Judicial Communications Office

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COURT REFUSES CHALLENGE TO CORONER'S FINDINGS

Summary of Judgment

Mr Justice Colton, sitting today in the High Court in Belfast, refused an application for leave to apply for judicial review by the mother and partner of Neil McConville of the findings of the coroner which were delivered on 11 April 2022.

Neil McConville ("the deceased") was shot by a member of the Police Service of Northern Ireland ("PSNI") on 29 April 2003 and died the same day. He sustained the fatal gunshot wound in the course of an operation named Operation Trill which was mounted as a consequence of specific intelligence received by police in that a Dee Somers was going to Belfast to collect a gun to be used in an attack on a named person. The deceased's mother, Colette McConville, and his partner at the time of his death, Caoimhe McCann ("the applicants") sought leave to apply for judicial review of the findings of the coroner following an inquest into the death which were delivered on 11 April 2022, arguing that the coroner failed to express a conclusion on major issues.

The factual background relating to the events giving rise to the shooting of the deceased is summarised in paras [7] – [19] of the judgment. These were also recorded in para [73] – [331] of the coroner's findings. The court said the findings demonstrated a "careful, considered presentation and recording of the evidence". The global grounds of challenge are that the findings:

- Failed to address the culpability of the officer (HH) who shot the deceased in selecting the fully automatic mode, as opposed to semi-automatic mode, and failed to conclude whether the second (and fatal) shot fired was justified.
- Failed to address the extent to which, or conclude on how, the PSNI's failure to identify the fault in the type of gun used in the fatal shooting caused or contributed to the death of the deceased.
- Failed to identify persons responsible and address the ways in which the operation was not planned and controlled so as to minimise recourse to legal force.
- Failed to address the issues relating to the credibility of officer NN including issues relating to the credibility of his evidence relating to tactical advice.
- Failed to make a finding as to what tactical advice officers NN and/or EE provided during the course of Operation Trill.
- The findings are irrational in relation to the conclusion that HH's action in taking the safety mode off before he had decided to fire did not increase the likelihood of opening fire.

It was submitted on behalf of the applicants that the central question for the coroner to resolve was whether the shooting of the deceased was justified, whether the force used was strictly proportionate to the aim of protecting persons against unlawful violence and whether the anti-terrorist operation was planned and controlled by the authority so as to minimise, to the greatest extent possible, recourse to lethal action.

The culpability of HH, his inadvertent selection of the fully automatic mode, whether each of the three shots, and in particular the second fatal shot, were justified

The coroner accepted that HH was an experienced, highly trained specialist firearms officer. He found that HH inadvertently selected the fully automatic fire mode as opposed to semi-automatic with the result that three bullets were discharged with one single press of the trigger rather than the intended single shot. The coroner considered the potential impact of stress on the use of the selector switch and concluded that even well-trained experts can make mistakes in stressful situations. HH told the coroner that he was aware of problems with the selector switch on some of the older MP5s in that it was very easy to move them from safe to automatic. HH thought that in some way the indents on the selector switch might have been worn and therefore the effect was that the weapon went from safety to fully automatic and effectively bypassed semi-automatic or single shot mode.

The coroner was concerned that the matter was not brought to the attention of the appropriate authorities and endorsed a Police Ombudsman's ("PONI") report published on 4 October 2007 which recommended removing the automatic capability of these weapons save for a very limited number held in the police armoury. Having reviewed and summarised all the relevant evidence on this issue the coroner was satisfied that the weapon was discharged in automatic mode rather than single shot or semi-automatic mode, that it was the intention of HH to discharge one aimed shot and that he believed that the weapon's fire selector was in semi-automatic mode. The coroner concluded that the level of force used by HH was no more than was absolutely necessary and therefore HH was justified in using lethal force as he did.

The court said it could find no illegality or irrationality in the coroner's consideration of this issue and in the conclusions he reached:

> "He concluded in accordance with the evidence that the fatal shot was the second one. He accepted the explanation by HH as to how that second shot came to be discharged. He accepted that HH had an honest belief that it was necessary to use force for the purposes of defending another person. He accepted HH's explanation as to the inadvertent selection of the fully automatic mode for the weapon. Having regard to the breadth of the discretion available to a coroner and the latitude that must necessarily be afforded in circumstances where he has heard detailed evidence in a manner and form which is not available to this court on judicial review the applicants have not established an arguable case with a reasonable prospect of success on this issue."

The court concluded that in exercising its supervisory function, it was satisfied that on this issue the inquest was conducted in compliance with the coroner's article 2 obligations and there was no basis for challenging his conclusions.

Failure to identify the fault

The coroner accepted the evidence relating to the known fault that the selector switch could be easily moved from safe mode to fully automatic, by-passing semi-automatic mode and that a number of officers, including HH, had experienced this fault on the firing range. However, no weapon fault was reported, recorded or identified by the PSNI.

The court accepted that the coroner could have been more explicit in his findings about the failure of the PSNI to have a proper system of reporting faults and the consequences of any such failure. It noted the coroner had said he was concerned that the matter was not brought to the attention of the appropriate authorities and endorsed the recommendation in the PONI report. The court said that in doing so it seemed that the coroner was critical of the failure to ensure that the difficulty experienced on the ranges was brought to the attention of the authorities. It added that by endorsing the PONI recommendation the coroner was addressing the issue of future safeguards so as to prevent a further incident such as this. The court did not consider that the failure to deal with this issue in more detail was sufficient to set aside the findings in the inquest and held that it did not meet the threshold of establishing an arguable case with a reasonable prospect of success.

Planning and control/credibility of NN

The court said the issue of the planning and control of this operation was probably the second fundamental issue for the coroner to consider in conjunction with whether the force used was justifiable. It was linked to the applicants' criticisms in relation to the credibility of NN and in particular in relation to practical advice allegedly provided by him and EE.

Officer NN was officer EE's manager. Both officers had received Firearms Tactical Advisory training and were giving tactical advice to the officers on the ground in Operation Trill. The applicants submitted that, in assessing NN's credibility and evidence at the inquest, it was proper to consider two previous adverse judicial findings where NN admitted to lying in his initial statement and that he may have sought to pervert the course of justice or commit perjury. The applicants submitted that this history indicates his evidence is not credible and that the coroner erred in failing to address this.

The applicants also referred to an error by NN in failing to record the tactical advice provided to officers on the ground in Operation Trill as to whether they should conduct an enforced stop from behind. EE gave the order to stop the Cavalier being driven by the deceased. The commander on the ground, officer GG, gave evidence that he sought and obtained confirmation that the enforced stop from behind was authorised however EE could not recall if officer GG had sought this information. The applicants submit the coroner erred in failing to make a finding as to what tactical advice, if any, NN and/or EE gave and failed to explain why he was unable to make such a finding.

In his findings, the coroner said there was evidence that Operation Trill was a so called 'fastball operation' as it developed on 29 April 2003 and not planned in advance. It was mounted as a consequence of specific intelligence received by police and as a result AA, who was the Duty Officer in charge, attached to PSNI's Regional Command Group ("RCG") South in Portadown, set up Operation Trill. The coroner said this was a proportionate response to the intelligence that AA had received at that time remembering always that there is a need to protect the public, prevent criminality and get illegal weapons off the streets. In the court's view, this was a clear unimpeachable finding.

The coroner then went on to specifically address the issue as to whether the RCG should have appointed/used a Firearms Tactical Advisor ("FTA"). He was satisfied there was a complete failure to appoint an FTA in the proper way and was unable to come to any conclusion as to what advice either EE and NN may have given due to a lack of relevant documentation and also by evidence he received from other officers. In reaching this conclusion, the coroner referred to

evidence of Superintendent BB who said that during the investigation phase of the incident EE had a designated role as a FTA in the operation and that NN subsequently took over from him. The coroner accepted that both of them were in the control room during the operation albeit not always at the same time and that they may well have given some advice but there was nothing by way of documentation to support that.

The coroner was satisfied that the way in which the command to stop the vehicle was given was reasonable and proper. The commander of the control room, BB, made a decision that the vehicle was to be stopped and he arranged for the decision to be communicated to those on the ground. The clarification sought by GG was sought to the extent that if GG thought it should be stopped from behind it was appropriate and he was permitted to utilise that option. The coroner was further satisfied that all of the officers in the two call signs that were involved in the actual stop were satisfactorily trained and had experience of stopping vehicles. He was also satisfied that all these officers were aware of their legal obligations and in particular their personal obligation to avoid the use of lethal force. The coroner, having considered all matters relating to the planning, control and supervision of Operation Trill, concluded that the operation was not planned and controlled in such a way that it minimised to the greatest extent possible the need for recourse to lethal force.

The court said that on the issue of planning and control it seemed that the coroner had examined the relevant evidence in detail, set it out in his findings, analysed that evidence and come to rational conclusions. In the court's view, the applicants had not established an arguable case with a reasonable prospect of success on this ground.

Irrationality

HH gave evidence that in the seconds before he opened fire, he exited the police car and moved towards the front of the Cavalier. As he moved, he took the weapon off safety mode to what he believed was semi-automatic mode (single shot) but was in fact fully automatic mode and brought the weapon to his shoulder.

The court said it should be apparent from its analysis that it did not find any basis for arguing that the conclusions of the coroner on this matter are irrational. In particular the coroner accepted that HH made a conscious decision to open fire in circumstances which were justified. Therefore, at some point he had to move the weapon from the safety mode.

Conclusion

The court concluded that this was not an appropriate case on which to grant leave and had it done so the application would have been refused on the merits in any event. It recognised that the killing of the deceased was a tragedy and that the applicants are entitled to an article 2 compliant inquest into his death which occurred at the hands of the PSNI. It said that requirement also imposed an obligation on this court to carefully scrutinise the conduct of the inquest and the findings of the coroner.

The court reiterated the general principles about the supervisory role of the court in this regard. It said it is not for the court to rewrite the findings or to substitute its own views on the circumstances that led to the deceased's death. The obligation on a coroner in these circumstances is to carry out an effective official investigation into the circumstances of the death of the

deceased. The essential purpose of an investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility and the investigation is also to be effective in the sense that it is capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. Furthermore, that there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory.

The court's view was that on any fair reading the coroner in this case had complied with these procedural obligations:

> "He has determined whether the force used in this case was or was not justified. He has conducted a thorough examination of all the relevant and background information relating to the killing. That examination has been conducted in public and the evidence has been thoroughly tested. The coroner has made findings which are critical of the PSNI operation. He has complied with his obligation under section 31 of the Coroners Act (Northern Ireland) 1959 in that he has set forth "such particulars as have been proved to (him), who the deceased person was and how, when and where he came to his death" in accordance with the relevant caselaw. "

The applications for leave to apply for judicial review were therefore refused.

NOTES TO EDITORS

1. This summary should be read together with the judgment and should not be read in isolation. Nothing said in this summary adds to or amends the judgment. The full judgment will be available on the Judiciary NI website (https://www.judiciaryni.uk/).

ENDS

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