IN THE CORONERS COURT FOR NORTHERN IRELAND

IN THE MATTER OF AN INQUEST INTO THE DEATH OF

Neil John McConville

HIS HONOUR JUDGE BABINGTON the Recorder of Londonderry, SITTING AS CORONER

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Glossary of Terms and Acronyms

A.C.P.O.	Association of Chief Police Officers
A.F.O.	Authorised Firearms Officer
Bronze	A designated operational role in Command and Control structures
Call Sign	Identifier of a particular operational police vehicle with a number attached
C4	PSNI specialist operations unit
C.I.D.	Criminal Investigation Department (of PSNI)
C.P.R.	Cardiopulmonary Resuscitation
C.S.I.	Crime Scene Investigation
D.P.P.	Director of Public Prosecutions
E.C.H.R.	European Convention on Human Rights
F.T.A.	Firearms Tactical Adviser
Gold	A designated strategic role in Command and Control structures
H.M.S.U.	Headquarters Mobile Support Unit
Operation Trill	The name given to the police operation on 29/4/03 that resulted in this death
P.O.N.I.	Police Ombudsman for Northern Ireland
P.S.N.I.	Police Service of Northern Ireland (established 2001)
R.C.G.	Regional Co-ordinating Group
R.I.P.A.	Regulation of Investigatory Powers Act 2000
S.O.B.	Special Operations Branch
Silver	A designated tactical role in Command and Control structures
S.O.C.O.	Scenes of Crime Officer
T.C.G.	Tasking and Co-ordinating Group
V.C.P.	Vehicle Check Point

Index to Call Signs

Mahon Road RCG AA/5049 (Detective Superintendent) CC/6218 (Detective Chief Superintendent 7191 (Detective Inspector) U201 (Inspector) U206 (Sergeant)	Belfast RCG NN/U102 (Inspector) PP/U106 (Sergeant) EE/U118 (Sergeant) BB/2018 (Detective Superintendent) RR/8130 (Acting Inspector) DD/9239 (Detective Chief Superintendent)
Helicopter MOD1 (pilot) O246 (passenger) (Detective Constable)	Call Sign 10 (Belfast) FF/U143 (driver) (Constable) GG/U137 (crew commander) (Sergeant) HH/U129 (shot and killed the deceased) (Sergeant)
Call Sign 7 (Mahon Road) II / U219 (driver) (Constable) KK / U208 (crew commander) (Constable) Paul Taylor / JJ (Constable)	Call Sign 2 (Belfast) YY / U123 (driver) (Constable) QQ / U111 (Constable) UU / U130 (Constable)
Call Sign 11 (Belfast) U126 (driver) (Constable) LL / U113 (Sergeant) U138 (Constable)	Call Sign 3 (Mahon Road) WW / U216 (driver) (Constable) VV / U207 (Constable) XX / U223 (Constable)
Call Sign 4 (Mahon Road) U217 (driver) (Constable) U202 (Sergeant) SS / U209 (Constable)	Call Sign 1 (Mahon Road) TT / U221 (driver) (Constable) MM / U203 (Sergeant) U213 (Constable)

Introduction

[1] On 29 April 2003 Mr. Neil John McConville was shot by a member of the Police Service of Northern Ireland and died from his injuries later that same day. Mr. McConville was the driver of a Cavalier registration number LDZ 2687 that had been under surveillance by police in the hours before he sustained a gunshot wound on Crumlin Road at Glenavy, County Antrim.

[2] This is the first inquest into the death of Mr. McConville. The Police Ombudsman for Northern Ireland conducted an investigation into this death which concluded in August 2005 and its report was published on 4 October 2007. There have been no criminal prosecutions arising out of the death of Mr. McConville.

[3] The Properly Interested Persons ("PIPS") at this inquest and their representatives are:

a) The Next of Kin ("NOK") of Mr. McConville, Mrs. Collette McConville, who was represented by Karen Quinlivan QC and Stuart McTaggart BL, instructed by O'Muirigh Solicitors.

b) Mr. McConville's partner at the time, Ms. Caoimhe McCann who was represented by Monye Anyadike-Danes QC and Nicholas Scott BL, instructed by KRW Law Solicitors.

c) The Police Service of Northern Ireland ("PSNI"). It was represented by Martin Wolfe QC and Stephen Ritchie BL, instructed by the Crown Solicitor's Office.

d) The Ministry of Defence ("MOD"). It was represented by Martin Wolfe QC and Stephen Ritchie BL, instructed by the Crown Solicitor's Office.

e) The Police Ombudsman for Northern Ireland ("PONI"). It was represented by Fiona Doherty QC and Andrew McGuinness BL, instructed by Legal Services, PONI.

f) Lawyers were appointed to assist me at this inquest. Ronan Daly BL was instructed by the Legacy Inquest Unit ("LIU") and I was attended by Ms. Angela Stevens and Ms. Shelley Maybin, both solicitors at the LIU.

[4] This inquest was heard by me, a County Court Judge and Recorder, sitting as a Coroner and without a jury pursuant to Sections 18(1) and (2) of the *Coroner's Act (Northern Ireland)* 1959. No Properly Interested Person submitted that this inquest should be heard with a jury.

[5] This inquest was held in Belfast at Laganside Courthouse between 12 April 2021 and 27 May 2021. Other hearing days were devoted to issues of Public Interest Immunity and review hearings prior to the inquest

commencing. At the conclusion of the oral evidence I issued a direction for the service of written submissions by the PIPs. A hearing was held on 11 October 2021 at the Royal Courts of Justice, Belfast for oral submissions. For the avoidance of doubt, in making these Findings I have considered all of the evidence and submissions. I wish to record my thanks to the legal representatives who acted for the Next of Kin, Ms. McCann, the PSNI, PONI and the Legacy Inquest Unit. A great deal of work has been undertaken by all the legal representatives in this inquest. Arguments have been made by all sides on many different matters arising during the inquest. I want to assure all the parties that their arguments have been considered with care although not everything might be commented on in my Findings. I have also studied the very helpful and thorough initial closing submissions from the PIPS running to 383 pages in total and an additional 75 pages by way of supplementary written submissions. Whilst I may make some references to those submissions in my Findings I want to assure all the PIPS that I have considered everything placed before me whether by way of written submissions or indeed oral submissions.

[6] I received 37 applications for anonymity and screening submitted on behalf of PSNI, Ministry of Defence and civilian witnesses. 29 applications were for anonymity and screening, 1 was for screening only and 7 were for anonymity only. I received written submissions from the PIPs and delivered written preliminary rulings. I received further written submissions from the PIPs on these preliminary rulings prior to delivering my final written rulings. I granted 24 of the applications for anonymity and screening, 1 screening only application and 7 anonymity only applications. The grant of screening in each case was partial screening. This allowed screening of the witness from the public while still permitting named members of the NOK and Ms. McCann (including her children) to view the witness giving evidence. As a consequence of these rulings many of the witnesses in this inquest are referred to by letters and/or number. I also issued rulings in respect of the format of witness evidence and I permitted some witnesses to appear before me via videolink. I issued a Video Link Protocol containing directions for those attending online and a copy of this is appended to these Findings at Appendix D.

Scope

[7] The scope of this inquest was set out in a document dated 4 March 2021 and agreed by the PIPS in advance of the inquest. That document contains the following narrative:

> "2. The inquest proceedings will consider the four basic factual questions, as required by Rule 15 of Rule 22(1) of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, concerning: (a) the identity of the deceased; (b) the place of death; (c) the time of death; and (d) how the deceased came by his death.

3. Related to the "how" question, the Coroner will consider the broad circumstances of the death under Article 2 ECHR to include whether the use of lethal force was justified. The Coroner will consider the following:

   i. the evidence of witnesses at the scene at the time of death;
   ii. pathology evidence;
   iii. evidence relating to the scene at which the incident occurred;
   iv. forensic and ballistics evidence relating to the police MP5 sub-machine gun fired at the scene;
   v. evidence concerning the vehicles involved in the incident and the movements of the vehicles prior to the death;
   vi. evidence concerning persons involved in the incident in which the death occurred;
   viii. such other evidence as may assist in determining the question.

4. In that regard the inquest will examine the police handling of the incident during which the death occurred including the following:

   i. The purpose of the police operation;
   ii. The planning, control and supervision of the police operation;
   iii. Whether the operation was planned and controlled in such a way as to minimise to the greatest extent possible the need for recourse to lethal force;
   iv. The information available to the police in the build-up to the shooting;
   v. The actions of those involved in the operation, at all stages of the operation;
   vi. The training and experience of those involved in the operation;
   vii. The state of knowledge of those involved, at all stages of the operation;
   viii. The guidance and policies applicable to the police operation, including in relation to: the need to stop the vehicle; methods available to stop the vehicle; and the deployment of lethal force;
   ix. The guidance and policies applicable to the use of force in such circumstances as at the time of the death;
   x. The nature and degree of force used;
   xi. Whether the use of lethal force was justified;
   xii. Issues concerning access to emergency medical care including the actions of police and any other relevant personnel in assessing, planning or delivering emergency medical care or arranging transfer for provision of such care.

5. The inquest will also examine Mr. McConville's actions prior to and at the time of the incident in which he met his death, and the circumstances in which he came to be at or about The Horseshoe Inn, Crumlin Road, Ballinderry, Co. Antrim, insofar as they are relevant to how he came by his death.

6. Insofar as it is relevant to the issues outlined above, the inquest will also examine the PONI investigation into the death."

The Law

[8] This inquest is governed by the Coroners Act (Northern Ireland) 1959 and the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, as amended. I have also considered the relevant provisions of the Criminal Law Act (Northern Ireland) 1967, the Justice (Northern Ireland) Act 2002 and the European Convention on Human Rights ("ECHR"). The ECHR was enshrined into United Kingdom law by the Human Rights Act 1998.

[9] I heard this inquest as a Coroner sitting without a jury. The relevant governing provision in this regard is section 18 of the Coroners Act (Northern Ireland) Act 1959. Section 18(1) provides for certain categories of inquest in which a jury must be sworn. This inquest did not fall within that provision. Section 18(2) confers a discretion on a Coroner to have a jury summoned in cases falling outside the mandatory categories, where it would be desirable to do so. I determined, with the agreement of the PIPS, that a jury would not be summoned to hear this inquest.

[10] Rule 15 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 governs the matters to which proceedings at an inquest shall be directed, as follows:

"The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely:-

(a) who the deceased was;
(b) how, when and where the deceased came by [his] death;
(c) [am. SR 1980/444] the particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death."

[11] Rule 16 goes on to provide that neither the Coroner nor the jury shall express any opinion on questions of criminal or civil liability or on any matters other than those referred to in Rule 15, provided that nothing in Rule 16 shall preclude the Coroner or the jury from making a recommendation designed to prevent the recurrence of fatalities similar to that in respect of which the inquest is being held.

[12] Rule 16 leads on to a consideration of the inquest findings. Having heard the evidence, it falls to the Coroner to record the particulars of the deceased, the cause of death and the findings on the Coroner's Certificate to the Registrar of Deaths (Form 21) and also on the Verdict on Inquest form (Form 22).

[13] Rule 22(1) provides:

> "After hearing the evidence the coroner… shall give a verdict in writing, which verdict shall, so far as such particulars have been proved, be confined to a statement of the matters specified in Rule 15. [Amended by SR 1980/444]".

[14] In this jurisdiction we do not have the short form verdict as used in England (such as, natural causes, lawful or unlawful killing, accident or misadventure or open verdict). In this jurisdiction, the Coroner instead, is invited to record findings in narrative format on the relevant form.

Burden and standard of Proof

[15] The inquest's task is to make findings of fact. An inquest is inquisitorial. There are no parties to an inquest but there are properly interested persons. Consequently, there is no formal burden of proof, save that when Article 2 is engaged there is an onus on the State to establish that the use of lethal force is justified, per Keegan J as she then was in Re. Ballymurphy (2021) NI Coroner 6 at paragraph 78.

[16] The standard of proof to which I must be satisfied in order to make any finding is the civil standard of the balance of probabilities. This standard of proof has been confirmed by various reported cases in the inquest arena. The Northern Ireland Court of Appeal approved the civil standard of proof in Re. Jordan (2018) NICA 34. More recently in dealing with suicide, it confirmed the civil standard: Re. Steponaviciene (2020) NICA 61 - on appeal from McCloskey J. as he then was Re. Stepanoviciene (2018) NIQB 90.

[17] The civil standard of proof was recently approved by Keegan J., as she then was, in Re. McElhone (2021) NI Coroner 1, paragraphs 19 to 21.

[18] At all times I remain aware that the events that are the subject of this inquest occurred in April 2003, some 18 years prior to the evidence being received in the inquest hearings. Memories can become frail with the passage of time. I have evaluated the evidence at this inquest mindful of the effects of the passage of time.

Article 2 ECHR

[19] In an inquest like this one, where it is alleged that the death resulted from the unlawful use of force by the police, Article 2 of the European Convention on Human Rights imposes exacting procedural requirements on an investigation into the death. In these circumstances the inquest must extend beyond simply an investigation into the immediate cause of the death and must consider also the broad circumstances in which the death occurred: R (Middleton) v West Somerset Coroner (2004) 2 AC 182.

[20] Article 2 has been interpreted to provide two protections: the substantive obligation on the State to refrain from taking a person's life, and the procedural obligation to establish a framework of laws, precautions, procedures and means of enforcement which will to the greatest extent practicable protect life and support the substantive obligation.

[21] A summary of the procedural requirements was identified by Stephens LJ in Re. Jordan [2014] NIQB 11, at paragraph 78:

(a) 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."

(b) The form of such an investigation may vary in different circumstances. The Strasbourg Court did not specify in any detail which procedures the authorities should adopt in providing for the proper examination of the circumstances of a killing by State agents. The aims of fact finding, criminal investigation and prosecution can be carried out or shared between several authorities, as in Northern Ireland, and the requirements of Article 2 may nonetheless be satisfied if, while seeking to take into account other legitimate interests such as national security or the protection of material relevant to other investigations, they provide for the necessary safeguards in an accessible and effective manner. However, the available procedures have to strike the right balance.

(c) Whatever mode of investigation is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures.

(d) For an investigation into alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence. That in order for the investigation to be effective, "the persons responsible for and carrying out the investigation must be independent and impartial, in law and in practice" (paragraph 112 of Nachova).

(e) 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. The authorities must have taken the reasonable steps

available to them to secure the evidence concerning the incident, including inter alia eyewitness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.

(f) A requirement of promptness and reasonable expedition is implicit. It must be accepted that there may be obstacles or difficulties which prevent progress in an investigation in a particular situation. However, a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts.

(g) 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 degree of public scrutiny required may well vary from case to case.

(h) In all cases the next of kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests. In respect of this matter, I would add that the next of kin must be involved regardless as to their personal circumstances or attributes.

Planning and control

[22] The reach of the inquiry must extend to the planning and control of the police operation that resulted in the death and findings must be made thereon. It is incumbent on the State to ensure that operations are planned and controlled in such a way as to minimise the need to resort to lethal force, Bubbins v UK (2005) 41 EHRR 24 at paragraph 141 and Makkartzis v Greece (2005) 41 EHRR 49.

[23] The inquest must also be capable of leading to a determination of whether the use of lethal force was justified, Re. Manus Deery (2017) NI Coroner 1 at paragraphs 8 and 9.

Use of force

[24] I have considered the findings of Horner J. in the inquest into the death of Pearse Jordan: Re Jordan [2016] NI Coroner 1. He summarised the governing legal provisions on the use of force at paragraphs 173 to 192. The death in that case also resulted from a shooting by a police officer.

[25] Horner J. drew attention firstly (at paragraph 173) to the actual terms of Article 2 ECHR. Article 2 provides:

> "1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.
> 2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:
> (a) in the defence of any person from unlawful violence;
> (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
> (c) in action lawfully taken for the purpose of quelling a riot or insurrection."

[26] As for the domestic legal standards, Horner J. went on to indicate that the common law permits the use of reasonable force in self-defence in prescribed circumstances. In addition to that, the law governing the use of force in the prevention of crime and lawful arrest at the relevant time was found in Section 3 of the Criminal Law Act (Northern Ireland) 1967. That provision was also applicable at the time of the death of Neil McConville. Section 3 provides:

> "A person may use such force as is reasonable in the circumstances in the prevention of crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large."

[27] Horner J. observed that this applied to the use of force to prevent, for example, the shooting of fellow officers. He then quoted from Beckford v The Queen [1988] AC 130, a Privy Council case in which Lord Griffiths had said (at page 145) that:

> "... The test to be applied for self-defence is that a person may use such force as is reasonable in the circumstances as he honestly believes them to be in the defence of himself or another."

[28] Horner J. then noted the judgment in 2016 of the European Court of Human Rights in Armani Da Silva v UK (Application no. 5878/08). In that case, the European Court had addressed the question of whether the domestic UK law governing self-defence conformed to the requirements of Article 2 ECHR. Importantly, the Court held, in summary, that the domestic law governing the use of force in self-defence was compliant with Article 2.

[29] Having identified the relevant domestic and European provisions, Horner J. then summarised the key question that the Coroner had to ask when considering whether the use of force was justified. His Lordship was

addressing the use of force by a police officer known as Sergeant A in 1992. At paragraph 187, he summed up the test as follows:

> "[187] Accordingly, the task for this inquest when conducting an Article 2 compliant inquest must be to ask whether Sergeant A had an honest and genuine belief that it was necessary for him to open fire. Whether that belief was subjectively reasonable, having regard to the circumstances pertaining at the time, is relevant to the question of whether it was honestly held. I should not examine A's belief from the position of a detached observer but from a subjective position consistent with the circumstances in which he found himself and which will necessarily also involve taking into account his training, experience and his knowledge and awareness of the RUC Code of Conduct. I have to consider whether his decision to open fire was "absolutely necessary". To put it another way, whether in all the circumstances it was proportionate, that is, "reasonable, having regard to what the person honestly and genuinely believed".

[30] This paragraph captures the essential aspects of the test that the Court will have to apply in determining whether, in a given situation, the resort to force by a police officer was justified.

[31] The following must be considered:

a) Did the person who fired the shot honestly believe that he needed to use that force to defend himself or others from unlawful violence? and,

b) Was the force used reasonable for the purpose of defending himself or others from unlawful violence, having the regard to the circumstances as he believed them to be.

[32] The first part of this test is subjective. Did the person honestly believe that the force was necessary? The second part of the test is objective. Was the force used objectively reasonable in the circumstances subjectively believed by the person using the force?

[33] The state of mind of the person using force is a question of fact. The objective reasonableness of any belief is relevant, although primarily only as to whether the person did in fact hold the belief claimed.

[34] At paragraph 58 of the judgment, Horner J said that in circumstances such as those under consideration in the case, where lethal force has been used by an officer of the State, the onus of proving that Article 2 had been complied with lay on the State. It was for the State authorities to provide a satisfactory and convincing explanation for the use of lethal force. I agree with this.

[35] I am also satisfied that when analysing the use of force by a police officer his training, experience and compliance with guidance will be particularly relevant. A trained and experienced police officer may be expected to exercise

more control when deciding whether to use lethal force than an untrained and inexperienced member of the public. Similarly, a police officer who has the benefit of being issued with guidance about circumstances in which a shot may properly be fired should generally be expected to comply with that guidance, Re. Jordan [2014] NICA 76 Morgan LCJ (as he then was).

[36] Training, experience and guidance are central factual considerations to be borne in mind when making the overall assessment of whether any use of force was justified. Those factual considerations do not, however, change the overall legal test to be applied.

Training and experience of relevant officers

[37] I heard evidence about Firearms Tactical Advisers and it is important that their role in this operation is fully understood. Their use, their duties and their role are set out in the General Force Order 64/2002 bearing date 18 October 2002. It is said that they can offer tactical advice on any operation or incident in which an armed police response is required or anticipated and it goes on in that vein but suffice to say that this incident clearly falls within its bounds.

[38] The Order states that Firearms Tactical Advisers must be contacted at the earliest possible opportunity, they must be briefed as to the current situation, and they will then assess the situation and complete what is known as a Tactical Options proforma which is set out at Appendix A of the Force Order. This proforma should be signed by the Firearms Tactical Adviser and countersigned by the receiving commander in charge of the operation. The Order reminds officers of the importance of record-keeping.

[39] The Order also says that Firearms Tactical Advisers do not make any decisions or take any independent action. The responsibility for the validity and reliability of the advice lies with the adviser but the responsibility for the use of the advice lies with the relevant commander in charge of the operation.

[40] I received the training records for PP/U106, NN/U102, QQ/U111, VV/U207, U126, KK/U208, LL/U113, SS/U209, JJ/U212, U202, MM/U203, U213, EE/U118, U123, WW/U216, HH/U129, UU/U130, GG/U137, U217, II/U219, U138, TT/U221, FF/U143, XX/U223, BB/2018 and RR/8130.

[41] I heard evidence from NN/U102 and EE/U118. In their written submissions the Next of Kin comment that neither NN/U102 nor EE/U118 in fact provided tactical advice but in evidence both these officers told me they had provided tactical advice to BB/2018 on 29 April 2003.

[42] NN/U102 told me that at the time of the incident he had been a police officer for 28 years and was an Inspector attached to the Tactical Firearms Unit at PSNI Headquarters. In 2003 he had approximately three and a half or four years experience within a police control room environment. Within that

environment he provided tactical advice, including advice on stopping vehicles, alongside his other responsibilities. He retired in 2007 after 32 years service, 25 of which had been spent attached to the HMSU. EE/U118 had been a police officer for 18 years at the time of the incident, having joined the police in 1985. He had been in service with the HMSU since 1989.

[43] The training records for NN/U102 and EE/U118 confirmed they had each received Firearms Tactical Advisor training on a date predating this incident. NN/U102 told me that he had also completed a firearms incident Spontaneous Silver Command course. This training did not appear on his training record but NN/U102 explained that this was a course that dealt with the duties of a Silver Commander in the event of a spontaneous incident occurring before it became a proper Silver operation. I note the Silver Commander's course was not introduced by PSNI until after 31 January 2005 which was after this incident.

[44] NN/U102 and EE/U118 were both asked about PSNI Force Order 64/2002. This Force Order related to Firearms Tactical Advisors. Appendix A of this Force Order required every firearms tactical option that had been considered to be specified and the pros and cons for each option to be outlined in writing. No documentary evidence was provided to me that specifically named any officer as the Firearms Tactical Advisor for this operation and no documentary evidence was produced regarding tactical advice that had been offered or considered. EE/U118 confirmed to me that he provided tactical advice to BB/2018 until NN/U102 joined the control room but he could not recall what advice he had provided and he confirmed that he had not recorded the advice at the time.

[45] NN/U102 confirmed that he was familiar with Force Order 64/2002 and that he would have been familiar with it at the time of this incident. His evidence was that the internal Special Operations Branch was not required to document the tactical advice provided because this Force Order did not apply to internal Special Operations Branch. The Next of Kin comment on this in their written submissions and submit that no one performed the role of Firearms Tactical Advisor and the main reason for that is that the RCG and by extension the HMSU simply did not consider that Force Order 64/2002 applied to them. NN/U102 agreed that there was no such exclusion set out in the Force Order nor was there any other documentary evidence to that effect provided to me. It is not altogether clear whether anyone was designated as a Firearms Tactical Adviser at Mahon Road (RCG South). There were suggestions that U201 and U206 were acting in that role at a time on that day. There are no training records relating to either of them for this role.

[46] EE/U118 told me that members of the HMSU had been trained on the tactic of a stop from the rear many times before the date of the incident and he personally had been trained on that tactic. He told me that the HMSU had its own training team and that officers had received cross training with other police forces. EE/U118 acknowledged that this training was not recorded in

his training record. He explained that if a training course couldn't be recorded with a generic code, it would not appear on training records. He explained that in-house training would fall into this category but he told me that there should be a record of this training in Special Operations Branch records.

[47] I heard from PP/U106 that on 29 April 2003 he was the loggist in the RCG. He told me that he joined the police in 1974 and became a member of the HMSU in 1983. He moved from the operational side of HMSU to a more administrative role in 2001. At the time of the incident he told me that he had limited experience as a loggist in a TCG liaison role and that he had only carried out that role at most twice. He didn't know who appointed him to the role of loggist for Operation Trill, which he commenced at 5.23pm.

[48] PP/U106 accepted that there was a certain skill to log keeping. He confirmed that he had never been trained for that role and he felt that he would have performed better in that role if he had been. He guessed that he had been allocated to the role on that day because there was nobody else available to do it at the time. In her written submissions Ms. McCann comments that there should have been a loggist in the Ops room and there is no reason why another RCG officer could not have been brought in to act as a loggist. PP/U106 was referred to his training record and he confirmed that it represented an accurate record of all of the training that he had received. He further confirmed that his record did not contain any training in control room operations but he clarified that he did not believe there was any formal training in this area. He said that the relevant skills and knowledge would have been acquired through experience on the job. Two officers, namely BB/2018 and RR/8130 did receive training that may be relevant to this matter, details of which are set out in their training records.

[49] In Call Sign 7, KK/U208 was the crew commander, II/U219 was the driver and Mr. Paul Taylor was the rear seat passenger. In Call Sign 10, GG/U137 was the crew commander, FF/U143 was the driver and HH/U129 was the rear seat passenger.

[50] All of the officers in Call Signs 7 and 10 had received weapons training and First Aid training prior to the date of this incident. Additionally Mr. Taylor, KK/U208, II/U219 and GG/U137 were trained Firearms Tactical Advisors and FF/U143 had completed training in driving.

[51] KK/U208 was asked if he had received training about what to do when something wasn't going to plan in circumstances such as the incident in question. KK/U208 said that it is very difficult to train for all eventualities, but you do your best to fill in whatever you can do.

[52] II/U219 was the driver of Call Sign 7. It was clear that he was inexperienced in the manoeuvre of stopping a car from behind. His evidence on whether or not he had in fact received training on the manoeuvre was less clear. He told me that training on stopping a car from behind was limited at the time, that

the manoeuvre was something new to him and the HMSU Special Operations training manual on this manoeuvre was produced after the date of this incident. In its closing submissions PSNI submits that the strong likelihood is that II/U219 had received limited training by that point in time in keeping with his short period of service within HMSU. They say that the suggestion that he had not received any training on the tactic appears improbable having regard to the evidence of NM28 and other officers in HMSU.

[53] GG/U137 was the crew commander of Call Sign 10 and he told me that police training covered two types of stops. One would be classed as a 'casual stop.' In this stop a police vehicle would approach a suspect vehicle from the rear, turn on its blue lights and sirens, and indicate to the suspect vehicle to pull over. He referred to the second type of stop as a 'hard stop'. It can be applied whether the suspect vehicle is static or mobile. In this stop the police would deploy two of its vehicles around the suspect vehicle and take control of the driver and any threat from within the vehicle like a firearm. GG/U137 told me that a 'hard stop' where the suspect vehicle is mobile is interchangeably referred to as an 'enforced stop'. I note in the Next of Kin's written submissions that it was the evidence of NM28 that it became and remains an absolute rule that no one moves between police and suspect vehicles and that this was to prevent officers being struck. GG/U137 told me however that he was satisfied that when the stop was initiated in this incident, everyone ended up in the positions that they were trained to end up in.

[54] GG/U137 was referred to the HMSU Special Operations training manual at page 57. This section envisages the police vehicle passing a suspect vehicle, getting in front of it and engaging in cadence braking to force the suspect vehicle to brake and eventually stop. GG/U137 acknowledged that Call Sign 10 did not undertake this manoeuvre. He explained that as Call Sign 10 attempted to pass the Cavalier it sped up. It was on a collision course with a brick wall and if Call Sign 10 had not slowed down, the Cavalier would have collided with the brick wall.

[55] GG/U137 also told me he had been a firearms instructor for over twenty years and that officers are trained regularly for a situation such as the one under investigation in this inquest.

[56] The driver of Call Sign 10 was FF/U143 and his training record confirmed at the time of this incident he had completed a number of driving courses and held a number of driving qualifications. There is no information relating to enforced stops in any of the training records produced to me. I note the written submissions of Ms. McCann that there is no evidence that the drivers of Call Signs 7 and 10 had received proper training as to how to stop a vehicle using their own vehicle. FF/U143 however was clear, that prior to this incident he had been trained in the enforced stop tactic quite a lot. He told me that he had successfully put his training into effect in a number of operations prior to the day in question but he had never met opposition or resistance of the kind that he met on this occasion.

[57] FF/U143 told me that in an overtaking manoeuvre like the one in this incident the tactic is that police identify themselves and the police horns are turned on. In their written submissions the Next of Kin note that FF/U143 accepted that on the day the positions adopted by the police after exiting their vehicle were not consistent with the training manual. FF/U143 acknowledged that this tactic was not set out in the HMSU Special Operations training manual but confirmed that he had received training on it.

[58] I heard evidence from NM28 who was not involved in the incident which led to the death of Mr. McConville. His evidence related to the type of training that would have been delivered to HMSU officers. NM28 told me that he joined the HMSU in 1985 and between January 2001 and January 2004 he was a Sergeant in the HMSU training team. This incident occurred in April 2003.

[59] NM28 told me that at the time of this incident all officers selected to join the HMSU received initial training. I was told that this training lasted for approximately 20 weeks and during it officers were continually assessed. This training included vehicle stops. I was also told that HMSU officers received refresher training at regular intervals. Training would have been delivered in a classroom setting and also in a practical setting 'on the ground'. NM28's evidence was that training records and assessment scores would have been maintained at the time, however he understood that they were no longer available. He could not explain why the training records of HMSU officers were not inputted into the PSNI training record system. In its closing submissions PSNI notes that while it is regrettable that PSNI cannot produce adequate records to demonstrate individual training of participation in tactics for stopping vehicles, there is little doubt that HMSU officers did receive regular and comprehensive training. This is very clear from the officers who gave evidence at the inquest.

[60] NM28 told me that he recalled training on vehicle stops including formal training for an enforced stop was introduced around 2001-2002. He produced his presentation slides that were contained in a booklet entitled 'Special Operations Training Vehicle Stops' to reflect the type of training that would have been undertaken at the time of this incident. NM28 acknowledged that the document produced to me was a version updated in 2007 and not the actual document in force at the time of this incident which would have been used in training at that time.

[61] NM28 confirmed he had read the statements of FF/U143, GG/U137, II/U219, KK/U208 and Mr. Paul Taylor, and it appeared that the type of stop executed in this incident was an enforced stop. This was the stop that was used if the suspect vehicle was not stationary. NM28 told me that the objective of an enforced stop is to try and contain the suspect vehicle and bring it to a halt. He said that this stop requires two HMSU vehicles and is carried out in stages. In stage one, the lead police vehicle passes the suspect vehicle. In stage two, the lead police vehicle employs cadence braking techniques to try

and slow the suspect vehicle down. In stage three, the rear police vehicle comes up behind the suspect vehicle, and blocks it in. I was told that there may be three HMSU officers in each lead and rear police vehicle and each officer in the vehicle would have his own position and role. NM28 further explained that on the day, as in every operation, things can change rapidly and officers are expected to think on their feet and apply the basic principles.

[62] NM28 also confirmed that officers would have been trained in personal safety skills which would have included the restraint of suspects in vehicles. He could not go further than that because it was not his area of expertise.

[63] NM28 was asked about the evidence of II/U219 who joined HMSU in September 2002 and who told me that specific training on stopping a vehicle from behind was "limited" at that time. NM28 said he could not comment on II/U219's evidence and it was his recollection that over the period 2001 to 2002 training was introduced to all HMSU officers.

[64] NM28 was also asked about GG/U137's evidence that when his call sign drove alongside the suspect vehicle GG/U137 showed the driver his weapon and pointed to his police emblem on his chest. NM28 confirmed that he would have expected GG/U137 to do this and confirmed that the application of horns and lights would also have been expected.

[65] Generally I found that the training and experience of the police officers who were involved in this police operation and subsequently in the incident leading to the death of the deceased was satisfactory. When that is combined with the experience of the relevant officers it paints a picture of very experienced officers who had received the relevant training in relation to the actions they had to carry out on this day. I used the word generally because I am not completely satisfied regarding these matters and will turn to that below.

[66] There were two officers – NN/U12 and EE/U118 – who acted as Firearms Tactical Advisers in RCG urban at Castlereagh. As mentioned above they had been trained in this role. I may comment elsewhere as to how they carried out their roles but I am satisfied that they had received the relevant training.

[67] There were six HMSU officers involved in the actual incident on the Crumlin Road at Ballinderry. I received the training records for all of them and noted that they had received appropriate weapons training and First Aid training prior to the incident. FF/U143, the driver of Call Sign 10 had completed training in driving whereas II/U219, the driver of Call Sign 7 had not.

[68] It was surprising that an officer who had not completed his driving training was driving a vehicle in an operation of this kind. It would appear to be the case that there were other experienced drivers who could have been driving the vehicle. That has to be balanced against the fact, and I accept, that all

HMSU officers were being regularly trained both in theory in the classroom and in real time on the ground.

[69] I heard important evidence on the subject of training HMSU officers from NM28. He was not involved in the incident itself but his evidence did relate to relevant matters on which the officers would have been trained. I have set out above the details of the training that officers in HMSU would have received both initially and then during their service in the unit. I am satisfied that all were trained to an appropriate level for the situation that unfolded on the Crumlin Road on the day in question.

[70] Whilst the driver of Call Sign 7 was relatively inexperienced I am satisfied that he knew what he was to do on the day in question. In response to questions I myself put to him he confirmed that he had received some training and knew about what was intended to happen and he also felt that it was a suitable location to undertake the planned manoeuvre.

[71] In particular I noted the evidence of the commander on the ground – GG/U137, who was quite clearly a very experienced officer and had experience of carrying out similar operations in the past for which he had received extensive training.

[72] Training is of the utmost importance and I am satisfied that those on the ground were highly trained both initially and throughout their service in HMSU. I am also quite satisfied that all the officers who gave evidence before me were highly experienced officers most of whom had served for long periods of time in HMSU and other associated units. I am satisfied that they were all appropriate officers to take part in this operation.

Planning and Control

[73] I heard from the police witnesses in this case in four broad categories. Firstly, officers from Mahon Road PSNI station in Portadown (RCG South) who received intelligence that formed the basis of the surveillance operation on Mr. Somers. Secondly, officers from the Command and Control room at Castlereagh (RCG Urban / Belfast). Thirdly, from HMSU officers who were involved in the operation on the ground. Finally, I heard from officers who attended the scene post-incident.

[74] In dealing with the planning and control aspects of the inquest evidence I remain cognisant of the inquest scope document agreed on 4 March 2021, set out elsewhere in these Findings, and the need to identify any failings that may have caused or contributed to the death in a more then minimal way.

[75] In Re. Deery (2017) NI Coroner 1 Colton J. noted that the inquest should consider whether the use of force and the operation in which it was used were regulated, planned and controlled in such a way as to minimise, to the greatest extent possible, any risk to life.

[76] I appreciate that there is some overlap in the evidence relevant to this section and the evidence included in the Surveillance and Stop sections.

[77] The most relevant Force Orders in place at this time were the PSNI General Order 11/98 'Command Structures – Police Operations / Events' (effective from 20 February 1998) and PSNI General Order 64/2002 'Firearms Tactical Advisers' (effective from 18 October 2002). These Orders are attached to my Findings at Appendices A and B.

[78] PSNI General Order 11/98 states that it seeks to provide common definitions with regard to particular command functions by title [when certain incidents occur including firearms incidents]. It states that the Gold (strategic) , Silver (tactical) and Bronze (operational) command structure ("G/S/B") is a role orientated system of command and focuses on the role of individual officers in command positions. A similar structure to Command is set out for Control using the G/S/B system.

[79] Gold Command is the highest level of command. It determines the policy, framework and strategy for an incident. It also maintains a top level overview of intelligence, resources and other factors that are likely to impact on the incident. Gold Control provides a resource and communications mechanism that allows the Gold Commander to exercise command.

[80] Silver Command is the second level of command and normally operates from a control room. The Silver Commander deals with the immediacy of the incident and works within the policy and strategy determined by the Gold Commander. The Silver Commander determines the tactics for policing the incident and should co-ordinate the input of other resources. Silver Control provides a resource and communications mechanism that allows the Silver Commander to exercise command.

[81] Bronze Command is the third level of command. The Bronze Commander is responsible for 'making things happen'. They have some discretion in how they do this but must always seek to achieve the set objectives and advise the Silver Commander of their plans and progress. Bronze Control is rarely used and is normally associated with specialist functions like Firearms Response Teams.

[82] PSNI General Order 64/2002 states that a number of officers are available as ACPO accredited Firearms Tactical Advisers. They may offer tactical advice on any operation in which an armed police response is required or anticipated, or intelligence indicates that firearms may be involved, including both planned and spontaneous incidents. It states that the use of FTAs will be crucial in both the planning and implementation stages of any planned operation or prolonged spontaneous incident.

[83] FTAs must be contacted at the earliest possible opportunity in the above circumstances. While the need for tactical advice will always exist at the level of Silver Commander as a priority, Gold Commanders may also wish to seek the advice of FTAs regarding the setting of operational parameters. The FTA will assess the briefing provided and complete a 'Tactical Options' pro forma (Appendix 'A' to the Order). This will highlight all the options that are available to the relevant commander and include a preferred option.

[84] The Order reminds officers of the importance of record keeping and any use of FTAs should be fully documented within policy files, journals and official notebooks as applicable. Should circumstances or information change during an operation the FTA may make additional tactical assessments and complete additional tactical proformae if necessary. FTAs do not make any decisions or take action. The responsibility for the use of their advice rests with the commander in charge. Personnel involved in policing a planned operation or reacting to a spontaneous one should be properly trained for the role.

[85] There was some evidential conflict around who signed the authority for directed surveillance on the 29 April 2003 and whether it was created retrospectively in purported compliance with RIPA – I have noted the differing accounts of AA/5049 and RR/8130. It is not suggested by the NOK that this purported failing caused or contributed to the death of Mr. McConville but that it is indicative of a general police attitude. I will return to this briefly in the surveillance chapter.

[86] The Next of Kin alleges systemic failings around the planning and control of Operation Trill. They say that there was no effective command and control of the operation and it was not planned and controlled so to minimise, to the greatest extent possible, recourse to lethal force. The Next of Kin submits that the command structure failings detrimentally affected the ability of officers to adhere to applicable Force Orders. They say the lack of firearms tactical advice was a serious systemic failing and led to appropriate and safer options not being considered.

[87] The Next of Kin says that the PSNI failed to train its officers in Force Order 11/98 and they did not consider that Force Order 64/02 applied to them. They say effectively there was no Gold Command structure. They also say that BB/2018 failed to secure proper firearms tactical advice. Consequently, safer options were not considered in Operation Trill.

[88] The police operation which became known as Operation Trill lasted from 15.10 hours to approximately 19.15 hours on 29 April 2003. It became known as Operation Trill at about 17.00 hours when responsibility for it was taken over by RCG Urban in Belfast.

[89] There was evidence that Operation Trill was a so called 'fastball operation' as it developed on the day of the incident. It was not planned in advance of 29 April 2003. It was a specific operation that was mounted on 29 April 2003 as a

consequence of specific intelligence received by police on that date. It started in the following way. Police at Mahon Road received intelligence at 15.10 hours that a Dee Somers was going to Belfast to collect a gun to be used in an attack on a named person. That intelligence was subsequently updated a short time later. As a result of this further intelligence AA/5049, who was the Duty Officer in charge, attached to RCG South at Mahon Road PSNI station, Portadown, initiated actions by the police.

[90] AA/5049 explained that there were three RCGs in Northern Ireland at the relevant time; one in the North region, one in the South region and one in Belfast. He explained that RCGs would co-ordinate operations (which were mostly covert), in response to intelligence received regarding terrorists or criminals. The operation would be co-ordinated from the RCG control room which would be manned by officers with various roles including surveillance, uniform support (HMSU), tactical advisors and log keepers.

[91] AA/5049 briefed 7191 (a Detective Inspector) to get resources available for an operation. AA/5049's actions in doing this were appropriate as it was clear that intelligence was suggesting that serious crimes were going to be committed.

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[92] AA/5049 later briefed 8130 who was an acting Detective Inspector in Belfast at RCG Urban based at Castlereagh. 8130 was briefed at 16.13 hours and the objectives of the operation were set out – that surveillance was to be mounted against Mr. Somers, that he was to be identified whilst collecting weapons, he was to be directed into a VCP to be set up by the HMSU and he was to be arrested for possession of those weapons.

[93] I am satisfied that AA/5049 acted appropriately in setting up Operation Trill, and in briefing 8130 as he did. It was a proportionate response to the intelligence that he 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.

[94] U201's evidence was that on the day in question he was an Inspector attached to HMSU at Mahon Road Portadown, and he had line management responsibility for a number of persons involved in the incident, including Paul Taylor. He told me that at the time of giving evidence he had no personal memory of Operation Trill. He did not recall briefing Call Signs 1, 3 and 4 about the operation nor could he recall being briefed himself.

[95] He did not recall whether he acted as the Firearms Tactical Advisor and stated that he would be surprised to learn that AA/5049 had identified him as the Firearms Tactical Advisor on the day.

[96] U206 provided evidence that he was a Sergeant attached to HMSU South Region on 29 April 2003. He had line management responsibility for the four call signs within South Region. He said that his recollection of the

incident was poor. However, he said that he was briefed verbally on the operation by U201, and that he was detailed desk duties. He also briefed the relevant call signs, but he could not specifically recall the briefing. He said that he liaised with the Belfast operations room, and he spoke to the person in charge of HMSU there. He said that he then released his crews to assist in Belfast, at which point his involvement in the operation effectively ceased. He did not recall giving firearms tactical advice during the operation and advised that he believed U201 would have been appointed Firearms Tactical Advisor. He stated that he did not commence a log as his practice was not to commence a log until the call signs were asked to take action. He remained on duty in the event that the operation returned to South Region. U206 attended the debrief on 30 April 2003. He told me that U202 would have been assigned as Bronze Commander in relation to the initial deployment from Mahon Road.

[97] The intelligence that had been received clearly indicated that firearms may be involved or indeed used and therefore consideration should have immediately been given to the use of a Firearms Tactical Adviser. It is not completely clear whether that was done. There was evidence before me suggesting that U201 and/or U206 could or may have been appointed but there was no confirmation of this either in writing or orally. It is my view that no FTA was appointed in South region for this operation. Force Order 64/2002 makes it clear that when matters relating to firearms are either required or anticipated an FTA should be used and indeed it is stated that the use of FTAs will be crucial in the planning and implementation stages of any planned operation or prolonged spontaneous incident. It might be suggested that an FTA was not necessary because RCG South was only involved for a short period of time from 15.10 hours to 17.00 hours. That may be so but the whole incident only lasted abour four hours. It is my view that an FTA should have been utilised.

[98] Force Order 11/98 seeks to put in place common definitions with regard to particular command functions. This has been referred to in more detail above and I will refer to it as the G/S/B system. Such a system should have been in place in RCG South but was not. Indeed AA/5049 who was a Detective Superintendent and the duty officer in charge said this command structure was not used at this time. 7191 who has been referred to above and who was based in RCG South also said that the G/S/B system was not used at this time. The most senior officer in the South region to whom AA/5049 reported was CC/6218. He said that the G/S/B structure was not formalised in the Department at this time. It is quite clear that the command structure should have been used at the time of Operation Trill. Evidence later confirmed that training in relation to the G/S/B structure did not commence until 2005.

[99] Reference has already been made to intelligence that was provided but some of which is now lost apparently in the police computer systems. PONI requested expert assistance from the National High Tech Crime Unit which carried out an investigation. Its evidence was that this information had been

deleted during routine housekeeping – that is where more space is made available for information on the computer system. It was felt that this was a viable explanation for the deletion of the information – in other words human error. The investigator said that he saw no reason to doubt any of the information he had been supplied with. I have no reason not to accept this explanation although it does show that a proper system should be put in place in relation to this routine housekeeping of the computer system.

[100] As already stated, Operation Trill commenced under the control of RCG South at Mahon Road. It became the responsibility of RCG urban at 17.00 hours. This was when the Cavalier, which was the vehicle that it was suspected would be involved, was spotted or located in Belfast. The officer in control of RCG Urban was BB/2018 and officers subordinate to him had already received information about the operation. The reason for the transfer from one control room to another was simply geographic as the vehicle under suspicion had moved into the Belfast area. This transfer of responsibility was appropriate, and I am satisfied that it was done in such a way so that it was in effect a seamless transition of responsibility.

[101] DD/9239's evidence was that on the 29 April 2003 he was the Regional Intelligence Advisor for Belfast, based in Castlereagh. At around 5.20pm, on his journey home from work, he received a telephone call from BB/2018 asking him if he knew where the 'ACC' (the Assistant Chief Constable) was, as BB/2018 needed to inform her about an operation he was running in which he had briefed and deployed surveillance teams. BB/2018 told DD/9239 that intelligence was coming in that a vehicle was travelling from the Craigavon area to West Belfast to pick up a firearm. DD/9239 stated that he was unaware that there was potentially more than one weapon.

[102] BB/2018 said that the vehicle would then return to Craigavon and that the firearm was to be used either in a shooting or a kidnapping. DD/9239 understood this to be imminent. DD/9239 told BB/2018 that the ACC was at a meeting with the Chief Constable and her team, but he said that he would try to get in contact with her. DD/9239 then asked BB/2018 to go through the operation in more detail. BB/2018 explained that the vehicle was to be stopped on its way back to the Craigavon area when they were confident that the firearm was on board by means of a vehicle checkpoint and this would most likely be located on an approach to the M1 motorway. DD/9239 stated that he then asked BB/2018 if he had taken tactical advice, to which BB/2018 said that he had, and that he had the tactical advisor sitting beside him.

[103] DD/9239 asked BB/2018 if he had thought of any other options, to which BB/2018 replied that he had considered that the best way to recover the firearm was the plan discussed. DD/9239 told BB/2018 that he would get in touch with the ACC and that he would brief her as to what was proposed. DD/9239 then rang the ACC's phone, which was answered by her staff officer, and asked that the ACC contact him. DD/9239 stated that it was accepted good practice that the ACC should be the gold command for covert

arrest operations, and it was anticipated that the ACC would assume that role once briefed by him. DD/9239 then spoke to BB/2018 again when he arrived home, where he talked through the operation and sought an update, by which stage the vehicle was in west Belfast. He informed BB/2018 that he had not been able to get in touch with the ACC, but that he was content with the operation. DD/9239 stated that it was at this stage, approximately 6.00pm, that he assumed the role of Gold Commander from BB/2018 and it was from this point that he was providing strategic direction for the operation. DD/9239 later received a call from BB/2018 informing him that the HMSU had stopped the vehicle by way of a hard stop, and that there had been a fatal shooting. The ACC later contacted DD/9239.

[104] BB/2018 provided evidence that on 29 April 2003, he was a Detective Superintendent based at Castlereagh police station. He explained that he was in charge of the RCG for urban region. He described receiving authorisation from DD/9239 to carry out the operation, because the ACC was unavailable at the time. He said that he remained on duty in the RCG operations room throughout the operation. He described receiving tactical firearms advice from two senior officers in the operations room, U118/EE and U102/NN, but he could not recall what they said to him. He said that the tactical plan at that stage was to possibly place a VCP on the motorway, but that the vehicle took another route. He also said that the 'fall back plan' was a tactical stop, which he described as a forced stop, either from behind or the front. He further stated that when the vehicle went to a filling station at Pond Park he wanted a stop put in place, but the vehicle's occupants returned to the vehicle and got away. He stated that the G/S/B structure did exist at the time but was not used by HMSU or TCG.

[105] BB/2018 was asked about the G/S/B structure and said in evidence that was something that had not been adopted in his area of work. He said that he was aware of it but felt it was more used in uniform work and mentioned by way of example riot type situations. In saying that it was clear that he did know of it and was able to identify who would have been filling the role of Gold Commander, Silver Commander and Bronze Commander on the day in question. This system however was not in place in April 2003 and was not utilised by RCG Urban. BB/2018 was quite straightforward and said that he had not been specifically trained in the structure at the time but subsequently a year or so later he did receive the relevant training. It is clear that BB/2018 and his colleagues in RCG Urban should have been trained at the time of this matter.

[106] The fact that such a structure was not properly in place meant that at times there was a lack of clarity in the thinking and direction of those in the control room both in terms of who was fulfilling what role and then in their responsibility in terms of decision-making. Proper utilisation of the G/S/B structure ensures that lines of responsibility are clear and that decisions, when made, are taken by the appropriate officer.

[107] I have already referred to FTAs, their purpose in operations and also the necessity for their use in relevant operations of which this was undoubtedly one. I have considered all of the evidence given to me on this subject and I am not satisfied as to whether an FTA was ever appointed either formally or informally in RCG Urban or what advice or various options were given. This is because there is no contemporaneous documentation in existence as to whether an FTA was ever appointed and secondly no pro forma, as referred to in Force Order 62/2002, was ever completed. At the same time, I have no doubt that there may have been some informal discussion in the control room as to what should or may happen but this falls very far short of what was set out and envisaged in the Force Order relating to FTAs.

[108] Superintendent BB/2018 said during the investigation phase of this incident that EE/U118 had a designated role as an FTA in this operation. He also said that NN/U102 then took over from him. It is clear that both of them were in the control room during this operation albeit not always at the same time. They may well have given some advice although there is nothing by way of documentation to support that. It is interesting that PP/U106 who was acting as the loggist could not recall anyone being appointed as an FTA and neither could RR/8130. I am satisfied that there was a complete failure to appoint an FTA in the proper way and I am unable to come to any conclusion as to what advice either of these two officers may have given. This is due mainly to a complete lack of relevant documentation and also by evidence I received from other officers as set out above.

[109] I have already commented on the role of an FTA, that it is quite clearly an important role in that he or she is independent of the operation in question, advices are given and then acted upon by the commander of the operation. I did gain an impression that there was a feeling that FTAs, as envisaged in the Force Order, did not apply to Special Operations Branch (SOB). That is not something that is supported by documentation or Force Orders.

[110] BB/2018 was in charge of the control room and could have been said to be the Silver Commander if the structure had been in place. His superior was DD/9239 who was the Regional Intelligence Adviser. As set out above BB/2018 contacted him and as the ACC was not available DD/9239, assumed a role that was akin to her role at about 6.00pm. He said he provided strategic direction and discussed matters with BB/2018. Although the G/S/B structure was not in place I am satisfied that he performed the role of Gold Commander. Whether he realised he was performing that role at that time or whether that occurred to him at a later date once he had been familiarised or trained, I do not know. DD/9239 however did provide appropriate strategic support to BB/2018.

[111] The objectives of Operation Trill have already been set out above. The tactical option or options for achieving those objectives were primarily the responsibility of BB/2018 at RCG Urban. It was clear that the preferred option was to stop the vehicle by way of a VCP (vehicle checkpoint). It was felt that it

was more likely than not that the vehicle would be returning to the Craigavon area and the most likely route to be used was via the motorway. The intention was to mount a VCP on what I understood would be either an on slip or off slip road from or to the motorway. The vehicle had taken a very circuitous route around greater Belfast and there came a time when it was obvious that although the vehicle might be returning to Craigavon this would not be by way of the motorway. There also appears to have been some consideration of an operation at Pond Park filling station but the opportunity was lost as there did not appear to be sufficient personnel available. When the vehicle took to country roads the preferred option changed to a tactical or enforced stop. This change in tactics appear to be logical and reasonable in all the circumstances.

[112] Any examination of what occurred during this operation must include a consideration of whether BB/2018 and his colleagues missed opportunities to achieve their objectives prior to the incident on the Crumlin Road. The vehicle was first seen by police in Belfast at 16.30 hours. It then spent time in the city centre and West Belfast areas before parking up in Agincourt Avenue in the university area. It remained there until 18.04 hours. It then left and proceeded into West Belfast and was being driven at speed. It moved generally in a countrywards direction and stopped at Colinglen Road where all five people in the vehicle got out. Shortly afterwards another car arrived. All the occupants went into an area of trees.

[113] BB/2018 said in evidence to me that the general movements of those involved and in the area prior to Colinglen Road made him feel that there was some sort of drugs deal going on. It did not feel like a weapons move. The situation in the wooded area at Colinglen Road was however different. He said that once they went into the area he suspected that was where the weapon was going to be picked up. It was suggested that this was an appropriate place for the police to move in and achieve their objectives. BB/2018 said that was not his opinion because he would not send officers into the area as he put it "blind" because it could end up as a "shooting match". He said that members of the public walked their dogs there and generally there was too much of a danger to the public to have the police charging in. He said that his tactical plan still involved a VCP near the motorway. He told me that it was his experience that criminals and terrorists appeared to prefer moving weapons on the motorway because in some way and for some reason they felt safer from being stopped by police. It is easy to say that some sort of action should have been taken at Colinglen but BB/2018 outlined various imponderables and uncertainties which militated against this. It is clear however that he gave consideration to it and dismissed it for reasons that can be said to be logical and reasonable.

[114] It seems that the police intended to stop the vehicle by way of a VCP when they first became involved and as already stated that only changed after Pond Park. Putting to one side the point whether the vehicle should have been stopped before Pond Park I must consider the reasonableness of effectively abandoning the use of a VCP and replacing it by a tactical stop or stop from

behind. BB/2018 said in his evidence that the more appropriate tactic on country roads is usually a tactical stop because a VCP on country roads, which he described as bendy roads, can be dangerous to the general public. On the other side of the coin so to speak a VCP was preferable if it was a straightforward road such as in this case the road to the motorway. In addition BB/2018 said that the police did not know the route the vehicle was taking which is an added complication. I am satisfied that it was reasonable for the police to effectively abandon the idea of a VCP and replace it with a tactical stop from behind.

[115] During the course of this operation there was discussion between BB/2018 and the two officers who are said to have given tactical advice namely EE/U118 and NN/U102. It is said that various tactics and strategies were discussed and advice was given. BB/2018, himself a very experienced officer, also indicated that these two other officers also had great experience in this type of work. Unfortunately it seems that very little or nothing has been recorded in relation to strategy and advice. This was a failing that should not have occurred especially as there were a number of documents in existence in the control room. In addition, as already mentioned, the FTA pro forma was not completed.

[116] The order to stop the vehicle was given at 18.55 hours by EE/U118 and was given to all seven call signs that were travelling supposedly in the pattern of something akin to a 'loose box' around the Cavalier. There is obviously no dispute about this and further that the order was given to all the call signs rather than directed to any particular one. I am satisfied that the order to stop the vehicle was simply that. It went no further than stop in that the method of stop or location of stop was not communicated to the call signs. GG/U137 who effectively became the commander on the ground or if the appropriate command system was being used, the Bronze Commander, says that he sought and obtained information that a stop from behind was authorised – in other words a hard stop was permitted.

[117] I am satisfied that this clarification did take place as GG/U137 accepted at the time he received the order to stop the vehicle it was his call as to how the vehicle would be stopped. It appears that he wanted to ensure that this included the stop from behind if he deemed it necessary.

[118] I am satisfied that the way in which the command to stop the vehicle was given was reasonable and proper. The control room is naturally divorced to an extent from what is happening on the ground. The commander of the control room – BB/2018 – made a decision that the vehicle was to be stopped and he arranged for the decision to be communicated to those on the ground. He knew that the vehicle was travelling into the country and that it was most unlikely that it could be stopped by means of a VCP. His instruction to stop the vehicle did not rule out a VCP and it remained an option albeit an unlikely one. The clarification sought by GG/U137 was very properly sought

and sought to the extent that if GG/U137 thought it should be stopped from behind it was appropriate and he was permitted to utilise that option.

[119] I am 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 in the past with the exception of II/U219. I am 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.

[120] Both RCG South and RCG Urban were aware of intelligence that identified the person or persons against whom the weapon in question was to be used. It was not the responsibility of those in the control rooms to ensure that the person or persons at risk were notified of the danger although it was stated that it was the responsibility of someone else. No further evidence was given on this point and I do not know if any such information was communicated to anyone.

[121] I have considered all matters relating to the planning, control and supervision of Operation Trill. I have made various Findings and have drawn various conclusions in the preceding paragraphs in this section. I have given careful consideration to those Findings and conclusions and having done so I am satisfied 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 surveillance operation

[122] I received a significant amount of evidence about the surveillance operation that was deployed during this incident during the course of the afternoon and evening of the 29 April 2003. Surveillance resources included those available in the Mahon Road and Belfast Control Rooms, various Special Operations Branch ("SOB") operatives and call signs on the ground, and an MOD Gazelle helicopter in the sky. A surveillance log was completed and made available to the inquest.

[123] The Next of Kin contends that the directed surveillance operation was not properly authorised and consequently it was illegal. It is not submitted that this purported failing caused or contributed to this death, but it is suggested that it is indicative of more general failings and a poorly planned operation that breached the Regulation of Investigatory Powers Act 2000 ("RIPA"). The Next of Kin submits that the credibility of witnesses on this issue, including AA/5049, RR/8130 and 7191, is called into question. It is submitted that the authorisation was effectively created retrospectively.

[124] PSNI describes this issue as a technical one that is not germane to the key issues before me under scope.

[125] The surveillance log recorded a sequence of events, that was relayed by the SOB operatives and helicopter to the control room. Many of these events were also referred to in witnesses' oral evidence. The Cavalier car travelled extensively across South Belfast, into West Belfast and the Lisburn area. Many of its movements were reported on by the surveillance resources. I was greatly assisted by Brian Murphy of TBM Consultants who was instructed on my behalf to produce maps and photographs that showed the route taken by the police vehicles and by the Cavalier from the location of where it first came under surveillance by the police to its ultimate stop.

[126] When the Cavalier was picked up in Belfast around 5.00pm the surveillance log records that its journey then included travelling in Belfast on Grosvenor Road, Springfield Road, Falls Road, through the city centre, Ormeau Road, Donegall Pass, University Street, the University Area, Botanic Avenue, Lisburn Road, Donegall Road, Whiterock, Monagh bypass, Glen Road, Colinglen Road, Colinwell, Old Colin Road, Whitemountain Road, Glenavy Road, Lisburn Road and Crumlin Road.

[127] The surveillance log records that the Cavalier stopped on a number of occasions during that time period prior to the final stop at around 7.10pm. The PIPs have made submissions to me on various points about the Cavalier's journey that day and some of the recorded stops that it made.

[128] One stop recorded by the surveillance teams occurred at 17.35 in Agincourt Avenue, Belfast for approximately 30 minutes when the driver exited the car and a number of other people subsequently entered it. One person was observed carrying a bag. It is not known what it contained.

[129] Another stop recorded was at Old Colin Road at 18.27 to 18.43 when people moved between the Cavalier and a wooded area. The Next of Kin submitted that this was a good, but missed opportunity, to stop the Cavalier car and make arrests. BB/2018 gave evidence that it would have been unsafe to do so at this location.

[130] Relevant witness evidence given to me on the intelligence received and consequent surveillance operation includes the evidence discussed hereafter.

[131] Detective Superintendent AA/5049's role has already been described in my Findings.

[132] AA/5049's evidence was that at 3.10pm he received intelligence from a CID Detective Sergeant that a David "Dee" Somers was going to Belfast to collect a gun to be used in an attack on a named person. AA/5049 was aware that there had been previous surveillance operations in relation to David Somers. AA/5049 stated that the initial intelligence received was not sufficient to mount an operation and he asked for further details. A short time later AA/5049 received further details, including the dates and times that David Somers was travelling to Belfast to collect a gun.

[133] Intelligence was received at around 3.50pm that he was to meet a named person at the fire station on the Springfield Road, in Belfast. AA/5049 subsequently orally authorised covert surveillance to be commenced on David Somers. He briefed the RCGs in the South region and in Belfast on the details of the planned operation, which was for HMSU to provide support to the surveillance officers to effect an arrest and recover any firearms. He stated that the control room was up and running by around 4.13pm.

[134] At 4.20pm, AA/5049 received intelligence that David Somers was travelling to Craigavon Area Hospital to pick up a person called Neil McConville. AA/5049 informed RR/8130 (Belfast RCG) of this information. Surveillance was deployed to locate Mr. Somers, but that surveillance did not pick up on Mr. Somers in the South region. At 4.55pm AA/5049 briefed CC/6218, the Chief Superintendent and AA/5049's superior, on the circumstances of the operation. At 5.00pm AA/5049 received a call from Superintendent BB/2018 who advised him that they had picked up on a Cavalier registration LDZ 2687, with two persons on board, and that Belfast HMSU was now in control of the operation.

[135] I heard from Detective Inspector 7191 that he was attached to the RCG in Mahon Road PSNI station and that on 29 April 2003 he was the Duty Inspector. He told me that at 3.50pm he was informed by Superintendent AA/5049 that a crime operation may be occurring involving a Dee Somers from Craigavon who was to travel to Belfast to purchase a shotgun from a named person which was to be used in the murder or kidnapping of two persons. He said that Superintendent AA/5049 tasked him to set up an operation in response to the intelligence received.

[136] He said that he and AA/5049 agreed the objectives of the operation at around 4.00pm which were the recovery of illegal firearms, the prevention of criminal acts by Dee Somers or others and to effect arrests. He told me that at 4.00pm he briefed the acting inspector of Special Operations South and at 4.15pm he briefed the inspector in charge of HMSU South, Inspector U201. At 4.20pm he was informed by AA/5049 that David Somers was on route to Craigavon Area Hospital to pick up a Neil McConville.

[137] Detective Inspector 7191 informed the surveillance team, who deployed support from HMSU, but there was not sufficient time available to deploy support and locate David Somers in South region. He confirmed that at no time did the surveillance team detect David Somers in South region. At 5.00pm, he was aware that David Somers was in Belfast and the operation was taken over by Belfast RCG. After that, he informed me that he was waiting to see if the vehicle returned to South region, which it did not. Regarding his purported refusal to sign the surveillance form he couldn't recall being asked to do so but stated that he would have refused to do so if he had been requested to.

[138] Chief Superintendent CC/6218 provided oral evidence to me that on 29 April 2003 he was the Regional Intelligence Advisor, based at South Region Headquarters in Mahon Road, Portadown. His role was to evaluate and act upon all intelligence that was coming in, particularly regarding terrorist related crime, from all organisations. He was the most senior person in Mahon Road and he reported primarily to the Assistant Chief Constable. He told me that on 29 April 2003 AA/5049 telephoned him at around 5.00pm for approximately five minutes.

[139] AA/5049 told him that intelligence had been received that criminals were leaving the Craigavon area to go to Belfast to pick up weapons to carry out an attack on other persons in the Craigavon area. AA/5049 told him that the persons involved were now in the Belfast area and that the matter was being handed over to the Belfast region. CC/6218 told me that he asked AA/5049 if he was happy with everything, and AA/5049 confirmed that he was satisfied that everything was under control. CC/6218 also gave evidence that AA/5049 had advised him that the strategic aim of the operation was to stop the car within the greater Belfast region and this aim was given by the Belfast region.

[140] EE/U118 gave evidence that on 29 April 2003 he was a Sergeant in the PSNI attached to the Headquarters Mobile Support Unit. He was in the RCG Command and Control Operations Room, Castlereagh. At approximately 4.45pm he was briefed by RR/8130 that a Dee Somers was to collect weapons in the afternoon in the Belfast area. It was said that Mr. Somers would be driving a Cavalier and would meet an unknown person at the Springfield Road fire station. EE/U118 passed this message via a radio transmission to all of the vehicle call signs that were deployed in the greater Belfast area. A short time later, he was aware that surveillance had picked up a Cavalier, registration LDZ 2687. EE/U118 stated that he passed all relevant messages from the surveillance desk to his call signs via radio.

[141] I heard from RR/8130 that on the 29 April 2003 she was 'acting up' as the Duty Inspector for RCG Castlereagh between 3.00pm and 11.00pm. She stated that she remained in the RCG operations room throughout the operation along with Superintendent BB/2018. She told me that her role was to brief the surveillance teams and HMSU and thereafter to take notes of what happened in relation to the surveillance teams, reaction teams and intelligence updates. She said that she used these notes to update the policy book. She said that at 4.10pm, specific intelligence from Superintendent AA/5049 indicated that Dee Somers from the Craigavon area was to travel to West Belfast to collect a weapon or weapons to be used in an imminent criminal operation. RR/8130 stated that she was not informed of the details of the target. It was said that Somers would be driving a Cavalier, with an unknown registration number, and would be meeting a Mr. Valliday at the Springfield Road fire station. AA advised RR/8130 that oral authority for the surveillance operation had been granted.

[142] At 4.20pm RR/8130 briefed the Sergeant in charge of the SOB surveillance teams on the intelligence and requested that surveillance resources deploy in the area of the fire station in an attempt to identify the Cavalier. At 4.45pm, RR/8130 briefed Sergeant EE/U118. At 5.00pm, surveillance identified a Cavalier travelling countryward on the Grosvenor Road, with two persons on board. Nine minutes later, surveillance indicated an unknown male getting into the Cavalier at the Springfield Road fire station. RR/8130 assessed this to be Somers collecting the male, as intelligence had indicated would occur.

[143] RR/8130 stated that she signed the surveillance authorisation form because AA/5049 indicated to her that Detective Inspector 7191 in Mahon Road had refused to do so. RR/8130 did not know why he had refused to sign it.

[144] DD/9239's evidence was that on the 29 April 2003 he was the Regional Intelligence Advisor for Belfast, based in Castlereagh. At around 5.20pm, on his journey home from work, he received a telephone call from BB/2018. BB/2018 asked him if he knew where the 'ACC' (the Assistant Chief Constable) was. BB/2018 needed to inform her about an operation that he was running in which he had briefed and deployed surveillance teams. BB/2018 told DD/9239 that intelligence was coming in that a vehicle was travelling from the Craigavon area to West Belfast to pick up a firearm.

[145] MOD1 told me that on the day in question he was a helicopter pilot with 665 Squadron 5 Army Air Corps, based at Royal Air Force Aldergrove. He piloted a Gazelle helicopter in support of the C4 department of the PSNI for surveillance operations, primarily over the Belfast area. At about 5.00pm, he was tasked to Palace Barracks in Holywood to uplift a C4 member, O246, for a surveillance operation. After being lifted, O246 informed him that they needed to fly to the Ormeau Road area of Belfast, to look for a Cavalier type vehicle which was parked in the area. They departed at about 5.30pm, and once over the target area, O246 pointed out the target vehicle.

[146] MOD1 described the journey taken by the aircraft, following the movements of the Cavalier. MOD1 described that as the vehicle moved south-west out of the city, he observed it driving very erratically as it overtook many vehicles on the ring road. He stated that the vehicle then moved towards a quarry or brick works and then pulled off onto a single-track road and stopped amongst some trees. MOD1 said that, at that time the weather was very poor with heavy rain and was becoming quite cloudy.

[147] MOD1 stated that he was concerned that thunderstorms and cloud to the north would drift down towards Belfast, and he voiced this concern to O246. He said that the vehicle stayed where it was for 10 to 15 minutes and then it moved out of Belfast. It then stopped at a garage for a few minutes and then it left, turning several times up country lanes. It stopped again at a t-junction and O246 told him that one of the occupants had exited the vehicle.

[148] He said that when the vehicle left Belfast, and one of the occupants had exited it, MOD1 informed O246 that there was only about 30 minutes of fuel left. By this stage, MOD1's evidence was that the weather had improved, and the sky had cleared. The person then returned to the vehicle and the vehicle continued along country lanes. MOD1 said that O246 then informed him that that they were going to "take them". MOD1 told me that O246 said to him that the vehicle was being blocked in, that one or two people had been knocked down and that shots had been fired. O246 then asked MOD1 to move the aircraft away from the direct area of the incident and he did so. The aircraft was stood down soon thereafter.

[149] O246's evidence was that on the day in question he was a Detective Constable attached to the HMSU undertaking surveillance in the helicopter flown by MOD1. He used binoculars to observe the Cavalier. During the operation, he was in contact with his control room via radio, where a log was kept of his surveillance. He stated that his communications would also be heard by the surveillance liaison officer in RCG. He recalled that in the Belfast area, the weather was very poor, but said that as the helicopter moved into the countryside, the weather greatly improved. He was unsighted for approximately nine minutes at 6.40pm.

[150] FF/U143 told me that on 29 April 2003 he was tasked to Call Sign 10, with GG/U137 and HH/U129 and had taken his MP5 weapon. He was the driver of Call Sign 10. He recalled his vehicle's movements in the Belfast area and that of the Cavalier, as provided by the surveillance teams. He told me that the Cavalier went to the Agincourt area of the Ormeau Road, with the surveillance teams reporting that persons in the Cavalier had called into a house and then gone back to the car.

[151] FF/U143 also said that he was aware at some point that a white bag was put into the Cavalier, which was not identified as a firearm. He also recalled his call sign meeting with Call Sign 7 at Donegall Pass, telling me that the two crew commanders spoke about the actions to take if the Cavalier was to be stopped. He said that he understood what he was to do in the event of either a VCP or a stop from behind.

[152] He also described a period where the Cavalier was in an area off the Colinglen Road with another vehicle, with unknown persons moving around in the undergrowth at the side of the road. FF/U143 believed that this was the firearms or firearm being collected as indicated by the intelligence. He said that the Cavalier then went back onto the Glen Road and the other suspect vehicle, he believed, moved back towards the city. He said that the Cavalier was said by surveillance to be travelling at speed on the Glen Road, and it then stopped for fuel at the fuelling station at the top of Pond Park.

[153] KK/U208's evidence was that on 29 April 2003 he was a Constable attached to Mahon Road police base. At 4.30pm he attended a briefing by U201 with Paul Taylor, II/U219 and other officers regarding a 'fast ball operation'. He

said that he was told that Dee Somers from the Craigavon area was to travel to the Belfast area to meet with a man and to buy a shotgun from him for £750 which would be used in a criminal job in Craigavon. He recalled being told that Mr. Somers had fallen out with someone. KK/U208 stated that he was the crew commander of Call Sign 7, and he said that his role was to operate the radio, read the maps and make decisions regarding the actions of his vehicle. He described that his call sign's role was to provide support for the surveillance teams and to be available for any stops required. He said that he had with him his personal issue firearm and he also booked out his usual Heckler & Kock MP5 submachine gun.

[154] He recalled being redirected to Belfast and contacting EE/U118 to inform him that his call sign was the nearest South call sign to the Belfast region. He said that EE/U118 informed him that the subject vehicle had been found and was on the Grosvenor Road, travelling west. He also recalled being told the registration of the vehicle and that a meeting was to take place in the Springfield Road fire station.

[155] BB/2018 gave evidence that on 29 April 2003, he was a Detective Superintendent based at Castlereagh Police Station. He explained that he was in charge of the Urban Region RCG . He said that he was briefed by Assistant Detective Inspector RR/8130 on Operation Trill and explained that the intelligence indicated that a suspected criminal from the Craigavon area, named Dee Somers, was to travel to Belfast to collect a weapon or weapons to be used in a criminal operation. He told me that he knew that the intended targets were in the Craigavon area.

[156] BB/2018 said that he spoke with Detective Superintendent AA/5049 of RCG South Region, and they agreed that if surveillance could identify Mr. Somers and his vehicle, his activities would be monitored in Belfast. He also said that once the vehicle returned from Belfast towards the Craigavon area, the intelligence assessment was that the vehicle would contain a weapon or weapons. He said that HMSU would then possibly be required to stop the vehicle and search for any weapon or weapons. He said that RR/8130 briefed the HMSU and the SOB surveillance teams on the available intelligence and their requirements. He further described receiving authorisation from DD/9239 to carry out the operation, because the ACC was unavailable at the time.

[157] He said that he remained on duty in the RCG operations room throughout the operation. He stated that at 5.00pm surveillance identified a Cavalier, registration LDZ 2687, in West Belfast. His evidence was that he took over the operation when the car was identified in Belfast. He stated that RR/8130 kept a log during the operation. He explained that the vehicle's movements were monitored by the surveillance teams and his assessment, on the basis of its movements and the intelligence received, was that a weapon transaction had probably taken place in a wooded area on the Colinglen Road, Poleglass.

[158] I heard evidence relating to the movements of the Cavalier and in particular to the various stops made by the vehicle. Furthermore the surveillance detailed occasions when persons got in or out of the vehicle. I am quite satisfied that the surveillance was carried out properly and accurately whether by SOB operatives, HMSU call signs or by helicopter. It was accurate in reporting on the Cavalier's movements. It could not, of course, forecast the route to be taken by the vehicle.

[159] A matter that did arise during the course of the evidence that caused some apparent contradictions was the RIPA authorisation for directed surveillance on Mr. Somers, the passenger in the Cavalier. AA/5059 said that he gave authority for the granting of an urgent oral application, something he was permitted to do by reason of his rank. This required to be put into appropriate written form when that is possible.

[160] In this instance the written copy is signed indicating that it was made by RR/8130. She was an acting Inspector in RCG Urban. She told me that after the incident she was telephoned by AA/5059 and asked to sign the surveillance requests – this in effect was to document the authorisation from earlier in the day. She says she was being asked because Inspector 7191, based at Mahon Road had refused to sign it. She did sign it although it was clear she had not made the application at 14.25 hours – she just signed the form later. Inspector 7191 said that he never refused to sign any form and had only ever been asked to mount a surveillance operation.

[161] AA/5059 speculated that RR/8130 signed the form because the vehicle was heading towards Belfast, and she said that she would fill out the paperwork. He also said that he did not remember 7191 refusing to sign the form, nor could he see anyone refusing to do that.

[162] I have noted and considered what both the Next of Kin and PSNI have said about this in written submissions. I do not regard this is as a particularly relevant matter as far as this inquest is concerned but it does show some confusion, at the very least, over documentation which requires completion in an appropriate manner. It must be remembered that directed surveillance impinges on an individual's right to privacy and such matters should be strictly and properly dealt with in compliance with the relevant legislation. I do not feel that I have to make a finding as to who may be telling the truth but the position is far from satisfactory.

The Stop

[163] NN/U102 gave evidence to me that when the Cavalier exited the petrol station at the top of Pond Park Road, it drove erratically at speeds of 50 to 60 miles per hour on twisting country roads. At this time it was being monitored by surveillance resources, including a helicopter. The control room was advised that the helicopter may lose sight of the vehicle and NN/U102 was concerned that surveillance teams on the ground could also lose sight of it.

[164] NN/U102 told me that once the Cavalier left the petrol station at the top of Pond Park Road and turned onto the Sheepwalk Road, a VCP was no longer an option. NN/U102 states he gave tactical advice to BB/2018 in the RCG not to carry out a VCP but instead to plan to stop the vehicle from the rear. The Association of Chief Police Officers (ACPO) called this an enforced stop. In its written submission to me the PSNI comment that tactical advice was received and taken by BB/2018 while Ms. McCann in her submission comments that NN/U102's tactical advice was neither sought nor received before BB/2018 took the decision to stop the vehicle. NN/U102 could not recall any discussion around the pros and cons of an enforced stop but he told me that if BB/2018 had not been content with his advice, he would have mentioned it. I asked NN/U102 what factors he had taken into consideration in giving this tactical advice.

[165] He told me that he believed the Cavalier contained an illegal firearm and a person who was suspected of being involved in a murder. Additionally, the Cavalier was taking an obscure route and travelling at speed. He didn't know if the weapon in the Cavalier was going to be used immediately for an attack somewhere along that road or somewhere convenient to that road. NN/U102 also said that he had no idea where the Cavalier was going to and as it travelled at speed along that road, its options began to increase and there were more directions that it could travel in.

[166] He told me that a stop from the rear is a safer option on country roads than a VCP and that he considered this to be the safest type of stop, in the circumstances, for the officers, the subjects of the surveillance and members of the public. NN/U102 also said that if any of the police vehicles on the ground at that point thought that conducting a VCP was the correct thing to do, then their advice would have been taken. He said that when he gave the advice to stop the car, he had not entirely ruled out the possibility of a VCP being conducted and that he still had police vehicles travelling on the motorway in the hope that they may get in front of the Cavalier again.

[167] The instruction to stop the car was directed at all call signs involved in this operation because it could not have been known in advance which call signs would end up in a position to conduct the stop. The entry in the HMSU logbook to stop the car is recorded at 6.55pm. The next entry is at 6.57pm and records coming towards Sheepwalk Road'. There are no further entries until 7.10pm and NN/U102 could not explain why this was. NN/U102 said that at approximately 7.10pm he was made aware via the radio that Call Signs 10 and 7 had stopped the Cavalier, shots had been fired and that two persons were injured.

[168] EE/U118 was on duty in the RCG controlling the operations desk and managing the radio network. He was giving tactical advice until his manager, NN/U102, arrived in the operations room and took on the role of tactical advisor. EE/U118 told me that as time moved closer to 7pm the option of

setting up a VCP became too risky. He would have had to redirect resources to set it up and the Cavalier might not have taken the anticipated route, resulting in the operation losing those resources.

[169] EE/U118 said that the safest way to deal with the Cavalier was to stop it from the rear. At approximately 6.55pm, BB/2018 directed him to instruct the call signs to stop the Cavalier. He could not say one way or another if the instruction to stop the Cavalier was a definitive instruction to stop from the rear. He also could not recall if there was any further instruction about the stop from BB/2018. While a further communication would have been normal practice when it was known that call signs were in position, EE/U118 acknowledged that the HSMU log had no recorded entries between 6.57pm and 7.10pm, when the control room was informed by call signs on the ground that the Cavalier had been stopped and shots had been fired.

[170] EE/U118 could not recall GG/U137, the crew commander from Call Sign 10, asking RCG to confirm the instruction to stop the Cavalier from the rear. He told me that he would have been surprised if GG/U137 had questioned the instruction and confirmed that the ultimate decision on the tactic would have lain with the Superintendent, who was BB/2018.

[171] PP/U106 gave evidence before me that on 29 April 2003, he was the appointed loggist and he commenced the HMSU log at 5.23pm. His line manager was NN/U102. At 6.55pm PP/U106 heard the instruction to stop and recorded it in the log. He told me that he did not hear an instruction to stop from the rear. He also did not hear any request from the cars on the ground for confirmation of that instruction. He told me that if he had heard either of these, he would have recorded it in the log.

[172] PP/U106 could not account for the gap in the log between the entries at 6.57pm and 7.10pm. He told me that he had been in the HMSU for twenty years at the time of the incident but he had never been trained in logkeeping and generally didn't complete logs in his day to day work. He felt that he would have done a better job if he had had more experience in keeping logs. However, he did tell me that most of the radio transmissions after the order to stop had been given, would have been between the call signs in relation to getting themselves organised to stop the Cavalier. PP/U106 told me he was not recording the conversations between the police vehicles on the ground but he was recording conversations or transmissions between EE/U118 and the police vehicles on the ground.

[173] PP/U106 could not recall making any comment on the timelag in the log at the debriefing held the next day. Consequently he could not explain the reference in notes made by a PONI attendee at the debrief to him saying that he hadn't been able to record entries because of the Cavalier's speed.

[174] I heard from RR/8130 that on 29 April 2003 she was the RCG Duty Inspector from 3.00pm to 11.00pm, and for this operation she reported directly to

BB/2018. At 6.55pm RR/8130 was in the Operations Room when she heard BB/2018 order the call signs to stop the Cavalier as soon as possible. RR/8130 told me that she was not aware of any further direction being given on how the car should be stopped and she had no knowledge of the crews on the ground seeking clarification of a stop from the rear. She told me that she would not have expected any further direction to have been given after the order to stop the car because in her experience officers on the ground need an element of discretion in how to give effect to commands.

[175] RR/8130 said she understood that one of the reasons the Cavalier had to be stopped as quickly as possible was the potential loss of helicopter support due to bad weather but she could not recall if that was the only reason. She recorded cloud cover at 6.40pm in her notes at the time but acknowledged in evidence that the helicopter was in the air until 7.20pm.

[176] RR/8130 said that at 7.09pm the crews on the ground reported that the Cavalier would not stop when it was requested to do so and at 7.10pm they reported that shots had been fired and two persons had been injured.

[177] DD/9239 gave evidence that at the time of this incident he was the Regional Intelligence Advisor for the Belfast area. He confirmed that he had spoken with BB/2018 by telephone on the day about the operation and they discussed how the Cavalier would be stopped using a VCP. DD/9239 told me that the next time he spoke with BB/2018 was when he was advised that the car had been stopped by means of a hard stop and there had been a fatality.

[178] DD/9239 confirmed that a hard stop had not been part of the plan that he had discussed earlier with BB/2018. He said that at the time of his discussions with BB/2018, he considered himself to be the Gold Commander. He told me that in making the decision to conduct a hard stop BB/2018 could have telephoned him to discuss that option and ideally that should have happened. However, the job of the Superintendent was to make fast moving hard decisions and in any event Gold Commanders should not become involved in tactical decisions.

[179] MOD1 gave evidence to me that after the Cavalier left the petrol station at the top of Pond Park Road it turned several times up country lanes. MOD1 told O246 that there was only about 30 minutes of fuel left. MOD1 said that the weather had improved, the sky had cleared and he was told by O246 that "They were going to take them". MOD1 saw the Cavalier approaching a t-junction near a small village and this was the last time he had eyes on the Cavalier. MOD1 maintained the helicopter in its position because O246 said that the Cavalier was being blocked in. O246 then said that one or two people had been knocked down and that shots had been fired. MOD1 confirmed that the helicopter did not have any surveillance equipment attached to it at the time of the incident. MOD1 confirmed his recollection of receiving a radio message suggesting the helicopter may be used to evacuate a casualty but he

was then asked instead to retrace the route of the Cavalier. Due to the nature of the roads he was unable to do that and in evidence he didn't have much of a recollection of attempting to do so. MOD1 told me that it was difficult to estimate how much fuel would have been used by the helicopter in landing at the incident site, loading a casualty and transporting him to hospital. In terms of capacity on board the helicopter MOD1 told me that he could have accommodated a sitting casualty and one medic.

[180] O246 gave evidence to me that he was the police observer in the helicopter alongside MOD1 and that he was observing events through a pair of binoculars. He told me that he was wearing a helmet with a microphone, and he could speak to RCG while looking through the binoculars at the same time. At approximately 7.08pm he saw two police vehicles approaching the Cavalier. He said that the lead police vehicle moved out and drove up alongside the Cavalier, travelling alongside it for a number of seconds. He then saw the Cavalier ram into the near side of the police vehicle as if to try to force it off the road. O246 saw the lead police vehicle slow down and the Cavalier took the lead, driving across the front of the lead police vehicle at approximately 45 degrees.

[181] O246 described how the rear driver's side of the Cavalier came into contact with the front near side of the lead police vehicle. The Cavalier then skidded firstly to the left, and then around to the right in a 180-degree angle. It stopped in the middle of the road, facing the direction that it had just travelled from.

[182] The Cavalier only stopped for a few seconds and O246 described that it then drove directly at the lead police vehicle. O246 saw smoke coming from the front tyres of the Cavalier as it moved off. The lead police vehicle then made contact with the front driver's side of the Cavalier. This action forced the Cavalier into a hedge at the opposite side of the road. The lead police vehicle was tightly alongside it, its passenger side against the driver's side of the Cavalier. O246 said the second police vehicle had now passed the two vehicles and was blocking the other side of the road.

[183] O246 said that there was a pause and then one person, whom he assumed to be a police officer, approached the front passenger side door of the Cavalier. The Cavalier then reversed and simultaneously the front of the vehicle turned left in a J-turn manoeuvre. O246 described that this action caused the front passenger side wheel arch to hit the police officer who was thrown backwards and into the middle of the road.

[184] O246 said that the police offer was lying in the middle of the road. The Cavalier was stationary and facing towards the police officer. O246 was aware of one other police officer close by but could not say accurately where he was positioned. O246 said that there was no more movement from the Cavalier after this point, and he was unable to see into the vehicle. A number of other police officers were moving closer to the Cavalier but their position

was more difficult to distinguish because their clothing was dark. O246 said that at 7.24pm his control room instructed him to return to base. When he got there he attended a debrief. O246 said that he did not record his observations in relation to the incident in his notebook because he was instructed not to do so.

[185] GG/U137 was the front seat passenger and crew commander of Call Sign 10. The other occupants of Call Sign 10 were the driver, U143 and the rear seat passenger U129. GG/U137 gave evidence to me that he was aware that the Cavalier had left the petrol station at the top of Pond Park Road and was travelling towards Lisburn on the Glen Road. He told me that at this time EE/U118 contacted all units and gave the instruction that the Cavalier was to be stopped. Call Sign 10 then travelled at speed in pursuit of the Cavalier, using its hazard warning equipment.

[186] There is no police notebook entry or contemporaneous police documents that record the instruction that the car was to be stopped from behind or that it should be a 'hard stop'. However, GG/U137 told me that he contacted EE/U118 on two occasions to clarify if the Cavalier was to be stopped from behind and that this instruction was confirmed.

[187] GG/U137 explained that the term 'hard stop' applies to both static and moving vehicles. He said that the objective of a 'hard stop' is to stop the subject vehicle by placing two police vehicles in a position around the subject vehicle. He explained that an 'enforced' hard stop is where the subject vehicle is mobile and a police vehicle moves in front of it, uses cadence braking to slow the subject vehicle down and bring it to a stop. In written submissions to me the Next of Kin say there does not appear to have been any documentation as to whether the conditions for using such a stop had been met and nor is there any documentation referencing the issues which should be borne in mind before such a stop is carried out. The PSNI point out that allowance must be made to the police to adapt their tactics, by necessity, to address an unplanned situation.

[188] GG/U137 described to me in some detail Call Sign 10's route towards the Crumlin Road. He described it as a tight twisty country road with few overtaking opportunities, but with sufficient room for cars travelling in opposite directions to pass without having to pull in. GG/U137 saw the Cavalier approximately three to four hundred metres in front of Call Sign 10 driving at an estimated speed of 50 to 60 miles per hour. Call Sign 10 reduced this distance to a following distance of about 30 to 40 metres. Call Sign 10 maintained this distance and GG/U137 was satisfied that the occupants of the Cavalier were unaware of his presence.

[189] GG/U137 instructed his driver, U143 to wait for a straight section of the road before attempting to stop the Cavalier. When Call Sign 10 entered a straight section of the road, GG/U137 instructed U143 to overtake the Cavalier.

GG/U137 turned on the police vehicle's hazard warning equipment and the police vehicle increased its speed and pulled alongside the Cavalier.

[190] GG/U137's evidence was that he rolled his window down and was sitting sideways, facing the offside of the Cavalier as Call Sign 10 pulled alongside and slightly in front of it. GG/U137 had a clear view of the driver. He raised his MP5 up to show it to the Cavalier driver and pointed with his right hand, indicating to him to pull in. GG/U137 also told me that he was shouting "Police, stop, pull in", and that he had a police badge on his left breast that he ensured was clearly visible.

[191] GG/U137 said that the Cavalier driver looked at him and the Cavalier started to increase speed. GG/U137 then saw the Cavalier driver wrench the steering-wheel to the right, causing the Cavalier to ram the police vehicle. GG/U137 told me that shooting the tyres of the Cavalier was not an option because doing so would not have stopped the vehicle. It would have been dangerous because the rounds used in his weapon were jacketed rounds. If you fire a full jacketed round into a wheel, you don't know where that round will go.

[192] GG/U137 then described that U143 drove the police vehicle ahead of the Cavalier and both cars drove alongside each other. GG/U137 described seeing a brick wall that both cars were driving towards and he told me that but for the wall, he could not think of any reason why Call Sign 10 would not have overtaken the Cavalier. Call Sign 10 slowed down because of the wall and GG/U137 thought that the Cavalier was going to hit the wall. GG/U137 said that the Cavalier avoided hitting the wall but went into a spin and the driver lost control of the car. The Cavalier travelled sideways down the road before turning to face Call Sign 10 and coming to a temporary halt. GG/U137 noticed that Call Sign 7 had driven ahead and was blocking the road.

[193] GG/U137 was referred to Chapter 5 of the ACPO manual under the heading "Armed subjects in vehicle", where it states that total physical obstruction of a road is inherently dangerous. GG/U137 was asked about the stop taking place facing the brow of a hill. GG/U137 explained that FF/U143 was an advanced driver who would have assessed the risk of stopping the Cavalier at any particular point. The police vehicle was high-powered and when Call Sign 10 entered the straight section of road, he assessed that there was an opportunity to stop it.

[194] GG/U137 said that his police vehicle was parked in front of the Cavalier and he could see its two occupants face on, positioned slightly to the offside of Call Sign 10. He said that the driver of the Cavalier was still trying to drive it and it started to move towards Call Sign 10. It appeared to be trying to pass Call Sign 10 on the offside to travel back in the direction that it had come from. GG/U137 said that he was concerned about the cyclists he had seen further back on the road and shouted at U143 to "Stop him".

[195] I was then told by GG/U137 that U143 drove into the front offside of the Cavalier. He made contact with its front wing and pushed the Cavalier anticlockwise into the verge and offside of the road. It was positioned at 90-degrees to the carriageway, facing the hedge. He said that Call Sign 10 remained close to the Cavalier and was possibly still in contact with it. GG/U137 exited the passenger door of Call Sign 10 with his MP5 weapon on a sling. He set the safety on. I note in their written closing submissions the Next of Kin state that the enforced stop tactic requires police officers to be absolutely sure that the subject vehicle is stopped before anyone steps out of their own vehicle. They say it is simply safer this way and that the decision not to take steps to ensure that the Cavalier was static before exiting the cars contributed significantly to the events which followed and directly contributed to the decision to deploy lethal force.

[196] GG/U137 ran towards the driver's door of the Cavalier and he could see that the driver was still trying to get the vehicle in gear. GG/U137 smashed the driver's window behind his head with the barrel of his MP5 gun while shouting repeatedly "Stop, police, show me your hands". GG/U137 described an abundance of noise, including police sirens, shouting and the engine of the Cavalier revving. He said that the driver continued to attempt to get the vehicle into gear and that he did not look at him. He saw Mr. Paul Taylor approach the nearside of the Cavalier. GG/U137 took hold of the driver and attempted to pull him away from the steering-wheel. GG/U137 told me that he did not consider using the butt of his MP5 to hit the driver and attempt to physically incapacitate him. This was because the MP5 was on a sling around his neck and to have used it in that way would have taken some time. In any event GG/U137 said that police are not trained to strike people with the butt of a gun when they're driving a car.

[197] GG/U137 said that just as he got hold of the driver's clothing, the Cavalier shot back with the nearside of the vehicle moving rapidly anticlockwise. GG/U137 described that he injured his hand on the driver's door and he moved a little to his left to follow the vehicle. At that point, GG/U137 said that he saw Mr. Taylor in the air at about head height and then land on his side on the ground in front of the Cavalier which which was now facing in its original direction of travel.

[198] GG/U137 positioned himself by the driver's pillar, slightly behind the driver. He said that the Cavalier was still revving, possibly flat out. Mr. Taylor was still on the ground, on the driver's side, approximately 10 feet from the car. U208 was also directly in the path of the Cavalier. GG/U137 said that it was quite clear at that stage that if the Cavalier moved forward, it would run over Mr. Taylor and hit U208. GG/U137 acknowledged that U208 was standing on his feet in front of the car with his weapon pointing at the driver.

[199] GG/U137 became aware that HH/U129 was standing on his right side, slightly behind him and shouting police warnings. He saw Mr. Taylor trying to get up on to his feet and then falling back down. GG/U137 saw that the

driver of the Cavalier was still working at its gears attempting to get the car into forward gear. He felt that there was a real and imminent threat to Mr. Taylor's life. GG/U137 took his weapon off safety setting, aimed it at the driver and shouted "Stop, police, show me your hands or I will fire."

[200] GG/U137 told me that he had previously experienced difficulty with the MP5 fire selector. When he used the weapon on the firing range, he unintentionally moved the fire selector from the single shot setting to the fully automatic setting. He told me that he had never reported a concern in writing about the weapon, and that was just the way the weapon was constructed.

[201] GG/U137 told me he was about 4 or 5 feet away from Mr. McConville. The muzzle of his weapon wasn't much further away, although he accepted that he could have been closer than that. He told me that despite being close to Mr. McConville he could not have opened the car door and physically pulled him out of the car. To reach inside a car and grab someone is an inherently dangerous thing to do. If the car moved off, it would make contact with the police vehicle in front of it. GG/U137 himself would have been half in and half out of the Cavalier and could have been killed. GG/U137 told me that because of the immediacy of the threat, the time available for decision-making and the opportunity to select a different option, was reduced to seconds.

[202] GG/U137 said that he could not fire any warning shots because he would have had to ensure that any shots would not pose a risk or threat to anybody else. To do that, he would have needed to take his focus away from the driver of the Cavalier to make a risk assessment of where the warning shot would go. GG/U137 said that wasn't achievable due to the situation that was developing in front of him.

[203] GG/U137 heard three to four shots fired and he realised that HH/U129 had discharged his weapon. GG/U137 confirmed that before any shots were fired, he did not see a weapon in the Cavalier.

[204] FF/U143 was the driver of Call Sign 10 and his crew commander was GG/U137. He told me that he had an advanced driver qualification. It was awarded to him after three or four weeks of intensive driving on roads in different conditions and at different speeds. He also told me that he had trained separately for the tactic intended to be used to stop the Cavalier and that he had implemented that tactic on other occasions. FF/U143 told me that on those other occasions he had never met opposition or resistance of the kind that he met on this occasion.

[205] FF/U143 told me that the Cavalier stopped for fuel at the filling station at the top of Pond Park Road at 6.55pm. All call signs were directed to stop the vehicle. He said that GG/U137 had confirmed with the RCG that the Cavalier was to be stopped and that it could be stopped from behind. FF/U143 told me that GG/U137 turned on the blue lights and two-tone horns of Call Sign

10. They pursued the Cavalier by following surveillance information that was transmitted to them. He didn't actually see the Cavalier until he was on the Crumlin Road. At approximately 7.08pm he saw it on the road ahead of him.

[206] GG/U137 switched off the blue lights and two-tone horns to allow Call Sign 10 to approach the Cavalier without giving its driver prior warning. Call Sign 7 was behind Call Sign 10. FF/U143 told me that the Cavalier driver appeared to be unaware of their presence. FF/U143 said that GG/U137 instructed him to pull out and overtake the Cavalier at the first safe opportunity.

[207] A short distance later, at 7.10pm, FF/U143 said that the vehicles were coming out of a corner. He had a good look at the road ahead. He could see that there was a straight piece of road and he believed that there was enough distance to overtake the Cavalier. There was no traffic coming towards them. FF/U143 told me he had the element of surprise over the driver of the Cavalier and he felt that he could have overtaken him swiftly and safely. He told me that he pulled out to overtake the Cavalier and GG/U137 turned the police vehicle's blue lights and two-tone horns back on. FF/U143 pulled his vehicle alongside and slightly in front of the Cavalier. He believed that it was at this stage that the occupants of the Cavalier became aware of the police presence. FF/U143 told me that Call Sign 7 moved up behind the Cavalier.

[208] As he moved his car alongside the Cavalier, FF/U143 could see GG/U137 indicating to the driver to pull in and stop, by pointing to the side of the road with his left hand. He said that GG/U137 had his MP5 in his right hand, pointing generally towards the Cavalier but not in the aimed position. FF/U143 heard GG/U137 shouting at the driver of the Cavalier, directing him to stop and pull in. FF/U143 said that he attempted to pull ahead of the Cavalier. This would have allowed him to move back into the left hand lane but instead he felt a severe impact on the nearside of his vehicle. There was contact between these two vehicles and they travelled a short distance in this manner.

[209] FF/U143 was asked why he didn't continue to accelerate past the Cavalier. He explained that he was trying to keep his vehicle on the road by steering in towards the Cavalier at the same time as he tried to get in front of it. Fearing that he may crash into a brick wall ahead, FF/U143 pulled back and allowed the Cavalier to move towards the centre of the road away from the verge. FF/U143 was asked why the brick wall posed as an obstacle to the vehicles if it wasn't protruding into the road. He explained that he was driving at speed, events were happening quickly and he considered that the wall was a safety concern. Consequently he lifted his foot off the car accelerator in order to avoid it.

[210] FF/U143 said that the driver of the Cavalier then lost control of his vehicle. It was travelling sideways up the road, passenger side first. FF/U143 said that the Cavalier skidded and spun 180 degrees. It came to a stop facing Call Sign

10, approximately 20 yards away. FF/U143 acknowledged that he couldn't say for certain if taking his foot off the accelerator put the Cavalier into a spin. FF/U143 stopped his car and he told me that he clearly heard the Cavalier revving.

[211] Call Sign 7 had overtaken both vehicles and blocked the road to the rear of the Cavalier. FF/U143 could see the driver of the Cavalier manoeuvring the gear stick, trying to select a gear. As the Cavalier started to move towards his police vehicle, FF/U143 told me that he drove into the Cavalier. He made contact with its front driver's wing and pushed the Cavalier towards the verge. He told me that both vehicles then came to a stop and FF/U143 believed that the vehicle pursuit was over.

[212] FF/U143 told me that GG/U137 and HH/U129 alighted from Call Sign 10 and ran towards the driver's side of the Cavalier. FF/U143 saw GG/U137 smashing the driver's window with his MP5 weapon. He was not aware where HH/U129 went to. FF/U143 could also see another police officer, who he later knew to be Mr. Paul Taylor, approaching the Cavalier from the passenger side. FF/U143 could hear police officers shouting warnings and instructions to the two men in the Cavalier.

[213] FF/U143 said that the Cavalier then suddenly flipped backwards to its left, at speed, and back onto the nearside lane. He saw Mr. Taylor being struck by the Cavalier and thrown backwards, approximately eight feet into the air. He saw Mr. Taylor landing heavily on the ground and he appeared to be hurt. FF/U143 observed that the Cavalier came to a stop but its engine was still revving flat out. At that stage he alighted from his own vehicle and saw Mr. Taylor lying injured on the road approximately 8 to 10 feet in front of the Cavalier.

[214] FF/U143 said that Mr. Taylor appeared to be unable to get onto his feet. FF/U143 was aware of the position of other officers and told me that KK/U208 was standing with his gun drawn in the aimed position, approximately 15 feet in front of the Cavalier. GG/U138 and HH/U129 were adjacent to the driver's door of the Cavalier, and both men had their MP5s at their shoulders and aimed into the vehicle. FF/U143 approached the rear of the Cavalier. He had his handgun drawn and in the aimed position, pointing into the Cavalier. FF/U143 was asked if he had considered firing his weapon. He said that he did not see a threat from anyone at the angle he was standing. He didn't see a need to fire.

[215] FF/U143 could see into the vehicle. He observed a lot of movement from the passenger who appeared to be waving his arms around. FF/U143 heard the Cavalier's engine revving, the two-tone police horns from his own vehicle and police officers shouting instructions at the occupants of the Cavalier. He then heard shots being fired. He didn't know if they had been fired by police officers into the Cavalier or fired by occupants of the Cavalier at police officers.

[216] Paul Taylor was the rear seat passenger of Call Sign 7. II/U219 was its driver and KK/U208 was the crew commander. Mr. Taylor gave evidence before me. He told me that while they were following the Cavalier, the call signs were being given updates by the RCG. He told me that the commander of Call Sign 10, GG/U137, was in charge of both Call Sign 7 and Call Sign 10 and also the tactic to be deployed. He also told me that he believed that GG/U137 had sought clarification from the RCG that the Cavalier was to be stopped from behind and that this was confirmed. He told me that he recalled a call sign asking for confirmation again from the RCG that the vehicle was to be stopped from behind and that this was again confirmed, however he could not recall if this was Call Sign 10 or another call sign.

[217] Mr. Taylor was asked whether the instruction to stop the car from behind emanated from the call signs and was approved by the RCG, or was an order from the RCG. Mr. Taylor explained that if GG/U137 was confirming with the RCG that the Cavalier was to be stopped from behind it would suggest that the instruction came from the RCG, but he could not recall having heard this instruction from the RCG. Mr. Taylor accepted that he could not give clear evidence on whether such an instruction was relayed to the call signs.

[218] Call Sign 7 was travelling behind Call Sign 10 and both cars caught up with the Cavalier. Mr. Taylor said that he saw Call Sign 10 move to the offside of the Cavalier and he saw something that was either a hand or gun barrel gesturing towards the Cavalier. He then noticed that the Cavalier started to slow down. It moved over to the nearside and then back across the offside. It rammed into Call Sign 10 in what he described as a side-by-side collision. Mr. Taylor then saw both the Cavalier and Call Sign 10 move to the offside. Call Sign 10 drove into the ditch beside the road. He explained that Call Sign 10 manoeuvred itself out the ditch and in doing so it hit the rear side of the Cavalier. This appeared to cause the Cavalier to spin. Mr. Taylor said that the Cavalier was facing the direction that it had just travelled from and was positioned bonnet-to-bonnet with Call Sign 10. Call Sign 7 passed both vehicles and pulled into the nearside lane, about two car lengths ahead of the position of Call Sign 10 and the Cavalier.

[219] Mr. Taylor got out of Call Sign 7 and was aware of a lot of noise from car wheels spinning and a siren. He ran around to the rear of Call Sign 7 and observed that the Cavalier had moved back to the left. It was now facing the hedge at a 90-degrees angle to the verge.

[220] Mr. Taylor told me that he saw two officers on the offside of the Cavalier. GG/U137 was standing at the driver's door. There was still a great deal of noise and GG/U137 was shouting armed police warnings. Mr. Taylor considered his main role to be control of the nearside of the Cavalier, in particular the passenger. He was asked why he considered this to be his main role when neither the Cavalier nor the driver were under control. He explained that he saw that two officers were dealing with the driver. He was

aware that there may be a firearm in the Cavalier. He considered that he had to take control of the passenger to control any risk from a firearm.

[221] He approached the Cavalier and stood slightly behind the passenger door. He shouted police warnings such as "Armed police, show me your hands, open the door." He told me that the passenger looked at him for a short time and then appeared to be looking or grabbing something in the foot well area of the car. Mr. Taylor considered that he needed to get control of the passenger as soon as possible. He pulled the door handle but it was locked.

[222] Paul Taylor was asked about his movements around the Cavalier after he emerged from Call Sign 7. He was referred to page 24 of the HMSU Special Operations training manual, exhibit C17, and specifically the role of the police officer described as 'Number 3' in the manual. The manual's instruction is that in a situation like this one, after exiting his own vehicle the Number 3 officer should take up a covering position at the rear passenger side of the suspect vehicle. When the officer has cover from a fellow officer and the driver of the vehicle is under control, he should move forward and deal with the person on the passenger side of the vehicle. In their written submissions I note the Next of Kin comment that that the officers' failure to comply with their training meant that officers put themselves at risk, enhancing the risk of recourse to lethal force and that Mr. Taylor is an obvious example. Mr. Taylor acknowledged that he moved forwards to deal with the Cavalier passenger without confirmation of cover from a fellow officer. However, he told me that he saw two officers dealing with the driver and there was nobody on the passenger side. Whilst the HMSU Special Operations training manual sets out a blueprint, he claimed that in an imprecise and changing situation officers have to adapt the manual's rules.

[223] Mr. Taylor said that he checked that the selector switch on his MP5 was set to safety and used its barrel to smash the passenger window behind the passenger's head. He said that the engine then appeared to go to full revs and everything just seemed to move into slow motion for him. He heard the sound of wheels spinning and realised that the incident was not over.

[224] Mr. Taylor explained that the Cavalier started to move backwards and anticlockwise. Its front wheels were on full lock. He saw the front of the vehicle coming towards him but it moved too quickly for him to get out its way. He said that he had tried to avoid being struck by the Cavalier. He intended to jump over its bonnet but the side wing of the Cavalier hit him around his knees and knocked him high into the air. He said that he felt the sensation of being high in the air and then the feeling of falling down to the ground.

[225] The evidence from the police witnesses about Mr. Taylor being hit by the Cavalier and being propelled into the air was challenged by the Next of Kin. In his statement, GG/U137 states that he saw Mr. Taylor at about head height. FF/U143 says that he saw Mr. Taylor as being approximately 8 foot in the air.

KK/U208 says that he saw the Cavalier strike Mr. Taylor knocking him up into the air above the bonnet and possibly higher than that. Mr. Taylor himself stated he was knocked high into the air. It is suggested by the Next of Kin that this evidence is exaggerated and also undermined by a lack of civilian witness corroboration. It is also suggested that the Cavalier had not moved at any great speed or distance before coming into contact with Mr. Taylor. At the same time it is not suggested that Mr. Taylor did not receive injuries as a result of contact with the Cavalier. I am quite satisfied that Mr. Taylor was knocked into the air by the Cavalier which not only suddenly moved but was turning and reversing so that Mr. Taylor was taken unawares. It must be remembered that the evidence from the police officers came from individuals who were looking at this matter from different angles. I am satisfied that it does not matter how high he may have been propelled into the air. I am satisfied that he was knocked off his feet and impacted the ground and further that the injuries that he sustained were consistent with those movements. I do not accept that this evidence is undermined by the lack of any civilian evidence. Individuals can only give evidence about what they have seen.

[226] Mr. Taylor gave evidence that he landed on the tarmac with his head facing towards the nearside verge. The Cavalier was facing its original direction of travel. Mr. Taylor told me that he held onto his MP5 and he saw rounds coming out of the magazine. He explained that he was lying across the road at a right angle on his back. As he looked to his left, he could see the Cavalier's grill and light clusters. Mr. Taylor said that he was a maximum distance of about 3 or 4 feet in front of the car. He described feeling dazed and very vulnerable. He knew that he was in extreme danger because the Cavalier still appeared to be at maximum revs.

[227] Mr. Taylor said he knew that if the Cavalier moved forward, it would have to drive straight over him to get away. He was aware that police officers were in the vicinity of the Cavalier. He told me that he kept thinking that the Cavalier's escape route would take it over him and around the back of Call Sign 7. He said that he tried to get onto his hands and knees and up onto his legs but he could not put weight on his right leg so he collapsed. At this point he told me that he was very frightened. He knew that he could not stand up so he tried to roll out of the way of the Cavalier. Mr. Taylor heard dull thuds and the engine noise stopped. He realised that someone must have been shot.

[228] I heard evidence from KK/U208 who was the crew commander of Call Sign 7. II/U219 was his driver and Mr. Taylor was the rear seat passenger of Call Sign 7. KK/U208 described his role as crew commander. He was responsible for operating the radio, reading the maps and making decisions about the actions of the vehicle. KK/U208 recalled receiving a message from EE/U118 at approximately 7pm, that the Cavalier was to be stopped. He said that Call Sign 7 travelled at speed towards the Cavalier's location and he described to me the route that it followed.

[229] When KK/U208 saw the Cavalier he turned off the warning equipment in Call Sign 7. He described seeing Call Sign 10 pull alongside the Cavalier. He said that at that point his understanding was that the Cavalier was now going to be stopped from behind. KK/U208 said that Call Sign 7 was about 20 metres behind the two vehicles and his vehicle took up a position in the centre of the road. He told me that he expected Call Sign 10 to overtake the Cavalier and then pull in front of it. He saw the Cavalier ramming into Call Sign 10. For a short period of time both cars continued travelling along the road in contact with each other. The Cavalier then drove in front of Call Sign 10. It entered a spin and ended up facing Call Sign 10 nose-to-nose, travelling down the road and backwards. KK/U208 could not assist me any further with the exact manoeuvres of the Cavalier and Call Sign 10 and how they ended up in their final resting place. Call Sign 7 passed both Call Sign 10 and the Cavalier and pulled into the left, in an attempt to block the road.

[230] KK/U208 told me that Call Sign 7 stopped about 10 to 15 metres in front of the two vehicles. He got out of his car and took his personal issue firearm with him. He approached the driver's side of the Cavalier and he saw Mr. Taylor approaching its passenger's side. KK/U208 said that he heard police officers shouting warnings. He could smell burning tyres and he noticed smoke. He could not explain how the tyres of the Cavalier could have been spinning if it wasn't in gear. He estimated that the distance between himself and Mr. Taylor was five to seven metres. KK/U208 described that the Cavalier suddenly shot backwards. He observed that it struck Mr. Taylor. It knocked him up into air, above the bonnet and possibly higher than that.

[231] He saw Mr. Taylor then hitting the ground. KK/U208 moved slightly to his right and he was facing the Cavalier. He had drawn his handgun and he was pointing it at the driver. He said that he decided if the driver got the Cavalier into gear and drove forward, he was going to shoot him to prevent himself being seriously injured or killed. KK/U208 acknowledged that he drew and aimed his gun at the driver of the Cavalier, because of concern for himself, not for Mr. Taylor. He could not recall whether he considered taking evasive action to protect himself. He then heard three to four shots being fired.

[232] II/U219 was the driver of Call Sign 7. KK/U208 was its crew commander and Mr. Taylor was the car's rear seat passenger. II/U219 was an advanced driver. He told me that although he had received training for vehicle check points, he had no specific training for the manoeuvre carried out in this incident. II/U219 told me that instructions came over the radio from the RCG that the Cavalier was to be stopped. He told me that Call Sign 10, which he described as the lead vehicle, sought clarification that it was OK to stop the Cavalier from behind. This was confirmed, although he acknowledged that he didn't know what the decision-making process had actually been.

[233] II/U219 described the route that he travelled to the Crumlin Road where he observed the Cavalier. He told me that he saw Call Sign 10 driving alongside the Cavalier for a brief period of time. The crew commander of Call Sign 10

identified himself as a police officer. As he understood events Call Sign 10 was then going to accelerate and pull in front of the Cavalier. II/U219 acknowledged that this was a manoeuvre that he had not received any specific training on. II/U219 saw the Cavalier hitting Call Sign 10. This resulted in the Cavalier cutting across in front of Call Sign 10 before it went into a spin. II/U219 had no specific recollection of how the Cavalier and Call Sign 10 ended up in their final resting places. II/U219 drove Call Sign 7 past both vehicles and pulled into the nearside of the road. II/U219 was asked about the purpose of overtaking the vehicles and he explained that he intended to block the Cavalier to prevent it from effecting an escape.

[234] II/U219 was aware that KK/U208 and Mr. Taylor had exited from Call Sign 7. He told me that he had stalled Call Sign 7 when he stopped it. He focused on restarting the engine so he could respond to any movement of the Cavalier, although he didn't actually see the Cavalier at that point. In her written submissions Ms. McCann comments that it is strange that II/U219 lost sight of the Cavalier and that it should have been his primary focus; if he did not know where the target vehicle was then he could not effectively position his vehicle to block the target vehicle in. II/U219 restarted Call Sign 7 and started to reverse it when he heard shots.

[235] HH/U129 gave evidence to me. He was the rear seat passenger of Call Sign 10. GG/U137 was the crew commander and FF/U143 was the driver. He described to me that during the course of this operation at 6.55pm, the call signs were directed to stop the Cavalier. HH/U129 was asked about this direction. He said that as far he was aware, the RCG was aware of the tactic to be used to stop the vehicle and had approved it.

[236] He described being in pursuit of the Cavalier towards Glenavy and then driving behind it on the Crumlin Road. He then told me that at 7.10pm as the convoy of vehicles approached a straight stretch of road, Call Sign 10's two tone horns were switched on and FF/U143 pulled the police vehicle alongside the Cavalier.

[237] HH/U129 saw that GG/U137 had indicated to the driver of the Cavalier to stop. However, the Cavalier swerved over towards Call Sign 10 and collided with its near side, forcing the police vehicle towards the right hand verge. Thereafter he described how the two vehicles collided again and the Cavalier lost control, before coming to a stop. HH/U129 told me that Call Sign 10 also came to a stop. He immediately got out of the police vehicle with GG/U137 and he went to the front of the Cavalier.

[238] HH/U129 was asked to explain why they both exited their police vehicle when it appeared from the position of Call Sign 7 that it wasn't blocking the Cavalier in, and thereby preventing it from moving. HH/U129 said that because the Cavalier had been in a collision there was a question around whether it was still capable of being driven. His action was the quickest way of getting control of the occupants and the situation. He told me that he

thought the Cavalier was immobilised and it wasn't until he was moving towards it that he heard the revving of its engine.

[239] As he approached the front of the Cavalier, HH/U129 told me that he took off the safety catch of his MP5 weapon. He intended to put it into single shot mode, and he brought it to his shoulder position to cover the occupants of the Cavalier. HH/U129 acknowledged that he did not take the safety catch off his weapon because there was a specific threat from the Cavalier. He explained that there was a threat because of the contact between the Cavalier and Call Sign 7. In addition he said it was suspected that the Cavalier contained a firearm. HH/U129 also told me that it was general practice when you stopped a vehicle in these circumstances that police would bring their firearms into the aim position to exercise control over the driver or occupants.

[240] HH/U129 rejected the suggestion that he could only be justified in taking the safety selector off his gun if he had concluded that he would be justified in opening fire. HH/U129 insisted that taking the safety selector off his gun with a bullet in the chamber was standard operational procedure in those circumstances. No documentary or other evidence was provided to me to confirm this. I heard from another officer, GG/U137, on this point. He told me that he specifically ensured that the safety switch of his MP5 was on when he emerged from the police vehicle and he only removed it when he intended to open fire. Additionally, Mr. Taylor had also checked that his MP5 safety switch was on before he used his weapon to smash the passenger side window.

[241] HH/U129 said that he was aware that GG/U137 had broken the driver's side window with his MP5. He told me that the engine of the Cavalier was revving, and its driver appeared to be getting or attempting to get the vehicle into gear. He said that the Cavalier suddenly started to reverse at speed. It knocked GG/U137 out of its way and an officer, who he later knew to be Mr. Taylor, was flung several feet into the air. He said that the Cavalier came to a sudden halt, but the engine continued to rev. He ran to the driver's side window shouting "Armed police, stop" several times but the driver continued to work at the gear stick.

[242] HH/U129 said that he noticed Mr. Taylor lying to the front of the Cavalier in the vehicle's intended travel path. He noticed another officer to his right, in the general path of escape for the Cavalier. HH/U129's MP5 was still at his shoulder and was aimed towards the Cavalier. He said that the driver was still putting the Cavalier into gear. He felt that if the Cavalier moved at all it would run over and seriously injure or kill Mr. Taylor. It was suggested to HH/U129 that he could have run forward from his location and assisted Mr. Taylor in getting off the road. HH/U129 rejected that suggestion. He said that he was positioned sideways at the driver's window and Mr. Taylor was some eight to ten feet away from him. It would have been impracticable to

help him. Additionally the Cavalier was revving highly and its driver was working at the gear stick.

[243] HH/U129 told me that he was aware of another police officer to the left of his position. He didn't know if that officer was positioned forwards of him because his attention was focused on the driver of the Cavalier and Mr.Taylor on the ground. HH/U129 did not accept that GG/U137 was closer than him to the driver of the Cavalier and therefore in the prime position to exercise control of the driver. HH/U129 said that he was not aware that GG/U137 had his weapon in the aimed position and was in a position to fire towards the driver. HH/U129 told me that he felt the only option he had was to discharge his MP5, so he fired what he considered at the time to be an aimed shot at the driver. HH/U129 said that before firing his weapon he shouted at least four or five warnings to the driver and that there had been lots of shouts by other armed police.

[244] In their written submissions the Next of Kin recount that while GG /U137 and KK/U208 were both prepared to deploy lethal force, this was contingent on movement of the car that posed a threat to Mr. Taylor. HH/U129 told me that, with the benefit of hindsight, even now he believed that there was no other option available to him except to discharge his weapon.

[245] HH/U129 said that he intended to fire only one shot but when he pulled the trigger of his MP5, he immediately realised that the fire selector was on fully automatic mode because he felt the recoil in the weapon. He immediately released the trigger. He believed that he had fired three or possibly four aimed shots at the driver and that he was four to five feet away from the driver's door when the shots were discharged.

[246] HH/U129 confirmed that HMSU officers were the most highly trained firearms officers within the PSNI. On the date of the shooting he had been a serving police officer for 15 years. He confirmed that he had operated within this specialist HMSU unit for six months at the time of this incident and had previously operated in it for five years. I received a copy of HH/U129's training records. I note that he had received training in the use of the Heckler & Koch MP5 weapon and indeed on 25 April 2003, just 4 days before this incident, he had passed a further assessment in relation to the MP5 with a 100% success rate.

[247] I have already referred to the law and I must give consideration to whether HH/U 129 was justified in opening fire on 29 April 2003. The law permits an individual to use force, including the use of a weapon, when that individual honestly believes that it is necessary to do so to defend himself or another. The level of force used in such circumstances must be no more than is absolutely necessary.

[248] The law has developed in such a way that there are two questions that I must ask myself. The first question is whether HH/U129 held an honest and

genuine belief that it was necessary for him to use force. The second question that I must ask myself is whether the level of force was absolutely necessary for the achievement of, in this matter, the defence of another person from unlawful violence. To put it another way, as I have already done earlier whether in all the circumstances it was proportionate, that is reasonable, having regard to everything that HH/U129 honestly and genuinely believed.

[249] It is clear that in relation to the first question the focus is on the subjective belief of HH/U129 and therefore one has to carefully consider and examine the circumstances pertaining at the time. HH/U129 was at the time a police officer in the PSNI and served in the HMSU. On 29 April 2003 he was on duty and was one of several officers engaged in what is called a 'fastball operation'. The details of this have been set out above but suffice to say he was the rear seat passenger in one of two call signs which received an order to stop a Cavalier in which it was believed there was an firearm.

[250] The officers involved attempted to stop the Cavalier but this was only partially successful as the driver of the Cavalier sought to escape by driving the vehicle away from the location where the attempted stop had taken place. I note the written submisisons by the Next of Kin that the police had not effectively boxed the Cavalier in as they should have done and then compounded that failing by exiting their vehicles without taking further steps. When the Cavalier and the two police vehicles were thought to have come to a halt five of the six police officers got out of their vehicles. One of these officers, Mr. Paul Taylor, was on the passenger side of the Cavalier when it carried out a manoeuvre known as a J-turn. This caused Mr. Taylor to be struck and he was knocked down and found that he was unable to move from the position that he found himself in. The Next of Kin and Ms. McCann queried the extent of Mr. Taylor's injuries. PSNI recount his documented injuries in its written submissions and note that they are consistent with Mr. Taylor's account that he initially found great difficulty in trying to get to his feet at the scene, and that he collapsed because he could not put weight on his right leg.

[251] HH/U129 had seen Mr. Taylor being struck and said that he was flung into the air several feet. HH/U129 says he ran round the back of his police car and went to the driver's side window. He shouted "Armed police, stop" several times but during this time the driver did not look at him and continued to work with the gearstick. The engine was revving and it was clear that the driver was attempting to drive the vehicle away from where it was. He said he noticed Mr. Taylor lying to the front of the Cavalier in the vehicle's intended travel path. He said that the driver was still trying to put the Cavalier into gear and he came to the conclusion that if the Cavalier moved it would run over and seriously injure or kill Mr. Taylor. It was suggested to HH/U129 that he could have run forward and in some way rescued Mr. Taylor from this position in front of the Cavalier. He said that was not practicable as he was sideways on at the driver's window, the driver was revving the car and working at the gearstick.

[252] In all the circumstances as presented to HH/U129 on the day in question I find that he did have an honest belief that it was necessary to use force for the purpose set out in Article 2 (2) (a) of the European Convention on Human Rights, namely the defence of another – in this case Mr. Paul Taylor.

[253] Having come to the conclusion that I have that HH/U129 had an honest belief that it was necessary to use force I then have to consider the second question which I have referred to above which is whether the level of force used by HH/U129 was no more than absolutely necessary. As I have stated this is an objective test. It is necessary to consider the options that might have been available. It might be arguable that he could have done nothing but I have already decided that he honestly believed that it was necessary to use force so that does not arise. Similarly the question of rescuing Mr. Taylor is not something that was a realistic option. The possibility or otherwise of shooting out the tyres was at one time suggested in evidence but GG/U137 explained that the police were using fully jacketed rounds which meant that if one was fired into a wheel you did not know where that round would go and therefore it was not an option. It was also suggested that the driver could have been pulled out of the car but efforts in this regard had failed. He could have been hit on the head by a gun butt but this was dismissed as being impractical as the weapons were on slings and the officers had not been trained in such a tactic. It is also quite clear that time was of the essence in that a decision had to be made as to what could or should be done. Indeed HH/U129 said that the whole incident from getting out of the police vehicle to discharging his weapon was a matter of seconds.

[254] It is not irrelevant to my consideration of the second question that GG/U137 had come to a similar conclusion and had taken his weapon off safety – had shouted another warning to the driver and was preparing to fire when he heard shots fired by HH/U129. Similarly KK/U208 who was in a position facing the Cavalier had come to the view for his own self-preservation that he would fire his handgun at the Cavalier if it moved forwards towards him.

[255] I also take into account the fact that HH/U129 was an experienced officer with an unblemished record. He had never previously had to fire a weapon while on duty. He has also been consistent with his version of events through a note book entry, his interview with PONI and his evidence at this inquest.

[256] I have considered carefully all these matters and have come to the conclusion that the level of force used by HH/U129 was no more than was absolutely necessary. Bearing in mind that the onus of proving that Artice 2 has been complied with lies on the state, I am satisfied that HH/U129 was justified in using lethal force as he did on the day in question.

Post Discharge of Police Weapon

[257] Paul Taylor gave oral evidence that when the shots were discharged by HH/U129, he was still on the ground and he could not recall if he managed to get to his feet by himself or if he was helped. He felt like both of his legs were numb. He recalled looking up at the scene and he saw that the driver of the Cavalier was out of the car and on the ground. He saw HH/U129 providing cover to the driver and GG/U137, on the passenger side. Mr. Taylor said that he was very dazed at this time and he was only able to focus on one thing at a time. He had a recollection of picking up the magazines from the floor and placing them back in his gun but he did not remember if he picked up the loose rounds. Mr. Taylor said that he made his way over to HH/U129 who was with the driver of the Cavalier because someone had shouted for a medic. HH/U129 told Mr. Taylor to deal with Mr. McConville but Mr. Taylor said that he was injured. Mr. Taylor recalled HH/U129 saying that he couldn't deal with Mr. McConville any further himself because he was "too involved". Although Mr. Taylor felt dazed and was in a lot of pain, he asked for a medical pack and administered First Aid to Mr. McConville. He recalled that Mr. McConville's pulse was weak and that his breathing was shallow. He cut off Mr. McConville's sweatshirt and saw gunshot wounds to his right side, at the upper chest area. SS/U209 then took over the administration of First Aid to Mr. McConville.

[258] Mr. Taylor recalled his colleagues preparing a vehicle so that Mr. McConville could be placed flat in the back of it and taken to hospital. He recalled that SS/U209, QQ/U111 and YY/U123 were involved in this, and Mr. McConville was placed into the rear of the car whilst officers continued to administer first aid to him. Mr. Taylor got in the same vehicle and the car left the scene, travelling to Craigavon Area Hospital. In the area of the Airport Road, Mr. McConville's breathing became very shallow and then stopped. SS/U209 and Mr. Taylor administered chest compressions and around that time, the officers flagged down an ambulance that had been dispatched to the scene. Two paramedics extracted Mr. McConville from the police vehicle and placed him into the ambulance telling police that he would be taken to Lagan Valley Hospital. The police vehicle accompanied the ambulance to the hospital where Mr. Taylor received medical attention.

[259] The following day, 30 April 2003, Mr. Taylor attended with his General Practitioner and I heard evidence regarding his physical and psychiatric injuries in the period after this incident. Mr. Taylor was on sick leave from duty for approximately three months.

[260] I heard evidence from KK/U208 about events leading up to the shots being fired. KK/U208 told me that directly after the shots were fired, everything went quiet and he put his handgun away. In the background he heard EE/U118 calling him on his police vehicle radio for an update. KK/U208 spoke on the radio with EE/U118 and confirmed that the Cavalier had been stopped in the stated location, using the nearest pub as a reference point. He

also confirmed that shots had been fired. KK/U208 remained on the radio with EE/U118 and provided a commentary to the events as they unfolded. KK/U208 saw that FF/U143 had taken the vehicle passenger to the nearside verge and he appeared to be injured to his arm. The passenger was making a lot of noise and KK/U208 formed the opinion that he was not seriously injured.

[261] He also noticed that the driver was positioned on the ground between Call Sign 10 and the Cavalier and was being tended to by Paul Taylor and a number of other officers. He formed the opinion that the driver was seriously injured. KK/U208 relayed these facts to EE/U118 and requested an ambulance. KK/U208 saw other call signs arrive at the scene with trained medics. KK/U208 gave EE/U118 an exact location for the incident using a map reference.

[262] KK/U208 recalled seeing Paul Taylor walking around and holding his arm. The police logbook entry for 7.19pm records that Mr. Taylor had been removed from the scene and taken to hospital by Call Sign 7. This logbook entry conflicts with other information I heard in relation to Mr. Taylor being taken to hospital in the same police vehicle as Mr. McConville. That vehicle was Call Sign 1. KK/U208 was the officer relaying information from the ground to the control room but he could not assist me on this point. He recalled that he left the scene approximately 10 to 15 minutes after he had assisted in preparing a police car to be used to transport Mr. McConville to hospital.

[263] II/U219 provided oral evidence to me about events up to and including when he heard shots being fired. He told me that shortly after he heard the shots he got out of his vehicle with his MP5 weapon and went around the back of the Cavalier. The Cavalier was facing towards his car on the nearside of the road, at an angle towards the offside. As he ran towards the vehicle II/U219 saw two police officers, one at each door of the Cavalier. II/U219 took up a covering position at the front of the Cavalier, pointing his weapon at the driver. The Cavalier was moving forward very slowly. He put a foot up and halted this movement.

[264] II/U219 confirmed that he did not see Paul Taylor on the ground. He also did not see Mr. Taylor coming into contact with the Cavalier. He saw a police officer helping the driver out of the car and placing him on the ground near to Call Sign 10. He then moved past the man on the ground and proceeded to ask Call Sign 10 to turn off the warning equipment. When he returned to the man on the ground he saw that GG/U137 was dealing with him. The man had been shot and looked seriously injured.

[265] II/U219 ran back to his vehicle and retrieved his First Aid kit. He placed his weapon in the back of his vehicle. He returned to the casualty and saw that Paul Taylor was assisting GG/U137 to administer First Aid to him. When he arrived GG/U137 left, and II/U219 assisted Mr. Taylor with the

administration of First Aid. Mr. Taylor indicated to him that he had been hit by the Cavalier but he could continue to assist with the casualty. II/ U219 did so by placing a neck collar on the casualty. He noticed that he was very pale and appeared to have bullet wounds to his right upper arm and chest.

[266] Other police units arrived and assisted with the casualty. II/U219 continued to talk to him because he seemed to remain conscious. When more medics arrived II/U219 and Paul Taylor moved away from the casualty. Paul Taylor indicated to him again that he had been hit by the Cavalier and that he required hospital treatment. II/U219 recalled Paul Taylor telling him that when he was struck by the Cavalier, the magazine came off his MP5 weapon and hit the road. Mr. Taylor could recall seeing rounds coming out of the magazine and falling onto the ground. II/U219 took possession of Mr. Taylor's MP5 weapon and personal issue handgun and placed them in his own vehicle.

[267] Around this time, II/U219 was approached by GG/U137 who handed him a piece of paper that contained details of one of the casualties. II/U219 relayed those details over the police radio to the control desk. He then returned to the injured driver and helped to place him into the back of the police car.

[268] II/U219 recalled recovering his own MP5 weapon and Paul Taylor's MP5 weapon and handgun. He then left the scene with officers KK/U208, GG/U137, FF/U143 and LL/U113.

[269] GG/U137 told me that when the shots were fired he saw the driver, Mr. McConville, slumped back into his seat. His hand fell away from the steering wheel. GG/U137 placed his own weapon on the safety setting and opened the driver's door. He saw that Mr. McConville had a hole in his right upper arm. He was still conscious with his eyes open. GG/U137 took him by the arm and helped him out of the vehicle. Mr. McConville walked with him for about two metres towards Call Sign 10. GG/U137 then placed Mr. McConville on the road.

[270] GG/U137 told me that he continually tried to talk to Mr. McConville to establish the extent of his injuries. During this time he shouted for a medic. Two officers from Call Sign 7 joined GG/U137 and assisted with the administration of First Aid to Mr. McConville. GG/U137 noticed that Mr. McConville had two wounds to his right arm. He recalled that he had a wound to his upper chest area but could not recall to what side. The two officers from Call Sign 7 who had joined GG/U137 were qualified medics so he left them to deal with Mr. McConville and he joined FF/U143 who was dealing with the passenger. They were positioned in the verge area just in front of the Cavalier. GG/U137 saw that the passenger had gunshot wounds to his upper and lower left arm. GG/U137 tried to engage him in conversation to try to obtain his friend's identity but the passenger did not reply to him and continued to shout. GG/U137 obtained some field dressings

from the officers who were attending to Mr. McConville, and he assisted FF/U143 in applying these to the passenger.

[271] GG/U137 returned to his vehicle, placed his MP5 weapon into it and radioed the control desk to provide it with an update. He then returned to FF/U143 and continued to assist him with the passenger. Other police units with medics on board arrived to the scene and they appeared to take over the application of First Aid to both injured parties.

[272] GG/U137 looked into the passenger side of the Cavalier and saw a long thin item wrapped in a nylon windcheater. It was between the front seat and the gear stick, pointing in the general direction of the roof. GG/U137 loosened the windcheater at the top of the item and peeled back some newspaper that the item was wrapped in so that he could see it. Inside was a single barrel of what GG/U137 believed to be a shortened shotgun with a ribbed four grip. He did not touch the shotgun any further and left it in situ. He shouted a warning to his colleagues that there was a weapon in the vehicle and radioed this information into the control desk. GG/U137 did not recall whether he reported the casualties to the control desk but accepted that he probably did not do so because this was not in his statement.

[273] U202 assumed the role of scene liaison officer and GG/U137 gave him a briefing. GG/U137 recalled Mr. McConville being placed into the police vehicle, a silver Mitsubishi Gallant estate. Accompanied by a number of medics it left the scene and transported Mr. McConville to hospital. There was no ambulance, and the passenger was also taken from the scene in a police vehicle.

[274] When Mr. McConville and Mr. Somers left the scene, GG/U137 received medical treatment from LL/U113, for a cut finger. He left the scene and travelled to Ladas Drive PSNI Station where he booked in his MP5 weapon and two magazines, each containing 28 rounds of 9 millimetre ammunition. He was later seen by a force medical officer and he went off duty at 11pm.

[275] FF/U143 told me that after the shots were fired, everything seemed to stop and the engine noise of the Cavalier died completely. FF/U143 could hear police shouting instructions at the occupants of the Cavalier and he saw GG/U137 and HH/U129 approach the driver's door. At this point, FF/U143 believed that it was safe to approach the Cavalier and take control of the passenger. As he approached the passenger door from the rear of his vehicle, FF/U143 still had his handgun drawn and aimed at the passenger.

[276] FF/U143 informed the passenger that he was an armed police officer and instructed him to get out of the vehicle and to show his hands. FF/U143 could see something concealed under a light jacket in the passenger footwell, between the passenger's legs. The passenger, who he later knew to be David Somers, did not comply with the instruction but remained in the passenger seat, screaming and waving his hands.

[277] FF/U143 pulled Mr. Somers out of the car through the open window. He placed him on the ground and treated his injuries. He found what appeared to be bullet wounds in Mr. Somers' left forearm and upper arm. He checked the rest of Mr. Somers' body for further injuries but found none. FF/U143 had his own First Aid field dressing and treated Mr. Somers' injuries with this, applying pressure to the wounds. FF/U143 was aware that the driver of the Cavalier had been seriously injured. He was aware that officers had removed him from the car and were attempting to treat his wounds. When other police officers arrived UU/U130, who FF/U143 knew to be a trained medic, approached FF/U143 and took over the treatment of Mr. Somers.

[278] FF/U143 assisted other officers to place Mr. McConville into the rear of a police vehicle so that he could be conveyed to hospital. FF/U143 returned to his vehicle and secured his MP5 weapon in the boot. He locked the vehicle and left the scene at 7.37pm.

[279] HH/U129 did not provide a statement to my investigator but his interview with the Police Ombudsman was read into evidence at this inquest. He provided oral evidence to me about events during the course of 29 April, 2003 including the shooting. He told me that after he discharged his weapon he saw GG/U137 approach the Cavalier. GG/U137 removed the driver from the vehicle. He later knew this to be Neil McConville. He also saw FF/U143 remove the front seat passenger, who he later knew to be David Somers, from the vehicle.

[280] Initially HH/U129 assisted Paul Taylor and II/U219 in administering First Aid to Mr. McConville. U202 gave evidence before me that he had placed HH/U129 in a police vehicle and placed his MP5 weapon in the rear of that vehicle. U126 arrived to the scene and removed HH/U129 from the vehicle that he was in. He placed HH/U129 and his weapon in U126's vehicle and transported him to Ladas Drive PSNI Station. At 8.45pm HH/U129 was assessed by a force medical doctor to be unfit for duty. He was off duty for approximately two weeks, although he did attend the debriefing on 30 April 2003.

[281] TT/U221 provided oral evidence to me that on 29 April 2003 he was a police constable attached to Mahon Road PSNI Station, Portadown. He was the driver of Call Sign 1 and was accompanied by MM/U203 and U213. At approximately 4.30pm he was briefed by U201 about a crime operation in the Craigavon area. Call Sign 1 was deployed into the Craigavon/Sprucefield area and at approximately 4.45pm TT/U221 received a further radio transmission from EE/U118. Consequently he deployed into the Lisburn/Belfast areas.

[282] At approximately 7pm TT/U221 received a further radio transmitted message to stop a Cavalier, LDZ 2687, which was in the area of Sheepwalk Road, Lisburn. At approximately 7.05pm further radio transmissions informed him

that other police call signs were in pursuit of this vehicle. A short time later he was made aware, via a radio transmission that this vehicle had been stopped. There had been injuries and shots had been discharged. The location of the incident was on the road to Crumlin from Aghalee, adjacent to McIlroy's public house. MM/U203 directed Call Sign 1 to this area and it arrived a short time later.

[283] When they arrived at the scene, MM/U203 and U213 alighted from Call Sign 1 to provide assistance. MM/U203 then returned to the vehicle and directed that TT/U221 reverse the vehicle up to a male person who was lying on the road. TT/U221 was informed that this person had been shot, was seriously ill and had to be evacuated from the scene. TT/U221 helped to remove equipment from the rear of the vehicle and folded down the rear seats to create the necessary space. He observed other police officers lifting and carrying this person and place him in the rear of Call Sign 1.

[284] Also with this person in the rear of Call Sign 1 were QQ/U111, YY/U123, SS/U209 and Paul Taylor. MM/U203, who was in the front passenger seat, instructed TT/U221 to drive to the Accident and Emergency Department of Lagan Valley Hospital, Lisburn. TT/U221 told me that he was a grade 1 advanced driver.

[285] TT/U221 intended to drive along the main A26 road towards Moira Roundabout and then along the motorway, towards Lisburn. On the Airport Road near Moira, Call Sign 1 met with an ambulance that was en route to the scene. This ambulance stopped, and the injured party was transferred to it. TT/U221 was not able to recall if he spoke with the ambulance personnel nor could he recall if he knew Mr. McConville's name at that point. Call Sign 1 drove at speed in front of the ambulance towards the hospital. It was the fastest possible speed that allowed the ambulance to keep in touch with it. On arrival at the hospital, the injured party was admitted for further treatment. TT/U221 was made aware that Paul Taylor had also been admitted for treatment to the injuries that he had received at the scene.

[286] Some time thereafter TT/U221 handed the key of Call Sign 1 to a Reserve Constable from Lisburn Police Station. When he left Lagan Valley Hospital, TT/U221 went to Ladas Drive Police Station where he was seen by the Force Medical Officer. He then returned to Mahon Road Police Station.

[287] The statement of MM/U203 dated 14 May 2003 was read into evidence under Rule 17. It records that he was stationed at Mahon Road Police Station. On 29 April 2003 at approximately 7pm, he arrived at the scene of an incident on the Crumlin Road Ballinderry, close to the Horseshoe Bar. He was accompanied by U213 and TT/U221. On arrival at the scene, MM/U203 was aware that one male person had been shot and was seriously injured. It was obvious from those attending to this man that he needed to get to hospital as soon as possible. MM/U203 instructed his crew to put the rear seats of his Mitsubishi Gallant estate into a prone position. Other officers then

lifted this injured person into the vehicle. QQ/U111, YY/U123, SS/U209 and Paul Taylor got into the car with him. MM/U203 instructed TT/U221 to drive to the Lagan Valley Hospital. During the journey, MM/U203 saw SS/U209 and Paul Taylor giving mouth to mouth resuscitation to the injured person.

[288] Somewhere along the Airport Road, MM/U203 stopped an ambulance that was on route to the scene and the injured person was transferred into this vehicle. MM/U203's vehicle then escorted the ambulance to the Lagan Valley Hospital. At the hospital, MM/U203 gave his police vehicle over to another officer as part of the investigation. He then left the hospital and went to Ladas Drive Police Station.

[289] The statement of U213, dated 14 May 2003 was read into evidence under Rule 17. It records that he is a Constable and on 29 April 2003 he was on mobile deployment in the Belfast area accompanied by MM/U203 and TT/U221. At approximately 7pm they received a radio transmission instructing call signs to stop a Cavalier registration number LDZ 2687, which was in the area of Sheepwalk Road, Lisburn. U213 then heard on a radio transmission that other call signs were in pursuit of LDZ 2687. He was then made aware that this vehicle had been stopped, shots had been fired and that persons had been injured. This had occurred on the road between Aghalee and Crumlin, close to McIlroy's pub. U213, MM/U203 and TT/U221 were directed to the scene and arrived a short time later.

[290] On arrival at the scene, U213 spoke briefly to Paul Taylor who was walking towards him with an injured arm. U213 was aware of a person lying beside a green Omega car. A number of officers were treating this person who was injured. U213 went to the assistance of another person, who he later learned was David Somers. He was injured and lying on the grass verge. A number of other officers were already dealing with Mr. Somers and U213 could see that Mr. Somers already had two field dressings on his arm. Mr. Somers was conscious and was making groaning noises. U213 stayed with him and monitored his vital signs while UU/U130 checked over the rest of his body.

[291] U213 observed bruising on Mr. Somers' chest and a decision was made to remove him from the scene. U213 was aware of another casualty being removed from the scene. U213 assisted UU/U130 with Mr. Somers, who was capable of walking. They placed him in the rear of a police vehicle to transport him to hospital. UU/U130 and XX/U223 got into the rear of the vehicle beside Mr. Somers.

[292] U213 remained at the scene with U202 and VV/U217, and they sealed the scene. While at the cordon U213 spoke to a number of persons and two of them said that they had witnessed the incident. He heard a phone ringing from inside the Cavalier a number of times, shortly after scene had been secured. Other police officers arrived and took over the cordon. When CID officers arrived, U213 gave them details of the witnesses. U213

remained at the scene until it was handed over by U202 to other police officers. He returned to Mahon Road Police Station.

[293] I heard evidence from QQ/U111 that on 29 April 2003 he was a Sergeant in the PSNI. At approximately 7.10pm he attended the Crumlin Road, Ballinderry with YY/U123 and UU/U130 as part of Call Sign 2. On arrival there he was told that two individuals had been shot, and he saw them being given First Aid by other police officers. He delivered a First Aid box to one casualty, who he later learned was Mr. McConville. He applied bandages and pressure to Mr. McConville's upper right arm while Constable YY/U123 applied a dressing and pressure to his left side. QQ/U111 told me that Mr. McConville was very pallid, and he was made aware that his pulse was weak at the wrist. QQ/U111 was aware that a helicopter had been used to follow Mr. McConville but he did not recall seeing it when he was at the scene.

[294] QQ/U111 told me that Sergeant LL/U113 took on the role of medical manager and made the decision to move Mr. McConville to a hospital. QQ/U111 got into the vehicle with Constable YY/U123, SS/U209 and Paul Taylor. SS/U209 maintained the airway while the others kept the pressure on the Mr. McConville's wounds. QQ/U111 said that Mr. McConville's pulse got weaker and eventually could not be found. He said that SS/U209 gave mouth to mouth resuscitation to Mr. McConville while Paul Taylor applied compressions to him.

[295] QQ/U111 described how the police vehicle met an ambulance on the main Moira to Nutts Corner Road. He did not know if this meeting had been arranged but Mr. McConville was transferred into the ambulance. He said that he travelled in the ambulance with YY/U123. YY/U123 assisted with the oxygen mask while he ventilated Mr. McConville via an air bag. He told me that Mr. McConville was connected to a machine in the ambulance but he displayed no vital signs. Nonetheless, ventilation and compression was continued until the ambulance reached Lagan Valley Hospital and Mr. McConville was handed over to hospital staff there.

[296] I heard evidence from YY/U123 that on 29 April 2003 he was a Constable on duty and the driver of Call Sign 2. He was accompanied by QQ/U111 and UU/U130. He was the team medial officer. He arrived at the Crumlin Road, Ballinderry at approximately 7.10pm. He saw the Cavalier car sitting on the left-hand side of the road and there were two police vehicles in close proximity to it. He saw a male sitting at the side of the road and FF/U143 was administering First Aid to him. He saw another male, who he later learned was Mr. McConville, lying on his back with his head being supported. YY/U123 said that he observed a puncture wound on Mr. McConville's upper left side to which he applied a First Aid field dressing. He kept it in place using direct pressure. He surveyed Mr. McConville's legs but could not find any injuries to them. YY/U123 told me that Mr. McConville was still conscious at that point and was quite irate. However, he

became quiet very quickly thereafter. YY/U123 didn't recall what it was that Mr. McConville was shouting.

[297] YY/U123 stated that LL/U113 made the decision to move Mr. McConville to hospital in the rear of one of the police vehicles because his condition was deteriorating. YY/U123 could not recall if there was any discussion about using the helicopter to evacuate Mr. McConville to hospital. YY/U123 assisted in lifting Mr. McConville into the rear of the Mitsubishi police vehicle, keeping pressure on the wound all of the time. Whilst in the vehicle, he kept direct pressure on the wound and checked Mr. McConville's radial pulse.

[298] YY/U123 said after a short time in the vehicle he could not detect Mr. McConville's pulse. He had stopped breathing. CPR was commenced. SS/U209 was breathing for Mr. McConville, Paul Taylor was doing chest compressions and QQ/U111 was keeping direct pressure on Mr. McConville's other wounds on his right side. YY/U123 told me that the police vehicle met an ambulance, but he didn't know if it was a pre-arranged meeting.

[299] Mr. McConville was transferred from the police car into the ambulance. YY/U123 stayed with Mr. McConville until the ambulance arrived at Lagan Valley Hospital. He assisted the ambulance paramedic by holding a mask on Mr. McConville's face. QQ/U111 squeezed the bag and the paramedic carried out chest compressions.

[300] The statements of UU/U130 were read into evidence under Rule 17. The first statement is dated 12 May 2003 and reads that on the day in question he was a Constable attached to Police Headquarters. He was accompanied by QQ/U111 and YY/U123. At approximately 7.10pm, they arrived at Crumlin Road, Ballinderry. UU/U130 described observing two police vehicles and a Cavalier car between them. He also observed police treating two male persons lying on the road, and members of the public standing in their front gardens observing this. He was aware of a dark coloured vehicle, possibly a Renault car, with a large trailer attached to it. It was at the side of the road, behind the rear police vehicle. He was made aware by police at the scene that the driver and passenger had been shot at the scene and that a policeman had been knocked down by the driver of the Cavalier. He was also injured.

[301] He described going to see the male who had been in the passenger seat that FF/U143 was attending to. He observed bullet wounds to his left forearm and left bicep. UU/U130 took over First Aid and was assisted by U213. He described asking the person what his name was. The person replied "David Somers" and provided his date of birth. UU/U130 described writing down these details on a piece of paper and passing them to GG/U137. UU/U130 observed a bump on the left side of Mr. Somers' head and that he had a front tooth missing. His face had blood on it but it had no signs of any cuts. He had a bruise mark on his right shoulder, approximately two inches in

diameter. UU/U130 also found a bruise mark to the left side of the lower chest rib area. He found the rest of Mr. Somers' body to be unmarked. He was crying out with pain. UU/U130 said that he spoke with LL/U113 and it was decided to take Mr. Somers directly to Craigavon in a police vehicle.

[302] VV/U207, WW/U216 and XX/U223 travelled with UU/U130 to the hospital. On arrival there, XX/U223 assisted UU/U130 with moving Mr. Somers into the Accident and Emergency Department. Mr. Somers was able to walk into the hospital with little support from UU/U130. UU/U130 spoke with Dr Davison and informed her of the events that occurred. He remained with the medical team while Mr. Somers received treatment. During his treatment Mr. Somers asked for his girlfriend to be informed that he was in hospital. This request was passed to Staff Nurse McCoy. Mr. Somers mentioned £200 that he had at the scene. Mr. Somers' jacket had been removed and left at the scene by the side of the road. A mobile phone may also have been in the jacket. When CID officers arrived, a Detective Constable informed UU/U130 that he would take charge of Mr. Somers.

[303] The second statement of UU/U130 is dated 4 June 2003. It records that while he was giving First Aid to David Somers at the scene, UU/U130 was asked for Mr. Somers' details by other police officers. UU/U130 wrote down those details on a piece of scrap paper and passed them to GG/U137. It was then passed back to UU/U130 at the scene.

[304] The statement of VV/U207 dated 14 May 2003 was admitted into evidence under Rule 17. It reads that on 29 April 2003 he was on duty in the Lisburn/Moira area accompanied by WW/U216 and XX/U223 in Call Sign 3. At approximately 7pm VV/U207 received a radio transmission from EE/U118. It was a transmission to all call signs to stop a Cavalier car that was on the Sheepwalk Road, Lisburn. VV/U207 said that other call signs indicated that they were in pursuit of the Cavalier. At approximately 7.10pm he heard radio transmissions indicating that the Cavalier had been stopped, that shots had been fired and that persons had been injured. He was aware that the vehicle was stopped on the Crumlin Road, Ballinderry, near McIlroy's pub.

[305] VV/U207 describes that when he arrived at the scene he could see the Cavalier car stopped towards the verge. He could see several police officers giving First Aid to two casualties. One man was lying in the middle of the road, and seemed to be seriously wounded. The other man was lying on the grass verge in front of the Cavalier and appeared to have an arm injury. He was being treated by two police officers. VV/U207 was asked by GG/U137 to speak to witnesses to the north side of the incident scene. VV/U207 spoke to a witness who told him that she had seen the incident. At this stage LL/U113 asked him to evacuate one of the injured persons to hospital. He passed the details of the witness to U213 and assisted in evacuating a man that he later learned was David Somers, to Craigavon Area Hospital.

[306] The statement of WW/U216 dated 15 May 2003 was admitted into evidence under Rule 17. It records that at 4.30pm on 29 April 2003 he was briefed by U201 regarding a crime operation in the Craigavon area. He was detailed as the driver of Call Sign 3 which also included VV/U207 and XX/U223. At about 7pm, WW/U216 received a radio transmission from U118 to all call signs. This transmission was to stop a Cavalier car that was on the Sheepwalk Road, Lisburn. At this time Call Sign 3 was approaching Aghalee from Moira. At about 7.10pm WW/U216 heard a further transmission indicating that the Cavalier had been stopped on the Crumlin Road, Ballinderry near McIlroy's public house. Shots had been fired and two persons were injured. A transmission was then received from one of the call signs with a request for First Aid kits be taken to the scene immediately and for an ambulance to be sent there. WW/U216 said that as he approached the scene, he saw several vehicles across the road and some of them had blue flashing lights on. He also saw some civilians there. VV/U207 and XX/U223 got out of the vehicle and delivered the First Aid kit to the scene.

[307] WW/U216 said that he drove his vehicle to the crossroads beside the public house and redirected traffic that was approaching the scene. He was then instructed by VV/U207 to bring his vehicle up to the scene and assist with the evacuation of a male, who he later learned was David Somers. At about 7.30pm Mr. Somers was placed in WW/U216's vehicle and taken to Craigavon Area Hospital, accompanied by VV/U207, XX/U223 and UU/U130. They arrived at about 7.55pm. Later that evening at 9.15pm, WW/U216 handed over his vehicle keys to Sergeant J1 TSG.

[308] The statement of XX/U223 dated 15 May 2003 was admitted into evidence under Rule 17. It records that on 29 April 2003 at 4.30pm he was briefed by U201 regarding a crime operation in the Craigavon area and was detailed to Call Sign 3 with VV/U207 and WW/U216. At approximately 7pm he received a radio transmission that the Cavalier car must be stopped. Call Signs 7 and 10 transmitted the information that they were somewhere behind the Cavalier. Minutes later, a radio transmission was made to the effect that the car had been stopped and that contact had been made. A request was made for ambulances and First Aid kits to be brought to the scene.

[309] The statement records that on his arrival at the scene XX/U223 observed the Cavalier car and several police vehicles. Some of the police vehicles had blue flashing lights functioning. As Call Sign 3 approached the scene some civilians were standing about 40 metres from the incident, near to the pub. XX/U223 got out of his vehicle with the First Aid kit from it. As he approached the scene he could see a lot of police officers around someone on the ground, in front of a green Vauxhall Omega police car.

[310] UU/U130 was positioned to the right, on the grass verge and was giving First Aid to a male. He later was made aware that this male was David Somers. XX/U223 heard someone beside the other injured male calling for a clean dressing. He opened a field dressing and gave it to one of the persons who

were attending to Mr. McConville. Someone then called for two extra people to lift Mr. McConville into the back of a car that had been reversed up to the scene. XX/U223 helped to support Mr. McConville as he was placed in the rear of the car. It was decided to evacuate Mr. Somers to hospital and XX/U223 directed WW/U216 to bring up Call Sign 3. The back seat of Call Sign 3 was cleared and Mr. Somers was placed in it. XX/U223 and UU/U130 were also inside. The car drove to Craigavon Area Hospital. On arrival at the hospital XX/U223 accompanied Mr. Somers and UU/U130 into the casualty department. They remained there until Mr. Somers was taken into the x-ray unit.

[311] I heard evidence from U202 that he was stationed at Mahon Road Police Station and on 29 April 2003 he was briefed at 4.30pm by U201 regarding a crime operation in the Craigavon area. U202 was detailed to Call Sign 4 with USS/209 and 217. They deployed into the Craigavon area. At 4.45pm he heard a radio transmission from EE/U118 and as a result of this, Call Sign 4 deployed to the Belfast area. At approximately 7pm he heard a radio transmission instructing a stop to be carried out on a Cavalier LDZ 2687 which was travelling along Sheepwalk Road, Lisburn, country wards. Further transmissions were received regarding the Cavalier and U202 was aware that other call signs were in pursuit of it. He became aware via a radio transmission that the Cavalier had been stopped. Shots had been fired and persons had been injured. The stop had taken place in the vicinity of McIlroy's pub, Crumlin Road, Ballinderry.

[312] Call Sign 4 travelled to the scene of the incident and arrived a short time later. U202 dismounted from his vehicle and spoke to HH/U129 who informed him that he had discharged his firearm. U202 placed HH/U129 in the rear of Call Sign 4 and placed his firearm on the rear seat. U202 proceeded to the scene where he could see two police vehicles and the Cavalier car. He could see two persons, who he later learned were Neil McConville and David Somers, lying on the ground. First Aid was being administered to them by several police officers. U202 liaised with GG/U137 as to what had happened. He observed what he believed to be a shotgun in the front passenger footwell. This weapon was covered by newspapers and a blue running type jacket. The butt of the weapon was on the floor with the barrel pointing towards the roof of the car. Both of the injured persons were then taken to hospital by the two police vehicles. GG/U137 pointed out items of relevance to U202 and then all police officers except U202, U213 and U217 left the scene.

[313] SS/U209 provided oral evidence to me. He was stationed at Mahon Road Police Station and on 29 April 2003 he was on uniform duty. At 4.30pm he was briefed by U201 regarding a crime operation in the Craigavon area. He was detailed as Call Sign 4, accompanied by U202 and U217. They deployed into the Craigavon area. He told me that U217 was the driver, U202 was the front seat passenger, and he was positioned in the rear. At 4.45pm he heard a radio transmission from EE/U118 and as a result of this, Call Sign 4 deployed to the Belfast area.

[314] U209 told me that between 4.45pm and 7pm Call Sign 4 was patrolling the Craigavon to Sprucefield area. At approximately 7pm he heard a radio transmission instructing a stop to be carried out on a Cavalier LDZ 2687. This vehicle was travelling along the Sheepwalk Road, Lisburn. There were other transmissions concerning this Cavalier and there were other police vehicles involved in an attempt to stop it. U209 then heard a radio transmission stating that the Cavalier had been stopped close to McIlroy's pub, Crumlin Road Ballinderry. Shots had been fired and persons were injured. Call Sign 4 arrived at the scene a short time later and SS/U209 saw a person who he later learned was Neil McConville, lying on the road. It was obvious that he was badly injured and SS/U209 administered First Aid to him. SS/U209 told me that he made the decision that Mr. McConville should be removed immediately to hospital and that he never heard any discussion about lifting Mr. McConville to hospital by helicopter.

[315] Mr. McConville was placed into the rear of a police estate car. SS/U209 was in the rear with him. He provided medical assistance to him that included mouth to mouth resuscitation because Mr. McConville had no pulse and had stopped breathing. He told me that Paul Taylor was also in the back of the car with him doing chest compressions on Mr. McConville. On the Glenavy Road, Mr. McConville was transferred into an ambulance and the police vehicle drove in front of it to Lagan Valley Hospital. SS/U209 later returned to Mahon Road Police Station.

[316] The statement of U217 dated 14 May 2003 was read into evidence under Rule 17. It records that on 29 April 2003, he was on mobile patrol in the Lisburn area, accompanied by U202 and SS/U209. At approximately 7pm he received a radio transmission from EE/U118 to all call signs, to stop a Cavalier car that was on the Sheepwalk Road near Lisburn. A short time later he heard other call signs say that they were behind the Cavalier, and in a position to stop it. U217 was then made aware by radio transmission that the Cavalier had been stopped on the road between Aghalee and Crumlin, near to McIlroy's pub. Shots had been fired, and one person was seriously injured.

[317] On arrival at the scene U217 saw a male person lying on the road. He was being given First Aid by several police officers. Another injured person was being treated on the grass verge at the side of the road. U217 was quickly aware that the person lying on the road was very seriously injured, and it was decided to get him to hospital as soon as possible. Call Sign 1 reversed up to the casualty and U217 helped to clear the back of the car. While doing this he unloaded TT/U221's MP5 weapon, which was in the back of the car. Mr. McConville was then placed into the back of the car and other police officers got in with him to continue with First Aid. U217 assisted U202 and U213 to contain and seal the scene and placed tape to the north and south of the incident. Other police officers then arrived and took over the cordon around the scene. U217 remained at the scene until U202 handed the scene over.

[318] LL/U113 provided oral evidence to me. He stated that on 29 April 2003 he was a Sergeant acting as crew commander for Call Sign 11. Although his notebook records that he arrived at the scene at approximately 7pm, he acknowledged before me that it must have been after 7.10pm when he arrived at the scene with Constables U126 and U138. He saw two civilians being given medical treatment by other police officers. He saw Sergeant QQ/ U111 and Constables YY/U123 and SS/U209 giving medical treatment to Mr. McConville. Sgt LL/U113 took on the role of medical manager and made the decision to move the deceased to hospital using a police car. LL/U113 said that he could see that there were possible gunshot wounds to his chest and that while at first Mr. McConville reacted verbally to pain stimulus, vital signs were beginning to diminish. He briefed various officers on their medical responsibilities to the deceased including Sergeant QQ/U111 and Constables YY/U123, SS/U209 and Paul Taylor on their medical responsibilities to Mr. McConville in the police vehicle. LL/U113 was asked if he considered using a helicopter but he said he was not sure if he was aware that a helicopter was in the air at that particular time.

[319] LL/U113 couldn't recollect whether he knew that an ambulance had been tasked to the scene when he organised Mr. McConville's evacuation to hospital in a police vehicle. He wasn't sure how the police vehicle and the ambulance met each other. LL/U113 couldn't explain why his notebook recorded that Paul Taylor was removed to hospital by one of the crew call signs at 7.17pm but a few minutes later was one of the people who got into the police vehicle with Mr. McConville.

[320] There is no doubt that the deceased received serious gunshot wounds from which he subsequently sadly died. The police officers who were at the scene at the time or arrived within a short time had sufficient training in emergency First Aid and had with them appropriate medical equipment to assist them in their task in treating the deceased and also the passenger in the car which he had been driving. Whilst the police car was on its way to Lagan Valley Hospital with the deceased it met an ambulance that was on its way to the scene and the deceased was transferred into the care of paramedics. The deceased had been receiving appropriate care at the scene, in the police car and then from paramedics and police officers in the back of the ambulance. It is clear from the evidence that unfortunately his condition was always steadily deteriorating.

[321] Professor Crane, who carried out the autopsy, and two consultant forensic pathologists, Dr Cary and Dr Swift, agreed that the decision by the police officers to evacuate the deceased to hospital was the correct decision. They also agreed that the injuries were such that it was unlikely that a fatal outcome could ever been prevented. In her written submissions Ms. McCann acknowledges that the medical evidence appears to be clear – there was nothing more that could have been done by the HMSU officers to try and save Mr. McConville's life.

[322] LL/U113 also observed Mr. Somers. He was being given medical treatment by Constables U213 and UU/U130. LL/U113 observed gunshot wounds to Mr. Somers' left upper arm and bruising to his chest. Although Mr. Somers was fully conscious, and his vital signs appeared to be good, LL/U113 was unable to establish if there were any internal chest injuries. Consequently he organised for a police vehicle to evacuate Mr. Somers to the hospital. It left the scene approximately two to three minutes after the police vehicle that had Mr. McConville on board. LL/U113 told me that he then saw and treated Sergeant GG/U137 who had blood on his hand, and a small laceration to his index finger.

[323] I heard oral evidence from U126. His statement and notebook records events on 29 April 2003 only from 7pm, when he drove to the scene of the incident. In fact, U126 had been briefed about Operation Trill at around 4.30pm to 4.45pm. U126's explanation for this was that he only recorded relevant details and at no stage did his call sign see the vehicle involved. Therefore there was no need to mention it. He told me that he was on duty in Call Sign 11 accompanied by LL/U113 and U138. At approximately 7pm he drove his police vehicle to an incident on the Crumlin Road, Ballinderry. On arrival at the scene U126 ascertained that two civilians had been shot and a police officer was injured. The injured persons were being attended to by team medics. U126 spoke with HH/U129, who was seated in the rear of a police vehicle at the scene. HH/U129 informed him that he had fired his MP5 weapon and that he had shot the occupants of the vehicle.

[324] U126 removed HH/U129's MP5 from him and noted that it was still loaded with the safety selector at the safe position. U126's evidence was that he had not been given any direction about the steps that should be taken when dealing with an officer who had fired shots in circumstances where there would be a Police Ombudsman's investigation. U126 placed the weapon in the boot of his police vehicle. He then discovered that his police vehicle was defective. It later transpired that it had a broken clutch cable. U138 walked into the scene and retrieved another police vehicle. U126 then placed HH/U129's MP5 weapon in the boot of this vehicle and he conveyed HH/U129 back to the police station at Ladas Drive.

[325] U126 did not recall what conversation he had with HH/U129 during this drive. He did not take any note of anything that may have been said during this journey. It is hard to believe that nothing was said and the absence of any note at all is concerning. In her written submissions Ms. McCann draws attention to the ACPO manual which at the time required initial notes to be made as soon as practicable and the entry should be timed, dated and signed and, where notes have been made after conferring, or the incident has been discussed, the officers should endorse their notes to that effect, highlighting issues discussed and with whom, and any other document sources referred to when compiling notes should also be highlighted.

[326] At 11.30pm U126 removed HH/U129's weapon from the boot of the vehicle. It was still in the condition that it had been in when HH/U129 handed it to him. It had two magazines in the clip. The left-hand magazine was loaded and the fire selector was at the safe position. U126 carried the weapon to the unloading bay at Ladas Drive Police Station. Before unloading the weapon, he showed the investigating officer Mr. Dougan the state that it was in and which magazine was loaded. U126 removed the magazine from the magazine housing and ejected the round from the chamber to make the weapon safe. He then handed the MP5 weapon, two magazines and the magazine clip to Mr. Dougan.

[327] The statement of U138, dated 18 May 2003 was admitted into evidence under Rule 17. It records that on 29 April 2003 he was a Constable on mobile patrol with LL/U113 and U126. At approximately 7pm or 7.10pm they arrived at the scene of an incident on Crumlin Road, Ballinderry. U138 approached the scene and noted that two males were injured. They were being given First Aid by team medics. He also noted that HH/U129 was sitting in the rear of a police vehicle and had been involved in the discharge of his weapon. He said he liaised with U126 and they decided to remove HH/U129 back to their base. He recalled that his police vehicle's clutch had failed so he liaised with U202 to take another vehicle. U138 and U126 transported HH/U129 back to Belfast.

[328] The Police Ombudsman for Northern Ireland (PONI) was set up by the Police (Northern Ireland) Act 1998. As a result of the use of lethal force by the PSNI resulting in the death of Neil McConville PONI was required to undertake an investigation. The report of this investigation was not published until October 2007 although there were various reasons why it took as long as it did.

[329] I heard evidence from Anne McShane who was the only witness from PONI from whom I heard at the inquest. On 30 April 2003 she was appointed as office manager for Operation Airedale, which was the PONI investigation into the incident resulting in the death of Neil McConville. I am satisfied that there were a number of failings in the investigation which can be listed as follows:-

(a) A delay in PONI officers arriving at the scene.
(b) The failure to treat HH/U219 as a suspect and accordingly isolate him from other officers.
(c) Delay in taking a statement from HH/U129 and the delay in carrying out an interview.
(d) Allowing the debrief to proceed contrary to ACPO guidance.
(e) The failure to retain the weapon that was fired.
(f) The loss of a sketch map completed during HH's interview.
(g) The failure to secure HMSU training records.
(h) The failure to secure the relevant intelligence.

(i) The failure to secure first accounts from the police witnesses and statements from other relevant witnesses.

[330] Anne McShane accepted the majority of these failings by taking the position that PONI was really only a fledgling organisation at this time and that this was the first fatal shooting with which it had dealt since its inception. She also made clear that this was not how such a matter would be dealt with today and that new relevant procedures had been put in place to ensure that such failings would not re-occur. Whilst one can understand that PONI was a relatively new organisation it was staffed with people who had experience of police investigations. To that extent it is difficult to understand some of the failings and matters that came to light in connection with this matter. I am satisfied there were a large number of failings although they probably had minimal impact on the issues this inquest has had to consider.

[331] A debrief was held the following day, 30 April 2003 and lasted over 2 hours. Present at the debrief were officers from the control rooms in Belfast and in Mahon Road as well as the officers from Call Signs 7 and 10 with the exception of Paul Taylor. Two officers from PONI also attended this debrief. There is guidance from ACPO that initial witness accounts shall be recorded before a debriefing of any kind. This debrief was obviously in contravention of that guidance but it was held in the presence of the investigators – in this case PONI. Although the decision to hold the debrief before initial witness accounts were taken was wrong my concerns in this regard are lessened by the fact that PONI investigators were present and indeed their presence may well have benefited their investigation. Indeed Anne McShane said that by having investigators at the debrief it allowed an early record and allowed the investigators to observe the actual debrief and what was being said. She agreed with the suggestion that it provided investigators with a comprehensive overview of events at an early stage.

Civilian witnesses

[332] I received statements and heard evidence from a number of civilian witnesses who were also subject to examination.

[333] In relation to events surrounding the incident, I heard from Norman Brown. He told me that at about 7pm on 29 April 2003 he was in the kitchen of his home at Crumlin Road, Ballinderry. He was preparing a meal and heard what he believed to be emergency sirens. He looked out of the side window and saw a Cavalier coming from the direction of Crumlin. He said that the vehicle was out of control and was travelling in reverse up the hill at approximately 40 miles per hour.

[334] He said that emanating from it was what appeared to be the sound of an engine screaming. He said that the vehicle went out of sight and immediately afterwards he heard the sound of two or three loud thuds, which he believed was from vehicles colliding. He said that he exited his kitchen and walked

down the side of his house. He then heard a male voice shout loudly and clearly "There is a weapon in the vehicle". He immediately heard what he thought to be four or five shots, which he described as two shots in quick succession and then a further three shots, with a gap between them. He also saw that a green car had stopped behind and to the right rear side of the Cavalier, and he thought that three or four police officers wearing white shirts emerged from it.

[335] He said that he heard the shots but did not see who fired them. After he heard the shots, he ran back into his house and brought his wife, Margaret, and his two young daughters, Louise and Victoria, into the lounge and got the children to lie on the floor. He said that after everything went quiet, the family went to the front door. He said that a very short time later, another two police vehicles arrived. He described later assisting motorists who had come upon the blocked road. He also recalled seeing a person lying on their back on the road at some point after the shots were fired.

[336] Margaret Brown, Mr. Norman Brown's wife, also appeared at this inquest and told me that at around 7pm on the day in question she was in the lounge of her home with Mr. Brown and their two children when she heard what she thought to be speeding cars and the sound of emergency sirens. She looked out of her living room window and saw a red saloon vehicle, which had two occupants in the front, and behind it an unmarked green vehicle which was sounding a siren.

[337] At first, she thought that it was a joyrider. She said that after passing her house, the red vehicle reversed a short distance into the building site entrance, facing her home, and she saw it moving forwards and backwards several times there. She said that it then drove off in the direction of the Horseshoe Bar and drove into a large green police vehicle, which was situated in the middle of the road. She said that it then reversed before trying to force its way past the police vehicle a couple of times with its engine revving.

[338] She formed the opinion at this point that the occupants of the red car were not car thieves, they were not going to give up and she feared the car was carrying a bomb or something sinister. She said that she also heard car doors banging, which she thought was police officers getting out of the green vehicle. She recalled hearing a male voice shouting clearly "Police, remove yourself from the vehicle, we're armed. Get out of the vehicle now", or words to that effect. She said that the two occupants did not react and then she heard a different officer shout clearly "There's a weapon in the vehicle".

[339] She said that seconds after this she heard three, four or five gunshots with a split-second pause between each one, but she does not know who fired the shots. She then exited her home by the side door to check on her elderly neighbour. She said that when she went back into her house, herself, her husband and children went to the front of the house. She described seeing another police vehicle arriving and what she thought were two police Land

Rovers, which blocked her view slightly. She also recalled First Aid being given, possibly at the passenger side of the car. She described comforting her children and a sense of relief that she and her family were ok.

[340] Mr. and Mrs. Browns' daughter, Louise Brown also provided evidence to me. On the date of the incident she was eight years old. She recalled that she was watching television and heard a bang which sounded like a car back firing. She said that her father, who was making tea in the kitchen, came in and also said that it sounded like a car backfiring. She said that her sister, Vicky, her father and herself all went to the living room window and looked out. She said that her mother was there too. She described hearing a lot of shouting.

[341] She also described seeing a red car which was trying to reverse and ram another car, which was dark coloured. She heard someone shouting "Police, lower your weapon". She then heard noise that she later knew to be gunshots, and she heard three of these. She recalled her mother leaving the house to check on an elderly neighbour. She said that she could hear someone shouting at her mother to "Get down and get into the house", which she was assumed was the police.

[342] She said that her father then shouted at them to get down, and she and her sister dived onto the floor. She said that her mother then returned to the house. A short time later, she went outside and she saw three vehicles with policemen in the back seat. She now believes that they were police vehicles. She said that she saw other policemen lift the bodies of two men and a policeman. They placed them into the different cars across the legs of policemen who were sitting in the back seats. She also recalled seeing people lifting a wing mirror from the red car which was lying next to the pillar of the driveway of her home and thinks that it may have been forensic officers.

[343] Mr. and Mrs. Browns' other daughter, Victoria Jackson, also told me about her recollection of the events. She was ten years old at the time of the incident. She remembered being in the kitchen with her father, who was making the tea. She said that her father was looking out of the kitchen window and saying that there was a car driving up the road backwards. She said she could hear brakes, the screeching of tyres and sirens. She looked towards the living room window and she saw a number of cars outside which appeared to have blocked in another car. She said that she could hear an engine revving loudly and then saw that the car that was blocked in was attempting to reverse, as if to get away. She said that the car then stopped and she saw police get out of one of the other cars to approach the vehicle. She recalled hearing at least two voices shouting "Police, get out of the vehicle". She also heard one of the same voices shout "There is a gun", or words to that effect.

[344] She stated that her father sent her and her sister to the back bedroom and told them to get down on the floor. Whilst there, she heard what she believed to be three shots. She also stated that she heard voices whilst in the bedroom

and acknowledged that some of the words she heard may have been spoken whilst she was in the bedroom. She stayed in the room for what felt like a long time and then she ventured out as it seemed quiet.

[345] She recalled joining her two parents outside in the garden and seeing cars on the road, including the one that had been attempting to reverse earlier. She also described seeing a man's body lying face up, parallel between the two axles of that vehicle, with distinctive red shoes on.

[346] Jonathan Brown gave evidence to the inquest that on the evening of 29 April 2003 he had returned to his home on the Crumlin Road, Ballinderry with his wife and children. They were neighbours of Norman Brown and Margaret Brown. He said that he heard a siren which he initially thought was an ambulance. He then heard what sounded like a vehicle skidding on the road.

[347] He went to the fence and described seeing a red Vauxhall Cavalier with a driver and a front seat passenger in it. He said that the Cavalier was airborne as it came over the brow of the hill, the driver lost control of his vehicle and the car spun around. He said that while it spun, a police vehicle went in front of it and another police vehicle pulled to the back of it. He recalled that the Cavalier was then blocked in by the two police cars, one in front of it and one behind it. He said that the vehicle in front was parked at an angle across both lanes. Mr. Brown said that the driver of the Cavalier was attempting to drive away. He said that the driver was moving the vehicle forwards and backwards. This movement was in a manner that suggested the driver was fully locking the steering wheel each time it moved.

[348] The Cavalier was travelling in the direction of the police vehicles, and it looked as if the driver was trying to hit the police that were at the front of his vehicle. Mr. Brown told me that the uniformed and armed police officers got out of their cars, while the driver of the Cavalier was still attempting to get away. He heard the police shouting "Armed police, get out of the car", or similar words, and he saw police attempting to get the doors of the Cavalier open. He saw a policeman standing near the driver's front wing, attempting to open the driver's door and he said that this policeman had to jump out of the way because the Cavalier moved towards him.

[349] He said that the police officer pointed his rifle at the driver of the car. He described continuous shouting at the two men to get out of the car. This appeared to him to be coming from five armed policemen. He saw the Cavalier's driver window break outwards. He then described hearing two or three shots, very close together, before the Cavalier rolled into the side of the road. He said that police then got the doors open. He believed that the passenger was pulled out first and put on the ground.

[350] He said that the driver exited his vehicle himself. Mr. Brown saw that he was bleeding down his right shoulder, chest and arm and he seemed to be in a

trance. He said that the police beckoned the driver to come towards them and then to get down on the ground, and that the driver did so before receiving First Aid. He told me that another policeman shouted, "Weapon in the vehicle" and Mr. Brown saw a holdall being taken from the vehicle. He stated that he watched the events from the fence on the Crumlin Road, which he could see beyond, and that the scene was perhaps at most 30 feet from him.

[351] A number of witness statements were admitted into evidence under Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 ("Rule 17").

[352] The statement of David McRoberts, now deceased, dated 7 May 2003 reads that from around 6pm on 29 April 2003 he was drinking at the Horseshoe Inn. He had consumed a couple of pints of alcohol by 7pm. At 7pm the barman drew his attention to the fact that people were standing outside the bar, looking up towards the hill in the direction of Crumlin. Mr. McRoberts looked out through the left window of the bar and he saw a red Ford Sierra static outside a house, approximately thirty metres from the bar and up the hill. He recalled that it did not appear to have any damage to it, but he could not see if it had any occupants. He said that the vehicle was then reversed, or let to run back a couple of feet, and he presumed that it had collided into a fence outside the house. He stated that his vision was limited because of the position of the bar window so he only watched for about ten seconds. He remained in the bar until about 8pm.

[353] The statement of Irene Robinson dated 29 April 2003 was read into evidence. It states that she was sitting in the front room of her home on the evening in question. At about 7.05pm Ms Robinson heard two bangs and shortly thereafter the sound of a siren. She went to the kitchen and looked out of the window onto the Crumlin Road. Ms Robinson saw a red car with a man sitting in the driver's seat, which was facing up the hill right up next to the hedge. She went out to the gate at the Crumlin Road side of her house with her sister June, and as she looked up the road towards Crumlin she saw three cars stopped.

[354] The nearest car was green, the furthest one away was dark coloured and there was a red car in between them. Ms Robinson saw a man wearing a t-shirt and jeans lying in the ditch on the opposite side of the road from her home. She saw this man get up after a short period of time. She saw another man lying in front of the dark coloured car. He was still. Ms Robinson saw a lot of policemen standing amongst the cars. It then started to rain so Ms Robinson and her sister went back into the house. Ms Robinson estimated that the distance between the gate and the nearest car was about 20 to 30 yards, and it was still bright. She recognised the driver as a local man named Heatley.

[355] Irene Robinson made a second statement on 1 May 2003. She clarified that she heard bangs and a siren but she did not remember in which order they occurred. When she looked out of her kitchen window, she saw a wine

coloured car close to her hedge and the driver was in the driver's seat. She thought that the car must have been in an accident, and she and her sister June went out of the back kitchen door to see what happened.

[356] When she got outside, she recognised the driver as a local man named Heatley. Through the open passenger window he told her that there had been a shooting involving police. She looked down the Crumlin Road and saw the three cars that she described in her statement dated 29 April 2003. Ms Robinson watched the scene for ten minutes but could not remember anything said by police or any of the conversations. She remembered seeing one man sitting by the side of the road, very near to a For Sale sign, being bandaged by a police officer. She was aware of another body lying in the road beside the dark coloured car and she could see police standing around it. Ms Robinson remembered another car arriving with police in it. It was a big, silver saloon car but she did not think that the siren was sounding.

[357] The next statement to be read into evidence under Rule 17 was the statement of June Farr dated 29 April 2003. She records that she was sitting at home in her front room on 29 April 2003, when just after 7pm she heard the sound of sirens outside her house. She and her sister Irene looked out of the kitchen window that faces onto the Crumlin Road and she saw a red car sitting next to the hedge facing up the hill towards Crumlin. There was a man in the driver's seat but she didn't recognise him. Ms Farr's statement records that she and her sister went out to the gate that faced on to the Crumlin Road, and she saw three cars stopped in the road. The car nearest to her was green, there was a red car behind it and a dark coloured car behind that one. She saw a man across the road in a ditch. He was sitting up and a policeman was bandaging his left arm. She saw another man lying on the ground in front of the dark coloured car and he was not moving. There were a lot of policemen moving about the scene. Ms Farr had a clear view of the scene. It started to rain so Ms Farr and her sister went inside.

[358] On 1 May 2003 June Farr made a second statement. It confirms that police were involved in an incident outside her home on 29 April 2003 and that she had nothing further to add to her statement of that date.

[359] Edward Heatley's statement is dated 4 June 2003. It states that at approximately 7pm on 29 April 2003 he was in his car, a maroon Peugeot 405. He was coming from the Lurgan direction. He was close to two cottages which were to his left-hand side on the approach to the Horseshoe Bar. He heard the screeching of brakes and saw a dark blue car. He saw four police officers wearing black suits and carrying machine guns get out of this car.

[360] His statement records that their vehicle had blocked his path and that they were about 40 feet from him. He also observed the front of what he thought was an old shaped Vauxhall, possibly an Astra. It had stopped ahead of the dark blue police car. Prior to seeing this he believed that he heard two vehicles crashing into each other but he did not see this happen. Before the

impact he heard what he thought was a police siren, and the screeching sounds of vehicles braking.

[361] He also recalled hearing the sound of three shots, in quick succession but he did not see who fired the shots or which direction they had come from. After he was at the scene for about five minutes, a police car arrived from the direction of Lurgan. A plain-clothed police officer stepped out of it and told him to make way for the ambulance. Mr. Heatley then reversed and left the scene.

[362] The statement of Thomas John Matchet is dated 19 May 2003. It states that on 29 April 2003 at about 7.15pm he was working on his lorry, at the side of his house. He heard the sound of a crash. He looked up and saw a lamp post behind the Farr's house shaking. He heard shouting but he could not decipher what was being said. He also heard a number of shots and stated that he thought that there may have been four or five of them. He said that they were in quick succession but that they did not sound like automatic fire. He could not recall whether the shouting or the shots came first.

[363] After a couple of minutes, when the shouting had died down, Mr. Matchet walked across the road and went over to the Farr's gate. He spoke to them for a couple of minutes. He saw a red car sitting in the road at an angle and another dark coloured, possibly green car beside it. He could see possibly three or four police officers dressed in boiler suits. He recalled seeing a young male about 50 yards away sitting in a ditch at the side of the road. This male was at the passenger side of the red car and was having his arm bandaged by police.

[364] He recalled hearing him crying a bit and that a police officer said to him that he would be alright. He also recalled an estate car passing them and police working on someone at the back before it drove off in the direction of Lisburn. Mr. Matchet could not see if the injured person in this car was a civilian or a police officer. Shortly afterwards another police car travelled in the direction of Lurgan. Mr. Matchet's statement records that he was at the scene for about 20 minutes and that he left when it started to rain.

[365] Gerard Lundy's statement, dated 8 May 2003, was also read into evidence under Rule 17. On 29 April 2003 Mr. Lundy was part of a cycle club event time trial that involved approximately 40 cyclists. Between 7pm and 7.20pm they were in the process of starting the race about one mile from Glenavy, on the Moira side of the Moira/Nutts Corner Road. This was about two miles from the Horseshoe Inn. He became aware of a car passing at speed, followed by a second car also travelling at speed. He did not see these vehicles but heard them passing at speed.

[366] Shortly afterwards, a dark green four door saloon car with three to four police officers in it emerged from the road opposite to their start point. It stopped briefly at the junction, then sped off after the other two vehicles. Mr. Lundy

was close to this vehicle at the junction. He could smell the clutch and brakes, and he stated that it was obvious that the vehicle had been involved in high speed driving. He said that it sped off at high speed but was under good control. There were no sirens or flashing lights from any of the vehicles.

[367] Olive Totton's statement is dated 1 May 2003. It reads that she was sitting in the kitchen of her home at about 7.10pm on the day in question when she heard the sound of sirens. She went to the back of her house, looked towards the Crumlin Road and saw a red car stopped there. A policeman was pointing a gun and shouting something that she could not make out. He was about 30 to 40 yards away. She did recall hearing a voice saying "Weapon in the car" when she went outside.

[368] She stated that the policeman was standing at the front of the car, but she could not tell whether he was pointing the gun at the driver or the passenger, nor could she tell how many occupants were in the car. She ran back into the house and came out a few minutes later and saw a body on the ground behind the car. She went back into her house. She went out again a third time a few minutes later but the road was full of policemen, so she went back into the house again.

[369] Nurse Gethin Hughes' signed statement was received on 8 February 2021. It reads that on the 29 April 2003 he was a staff nurse attached to the Emergency Department at Lagan Valley Hospital. He recalled a colleague showing him a piece of paper with the words gunshot wound written on it and an estimated time of arrival. He recited what his medical role would have been on that day, and he stated that he recalled being present when the patient was pronounced dead. He could not recall if staff were informed of the patient's identity at the time that resuscitation was ongoing or whether this was provided after the patient's death.

[370] He did not recall having any information that the patient was of the Catholic religion or seeing any markers or chains that would have alerted them to this. He recalled a conversation with his colleague Angela Boyle at a later date in relation to Mr. McConville's last rites, stating that they had not been performed and that he had no information at the time of resuscitation attempts that Mr. McConville was of the Catholic religion. He stated that a decision whether to give the last rites or not would not have been an immediate thought for him or his team at the time because their focus was on trying to save the patient's life.

[371] Unfortunately it is clear that the deceased's religion and identity were not made known to staff at the Lagan Valley Hospital by anyone. Furthermore it is not clear whether there was anyone present at the hospital prior to his death or when he died who could have provided this information. In addition staff at the hospital did not notice any markers or chains that might have alerted them to his religion. Sadly therefore it was not possible to

administer the last rites to the deceased. In this regard notice should be taken of the evidence given by Nurse Gethin Hughes at paragraph 370 above.

[372] The statement of Anne Maguire was admitted into evidence under Rule 17. This statement provides that about 10.00pm on the evening of the 29 April 2003, Mrs. Maguire received a telephone call at home from the deceased's mother, Colette McConville who said that there had been a shooting in Antrim and she couldn't get in contact with the deceased. Mrs. Maguire and her husband drove to Mrs. McConville's house. She telephoned a local priest, Father McPartlan, to see if he could find out any information for them. Father McPartlan telephoned Mrs. Maguire back and told her that it was bad news.

[373] Kieran McPartlan's statement dated 16 June 2005 was also read into evidence. Mr. McPartlan was previously a priest and was based at St Peter's Parochial House in Lisburn. At around 11.pm on 29 April 2003 he received a phone call from Anne Maguire who was calling him on behalf of her sister, Mrs. Colette McConville. Anne said that they had heard rumours that Neil McConville had been shot and fatally wounded by police in Ballinderry. Mr. McPartlan immediately rang Lurgan police station and was put through to a policeman who confirmed that Neil McConville had been involved in a shooting incident. At around 11.15pm, Mr. McPartlan rang Anne Maguire back, told her that it was a serious situation and that police had asked for the family to go to the police station for further details.

[374] The deceased's mother, Mrs. Colette McConville gave evidence to the inquest. She told me that on the day that Neil died, she had attended Craigavon Area Hospital with the deceased at around 3.00pm to visit his new-born daughter. They left the hospital at about 4.20pm and they went their separate ways. She expected to meet up with her son again at the next hospital visiting session around 7.00pm. Mrs. McConville went back to the hospital later that evening with her husband Paul McConville but she did not see the deceased there.

[375] At around 9.pm to 9.30pm she received a telephone call from Martina, a sister-in law of Dee Somers, who advised her that the deceased and Dee Somers had been shot in Ballinderry. She then received a telephone call from the deceased's partner, Ms Caoimhe McCann, who told her that the deceased had been shot and had been taken to Lagan Valley Hospital. Ms. McCann was being discharged from Craigavon Hospital with her baby so Mrs. McConville went there to provide assistance and didn't get home from the hospital until the early hours of the morning. In the meantime her sister Anne Maguire had been told that Mr. McConville had been shot dead and somebody was needed to identify his body at Lagan Valley Hospital. Mrs. McConville told me that her husband Paul went to Lagan Valley Hospital and identified their son's body.

[376] The two statements of the deceased's father, Paul McConville, were admitted into evidence under Rule 17. Mr. McConville described how the deceased left

school at 16 years of age and was unemployed at the time of his death. The deceased's health during his lifetime was very good, except that he developed asthma when he was 11 years old and he had to use an inhaler. Mr. McConville confirmed that he attended the Lagan Valley Hospital on 30 April 2003 at 1.40am and identified his son's body.

Pathology

[377] Professor Jack Crane, State Pathologist for Northern Ireland conducted a postmortem examination on the body of Neil John McConville on 30 April 2003. Professor Crane was called as a witness and gave evidence to me on 25 May 2021. He commented that the deceased was healthy and there was no natural disease to accelerate death. Professor Crane then confirmed the following relevant findings of his autopsy report;

"Death was due to a bullet wound of the chest. He had been struck on the outer side of the upper arm by three bullets. One bullet had passed through the upper arm, fracturing the underlying humerus bone but, apart from this, did no serious damage. A second bullet had passed through the upper arm into the chest, fracturing the inner end of the right collar bone. It had passed superficially across the chest from right to left, more or less horizontally, to lodge in the front of the left shoulder from where it was recovered. The fatal bullet had also gone through the right upper arm and then into the chest, causing slight bruising of the top of the right lung. From here it had passed diagonally through the left lung and between the fifth and sixth left ribs, to emerge at an exit wound on the left side of the chest, below the armpit. There had been massive bleeding into the left chest cavity, and it was this haemorrhage which was responsible for his death in hospital shortly after admission.

The injuries were consistent with those from bullets of medium velocity. There was nothing from an examination of the wounds to indicate that they had been sustained at very close range but such changes could be absent if the bullets had first struck an intermediate target such as clothing.

Apart from the bullet wounds there were no other serious marks of violence. Abrasions on the forehead and left arm could have been caused by fragments of glass.

Following the shooting he was taken to hospital where he was transfused with fluids and a drain was inserted into the left chest cavity.

The report of Forensic Science Northern Ireland shows that at the time of his death there was no alcohol in the body. An analysis for the presence of drugs revealed a therapeutic concentration of the tranquiliser diazepam and its metabolite in the bloodstream. A metabolite of cannabis was also detected in the blood indicating that he had been using this drug for some time prior to his death".

[378] Dr. Nathaniel Roger Blair Cary, Consultant Forensic Pathologist was also called as a witness and gave evidence to me on 25 May 2021. He adopted his expert reports dated 19 March 2021 and 23 March 2021 that had been prepared for the inquest. He was instructed by the Next of Kin.

[379] Dr. Benjamin Swift, Consultant Forensic Pathologist was also called as a witness and gave evidence to me on 25 May 2021. He adopted his report dated 27 May 2020 that had been prepared for this inquest. He was instructed on my behalf by the LIU.

[380] During their oral evidence to me the three pathologists, Professor Crane, Dr. Swift and Dr. Cary also adopted a co-authored, signed and agreed note, in the following terms:

"Under the instructions of Counsel, we, Dr. Benjamin SWIFT, Dr. Nathaniel CARY, and Professor Jack CRANE (Consultant Forensic Pathologists) have been asked to produce a Joint Report regarding our opinions relating to the death of Neil McCONVILLE on the 29th April 2003. A joint meeting took place (via Microsoft Teams) on the morning of the 20th April 2021, at which time the issues were discussed.

We have the following comments:
1. We agree that Mr. McCONVILLE received three gunshot entrance wounds to the right upper arm/outer shoulder region. Further wounds to the inner right arm and outer left chest were points of bullet exiting (exit wounds).
2. We agree that the only wound considered immediately life-threatening was that placed in the middle of the group, which had damaged the lungs and exited the left side of the chest.
3. We agree that it is not possible to identify the order in which the gunshot wounds were inflicted.
4. We agree that the severity of the internal damage associated with the chest wound was such that it is unlikely a fatal outcome could ever have been prevented.
5. We agree that the appearance of the wounds are consistent with the discharging of a medium velocity firearm (such as the Heckler and Koch MP5 submachine gun) at "close range", but would defer to Ballistics Examination for further consideration of this matter.
6. We agree that the pathological findings do not allow identification of whether the firearm was in a single shot, semi-automatic or fully automatic firing mode.
7. We agree that there are no pathological findings to suggest the firearm was discharged through an intact glass window.
8. We consider it more probable that the bullet exiting Mr. McCONVILLE's chest had also resulted in the wounding of Mr. David SOMERS. We base this upon the knowledge that this bullet has not impacted bone, whereas the bullet that passed through Mr. McCONVILLE's right upper arm had impacted the humerus (upper arm bone), which likely would have reduced the latter projectile's momentum. It is therefore more probable that the bullet recovered by the driver side seat had passed through Mr. McCONVILLE's arm.
9. We believe there are no significant points of difference within our opinions."

[381] I accept this agreed evidence. In light of this evidence, I am satisfied that the middle wound of the three that were occasioned was the one that caused the deceased's death but that the pathologists cannot assist with the order in which these three wounds were inflicted.

[382] This fatal round went through the right upper arm into the chest, causing slight bruising to the top of the right lung. It then passed diagonally through the left lung (puncturing it in the process) and exited between the 5th and 6th ribs, emerging on the left side of the chest below the armpit. This led to massive bleeding into the left chest cavity and it was this haemorrhage that led to the deceased's death at Lagan Valley Hospital shortly after his admission.

[383] The other two bullets would not have proved fatal. The upper one entered the arm and then passed from right to left across the chest, embedding in the left collar bone. The lower of the three bullets entered the right upper arm and struck the humerus before continuing onwards. It did not enter the chest.

[384] In light of the agreed pathology evidence regarding the fatal wound I note that there is no suggestion that any of the First Aid treatment or the medical treatment at Lagan Valley Hospital was in any way a contributory factor in this death.

Ballistics

[385] The MP5 (weapon reference U126A) weapon fired by HH/U129 on 29 April 2003 was subsequently destroyed by PSNI in 2014. I asked PSNI to produce another similar weapon to court for demonstration purposes and for the PIPs and me to examine and inspect. This was done on 25 May 2021 and I am grateful that the inquest was facilitated in this regard. A PSNI firearms instructor illustrated the operation of a switch which is variously referred to as the safety lever, the fire selector or the fire lever. I was able to use this switch when I held the weapon.

[386] There were three locations on this switch; zero or safe, single round (also known as semi-automatic) and fully automatic. A note agreed by PSNI and the Nextof Kin (Exhibit C25) indicating their agreement on the details of the weapon used by HH/U129 on 29 April 2003 was provided to me and this reflected that these three locations were on the weapon used by HH/U129. This information was later expanded upon by the experts.

[387] The PSNI firearms instructor in court explained to me that the weapon would fire in the second and third positions. If single round (semi-automatic) was selected, the firing of each single round required a depression of the trigger and then a release. Holding the trigger in and not releasing it would have no effect beyond the firing of the single round. In automatic mode holding the trigger in and not releasing it would result in continuous firing of the bullets in the magazine.

[388] I received the expert evidence of Mr. Gary Montgomery, Forensic Scientist at FSNI, under Rule 17. Mr. Montgomery conducted the original forensic

examinations in 2003 but was unavailable to attend the inquest due to ill-health. I admitted his reports dated 13 February 2004 and 14 June 2004.

[389] Mr. Montgomery commented that from his examination of the firearms, clothing, bullets, cases and the car, three shots had been fired from the MP5 weapon and they had struck the deceased at the top of his right arm or shoulder. The location where he found the three spent cases was consistent with the firer standing and firing from the driver's side of the Cavalier car. The finding of propellant on the deceased's clothing indicated that the firer was within a few feet of the driver's door when he fired the three shots.

[390] I received expert Ballistics evidence in this inquest from Mr. Paul Olden, Forensic Scientist, who was instructed by LIU on my behalf, Mr. Mark Mastaglio, Forensic Scientist, who was instructed by the Next of Kin and Mr. Robert Huw Griffiths, Forensic Scientist who was instructed by the PSNI.

[391] I admitted into evidence the report of Mr. Olden dated 17 August 2020, the report of Mr. Mastaglio dated 27 April 2021 and the report of Mr. Griffiths dated 20 May 2021. I also admitted a joint report of these three experts dated 7 May 2021, an updated joint report dated 20 May 2021 and a short supplementary joint report dated 1 June 2021 dealing with video clips of their test firing on 19 May 2021.

[392] I heard oral evidence from each of these three experts on 25 May 2021.

[393] One of the issues considered was the mode of fire selected on the weapon and the impact that this may have had on the death of Mr. McConville. HH/U129 had previously stated that he had selected automatic firing mode as opposed to the semi-automatic mode, inadvertently, having accidentally 'pushed through' completely from position 1 (safe) to position 3 (fully automatic) mode.

[394] The three joint experts' report of 7 May 2021 noted that further work would be beneficial as below;

"We understand that MP5 guns were recovered from other officers in relation to the incident and recommend that the relevant guns are examined by us (at Key Forensic Services facility). This would allow us to assess the condition and operation of the selector switch for each gun. The tests would directly consider the issue of whether the switch could be moved inadvertently to the fully-automatic setting, rather than semi-automatic.

These tests would also allow us an opportunity to assess the sound of discharge for three shots in the fully-automatic mode using these guns. Further consideration would also be made regarding the chronological order and relative positions of the bullet impacts when test-firing three shots fully-automatically.

The FSNI case notes show only a limited set of test-firing in relation to the firing distance. If the ammunition recovered following the incident is available, further test-firing can be conducted by us to investigate the reliability of the assessment of 1 metre as the maximum possible firing distance."

[395] This suggestion of further testing arose due to the discovery that the other five MP5 weapons that PSNI officers in Call Signs 7 and 10 had at the scene on 29 April 2003, were still stored by PONI and were available for inspection. Three of this group of five weapons were the same make and model as the index weapon (U126A - destroyed). These were labelled BCL1, BCL2 and BCL5. They were examined and test-fired by the three experts on 19 May 2021 prior to producing their updated joint report dated 20 May 2021. I viewed some video clips of this test firing in court on 25 May 2021.

[396] This updated joint report of 20 May 2021 concluded as follows:

"*This joint report is an updated version of our previous report provided on 7th May, 2021. It summarises the points of agreement and any differences of opinion. This report follows the completion of further work proposed by us in our previous joint report, conducted at the PSNI CIFEX and the FSNI sites on 19th May, 2021.*

It is understood that the three entry wounds in the upper right arm of Neil McConville were denoted 1, 2, and 3, in order of distance from the shoulder. Professor Crane considered that entry site '1' related to the bullet that been recovered from the left shoulder, whereas entry site '2' related to the fatal bullet which had then travelled through the chest from right to left before exiting from the left side. He assessed that entry site '3' had been caused by a bullet that had subsequently exited directly from the upper right arm.

Agreed points:

The cartridge cases and fired bullets recovered at the scene provide evidence that three shots were fired in the incident.

2. The post-mortem examination of Neil McConville showed that the three shots had struck his right upper arm.

3. The regular circular appearance of these three entry wounds is consistent with a direct uninterrupted shot for each bullet. This assessment is supported by the recorded presence of bullet wipe on the sweatshirt worn by Neil McConville.

4. The post-mortem findings and the locations of the three cartridge cases are consistent with a firing position close to the driver's door.

5. The findings are consistent with Mr. Somers being struck by one bullet rather than two. (See further comment at end).

6. The FSNI notes record the presence of propellant on the sweatshirt in the region of the gunshot entry sites. This is consistent with a firing distance of less than a metre.

This distance is from the gun muzzle, rather than from the firer, to Mr. McConville's right arm. Further support for this firing distance assessment was provided during the additional testing conducted by us at FSNI, involving shots fired at clothing fabric.

7. The available physical evidence does not demonstrate whether the three shots had been fired in fully automatic or semi-automatic firing mode.

8. The chronological order of the three entry wounds to Neil McConville cannot be reliably ascertained by assessment of the available physical evidence. However, if the shots had been fired in fully automatic firing mode, the wound site denoted '2' is likely to have been caused by the second shot of the three. This observation is supported by our test-firings. Any alternative explanation would appear to require the gun muzzle reversing its initial direction of movement after the second shot had been fired. Such a reversal would not be expected and no such propensity was found during the firing tests.

9. The 'reconstruction' images provided (Mr. Kinnen) do not provide a reliable depiction of the firing position and direction. They are potentially misleading.

10. It is not possible to precisely determine the position or posture of U129 or the postures of either Mr. McConville or Mr. Somers, when the shots were fired.

11. The selector switch of an MP5 sub-machine gun is designed to engage distinctly in position for each of the switch settings (safe, semi-automatic, full-automatic), in a way that is perceptible to the operator.

12. The MP5 gun fired in the incident was not available to us for further testing. We assessed the selector lever for three other MP5 guns (BCL/1, 2 and 5) that had been recovered from other officers involved in the incident. For each, we found that the selector lever operated as designed, engaging normally at each of the three settings, with no mechanical defect. Although it was found physically possible without difficulty to move the lever with the thumb all the way from the safe to the full-automatic setting, this represented a longer and more forceful movement, and the design is intended to preclude this from occurring inadvertently.

13. During these tests, a continuous sound of discharge was evident when firing in the fully automatic mode. Although this sound indicated more than one shot had been fired, it did not allow us to reliably discern the number of shots fired during each test.

14. During these fully automatic firing tests with the MP5 gun supported normally at the shoulder, the dispersion of the three impact sites at a distance of 1 metre was found to be tighter than the dispersion of the three entry wound sites to the right arm. This implies greater movement of the gun muzzle during the firing of the three incident shots, if these had been fired in fully automatic mode, compared with the controlled test shots. The muzzle movement is generally greater if the gun is less firmly held and supported, or if the firer is in motion.

15. It is not possible to determine whether the three shots in the incident had been fired in the fully automatic or semi-automatic firing mode.

Further comments:

During our further work, the FSNI provided us with the two fired bullets within items BCL1 and AIP1. Although the original FSNI notes record that both of these were impact-damaged, such damage was only evident to the bullet AIP1 (recovered from the car). We found no impact damage to the bullet BCL1 (recovered from the road), and are unable to explain why the FSNI notes record impact damage to this bullet.

We understand that the post-mortem examination indicated that evidence of significant impact with bone (right arm humerus) would be expected for one of these bullets, but not the other. The absence of such evidence for the bullet BCL1 (despite the FSNI notes) therefore suggests that this bullet is not the one that had struck the humerus. This appears to provide support for the view that the wound to Mr. Somers had been caused by the bullet that had exited from the left chest of Mr. McConville.

The cause of the impact damage found to the bullet AIP1 has not been determined at this stage; analytical work would be necessary to assess whether the impacted material includes bone."

[397] The short further joint report dated 1 June 2021 explained aspects of the video clips of the test firing on 19 May 2021 viewed at the inquest on 25 May 2021.

[398] The Ballistics evidence focussed on the following areas;

- The number of shots that were fired during this incident.
- The location of the firer when he fired the shots relative to the Vauxhall Cavalier car and the deceased.
- The distance that the deceased was shot from.
- Whether the bullets that struck the deceased passed through any car windows before hitting him.
- The firing mode of the firing weapon.
- The chronological order of the three shots.
- Whether there were any defects in the fire selector in the weapons which were examined by the experts.

[399] There was expert evidence that three shots were fired during this shooting incident and that all three shots were fired by HH/U129. Three discharged 9mm bullets and cartridge cases were recovered from this incident and linked to the MP5 sub-machine gun that had been issued to HH/U129. Ms. McCann submits that either HH/U129 fired three separate shots in single shot mode or fired a burst of three shots in fully automatic mode. She submits that because he had not intended to fire more than one shot and the first was not fatal, assuming that HH/U129 is being truthful, the unintentional selection of automatic fire led to this death.

[400] There was expert evidence that a Heckler and Koch MP5 weapon ejects cartridge cases a few metres forwards and to the right of the weapon. The location of the spent cartridge cases supported the proposition that HH/U129 was on the offside of the Vauxhall Cavalier when he discharged his weapon. This was consistent with Mr. Montgomery's evidence admitted under Rule 17, notably on the propellant finding, and the post-mortem evidence.

[401] Point 6 of the agreed experts' report of 20 May 2021 (see above) assessed the firing distance at less than 1 metre, from the gun muzzle to the deceased.

[402] There was expert evidence that none of the bullets had passed through window glass before striking the deceased. There was direct and uninterrupted bullet impact on the deceased.

[403] Point 8 of the agreed experts' report of 20 May 2021 noted that the available physical evidence did not permit the chronological order of the three entry wounds to the deceased to be ascertained. However, if the gun was fired in fully automatic mode wound site two was likely to have been caused by the second shot of three. Mr. Olden gave oral evidence that it was likely to have been the fatal wound.

[404] The agreed experts' report of 20 May 2021 at point 15 concluded that it was not possible for them to determine whether the three shots were fired by HH/U129 in the fully automatic or semi-automatic firing mode.

[405] In their consideration of the firing mode issue the experts noted the relevance of dispersal of the shots, and witness evidence about what was heard at the scene, to this issue.

[406] There was expert evidence that firing on fully automatic mode would be expected to produce a tighter dispersal of shots and wounds due to the speed at which the shots would be fired. Firing on single shot (semi-automatic) mode would lead to a slower firing of the weapon and could therefore produce a wider dispersion of shots and wounds. The tightness of the firer's grip and how still the barrel of the weapon was held would also impact on this. Increased barrel movement would lead to increased dispersion, on either firing mode.

[407] It is submitted by the Next of Kin that the dispersion of wounds on the deceased indicates that semi-automatic mode had been selected by HH/U129. The Next of Kin also says that the dispersion could only have been caused on automatic mode if the weapon was fired by HH/U129 in a loose position inconsistent with his training.

[408] The joint experts' report, dated 1 June 2021, addressed the test-firing that they conducted and noted that firing the weapon in fully automatic mode in general, as long as the gun is held tightly with both hands and not e.g. in one

hand only, results in a tighter dispersal of the bullets than if not so held. They noted that the maximum vertical dispersion between the measured rounds for a tightly held gun against the shoulder in automatic mode was recorded as 12mm, 12mm and 24mm respectively.

[409] The Next of Kin asks me to compare this with the autopsy measurements of the deceased's wounds and suggest that this is evidence that HH/U129 fired in semi-automatic firing mode.

[410] I am also asked to consider the witness evidence from the scene as to what was heard in relation to the shots. I am referred to the joint experts' report of 20 May 2021 at point 13 that notes, during testing, a continuous sound of discharge in fully automatic mode, although it did not allow the experts to reliably discern the number of shots fired during each test. It is suggested to me that the semi-automatic mode produces a discernibly different sound of separate individual shots and specific expertise is not required to detect this.

[411] The Next of Kin submits that there is no expert evidence of mechanical fault to the weapon fired by HH/U129. Only Mr. Montgomery examined the actual weapon U126A and his notes do not record any mechanical fault. The weapon's service history does not record any fault.

[412] The joint experts' report of 20 May 201 at point 11 notes that the selector switch of an MP5 sub-machine gun is designed to engage distinctly in position for each of the switch settings (safe, semi-automatic, full-automatic) in a way that is perceptible to the operator.

[413] At point 12 it notes that in the weapons examined, BCL1, 2 and 5 the selector lever operated as designed, engaging normally at each of the 3 settings, with no mechanical defect. Although it was found physically possible without difficulty to move the lever with the thumb all the way from the safe to the full-automatic setting, this represented a longer and more forceful movement, and the design is intended to preclude this from occurring inadvertently.

[414] The Next of Kin refers me to other features on the weapon that are designed to preclude the switch moving all the way from the safe to full automatic setting and include a visual check, the feel and sound of a catch or click as you enter a detent and the fact that the switch is ridged to improve grip. The weapon training given to police officers is also directly relevant to safety.

[415] In contrast to the foregoing the Rule 17 statement evidence of Mr. Montgomery dated 13 February 2004 noted that while there are detents to identify each position of the selector (these being '0' safe, '1' semi-auto/single shot and '25' full automatic) by feel it is nevertheless quite possible, he stated in a stressful situation when rushing to select 1, to push from '0' through '1' and onto '25' inadvertently.

[416] I have the benefit of having examined the selector mechanism on BCL2 myself as noted above, in court on 25 May 2021.

[417] The PSNI refers me to the evidence of Mr. Montgomery, and I have considered it. PSNI submits that the HH/U129's selection of automatic fire was a mistake on his part.

[418] I am also referred to the evidence of Mr. Griffiths regarding the potential impact of stress on someone using the selector switch. PSNI submits that even well-trained experts can make mistakes in stressful situations.

[419] PSNI submits that none of the safety design features, including the detents, prevent the movement of the selector switch through the various positions. The user is not blocked from doing so. It is submitted that a visual check on the location selected was an opportunity that HH/U129 did not have in the circumstances before him.

[420] I have also been referred to a PONI investigation and Regulation 20 report into an incident that occurred some 13 months after the death of Mr. McConville. I was referred to an incident at Ballyhill Road, Belfast on 2 June 2004 when a police officer discharged his MP5 weapon. PSNI submits that it was another example of the wrong selection on the weapon being made inadvertently by the user. A firing mode other than single shot was accidentally selected to fire a three-shot burst rather than one. A further submission is made that the report lends support to the point that a witness hearing a number of shots could have heard automatic fire.

[421] The Next of Kin submits that I should not rely on the Ballyhill Road investigation and report because it is an entirely separate incident, involving a different weapon mechanism with no expert input. It falls foul of the *Re. Siberry* decision on opinion evidence, and I should not rely on conclusions reached by an investigator in another incident entirely. These conclusions were predominantly based on the witness accounts in that case. I agree with this and I am relying on the evidence that I have heard in this inquest.

[422] PSNI refers me to the findings of Horner J. in the Jordan Inquest (Re Jordan [2016] NI Coroner 1) at paragraphs 210, 316 and 330.

[423] The expert reports have allowed me to set out the areas of agreement in the preceding paragraphs in this section. In particular they explain the operation of the fire selector switch and the three settings on the kind of weapon that was used in this incident. The actual weapon that was fired by HH/U129 is no longer in existence and that is to be regretted. It was destroyed but I am satisfied that this was not done intentionally or in any way so as to disrupt this inquest or other legal enquiries. Fortunately and as set out above the other MP5 weapons that were being carried by other PSNI officers in Call Signs 7 and 10 had been retained and the experts were available to inspect them. Three of those weapons were of the same make and model as that

discharged by HH/U129. The experts were able to carry out a full examination of these weapons as well as test fire them.

[424] Although the experts were able to assist me in many ways they stated, by agreement, that the evidence that they had available to them did not demonstrate whether the three shots that have been fired by HH/U129 were fired in the fully automatic mode or in the semi-automatic firing mode. To my mind this is an important matter and I have carefully considered all the available evidence that touches upon it. Much of what the experts said before me in evidence has already been referred to in preceding paragraphs but suffice to say examination of the other three weapons did not reveal any mechanical defect in the fire selector switch and all aspects of the weapon worked as one would expect.

[425] I considered carefully evidence relating to dispersal of the wound sites on the deceased. This was because it was suggested by the Next of Kin that it was more likely that the weapon had been fired in semi-automatic mode rather than automatic mode. It is however important to realise that although the dispersal of wounds is important one must also consider the tightness or otherwise of the grip of the user of the weapon and that of course relates to how still or steady the barrel or muzzle of the weapon is during operation. Officers in the PSNI and in particular in the HMSU are trained to grip firearms as tightly as possible during discharge but it is really not possible, without further detailed research, to in any way relate that to what actually occurred during this incident.

[426] I also considered evidence from various witnesses, both police and civilian, as to what was heard in relation to shots being discharged. Whilst accepting that all these witnesses gave evidence to the best of their ability there is little consistency between them as to what they heard and thus to what may have happened. I note also what I set out in paragraph 410 above and when I consider this together with the evidence of the various witnesses it does not allow me to come to any specific conclusion based on the auditory evidence.

[427] The evidence of HH/U129 is to my mind very important in considering the mode of fire. Consideration has to be given to every aspect of his evidence relating to the selector switch. HH/U129 was an experienced member of HMSU having served from August 1992 until November 1997. He was then promoted and left the unit returning in November 2002 and thus was back in the unit for approximately 6 months at the time of this incident. His training with this type of weapon commenced in 1991 and even when he was not in the unit he said he often used this type of weapon.

[428] HH/U129 told me 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. He 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. He told me that he had personal experience of this on the range and he was aware that some of his colleagues also had this happen. He was asked how often did this problem occur on the ranges and he said in his opinion perhaps twice a year and my understanding of what he said was that this related to both himself and his colleagues. He himself had never reported this matter to his authorities or to the armourer although it seems that all weapons would have been maintained by the armourer on a routine basis and there was no issue about maintenance in this matter. I accept what he said about this and am somewhat concerned that the matter was not brought to the attention of the appropriate authorities. It is a matter of concern that at this time police officers were carrying weapons that had a tendency to allow the selector switch to move between safety and fully automatic effectively bypassing semi-automatic or single shot mode. I therefore endorse Recommendation 5 in the PONI report into Mr. McConville's death which recommended removing the automatic capability of these weapons save for a very limited number held in the police armoury.

[429] HH/U129 had a weapon marked "2" on this occasion and it appeared that this was in effect his weapon which he would invariably have used whilst training and whilst on operational duty. He told me that he was not able to recollect whether prior to this incident he ever had any issue with this particular weapon. During his evidence he accepted that there was a possibility that the selector switch on the weapon he was carrying could be moved from safe mode to automatic mode without him appreciating it although he stressed that this would be a very rare possibility.

[430] HH/U129 gave evidence about his training in the use of the MP5 and in particular his training in relation to the fire selector. He was asked whether he would have looked at the fire selector to see what mode the weapon was in – in other words a visual check. HH/U129 said that was never part of his training. It was also suggested to him at one time that as the fire selector was moved into the indents there would be an audible click but HH/U129 disagreed with this. He told me that he and his colleagues were trained by feel more than anything else. He did say that if the fire selector was moved with force one would not feel the indents as such.

[431] HH/U129 gave evidence about his use of the selector switch on the day of this incident. He explained that he was in the rear seat of one of the police vehicles and when his vehicle came to a stop he got out of the back passenger door and moved round the back of the police vehicle towards the front of the Cavalier of which the deceased was the driver. He told me that as he moved to that position he took the safety catch off meaning that he moved it from safety to what he believed was single shot (semi-automatic). As he did this he was moving and brought the weapon up to his shoulder. He told me that at this time he had already cocked his weapon, in other words he had put a round in the chamber of the weapon. He told me that this would have been done at base prior to leaving. He said this was a routine procedure.

[432] It was suggested that he would only be justified in taking the safety off when he had reached a point where he had concluded that he was justified in opening fire but HH/U129 said that was incorrect. In this regard his evidence was different to that of GG/U137 who said that he would not take the safety off until such time that he intended to open fire. No Force Order or guidance was produced to me on this point, and I do not consider that the practice adopted and used by HH/U129 increased the likelihood that he would open fire.

[433] HH/U129 then told of how he took what he believed and considered an aimed shot at the driver of the Cavalier. He said he pulled the trigger and in doing so he realised that the fire selector was on fully automatic and he immediately released the trigger. He said he believed that he had fired three, possibly four shots. One possibility suggested by the Next of Kin was that he he had deliberately selected automatic mode but he said that this was "incorrect, totally untrue".

[434] HH/U129 was cross-examined extensively about this aspect of the incident. He maintained that he had moved the selector switch by accident. Normal practice was to move it without looking. He was asked whether or not he had conducted a visual check and he said that he had no time. He pointed out that the incident took a matter of seconds from him leaving his police vehicle to discharging his weapon. Asked about the situation in which he found himself in he said that it was not a situation in which an officer would ever use a weapon in automatic fire mode.

[435] HH/U129 was interviewed by PONI on 19 June 2003 and answered questions about the incident along the lines already set out. This part of the Findings only relates to the ballistics evidence. I found HH/U129 to be an honest witness who was consistent in what he had said. He did not strike me as someone who was reckless in carrying out his duties on the day in question and consequently I am satisfied that the weapon was discharged in automatic mode rather than single shot or semi-automatic mode. I am further satisfied that it was the intention of HH/U129 to discharge one aimed shot and that he believed that the weapon's fire selector was in semi-automatic mode.

Conclusions

[436] I am concluding my Findings in the form of a narrative highlighting some, but not all, of my Findings and conclusions set out above. All of my Findings have been made on the balance of probabilities for the various reasons already set out.

[437] The deceased was Neil John McConville, a male, who died on 29 April 2003 at Lagan Valley Hospital. Mr. McConville was a single man who was born on 5 July 1981 in Craigavon Area Hospital.

[438] Mr. McConville was a father to two children, a partner to Ms. McCann, a brother, and a son to Mr. and Mrs. McConville. He lived with his mother and was not working at the time of his death.

[439] Mr. McConville died due to a gunshot wound to his chest.

[440] At the time he sustained a gunshot wound he was driving a Cavalier car, LDZ 2687, on the Crumlin Road at Glenavy, County Antrim.

[441] The time was between 7pm and 7.15pm.

[442] In the hours prior to his death police were engaged in an operation, called Operation Trill, which concerned, inter alia, stopping the Cavalier which the deceased was driving.

[443] All of the officers who were involved in this operation on the ground were appropriately trained and experienced.

[444] All of the officers who gave evidence before me were highly experienced.

[445] AA/5049's actions in setting up Operation Trill and then in briefing RR/8130 at RCG Urban were appropriate and proportionate as a response to the intelligence that he had received and the transfer of responsibility to RCG Urban was both appropriate and seamless.

[446] No FTA was appointed in RCG South which was contrary to Force Order 64/2002.

[447] There was no documentary evidence to confirm that an FTA was appointed in RCG Urban and no evidence that the appropriate pro forma was ever completed in relation to any advice that was given.

[448] No command structure was put in place in either RCG South or RCG Urban contrary to Force Order 11/98.

[449] It was not appropriate to attempt a police intervention at Colinglen and appropriate reasons were given for this.

[450] It was appropriate for the police to effectively abandon the possibility of putting in place a VCP after the Cavalier left Pond Park filling station.

[451] The way in which the command to stop the Cavalier was given was reasonable and proper as was the clarification sought by GG/U137 that the vehicle could be stopped from behind.

[452] Police attempted to stop the Cavalier by way of a stop from behind but there was contact between the Cavalier and a police vehicle and the Cavalier did not come to a permanent stop.

[453] The deceased tried to engage forward gear and drive the Cavalier away from the scene. It was clear that he would have driven over Mr. Paul Taylor and either killed him or caused him serious injury if he had been successful.

[454] HH/U129 discharged his MP5 weapon in automatic mode although it was his intention to discharge one aimed shot believing that the weapon's fire selector was on semi-automatic mode (single shot mode).

[455] HH/U129 fired all three shots which were discharged during the incident from a position adjacent to the driver's window of the Cavalier. At the time the muzzle of the weapon was less than 1 m away from the deceased.

[456] The surveillance was carried out appropriately by SOB operatives, HMSU call signs and a helicopter.

[457] Police officers at the scene had sufficient training in emergency First Aid and had with them appropriate medical equipment to treat the deceased.

[458] The deceased received appropriate medical care at the scene, on the way to hospital and at hospital. His injuries were such that it was unlikely that a fatal outcome could ever have been prevented.

[459] There were numerous failings in the PONI investigation into the deceased's death.

[460] 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.

[461] HH/U129 had an honest belief that it was necessary for him to use force for the purpose set out in Article 2 (2) (a) ECHR.

[462] The level of force used by HH/U129 was no more than was absolutely necessary and therefore HH/U129 was justified in using lethal force as he did on the day in question.

His Honour Judge Babington, the Recorder of Londonerry
Coroner
11 April 2022