

**THE BAHA MOUSA PUBLIC INQUIRY**

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VICTIMS’ RESPONSE: SUBMISSIONS OF HALLIWELLS WITNESSES

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**Introduction**

1. This document sets out the response of the victims to the closing submissions made on behalf of the witnesses represented by Halliwells. It essentially tracks the order of those submissions. The victims cross-refer to their own opening and closing submissions as “VOS” and “VCS” respectively, followed by the relevant Part and paragraph number(s).

**Cooper**

2. As to Cooper’s failure to intervene in abuse perpetrated by others,<sup>1</sup> the victims recognise the strict concept of chain of command within the military, the pressure of Regimental loyalty and a culture of rough treatment and casual violence in a hostile tour as systemic causes of the failure to speak up. Nevertheless, they do not regard the failure to intervene as a matter which is immune from individual criticism. As they set out in the conclusions to their closing submissions, those who must take moral responsibility for what happened at BG Main are not only those who took part but also those who were prepared to look on, turn a blind eye or ask no questions. Their level of responsibility may be on a sliding scale dependent on rank, age, and experience, but nobody who knew about the use of conditioning techniques such as hooding and stress positions or the more conventional violence perpetrated within the TDF can claim total absolution for doing nothing to stop these practices.
3. The victims’ main submissions as to the events immediately leading to the death of Baha Mousa are at VCS Pt II [291-330]. Further comments on the pathology evidence are at VCS Pt II [403-4]. In particular, for the reasons there set out and in the preceding sections dealing with the ‘escape narrative’ (VCS Pt II [280-3]) the victims do not accept

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<sup>1</sup> SUB000533 [2]

that what happened in the final stages was “the restraint of a prisoner who had freed himself from plasticuffs”.<sup>2</sup> Nor do they accept that, even if it was, “no part of the restraint (as distinct from a frenzied assault by Payne on BM at the time of the restraint) should necessarily have caused alarm to those doing the restraining”.<sup>3</sup> This was unjustifiable and dangerous violence against a man who was into his second day of torture, as Cooper and others well knew.

4. The victims’ main submissions regarding c/s 10A witnesses (including Cooper) are at the following parts of VCS Pt II:
  - a. [52-90] (relating to the hotel),
  - b. [178-193] (relating to the Sunday night handover),
  - c. [248-259] (relating to the abuse on Sunday night),
  - d. [260-272] (relating to the second day of detention),
  - e. [280-288] (relating to the witnessed events on the Monday afternoon),
  - f. [291-230] (relating to the death of Baha Mousa),
  - g. [282-398] (relating to the Third Day),
  - h. [417-423] (relating to the closing of ranks after the event),
  - i. [427-441], [443-445] (relating to conclusions).

Particular reference to Cooper is made at VCS Pt II [18, 137, 146-7, 180, 187, 191, 244-7, 257-8, 266, 292, 306, 314-5, 319, 322-5, 337, 396, 424-8, 430, 434].

### **Keilloh**

5. The victims’ main submissions as to medical training and the standards to be expected of an RMO are at VCS Pt III [40-44]. The victims’ main submissions as to the conduct of Keilloh and his medical team during the index incident are at VCS Pt II [332] and [353-381]. Further submissions on the system of medical oversight being operated at BG Main are at VCS Pt V [187-189].
6. The victims do not accept the analogy with medical checks in a police station or UK guardroom made on behalf of Keilloh.<sup>4</sup> Prisoners held in a police station are held subject

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<sup>2</sup> SUB000536

<sup>3</sup> SUB000539

<sup>4</sup> SUB000550

to the rule of law, with access to a lawyer, friend and their own medical adviser. Prisoners held in UK guardrooms are also not held incommunicado, and are subject to a far more established and regulated regime. Neither category of prisoner is being subjected to conditioning techniques. In any event, Keilloh was *told* to conduct medical checks on prisoners when they arrived at BG Main, so it is difficult to see how the analogy takes him anywhere even if accurate.

7. As to the medical risks associated with hooding, the Inquiry *has* received evidence that the practice was a cause for concern.<sup>5</sup> The SO2 J4 Med at PJHQ reported to the Evans’ review on the medical risks associated with the practice of hooding, citing the danger of asphyxia (only heightened by a hot and humid environment), heat related illness and physiological and psychological stress.<sup>6</sup> Dr James regarded hooding as a factor in Baha Mousa’s death.<sup>7</sup> More fundamentally, however, the Inquiry does not *need* expert medical evidence to conclude that putting a hessian sack over a prisoner’s head in temperatures of 50 degrees is medically risky. As General Bradshaw agreed, it is the application of “simple common sense”.<sup>8</sup>
8. Keilloh accepts that he *should* have seen detainees at entry and exit and that medical examinations should have been recorded in all cases, but bizarrely submits that this is not a matter in relation to which he should be subject to any adverse comment.<sup>9</sup> The speed with which he instituted these measures after Baha Mousa’s death, cited in his own defence,<sup>10</sup> shows how obvious they were. Both Lilywhite and Carmichael were absolutely clear that medical examinations (which Keilloh had been told to carry out) should be documented. Contrary to the submission made on Keilloh’s behalf,<sup>11</sup> Carmichael was clearly critical of him for the procedure he used at BG Main.<sup>12</sup>
9. Keilloh clearly *should* have known that the Op Salerno detainees had been brought in and had been checked by his medics (if indeed they had been checked) – he ought to

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<sup>5</sup> Cf. SUB000553 [28]

<sup>6</sup> MOD054208

<sup>7</sup> BMI 33/32/5-15.

<sup>8</sup> BMI 96/6/16-24.

<sup>9</sup> SUB000553 [30]

<sup>10</sup> SUB000580 [97-99]

<sup>11</sup> SUB000555 [36]

<sup>12</sup> BMI07430 [81], BMI07444 [144-145], BMI07445 [148].

have clear lines of communication with them and to have been supervising what they were doing: see VCS Pt III [43].

10. As to the visibility of bruising on Baha Mousa’s body in the immediate aftermath of the death, the victims’ submissions on the pathology evidence are at VCS Pt II [372]. Note should also be taken of the accounts of those who saw Baha Mousa being beaten well before the death,<sup>13</sup> and the accounts of those who saw injuries to his body before the death.<sup>14</sup> As for the evidence of the other medics, the victims do not regard it as at all unlikely (particularly given their other conduct) that the other medics have downplayed their accounts of what they saw. Their initial accounts were given to the SIB at a time when they were aware that something had gone very wrong in the TDF that they had not done enough to address, including having seen Baha Mousa’s body, and for which their colleagues in the Battle Group were likely to be held responsible. They had every reason to minimise their contemporaneous awareness of this. Conversely, Cpl Winstanley had nothing to gain in admitting to the Inquiry an extent of visible injury that he had not admitted before. His evidence showed that (a) he had not given a full account to the SIB and (b) he had not done enough to safeguard the other detainees after the death, given what he had seen. Such evidence is much more likely to have been prompted by his conscience than some desire to appear “more perceptive”.<sup>15</sup>
  
11. It is asserted in Keilloh’s defence that the indication of injuries given to him by some of his medical team was “low-key and not indicative of, or accompanied by, any particular concern”. Keilloh was the RMO, a qualified doctor. He did not need his juniors to tell him that injuries on a man who had just died unexpectedly whilst in military custody were a ‘particular concern’. Nor does it follow that the sight of shocking injuries would have led to a detailed discussion,<sup>16</sup> given shock and also an understandable reticence in vocalising the terrible truth they must have exposed. Nor does the lack of follow-up on the part of the other medics<sup>17</sup> show that there was no cause for concern. These were, after all, individuals who had been certifying prisoners as fit for hooding and stress

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<sup>13</sup> See for example Stirland MOD000601, BMI02823 [98], Aspinall MOD000124.

<sup>14</sup> See for example, A Riley and Hughes (VCS Pt II [285-6]), Aspinall (VCS Pt II [241]) and Redfearn (VCS Pt II [263]).

<sup>15</sup> SUB000563 [53].

<sup>16</sup> SUB000565 [58].

<sup>17</sup> SUB000566 [60]

- positions, whose attitude to medical checks was cavalier at best, and who visited the TDF when the detainees must have been in a terrible condition and yet did nothing.
12. Keilloh cites his immediate involvement of the RMP, but this is hardly a reliable indication of conscientiousness in patient care – it was to do no more than what would inevitably be required: see VCS Pt II [331, 352].
  13. The victims’ submissions in relation to the death certificate are at VCS Pt II [378-380]. The victims regard the information that was given to Shaibah hospital staff as manifestly incomplete. The abdication of responsibility to sign the death certificate must also lie in part with Keilloh. The victims strongly oppose his attempt in his submissions to somehow make a virtue of his conduct in this regard.<sup>18</sup>
  14. Keilloh did not report the complaints of assault he had received to the RMP until two days later, once the prisoners had been removed from the base. The victims do not regard the issue as to whether or not Goulding said that the other detainees should be checked as relevant to Keilloh’s blameworthiness – he ought to have made the decision that they be checked himself. One does not need expert evidence to know what Keilloh ought to have done in the situation that presented itself to him following the death, but Lilywhite’s evidence on this issue *is* of weight. It was given carefully and he gave responses to a number of different scenarios posed by the Chairman. The ‘different answer’ cited in Keilloh’s submissions<sup>19</sup> was in fact a clarification by Lilywhite that he would not have expected an RMO to automatically examine every detainee in the TDF prior to speaking with the CO, but he *would* have expected him to go to the TDF to ask if any other detainee had any complaints and to make enquiries of the guard commander.<sup>20</sup> Keilloh’s defence of his decision not to do this on the basis that (on his account) only one of the complaints of assault was said to be of assault *by a soldier*<sup>21</sup> is pathetic given the circumstances.
  15. In relation to events on the third day, the victims regard the suggestion that Quegan mistook Seeds for Keilloh as smacking of desperation – no doubt prompted by the impressiveness of Quegan as a witness. The distinctions between Quegan’s recollection

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<sup>18</sup> SUB000570 [73]

<sup>19</sup> SUB000576 [88]

<sup>20</sup> BMI 95/192/8ff

<sup>21</sup> SUB000577 [88a]

and his diary entry are slight and insignificant, and the victims do not understand what point is sought to be made by pointing out that Quegan had ‘half-spaced’ part of his diary entry.<sup>22</sup> The suggestion that Quegan’s recording in his diary that he was in “something of a dilemma” regarding his observation of a detainee at the generator and “overcome with self-analysis” upon learning of the death<sup>23</sup> meant that he was in such “considerable mental turmoil” that his recording of a memorable conversation and its participants cannot be relied upon is surprising, particularly given the level-headed and mature presentation of Quegan as a witness. Perhaps most significantly, if Quegan had mixed up Seeds and Keilloh his diary would show that he had asked Seeds whether he had seen the detainees the previous night<sup>24</sup> – self-evidently a ridiculous question as Quegan had been *with* Seeds when he saw the detainees.

### Parry

16. The victims’ main submissions in relation to this witness can be found at the following places in their own written documents: VCS Pt V [241-261]. They should be read in the context of the culture of violence submissions at VCS Pt V [202-240].
17. The victims’ submissions on the Garamsche incident make it abundantly clear that the abuse of the detainees must have been known about across the C Coy base. Three compelling pieces of evidence place the CSM at the heart of the incident (with his CO) in terms of knowledge and responsibility:
  - a. WO Lamb made a complaint to Parry at the OSB because of the way in which prisoners were being treated at the base;<sup>25</sup>
  - b. Pte Nasau amongst others explains that Parry was involved in the violence. Parry could give no reason as to why Nasau would have a grudge against him.<sup>26</sup> Other witnesses confirm features of the Nasau account.<sup>27</sup>
  - c. Parry admitted to the SIB that he was present at the handover of these prisoners to 1 KINGS.<sup>28</sup> The 1 KINGS witnesses describe the obviously visible injuries of

<sup>22</sup> SUB000579 [95b].

<sup>23</sup> BMI00296

<sup>24</sup> BMI00296

<sup>25</sup> BMI05147 [17] to [18], BMI 41/173/13 to 179/8, and BMI41/184/23 to 185/25

<sup>26</sup> MOD009441.

<sup>27</sup> Dunne MOD009454 and Morris MOD009475. See also Bond MOD0090449 and Meller MOD009408

the prisoners that they received.<sup>29</sup> The victims do not accept Parry’s account of the injuries.<sup>30</sup>

18. There is evidence of Parry’s conduct and attitude at other points in the tour that make it more likely that he was more involved in the Garamsche incident than he suggests. The victims rely upon S037’s account of an arrest in which unjustifiable force was ordered,<sup>31</sup> and the account of A Riley about how Parry responded to the death of Baha Mousa.<sup>32</sup>
  
19. Is unlikely to be giving truthful evidence (both to the RMP and the Inquiry) in asserting that detainees “were processed fairly, efficiently and in a humane manner”,<sup>33</sup> as regards the use of hooding beyond security imperatives,<sup>34</sup> the use of stress positions<sup>35</sup> and there being no acts of unlawful violence within his direct or indirect knowledge<sup>36</sup>:
  - a. The suggestion that hooding was not required once prisoners were in a “controlled area”<sup>37</sup> is seemingly contradicted by the evidence of prisoners hooded apparently in the corridor area, where he and the OC had rooms.<sup>38</sup>
  - b. Likewise the various photographs of people in stress positions either in common parts of the camp or in the corridor area<sup>39</sup> suggest that he is misleading the Inquiry about never having seen stress positions and in stating that he would certainly not have tolerated such a practice under any circumstances.<sup>40</sup> See also the above referred to descriptions of forced exercises and stress positions by witnesses to the Garamsche incident.
  - c. The victims do not accept that the violence in 9 September was an isolated incident as far as C Coy was concerned. There is evidence that at different times in the tour, detainees arrived in C Coy’s camp beaten, were beaten or otherwise assaulted at the camp, and were the subject of racist and degrading behaviour,

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<sup>28</sup> MOD009464.

<sup>29</sup> Ward MOD009498, Telford MOD009503, Sweeney MOD009495, and Griffin MOD009493.

<sup>30</sup> SUB000586 [12].

<sup>31</sup> BMI04333 [16]

<sup>32</sup> BMI00570 [148]

<sup>33</sup> MOD009462.

<sup>34</sup> BMI00867 [22] and [29].

<sup>35</sup> BMI00867 [26].

<sup>36</sup> BMI00868 [34] and [35].

<sup>37</sup> BMI00867 [22] and [29].

<sup>38</sup> MOD044640, MOD044679-80, MOD044722 and MOD044795.

<sup>39</sup> MOD044640, MOD044679-80, MOD044721-2, MOD044751, MOD044795.

<sup>40</sup> BMI00868 [26].

with a perception on the part of soldiers that the chain of command turned a blind eye to these matters.<sup>41</sup>

20. In his capacity as CSM, Parry would have known of these offences. He also had a room on the corridor where injured detainees were held and from time to time appeared to others to be injured or indeed were beaten. Aside from the evidence relating to the Garamsche incident Cpl Madine, as the embedded RMP, also reported to him that he had witnessed an injured detainee who was alleging an assault by the arresting soldiers.<sup>42</sup>

**Ellis-Davies**

21. The victims’ main submissions in relation to this witness can be found at the following places in their own written documents: VCS Pt III [5-18] and VCS Pt V [9-35] and [72-93].

**S056**

22. The victims’ main submissions regarding events within 1BW are at VCS Pt IV [73-75]. They make additional comments on the handling of FRAGO 63 by 1BW (including S056’s evidence regarding this) at paragraph 33 in their response to the submissions of the TSol witnesses. Submissions regarding the pre-deployment training for 1BW are at VCS Pt III [24-26].

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<sup>41</sup> Nasau MOD09440, Swarbrick MOD009472, BMI06157 [16] to [17], Milner MOD009468, A Riley MOD009525, BMI000587 [73] to [84] and BMI19/90/5 to 93/2, Liggins BMI00212 [29] to [30] and BMI19/17/15 to 20/17, Schofield BMI00365 [42], Quinn MOD010409, Smith MOD009395 and Madine MOD009519.

<sup>42</sup> Madine MOD009519.

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