The man was placed in the escort vehicle, a Ford Tourneo. He was not restrained, except by a seat belt. (The escort vehicles used by overseas escort teams largely resemble normal vehicles. Detainees travel in the main part of the vehicle, with escort staff sitting next to them. The passenger doors cannot be opened from the inside and the vehicles are fitted with audio and visual recording systems.) At 3.30pm, he and the escort team left Brook House for Terminal 5 at Heathrow Airport.
56. According to the DCOs' statements, the man was initially quiet but the mood in the vehicle was light and cordial. DCO 2 said that they talked about his time in detention, his family and his asylum case. He used his mobile phone several times during the journey to talk to his wife and friends. The SDCO said he was relaxed during the journey and laughed and joked with the escort team.
57. They arrived at Heathrow Airport at 4.40pm and the SDCO collected the man's travel documents. At 5.30pm, the SDCO arranged food and drink for the man and the DCOs. According to the escort team's account, the mood remained light and relaxed.
58. The vehicle arrived at the airport's security screening centre at 5.50pm, where detainees go through the same security checks as departing passengers in the terminals. After the security searches, the man was given the chance to smoke a cigarette, before being taken airside (which gives direct access to the aircraft). At 6.10pm, the team drove to stand 536, from where the British Airways flight number BA77 to Luanda would leave. DCO 3 described him as being constantly on the telephone to family and friends, apparently speaking in his native language. He thought that he was trying to arrange for someone to meet him in Angola.
59. While the others stayed in the vehicle, the SDCO went to speak to the flight captain and cabin crew. In his statement to the police, the captain said that he met the SDCO as he arrived at the gate at 7.00pm. He was told that a detainee would be travelling on the flight. He said that the SDCO told him that the man was quiet and well behaved. The SDCO remembered telling the crew that the man was calm and that he did not think he would be disruptive because he had been well behaved throughout the journey.
60. Members of the cabin crew gave statements to the police. The cabin service director said that he briefed the crew before they boarded the flight. He told them that a detainee and three escort staff would be travelling on the flight

and would be seated at the rear of the aircraft. He told staff that the escort staff would be “in effective control” of the detainee at all times.

61. At 7.20pm, the G4S escort team and the man boarded the aircraft. (It is usual for detainees and escort staff to board the aircraft and take their seats before other passengers begin boarding.) Their seats were in row 39 at the rear of the aircraft and the man’s seat was in a row of three between DCOs 2 and 3, with the SDCO seated in the row in front. The staff statements record that he sat in his seat calmly and immediately fastened his seatbelt. The driver, DCO 4, also boarded the plane and carried the man’s property onboard. Normally, the driver remains on the aircraft until all of the other passengers have boarded, however, as the mood was relaxed and friendly, the SDCO agreed that the DCO could return to the vehicle. Other passengers began boarding the aircraft.
62. At about 7.30pm, the man asked to use the toilet, although the aircraft was due to begin taxiing to the runway soon. DCO 3 escorted him to the toilet at the rear of the plane. In line with standard procedure, the toilet door was left slightly ajar while he used it. The SDCO waited outside with the DCO, and DCO 2 positioned himself in the opposite aisle. According to the staff statements, he used his mobile phone while in the toilet.
63. The SDCO led the man back to his seat, with DCO 3 following. In his statement, the SDCO explained that, as they drew level with their allocated seats, the man stopped, said he would not go and lunged at the SDCO, ripping his shirt open. Two of the cabin stewards described hearing a “harrowing” roar, which they believed had come from the man. The SDCO said that he and the other DCOs grabbed hold of him and, after struggling for about five minutes, managed to apply handcuffs to him. His hands were behind his back with one wrist above the other (known as the rear stack position). The escort team said he was very strong and that it was not easy to control him. They said he continued to struggle after the cuffs had been applied.
64. The cabin stewards told the cabin service director what was happening and he decided to stop other passengers from boarding until the situation was under control. The escort staff moved the man towards the crew seats in row 40 (the last row of seats) and into seat 40E. DCO 2 sat in seat 40D, DCO 3 sat in 40F and the SDCO positioned himself in seat 39E, in the row in front, but remained facing the man. His seat belt was fastened once he was in the seat. He apparently continued to struggle. Once cabin crew felt that the escort team had control of him, passengers were allowed to continue boarding.
65. At about 8.15pm, the aircraft began to taxi towards the runway. The man was still restrained by handcuffs. At about this time, the DCOs said that he stopped struggling, although he remained leaning forward with his head resting on the back of the seat in front. They said that they believed that he had accepted he was going to be removed. According to the escort staff, approximately five minutes after the aircraft began to taxi, he became limp

and they sat him more upright. He did not respond to any of their questions and they became concerned and removed his handcuffs. The DCOs checked his pulse and breathing and for signs of normal circulation. According to the statements made by the escort team, he was breathing and had a pulse at that time.

66. The captain said that he received a call in the cockpit at about 8.15pm, informing him that the man appeared to be unconscious. The captain asked if he was really unwell or faking illness in order to prevent being removed. The cabin service director told him that he was breathing and that he would consider whether any further action was necessary. The aircraft continued to taxi towards the runway.
67. Within minutes, the SDCO asked for the aircraft to return to the stand and paramedics be called because they were concerned about the man. The captain said that he radioed the air traffic control centre at about 8.20pm, telling them there was a medical emergency and that the aircraft needed to return to the stand. He asked for paramedics to attend. Although both the G4S staff and the British Airways crew were trained in first aid, and the aircraft was equipped with a defibrillator, no first aid was administered to him while the plane returned to the stand. He remained upright in his seat.
68. The London Ambulance Service received a call requesting attendance at 8.24pm. The first response paramedic based at Heathrow Airport arrived at the stand by bicycle and boarded the aircraft at 8.36pm. He assessed the man and found no signs of breathing or a pulse. A second paramedic arrived in an ambulance shortly after and also boarded the plane. The paramedics placed him on the floor at the rear of the aircraft and began to administer cardiopulmonary resuscitation (CPR). He was transferred to the ambulance and taken to hospital. At 9.45pm, a hospital doctor pronounced that he had died.
69. A pathologist carried out a post-mortem examination. He found that the man had markings on both wrists associated with deep bruising consistent with the use of handcuffs and struggling against them once applied. He had an abrasion to his forehead with deep bruising, consistent with him striking his head against the aeroplane seat in front. He had extensive bruising to his lower limbs, wrists and upper arms consistent with restraint and he had double fractures to two ribs.
70. The toxicological examination found no evidence of illicit drug use. Codeine and dihydrocodeine (pain relief medications) were present in low concentrations. The man's heart was examined and found to be normal, so did not explain his sudden collapse or death.
71. The pathologist wrote:

“In conclusion, the man was an extremely muscular man who as a consequence of restraint by third party individuals, restriction of movements of breathing by rear stack handcuffs, lent over positioning and

rib fractures together with struggling, even in the absence of movement, sustained critical depletion of oxygen, high levels of adrenalin and lactate leading to cardiac instability and cardiorespiratory arrest. There is no evidence of any natural disease process or toxicological obtundation [impairment of mental capacity] that could have caused this collapse.”

72. The cause of the man’s death was recorded as:

- 1a. Cardiorespiratory collapse
- 1b. Restraint

ISSUES

Preparing the man for his removal – events at Brook House

Removal from association

73. The day before the man's scheduled escorted removal from the UK, staff at Brook House decided that he should be removed from association under Rule 40 of the Detention Centre Rules, the Statutory Instrument which governs immigration removal centres. The Rule allows that, where it appears necessary in the interests of security or safety that a detainee should not associate with other detainees, they can be removed from association. The detainee cannot be removed from association for more than 24 hours without the authority of the Secretary of State and can only be removed from association for up to 14 days.
74. The Brook House Director was interviewed in July 2011 and said that removing from association detainees due for imminent removal, on the basis of a risk assessment process, reduced the risk of unrest across the centre and the removal being disrupted. He said that G4S was subject to performance measures if they failed to present a detainee at reception for removal, and that contractual considerations played a part in the decision to remove detainees from association. He said that it had become standard centre practice to remove from association any detainee due for escorted removal the next day. This was based on an assumption that the detainee was being escorted because he had failed to comply with a previous removal direction.
75. UKBA is responsible for deciding which removals require escorts. According to the UKBA file, the man had never previously failed to comply with a removal direction. Earlier removal directions had been cancelled because of successful legal action.
76. The Director said that detainees removed from association are subject to a restricted regime and are locked in their room most of the time. He said that they are allowed access to the unit telephones and are able to shower and use the outdoor exercise yard. They have access to limited in-cell activities and have a television in their room. DCO 1 said that the man would not have been allowed to keep his mobile telephone in his room while in the Removal from Association (RFA) unit, but would have been able to access any numbers stored on it. He said that the unit had a fax machine so that detainees could send faxes. Detainees in the RFA unit did not have access to computers or the internet, unlike other detainees.
77. It is our view that the decision to remove the man from association was an unduly risk averse one and not based on available evidence. The written reason for the decision was to assist with the facilitation of his escorted removal which was inadequate justification. Rule 40 should not be used as a matter of routine for a class of persons but should be based on evidence relating to a particular detainee which would indicate he was a threat. He had

twice previously refused to transfer between immigration removal centres, but as we discuss later, there is no evidence that his behaviour on these occasions was violent. The cancellation of earlier removal directions was not because of his behaviour. We have not seen any evidence to suggest that other detainees were planning to assist in disrupting his removal. Immigration removal centres should take a person-centred individual approach to removal, with decisions based on relevant evidence and justified by written reasons. Removal from association under Rule 40 should apply only if security or safety will be compromised. We do not consider there was evidence for this. Unnecessarily removing detainees from association before removal is highly likely to increase stress and worry at what is already a difficult time, not least because it becomes less easy for detainees to contact their families and legal representatives. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that immigration removal centres remove detainees from association under Rule 40 only when there is evidence that security or safety will be compromised.

The use of ACDT² and RASP

78. On the day of the incident, DCO 1, who was working in the RFA unit, opened a Raised Awareness Support Plan (RASP) when the man became tearful and said he did not want to return to Angola because his family were staying in the UK and he had nothing in Angola. The RASP remained open until he left Brook House for Heathrow Airport.
79. Brook House staff told us that, unlike ACDT plans, RASPs were local documents and did not transfer with the detainee when they left the centre. We understand the Raised Awareness Support Plan system was withdrawn by G4S in March 2013. The SDCO wrote in his statement that he had never heard of a RASP and, when told that the man had been subject to one, did not know what that meant. Presumably that means he was not aware that he had been upset that day, or had said that he did not want to be removed. While such knowledge might not have had any impact on how the escort team managed him or led to a different outcome, it is important that escort staff have access to all information which might help them assess the risk of the situation they are managing.

² The Assessment, Care in Detention and Teamwork (ACDT) process was introduced across the immigration detention estate in 2008, by Detention Service Order (DSO) 6/2008. ACDT plans should be opened whenever a member of staff has concerns that a detainee may be at risk of suicide or self-harm. The purpose of ACDT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the detainee. Levels of observations (where staff must check the detainee) and interactions (where staff must have a conversation with the detainee) are flexible and can be set according to the perceived risk of harm.

An open ACDT plan must accompany the detainee when he leaves a place of detention. When the detainee is due to leave the centre, staff must inform the UKBA Detainee Escort and Population Management Unit (DEPMU) of the open ACDT plan and ensure that the escorting staff have been fully briefed about it.

The Director General of Immigration Enforcement should ensure that any concerns about a detainee's mental state or behaviour are effectively passed to escort staff.

The risk assessment process and the allocation of escort staff to the man's removal

80. On the day of removal, the man was accompanied on the flight by three G4S escort officers. We have examined how the decision to allocate three staff to the removal was made.
81. Detainees are subject to a variety of risk assessments and risk related information is recorded in different ways and places. Risk assessments can include information about factors such as known medical problems, past behaviour (including the type of any criminal convictions) and risk to self through self-harm or suicide attempts. Over the years, the man's risk had been assessed on several occasions. A review of the information in his file highlights a number of discrepancies and factual inaccuracies which might have affected how his risk was assessed.
82. In 2006, the man received a two year prison sentence for assault occasioning actual bodily harm. Immigration documents completed after his release from prison often marked him as having committed serious criminal activity. A movement order completed on 27 September 2010 incorrectly recorded that he had been convicted of robbery in 2007 as well as assault. The movement order also noted that he had previously been incorrectly marked as a MAPPA 1 offender. (Multi-Agency Public Protection Arrangements were introduced in 2000 to manage offenders charged with specific sexual or violent offences and who posed a serious risk of harm to the public. He was never managed under MAPPA arrangements.)
83. Various documents completed in 2010 record that the man posed a high risk of reoffending and harm to the public. It is not clear what information was used to reach these judgements. On 27 September 2010, the movement notification relating to his detention at Becket House stated that he was "extremely violent". Without in any way wishing to belittle the seriousness of his offence, we note that he had a single conviction for violence. Some subsequent risk assessments in 2010 record that he had a history of abuse of women and/or children. The victim of his assault was female (and was apparently unknown to him), but we believe that the evidence does not support the generic categorisation of having a history of abuse of women and/or children.
84. In July and September 2007, the man had refused to transfer from immigration removal centres in or near to London to centres in other parts of the country. On both occasions, he argued that his family would not be able to visit him if he was moved, which appears a reasonable objection. There is nothing in his immigration file to suggest that his behaviour was violent, but he was classified as disruptive. This classification remained with him for the next

three years and appears on some, but not all, of the risk assessments completed in that time. The assessment of 15 September 2010 classified him as being very disruptive and because of this should only travel on a British Airways flight. (G4S staff told us that British Airways generally agreed to carry detainees who had been identified as potentially disruptive. They said that some other airlines are less happy to do so.)

85. In July 2011, we interviewed an Assistant Director with the UKBA Criminal Casework Directorate. He explained that UKBA did not have a “unified language of harm”, and different types of risk assessment were carried out by different departments. The documents in the man’s file suggest that incorrect or out of date information was not removed from the file. The Assistant Director did not think that positive behaviour was logged anywhere or used to counter-balance risk assessments. As UKBA staff are responsible for deciding which detainees will need to be escorted during their removal (although not the strength of the escort team), it is important that the information they base this decision on is accurate, evidence-based and defensible.
86. The decision about how many escort staff should be allocated to a removal is made by the overseas escort contract holder. In October 2010, G4S were responsible for the decision. The Operations Manager for the overseas escort contract in October 2010 explained that her team received initial notification of the escorted removal from the ticket booking company (not directly from UKBA). The default position was that two escort officers would accompany an escorted removal. A risk assessment was carried out using available information about the individual, and if necessary, additional escort staff were allocated. She said that usually, there was no direct communication between UKBA and G4S about the strength of the escort team.
87. The Operations Manager said that, generally, no more than four escort staff were allocated to the removal of an individual. If necessary three escort officers might be involved in restraining someone who was being removed and this would allow the fourth to communicate with the captain, cabin crew and passengers. Decisions were based on any information available at the time. She said that the movement order did not normally arrive until 24 hours before the removal, but that this document included risk related information and information had to be taken at face value. For example, if the order noted that the detainee had been disruptive during a previous removal and did not provide any further information about the nature of the disruption, she assumed this meant that they had been violent.
88. She said she could not recall considering the man’s removal in October 2010, but believed that on the basis of the information available at the time, she would have decided that he should be accompanied by three escort officers. She said that she might have allocated four escort officers to the removal had they not been flying with British Airways as that airline was “quite robust in terms of disruptive behaviour ... [and] quite willing to carry on despite shouting or physical disruption”. The decision making process about the strength of the escort was not recorded anywhere.

89. The man had been served with removal directions several times in the past and at least three of those resulted in travel arrangements being made, including the level of escort. On 31 July 2009, two escort officers were allocated to escort him. Twice in November 2009, four escorts were allocated and four were allocated on 24 March 2010.
90. On the day of his removal, the man was accompanied by three escort officers. It is not possible to know whether the outcome would have been any different had the escort team comprised two or four escort officers. However, we are concerned that the decision making process does not appear to be structured or robust and that the same information can result in three different levels of escort within the space of just over a year, seemingly only dependent on the airline being used rather than the individual's risk assessment. We make the following recommendation:

The Director General of Immigration Enforcement should introduce a uniform, robust and evidence-based risk assessment process based on accurate information and which includes guidance to decide the size of escort team needed.

The use of force against the man on the day of removal

Control and restraint training for overseas escort staff

91. All three of the accompanying escort staff had been in post for at least two years. They had all attended the full use of force training course. The SDCO joined G4S in 2007 and was promoted to SDCO in April 2010. He completed use of force refresher training in March 2010 and was judged by the use of force trainers to be competent in the techniques and theory. He completed first aid at work training in July 2010.
92. DCO 3 had previously worked for other overseas escort contract holders before joining G4S in 2008. Although he was acting in the capacity of a DCO on the day of the removal, he was also an SDCO. He completed use of force refresher training in March 2010 and was judged to be competent by the trainers. He completed first aid at work training in October 2008 (the certificate is valid for three years).
93. DCO 2 joined G4S in 2008. He completed use of force refresher training in May 2010 and was judged competent by the trainers. He completed first aid at work training in June 2008.
94. As part of our investigation, we have considered whether the control and restraint training provided to the G4S escorts was adequate. Both the SDCO and DCO 3 told the police that the control and restraint training they had received as employees of G4S did not provide any guidance or techniques for restraining someone on an aircraft. The SDCO said that he had raised concerns about this after his last two control and restraint refresher courses. We have seen the training feedback forms the three escort officers completed

after refresher training courses in 2010. Each of the three said that they strongly agreed with the statement “I now feel confident to apply the skills and knowledge in the workplace”. We have not seen any evidence that any of the three raised formal concerns about the suitability of the training.

95. We interviewed an officer who for the last 12 years has been part of the National Tactical Response Group (NTRG) in NOMS. The NTRG is responsible for the design and delivery of the use of force curriculum across the prison estate. The group is also responsible for training escort contract holders, including G4S and Tascor staff. (NTRG train the contractor’s instructors who then train the escort officers.) He confirmed that the training given to escort staff is exactly the same as that delivered to staff working in prisons and immigration removal centres. He said that in 2010 the training for escort staff did not include any scenario-based training for restraining detainees during an overseas removal, for example, up steps to an aircraft, along narrow aisles or in aircraft seats. He said that, in his view, the lack of escort-specific training meant that the training delivered did not adequately equip escort staff for their role. At the draft report stage, the Home Office noted that although the NTRG training did not include any scenario-based training for overseas removals, instructors were told to develop the training for escort staff.
96. The G4S assistant operations manager for the overseas contract in 2010 was also a G4S control and restraint trainer and was one of the people responsible for training escort staff in the NOMS control and restraint techniques.
97. He said that, in 2005, he raised concerns with Securicor managers about the lack of specific training for overseas escorts. In 2008, UKBA consulted NTRG about the “unique and potentially difficult scenario” of restraining someone on an aircraft. To evaluate current practice, the officer from the NTRG and his colleague accompanied G4S escort staff and UKBA managers on a chartered flight removing detainees from the UK. In June 2008, he prepared a report detailing their findings. NTRG made a number of recommendations in the report, that:
 - Facilities be sought to provide training in realistic scenarios, specifically, an aircraft with a centre aisle and passenger seats on both sides.
 - All movement of detainees is recorded by video camera, including during the flight.
 - UKBA and G4S re-assess the current type of handcuff being used for escort procedures and develop a system for mechanical restraints.
 - The use of the head support position from the front is not used in a seated restraint. (In control and restraint incidents, one member of staff is allocated to control the head of the restrained person. Head control helps to ensure that the person does not injure themselves, for example, by banging their head against a hard surface. When a person is being restrained while standing up, head control involves bringing the head slightly forward from the torso.)
 - Techniques are developed for use by fewer than three escort staff and to include seated restraint positions.

98. In September 2008, G4S issued guidance to control and restraint instructors which informed staff that all control and restraint techniques which involved the detainee being bent forward in a seated position were no longer to be used. The guidance also instructed staff to adapt the head support position to control the head in an upright position (rather than bringing the head forward).
99. We asked UKBA what action had been taken in response to the NTRG report. Due to the passage of time and the departure of key persons, UKBA was not able to say what the agency's response to the report and recommendations had been. The NTRG officer said that, in any case, after the 2008 report, NOMS control and restraint instructors incorporated some of the learning into their training. For example, staff were trained to apply head control from behind the restrained person to ensure that the head was controlled in an upright position. Both he and the G4S Assistant Operations Manager made it clear that the training for escort staff emphasised that there was no specific training for restraint on an aircraft and that staff were expected to adapt the safe techniques they had been taught. The three escort officers had all attended use of force training since 2008 yet it seems that they did not follow the guidance on 12 October 2010.
100. The G4S Assistant Operations Manager said that, after receiving the NTRG report in 2008, he put together a business case for introducing more scenario specific training for overseas escort staff. He also developed a training package tailored to the needs of overseas escort staff, but UKBA insists that all such training is accredited. The only accredited use of force training available to G4S staff was that being delivered by NOMS. UKBA said that they asked NOMS to accredit the G4S designed training but that accreditation was not part of NOMS' function. UKBA told us that, at the time of the man's death, they were trying to persuade NOMS to take on the accreditation role.
101. In November 2008, the PPO reported on an investigation into a complaint made by a detainee about her treatment during a removal. We recommended that UKBA conduct a thorough review of the use of restraints by escort staff and issue guidance beyond that already contained in the use of force manual. In January 2009, UKBA responded that they had already reviewed the control and restraint techniques used by escort staff and found them to be appropriate. However, UKBA said "we will be providing specific additional top-up training for overseas escorts which will include the use of [control and restraint] in small enclosed spaces such as vehicles and on aircraft, and first aid techniques in enclosed spaces". This had not been done by the time of the man's removal.
102. It is clear that in October 2010, when the man died, G4S, NOMS and UKBA were aware of the shortcomings of the use of force training being delivered to overseas escort staff. G4S had attempted to design more appropriate training but, under the terms of their contract with UKBA, were obliged to use their accredited training. It was not NOMS' responsibility to ensure that the accredited use of force training was appropriate for overseas escort staff. On the basis of the evidence we have seen, we do not believe that UKBA acted

with sufficient urgency to remedy the acknowledged shortcomings in the training.

Progress since the man's death

103. After the man's death, UKBA asked NTRG to review the use of force practices and training for overseas escort staff. The review was carried out by the officer of the NTRG, who concluded that control and restraint techniques used "in their purest form" were safe. However, he added that while the established techniques helped staff to restrain detainees in vehicles and aircraft, there was still no structured or independently accredited training for those specific situations.
104. UKBA commissioned a further review from NTRG to research how to make the control and restraint techniques used in removals safer. The review group issued a report to UKBA in January 2012 (the PPO has not seen the report) and made a number of recommendations, all of which UKBA accepted. The key recommendations were that:
- UKBA develop, own and clear with Ministers, its own overarching policy and techniques on the use of force. The agency said that work on this is currently underway.
 - UKBA develop its own bespoke training package and procure its own training environments (for example, vehicles used for escorting, holding rooms and aircraft) to better meet the needs of escort staff.
105. UKBA commissioned NOMS to develop a bespoke training package and the project began in May 2012. An independent advisory panel has been appointed to assess the quality and safety of systems of restraint and any equipment proposed for use by escort staff. The final phase of the project will be to train escort staff in the revised training package once agreed by Home Office ministers. The introduction of appropriate training for escort staff is long overdue and we make the following recommendation:

The Director General of Immigration Enforcement should, as a priority, introduce appropriate scenario-based use of force training for escort staff.

The actions of the escort staff in October 2010

106. Although we have identified the lack of role specific control and restraint training for escort staff, all G4S escort staff had received the NOMS use of force training, which includes an overview of the potential risks to a restrained person's physical health, and first aid. We must, therefore, consider the actions of the three escort staff in October.
107. The Metropolitan Police gathered statements from passengers on board the British Airways flight to Angola and the cabin crew and pilots. They also interviewed the three escort staff who restrained the man. The police gathered expert evidence on the use of force, positional asphyxia and first aid.

We have had access to this evidence and it forms the basis for much of the following discussion. While the evidence provides some information about the events that occurred, some of the witness evidence is contradictory. We do not intend to provide a detailed account of the use of force incident as the contradictory accounts make it difficult to be clear of the events.

108. The escort staff said that the man became aggressive when he came out of the aircraft toilet at about 7.30pm. After a struggle that probably lasted up to five minutes, they said that they were able to apply rigid bar handcuffs in the rear stack position (hands behind the back). They then manoeuvred him into a seat in the last row of seats on the aircraft (row 40, which are crew seats) and fastened his seatbelt. The escort staff said that he continued to struggle once seated. They said that he tried to kick and bite them and attempted to stand up. They described him as keeping himself bent at the waist, with his chest and head lent towards his thighs. The SDCO agreed that the restraint lasted for up to 36 minutes. According to the evidence, he stopped struggling at around 8.15pm, when the aircraft began to taxi towards the runway. It is possible, therefore, that he was restrained with his hands cuffed behind his back for up to 45 minutes.
109. The officer from the NTRG and the G4S Assistant Operations Manager were asked about the appropriateness of applying handcuffs in the rear stack position. They agreed that, ideally, for safety and comfort, handcuffs should be applied to the front but that, in reality, this was not always possible. They said that there were approved techniques for moving handcuffs from the rear to the front but that this could not be done until the restrained person was calm. Both agreed that an individual should not be restrained with their hands cuffed behind their back for an extended period of time. The Manager said that guidance on handcuffing procedures had been given to escort staff before 2010. The guidance directs that escort officers transfer handcuffs to the front “at the earliest opportunity when it is practical and safe to do so”. The guidance highlights that handcuffs applied to the rear can increase the risk that the detainee’s breathing is restricted and can lead to positional asphyxia. We accept that it might not have been safe to move the man’s handcuffs to the front because he continued to struggle, but, if so, that should have made escort staff more alert to the possible dangers.
110. The officer from the NTRG and the G4S Assistant Operations Manager were asked whether escort staff were given any guidance on the maximum time they should restrain someone. They said that no specific maximum time limits were set but that staff were warned of the particular dangers of prolonged restraint. The officer explained that it was difficult to set a time limit because it depended on the particular circumstances. He thought that restraint should last “minutes rather than hours”. The Manager gave his own view of what amounted to prolonged restraint:

“For me, really if you’re restraining anyone over like 15 minutes, then I would say that they’re either not going to give up, they’re either on drugs or alcohol or maybe they’ve got a mental illness and they’re just not going to give up. And if they’re not going to give up then you’ve got concerns

because you're just going to continue the restraint and at some point their body will give up."

111. The escort staff said that the man kept leaning forward from the waist, taking his chest and head towards his thighs. They said that they tried to get him to sit more upright in his seat but, because he was very strong, they found this difficult. Because his hands were cuffed behind his back, his upper body was already pushed forwards and it would have been very difficult and painful for him to sit completely upright.
112. The officer from the NTRG, the G4S Assistant Operations Manager and the Quality and Compliance Manager at G4S in October 2012, were all asked what escort staff could do if they did not feel they could adequately control a detainee. They agreed that escort staff could decide, at any point up to the aircraft taking off, that a removal should be aborted and take the detainee off the aeroplane. The Quality and Compliance Manager said that neither escort staff nor the escort contractor was under any pressure to continue an unsafe removal. The SDCO and DCO 3 told the police that they were not under pressure to complete removals.
113. It appears that the use of force incident had lasted more than 30 minutes by the time the aircraft began to taxi and the man had shown no signs of calming or stopping struggling. The flight to Luanda was eight hours long. If, as the escort staff said, the three of them could not sufficiently control him to get him to sit more upright in his seat there was clearly a danger that they would not be able to control him during the flight. However, it does not seem that they considered aborting the removal. We believe that this would have been wholly justified in the circumstances.
114. A review of the evidence suggests that a common presumption during escorted removals was that a non-compliant detainee would calm down and resign himself to the removal once the flight took off. Some of the cabin crew shared this view. Both managers said that escort staff were told this during training. The Quality and Compliance Manager said that analysis of use of force incidents had indicated that disruption tended to end once the flight had taken off. However, he said that staff were trained to remain alert and to risk assess the situation continually.
115. We are concerned that the presumption that a non-compliant detainee will calm down once the flight is airborne is a dangerous one. On the basis of the evidence we have seen, it seems that the escort staff restraining the man gave this theory prominence, rather than continuously risk assessing the situation. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that escort staff continuously risk assess the detainee and the unfolding situation during a removal and abort the removal if they do not have full control of the detainee.

116. When interviewed by the police, the escort staff denied using any force to keep the man in a forward leaning position. As already described, they said that he placed himself in this position despite their efforts to sit him upright. However, it is difficult to see how a large framed person like him would be able to sit upright in the confined space of an airline seat with his hands handcuffed behind his back. This position is known to increase the risk of positional asphyxia because it can restrict the body's normal breathing movements. One of the documented signs of positional asphyxia is the individual complaining that they cannot breathe.
117. The police took statements from 57 passengers on board the flight in October 2010. According to the information passengers gave, 16 said that they heard the man complain that he could not breathe. Of these 16, 13 were sitting within five rows of row 40. Two members of British Airways staff also said that they heard him say he could not breathe. Despite this evidence, all three of the escort staff denied having heard him say he could not breathe.
118. Our interviews with those involved in managing and training overseas escort staff and a review of use of force policy documents show the prominence given to positional asphyxia and the risks related to the use of force. The SDCO told the police that he could not remember positional asphyxia being a prominent topic in his use of force training. He said that he considered positional asphyxia when the man had his head lowered but that, because their training did not include use of force in confined spaces, he did not generally consider that it was a risk. He said that it did not occur to him that the fact he had been leaning forwards for 30 minutes or more might increase the risk of positional asphyxia.
119. DCO 2 said that it was only when the man stopped responding that he became concerned about the possibility of positional asphyxia because he had been bent over. He said that until that time, he had not seen any of the symptoms of positional asphyxia which he had been trained to look out for.
120. DCO 3 said that he did not consider positional asphyxia at any time during the incident. He did not think that the man's head had dropped below the level of the television screen on the seat in front of him. He said that the man "put himself" in that position and was "shouting away merrily" so he did not consider positional asphyxia.
121. We are satisfied that the theoretical training for escort staff in 2010 gave sufficient prominence to positional asphyxia. We cannot be sure how much prominence it was given in individual training sessions but it is apparent that it is an aspect to which the training attaches importance and all the staff agreed they had had some training about the dangers. It is therefore a concern that only one of the escort officers considered that the man was at risk of positional asphyxia during the use of force incident. This suggests that, despite the training, positional asphyxia was not sufficiently prominent in the minds of the escort staff when they had to put their training in practice. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that escort staff fully understand the risks and symptoms of positional asphyxia and apply their training when carrying out their duties.

122. The escort staff's evidence indicates that when the man stopped responding and appeared to have lost consciousness, they thought that he might be feigning illness in an attempt to abort the removal. Some of the cabin crew and the flight captain appeared to share the view that this was a possibility. G4S Operational Policy Standards and Procedures: Acute illness of a detainee or dependent child provides guidance for staff if a detainee becomes unwell. It directs that escort staff must "risk assess the situation, and take account of the fact that a detainee may be feigning illness to thwart intended UKBA action or in order to engineer an escape scenario".
123. We are concerned that the idea that a detainee might feign illness has gained undue prominence in the minds of escort staff. A clinician, with a special interest in trauma and resuscitation, provided expert evidence to the police. In his statement, he suggested that training for escort staff should emphasise that a detainee who complains of difficulty breathing, being unable to breathe or being short of breath should be assumed to be telling the truth rather than the symptoms being dismissed as a fabrication. Because of the risks involved, we agree with the clinician's view and make the following recommendation:

The Director General of Immigration Enforcement should ensure that policy and training related to the use of force and first aid makes clear that there is a presumption that a person who appears to be experiencing breathing difficulties while under restraint is genuine and is treated in line with first aid policy.

Emergency responses

124. According to the escort staff, they first became concerned about the man's health when the aircraft began to taxi towards the runway. They said that it was not until this point that he stopped responding when they spoke to him. The SDCO said that the escort staff removed the handcuffs and sat him upright in the seat as soon as he stopped responding. He also said that they checked his fingertips for signs of circulation (this is normally done by pressing on the fingernail for a few seconds until it becomes white and then releasing the pressure and checking how quickly the nail colour returns to normal). They also checked his pulse and for signs of breathing. The escort staff said that he had a weak pulse and shallow breathing. However, they thought that he was "in distress" and asked the cabin crew for the aircraft to return to the stand so that paramedics could check him.
125. According to the evidence, the escort staff first became concerned about the man at 8.15pm, and the captain was alerted that he was unresponsive. At about 8.20pm, the cabin services director told the captain that the aircraft needed to return to the stand. The first paramedic boarded the plane at 8.36pm. During those 20 minutes, he remained sitting upright in his seat and

neither the escort staff nor British Airways cabin crew delivered any first aid. As soon as the paramedics boarded, they placed him on the floor of the aeroplane and began CPR.

126. The clinician considered the escort staff response to the medical emergency, including whether the man should have been placed in the recovery position and given CPR earlier. He considered this against the first aid training the escort staff had received. He explained that the recovery position is used to help protect and maintain a patient's airway. He concluded that if, as the escort staff said, he was breathing, it was reasonable for them not to have thought of placing him in the recovery position.
127. The clinician noted that checking for a pulse is notoriously inaccurate in an unwell patient. He explained that the absence of signs of life (such as responding to gentle shaking) and the absence of normal breathing are the main signs of cardiac arrest that should prompt CPR. However, he concluded that, the training the G4S staff received was unclear about whether CPR should be given to someone with abnormal breathing. While he felt it was not unreasonable that the staff had not begun CPR, he concluded that the training staff received needed to be improved so that they were better equipped to cope with such an emergency. We make the following recommendation in line with his findings:

The Director General of Immigration Enforcement should ensure that all escort contract holders deliver first aid training to staff which makes clear that an unresponsive or unconscious patient should be placed in the recovery position and that cardiopulmonary resuscitation should be delivered when a patient is unconscious and not breathing normally.

128. We have some concerns about the extent of communication between the escort staff and the British Airways crew. The evidence of the cabin crew and captain and co-pilots suggests that they were unclear about the seriousness of the man's condition. Although some of the crew said that the cabin services director checked him for a pulse, in his evidence, the cabin services director denied having done so. It seems that the crew believed that the escort staff were responsible for all aspects of his care, including any first aid response. This is despite the aircraft being equipped with an automated external defibrillator (AED, which can deliver an electric shock to restart the heart in certain circumstances). The actions of British Airways staff are outside our remit, but we are surprised they did not ask if there was a doctor on board and that the escort team did not request that they do so or otherwise seek help from the crew. We make the following recommendation:

The Director General of Immigration Enforcement should ensure that escort staff seek support from airline crew if a detainee is seriously unwell and in need of first aid and medical assistance.

The inquest verdict

129. The inquest into the man's death began at West London Coroner's Court on 13 May 2013 and concluded on 9 July 2013. The jury returned a verdict of unlawful killing and wrote the following:

"In October 2010, the man 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, he 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 him and the rear of the plane.

"Based on the evidence we have heard, we find that he 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 he 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 would have caused him harm in their actions, if not serious harm.

"We find that he died in his seat at approximately 20:24, but before the paramedics boarded the aircraft at 20:38."

RECOMMENDATIONS

The Home Office response to the recommendations is included in italics beneath each recommendation.

1. The Director General of Immigration Enforcement should ensure that immigration removal centres remove detainees from association under Rule 40 only when there is evidence that security or safety will be compromised.

The Home Office accepted this recommendation, noting that “Brook House are now using Rule 40 appropriately and Immigration Enforcement staff are monitoring the use of Rule 40 across the estate to ensure that it is used in accordance with the Detention Centre Rules.”

2. The Director General of Immigration Enforcement should ensure that any concerns about a detainee’s mental state or behaviour are effectively passed to escort staff.

The Home Office accepted this recommendation, noting that it had already been achieved: “The Person Escort Record (PER) has been adopted by the Home Office since January 2012 and records the result of the risk assessment process. It has a dedicated section for healthcare clinicians to complete to highlight medical and mental health issues, as well as suicide and self-harm risk factors. The purpose of the PER is to ensure that all staff transporting and receiving detainees are provided with all necessary information about them, including any risks or vulnerabilities that the person may present.”

3. The Director General of Immigration Enforcement should introduce a uniform, robust and evidence-based risk assessment process based on accurate information and which includes guidance to decide the size of escort team needed.

The Home Office accepted this recommendation noting that “We already have a robust risk assessment process. An important part of the removal process is the carrying out of risk assessments in relation to each returnee. The escort company conducts a risk assessment for each movement based on information provided by the Home Office and the establishment where the individual has been detained. The effective operation of the risk assessment system is extremely important. Management information from November 2012 and April 2013 indicated that there were a total of 139 escorted removals on scheduled flights in which force was recorded. Of those instances, only 17 took place in the context of two-person DCO teams, i.e. 12.23% of the total number of incidents, indicating that the current system is generally very effective in identifying those detainees who present a real risk of physically resisting removal. However, we are always looking to improve processes and risk assessment is also being reviewed during the development of the bespoke training package for escorts which NOMS are

currently producing. An improved process will be developed based on the NOMS review, any comments from the inquest and also input from escorts.

4. The Director General of Immigration Enforcement should, as a priority, introduce appropriate scenario-based use of force training for escort staff.

The Home Office accepted this recommendation: "Scenario based training is already required with instructors adapting training to meet their specific needs. However, we will liaise with the current escorting provider and NTRG to see if a reminder is needed on this point. Enhancements to training can always be made and following a scoping report, the Home Office have commissioned NOMS to produce a bespoke training package for escorts. This project started in May 2012. Scenario based training will form part of the training package. The Home Office has appointed an independent advisory panel – the Independent Advisory Panel on Non-Compliance Management – to independently assess the quality and safety of systems of restraint and equipment proposed by NOMS for use on escort vehicles, at airports, onto, on board and off the aircraft. The Panel are currently reviewing NOMS' proposed training package and will submit a final report to Ministers once their work is complete. It is not possible to determine the timeframe for the introduction of the new training as this will depend upon NOMS and the Panel."

5. The Director General of Immigration Enforcement should ensure that escort staff continuously risk assess the detainee and the unfolding situation during a removal and abort the removal if they do not have full control of the detainee.

The Home Office accepted this recommendation, noting "Dynamic risk assessment is already part of the current training package with escorts taught to continuously risk assess moves and to abort a removal if they do not have full control of the detainee. An instruction will be sent to the escorting contractor to remind their staff of the need to dynamically risk assess each move."

6. The Director General of Immigration Enforcement should ensure that escort staff fully understand the risks and symptoms of positional asphyxia and apply their training when carrying out their duties.

The Home Office accepted this recommendation: "This already forms part of escort staff training and the new training package being developed by NOMS will include a volume covering medical issues, including positional asphyxiation. An instruction will be sent to the escorting contractor to remind their staff of the risks and symptoms of positional asphyxia and also that they apply their training when carrying out their duties."

7. The Director General of Immigration Enforcement should ensure that policy and training related to the use of force and first aid makes clear that there is a presumption that a person who appears to be experiencing breathing difficulties while under restraint is genuine and is treated in line with first aid policy.

The Home Office accepted this recommendation: "Escorts are already made aware, however Immigration Enforcement have written to the escort provider instructing them to remind all their staff that there should be presumption that a person who appears to be experiencing breathing difficulties while under restraint is genuine and should be treated in line with first aid policy."

8. The Director General of Immigration Enforcement should ensure that all escort contract holders deliver first aid training to staff which makes clear that an unresponsive or unconscious patient should be placed in the recovery position and that cardiopulmonary resuscitation should be delivered when a patient is unconscious and not breathing normally.

The Home Office accepted this recommendation, noting "The current first aid training for escorts already makes it clear that an unresponsive or unconscious patient should be placed in the recovery position and that cardiopulmonary resuscitation should be delivered when a patient is unconscious and not breathing normally. The new bespoke training package will also include instruction on how escorts should address medical warning signs and symptoms."

9. The Director General of Immigration Enforcement should ensure that escort staff seek support from airline crew if a detainee is seriously unwell and in need of first aid and medical assistance.

The Home Office accepted this recommendation: "Immigration Enforcement have written to the escort provider instructing them to remind all their staff that they should seek support from the airline crew if a detainee is seriously unwell and in need of first aid and medical assistance."