

Office of the Police Ombudsman for Northern Ireland:

Statement under Section 62 of the Police (Northern Ireland) Act 1998.

**REPORT ON THE CIRCUMSTANCES
OF THE DEATH OF
MR NEIL McCONVILLE
ON 29 APRIL 2003**

SCHEDULE OF ABBREVIATIONS

SB	Special Branch
PSNI	Police Service of Northern Ireland
RCG	Regional Co-ordinating Group
VCP	Vehicle Check Point
ACPO	Association of Chief Police Officers (for England, Wales and Northern Ireland)
RUC	Royal Ulster Constabulary
AFO	Authorised Firearms Officer
UK	United Kingdom
OPONI	Office of the Police Ombudsman for Northern Ireland
CPR	Cardio Pulmonary Resuscitation
ECHR	European Court of Human Rights Also used as European Convention of Human Rights
HMSU	Headquarters Mobile Support Unit

EXECUTIVE SUMMARY

The Incident

1. On 29 April 2003 the Police Service of Northern Ireland learned that an individual (Man 'A') was to travel to Belfast in a Cavalier car and collect a gun, which may subsequently be used in an attack on an individual. An operation was mounted, directed by HMSU officers. A helicopter was used to monitor the car's progress.
2. The car was identified and traced in Belfast, and followed to various locations. Police suspected that a gun had been collected at one of these locations.
3. At that stage, Detective Chief Superintendent DD was the Gold Commander, and had strategic responsibility. Detective Superintendent BB, was in charge of the operation, as Silver Commander. As the red Cavalier left Belfast at 1855 hours a decision was made by Detective Superintendent BB that the vehicle must be stopped by police. This was communicated to the officers on the ground. No commander on the ground (Bronze Commander) was appointed by Detective Superintendent BB. These Gold, Silver and Bronze command structures should exist for firearms operations to ensure proper planning and management of all aspects of the operation and thereby to minimum any risk to life: each commander has specific responsibilities in relation to the operation.
4. At 1910 hours two vehicles containing officers from the HMSU, armed with MP5 sub-machine guns sought to stop the vehicle. A collision took place before the vehicle was brought to a stop. Officers then approached the vehicle and challenged the driver, Neil McConville, to turn the engine off. He reversed the car at speed and spun it round.

The front wing of the vehicle caught an officer and threw him to the ground in front of the car, where he lay injured.

5. The driver then tried to engage the gears to drive forward. The injured officer was directly in the vehicle's path. At least three of the officers present feared that, if the car drove forward, this officer would be killed or seriously injured and challenged the driver to stop, shouting that they were armed police. Mr McConville did not stop and continued to try to get away. An officer then discharged his MP5 at Neil McConville. The officer had inadvertently selected the 'automatic' mode on the weapon, rather than 'single shot' and three bullets were discharged. These caused fatal injuries to Neil McConville, who was pronounced dead at Lagan Valley Hospital at 20.07 hours. The front seat passenger, Man 'A,' suffered less serious injuries, when a bullet passed through Neil McConville and struck him.
6. An unloaded "sawn off" shotgun was found wrapped in a nylon windcheater in the front of the vehicle. No ammunition was found in the vehicle.

The Investigation

7. The Police Ombudsman for Northern Ireland was notified by the PSNI in accordance with standard procedures. An investigation began.
8. A total of 37 investigators were sent to various locations in response to the call. The scene of the shooting was forensically examined, and photographed. Vehicles involved and other evidence was seized for necessary forensic examination. House to house enquiries were conducted and an appeal for witnesses was made. Witnesses was identified and interviewed, including officers involved in the operation, ambulance and hospital personnel, civilian witnesses, a forensic scientist and the helicopter pilot.

9. Investigators attended the police debrief, (a standard police practice following any critical incident), which was held on the day after the incident. They secured a variety of police documentation relating to the operation. Forensic experts were engaged to produce a computerised representation of the circumstances of the shooting.
10. Among the police documentation sought by the investigators was the intelligence on which the operation was based. It was requested from Special Branch. The Assistant Chief Constable (Crime) declined to provide it, on the basis of advice he had received. After several requests the PSNI was given seven days to make the information available.
11. The Chief Constable intervened at this stage and access to the intelligence was agreed. The Police Ombudsman was then told that a specific piece of intelligence, critical to the investigation, had been accidentally deleted from a police computer. Despite seizing the relevant computer hard drive and securing expert assistance, it proved impossible to recover the intelligence. There was no evidence to either support or disprove the police explanation of human error for the deletion of the information. The disappearance of this material is of the gravest concern to the Police Ombudsman.
12. A note of the intelligence had been prepared by a police officer and this was available. However it was not possible to check its accuracy.
13. The shooting incident was fully investigated. Officers at the scene fully co-operated with the investigation and their version of events was found to be substantially corroborated by independent witnesses and scientific evidence.
14. The Police Ombudsman did not criticise the officer who fired the fatal shots. There were six officers at the scene initially, and at least two other officers were preparing to discharge their firearms having also concluded that there was a serious and imminent threat to life.

Independent advice also indicated that the lever controlling the mode of fire of the MP5 could easily be selected in error or accidentally moved to a different setting during a pressurised situation. This is not the first time that the Police Ombudsman has investigated a situation when a Heckler and Koch MP5 was accidentally engaged in the fully automatic mode, and on 17 January 2005 the Police Ombudsman recommended that this function be disabled on the weapon.

15. The planning and management of the operation was investigated. Five officers were identified as being in the Control Room. The senior officer, and Silver Commander was Detective Superintendent BB. He co-operated with the investigation, but the evidence shows that he did not plan and control the operation so as to minimise the possibility of recourse to lethal force as required by the PSNI Code of Ethics and Article 2 of the European Convention of Human Rights. His failure to consider properly the options available, failure to consider all the issues or to communicate proper decisions, and failure to document clearly his actions was a serious deficiency. In the course of the misconduct investigation the officer retired.
16. The failure of Detective Chief Superintendent DD to provide proper support to Detective Superintendent BB was considered. This officer retired and the matter was not pursued any further by the Police Ombudsman.
17. Three officers did not co-operate fully with the investigation, although they were initially being treated as witnesses not suspects. Two, Inspector NN and Sergeant EE, refused to be interviewed, gave written answers to questions asked by the investigators, and then alleged that their written answers had been tampered with. When they were challenged they withdrew these allegations.
18. A third officer, Acting Inspector RR also failed to co-operate with the investigation. Appropriate action was recommended against that officer in respect of the refusal to write a witness statement, when

ordered to do so by PSNI at the request of the Police Ombudsman. The officer retired soon afterwards, and cannot now be subjected to disciplinary action.

19. The evidence showed that the Police Service of Northern Ireland had not ensured that its policies and practices were updated to comply with the appropriate standards, particularly those contained in the ACPO Manual of Guidance on Police Use of Firearms. PSNI had contributed to the creation of this Manual, and account had been taken of the Northern Ireland situation as the Manual was produced.
20. Because of the potential for loss of life, police firearms operations should be managed in accordance with clear rules and procedures. Two officers in the Control Room gave conflicting evidence about what was required of them and about whether they were or were not acting as independent Tactical Firearms Advisers (in accordance with PSNI policy). They should not have been doing so, as they were involved in running the operation.
21. Officers also stated that the rules about running firearms operations did not apply to them. This was incorrect.
22. Officers engaged in the management of this high-risk operation had not received appropriate training.
23. Recommendations have been made concerning individual officers and PSNI practice. These can be found at Chapter 17 of this Statement. The PSNI response is appended to each recommendation.
24. The Police Ombudsman received a number of complaints from Neil McConville's father, Mr Paul McConville, and the mother of Neil McConville's child. Paul McConville alleged that police had shot dead his son unlawfully and without good reason. He also alleged that police did not notify the family of the death and delayed in taking Neil to hospital. These complaints were not substantiated.

25. The mother of Neil McConville's child said that, before his death, Neil had twice been chased by police who had threatened to shoot him. She also alleged that after his death an officer had used abusive language towards her and said Neil had "deserved it anyway." There was no evidence to substantiate these complaints.
26. This investigation was finalised and the family of Mr Neil McConville were informed of its content in October 2005. Publication of this Statement was not possible until the conclusion of related criminal proceedings against Man A.
27. The management of this operation by Detective Chief Superintendent DD and Detective Superintendent BB, the Gold and Silver Commanders, was totally inadequate. In effect, the officers on the ground were left to manage the process as they thought best. There was no identified Bronze Commander. The officers on the ground did respond appropriately, given Mr McConville's determination to drive away, despite the fact that a police officer was lying on the ground in front of his car.

1.0

INTRODUCTION

- 1.1 The Police Ombudsman for Northern Ireland is, by virtue of Section 51(4) Police (Northern Ireland) Act 1998, responsible for delivering an effective, efficient and independent police complaints system. All Investigators working for the Police Ombudsman have full police powers for the purpose of their role. Section 55(2) Police (Northern Ireland) Act 1998 states:

“The Chief Constable shall refer to the Ombudsman any matter which appears to the Chief Constable to indicate that the conduct of a member of the police force may have resulted in the death of some other person.”

Section 55(3) states:

“Where any matter is referred to the Ombudsman under subsection (2), he shall formally investigate the matter in accordance with Section 56.”

- 1.2 On 29 April 2003, a police officer from the Police Service of Northern Ireland (PSNI) discharged three shots from an MP5 Heckler and Koch 9mm sub-machine gun and shot dead Mr Neil McConville, aged 21 years, who was driving a red Vauxhall Cavalier Car. One of those bullets also injured his front seat passenger, Man ‘A’. The Chief Constable, in accordance with his legal obligation, immediately referred this matter to the Police Ombudsman for independent investigation, under the provisions of Section 55(2) Police (Northern Ireland) Act 1998.

1.3 This Statement deals with the events of the day, related events before and after, and the investigation undertaken by the Police Ombudsman. It is published pursuant to Section 62 Police (Northern Ireland) Act 1998.

2.0

THE CIRCUMSTANCES WHICH LED TO THE SHOOTING OF MR NEIL McCONVILLE AS DESCRIBED BY THE POLICE INVOLVED

- 2.1 At 1510 hours on 29 April 2003 the PSNI became aware that an individual had several firearms in his possession in Belfast, and that Man 'A' would be meeting him to receive at least one of them for an unlawful purpose. It was believed this weapon may be used in an attack on a named individual. A Detective Inspector from Special Branch advised Detective Superintendent AA of the circumstances. This Detective Superintendent was in charge of the Regional Co-ordinating Group which functions as a Control Room, to assess intelligence of an urgent nature, decide on action to be taken and then co-ordinate that activity. The Detective Superintendent reported to the Head of Special Branch.
- 2.2 Detective Superintendent AA noted in his journal (an official diary kept personally by police officers of the PSNI) that there was insufficient information to mount an operation. He told the Detective Inspector to warn and advise the intended victim of the threat, and to ascertain the availability of resources for an operation.
- 2.3 Police also learned of a location where a meeting would take place in Belfast with the purpose of collecting a firearm.
- 2.4 Some research was undertaken on Man 'A' and it was established that he had access to a red Vauxhall Cavalier car; the registration mark of which was not known. It was decided to mount an operation in an attempt to trace the vehicle in question, and place it, and its occupants, under surveillance. The officers involved were from the HMSU and had specialised training in the use of firearms. Detective

Chief Superintendent CC was informed of the operation by Detective Superintendent AA.

2.5 At 1630 hours officers from the HMSU attended a briefing, where they were given details of the intelligence available, and were told that they would be in support of the surveillance operation, with a role to stop the suspect vehicle if necessary. The briefing advised the officers that the occupants of the vehicle would be likely to have a firearm. Two police vehicles containing crews from the HMSU were identified to take the principal role of, if necessary, stopping the suspect vehicle; Call Sign 10 which was a green Mondeo car and Call Sign 7 which was a green Vauxhall Omega estate car. Call Sign 10 was crewed by Constable FF who was the driver, Sergeant GG, who sat in the front seat, and was the Crew Commander, and Sergeant HH, who was the rear seat observer. They were dressed in police issue boiler suits. Call Sign 7 was crewed by Constable II, who was the driver, Constable JJ, who was the rear seat observer, and Constable KK, who sat in the front passenger seat, and who was the Crew Commander. They were dressed in police shirts and green police trousers. There was no identified individual in overall charge of all the police officers on the ground. The two Crew Commanders were responsible for making decisions within their own vehicles.

2.6 At 1700 hours Detective Superintendent BB, who was in charge of the Regional Co-ordinating Group for the Greater Belfast area, was informed that contact had been established, in the Greater Belfast area, with the red Vauxhall Cavalier, which was believed to be the suspect vehicle, There were two occupants, one was believed to be Man 'A' and the other was unidentified at this time. Detective Superintendent BB informed Detective Superintendent AA that the car had been identified, and assumed full operational strategic control of the operation. He was kept informed as to the movement of the vehicle and its occupants.

2.7 Detective Superintendent AA had kept a policy log in which he recorded details of the intelligence received, the decisions he had taken and the reasons for those decisions. He recorded that control of the operation was handed to Detective Superintendent BB at 1700 hours and he then made arrangements for resources to be on stand-by to 'pick up' the suspect red Vauxhall Cavalier when it returned to South Region (i.e. his area of responsibility). He was kept up to date with events by Detective Superintendent BB who told him that he intended to stop the red Vauxhall Cavalier as it left Belfast. Detective Superintendent AA told him that he had surveillance resources which would be available to trace and follow the vehicle in South Region, if it was lost or those resources were otherwise required.

2.8 Detective Superintendent BB recorded his objectives as:

1. To mount surveillance against Man 'A' when he met with (named individual) at (a given location).
2. Identify Man 'A' collecting weapons and direct him into a police Vehicle Check Point (VCP) and arrest him in possession of weapon(s).

It appears this was recorded by Acting Inspector RR and signed by that officer and Detective Superintendent BB.

2.9 Detective Superintendent BB also recorded that he spoke to Detective Superintendent AA and agreed that once the red Vauxhall Cavalier left Belfast and travelled towards South Region the intelligence would indicate that, by that stage, a weapon(s) would have been picked up and would be in the vehicle. His record then states, *"once we reached that situation then the vehicle would be stopped by [police]."* He recorded that he briefed Detective Chief Superintendent DD on that policy and that he was unable to contact the Assistant Chief Constable.

- 2.10 The police officers from the HMSU were updated on the progress of the surveillance. They had made their way to the Belfast area and were regularly updated on the progress of the activities of the vehicle's occupants and the vehicle itself. The information was relayed by Sergeant EE, situated with Detective Superintendent BB and others in the control room. Whilst two principal vehicles were to stop the suspect vehicle, there were a significant number of other officers from the HMSU, in various vehicles, running parallel with the operation or on stand by for it.
- 2.11 The two principal police vehicles from the HMSU met in Central Belfast, where the two Crew Commanders discussed the options for stopping the vehicle, should it be necessary. They considered a Vehicle Check Point and discussed the fact that Call Sign 7 had a 'Stinger' (a device that can be stretched across the road and which would puncture car tyres in an attempt to immobilise a vehicle) which they could use, and they also considered the option of stopping the vehicle from behind (this would involve activating their audible warning equipment when following, with the possibility of overtaking the vehicle and indicating it should stop). No decision was actually taken at this time. The police officers were aware that a helicopter was also involved.
- 2.12 At 1855 hours Detective Superintendent BB was advised that the vehicle had left the Belfast City area, and was heading towards Stoneyford (a rural village to the southwest of Belfast). At this point Detective Superintendent BB directed Sergeant EE to tell the Call Signs to stop the red Vauxhall Cavalier. This instruction was relayed to the police. The officers were told to stop the vehicle from behind. They applied their blue lights and audible warning equipment and travelled at speed to take visual control of the red Vauxhall Cavalier. They were aware at this stage that there were two occupants.

- 2.13 Sergeant GG checked on two occasions that the instruction was to stop the vehicle from behind. This was confirmed by Sergeant EE in the Control Room. Other officers involved heard this confirmation being sought, and the response being given. The method of stop was thus directed. The Control Room receives all information and intelligence related to the operation. This would include information from surveillance units and the helicopter, and any update on the intelligence that instigated the operation. The police officers would have been aware that they did not have an overview of all information and would thus have felt obliged to implement instructions from the Control Room.
- 2.14 On the Crumlin to Aghalee Road they caught up with the red Vauxhall Cavalier and turned off their warning equipment so as not to alert the driver. It had been decided that Call Sign 10 would take the lead in stopping the vehicle as the crew were Belfast officers. They closed the gap on the vehicle and were following at an even speed and distance. It was decided to wait until the vehicle was on a straight road before stopping it. They waited until they were on the Aghalee Road, near Ballinderry, which seemed a suitable location. By now the red Vauxhall Cavalier was driving at speed.
- 2.15 Sergeant GG instructed his driver, Constable FF to overtake the red Vauxhall Cavalier and he commenced that manoeuvre. The police siren and blue lights were switched on, so that the driver of the Vauxhall would be aware that they were police officers. As the car pulled alongside, and slightly ahead, Sergeant GG showed the driver of the red Vauxhall Cavalier his MP5 sub-machine gun, shouted they were police and instructed him to pull over. The Sergeant states that he had a police badge on his breast which was also clearly visible.
- 2.16 The car pulled slightly to its left, and then swung right into the police vehicle colliding with it. The vehicles were locked together for a short while and the driver of the red Vauxhall Cavalier had difficulty maintaining control. The red Vauxhall Cavalier car pulled ahead and

then spun around. It came to a stop in front of the police vehicle and facing it. It was now facing the direction from which it had just travelled. Call Sign 7 drove past them to block the road. It is believed that its wing mirror struck the Cavalier as it passed the car. The red Vauxhall Cavalier then started to move forward towards the police car (Call Sign 10), and Sergeant GG believed that the driver intended to try and pass police to their offside. He feared that a high speed pursuit would then occur and was conscious of about 30 cyclists they had passed on the road. He shouted, "*Stop him*" to Constable FF, the driver. Constable FF drove forward and made contact with the offside front wing of the red Vauxhall Cavalier. The red Vauxhall Cavalier was pushed around anti-clockwise into the verge on the offside of the road and at ninety degrees to the carriageway facing a hedge.

2.17 Sergeant GG left his vehicle with his MP5 sub-machine gun in his hand. The safety catch was on. He went to the driver's door, and saw that the driver was trying to engage the car in gear and the engine was revving hard. He smashed the driver's window with the barrel of his gun and shouted to the driver, "*Stop police, show me your hands*". The driver continued to work with the gear stick, and Sergeant GG leant into the car, caught hold of his clothing at the collar area and tried to pull the driver away from the steering wheel. The audible warning equipment of Call Sign 10 was still switched on at this stage. Constables JJ and KK had, by this time, left Call Sign 7 and had positioned themselves at the passenger side of the vehicle. Constable JJ was shouting warnings at the passenger, Man 'A', and tried to open the door but it was locked. He smashed the passenger window with the barrel of his gun.

2.18 Other officers were shouting warnings at this stage. As Sergeant GG had hold of the driver's clothing the car shot back. This caused an injury to Sergeant GG's hand as it caught on the doorframe. As the car swung around Constable JJ was knocked into the air by the front wing of the vehicle with some force and landed on the tarmac with 'a thud'. His MP5 sub-machine gun also hit the tarmac, ejecting the

magazine and he believes some bullets sprang out. The red Vauxhall Cavalier was now facing up the road in the direction it was originally travelling. A gap of four to five feet now existed between Call Sign 7 and the verge which the red Vauxhall Cavalier would have to use to drive away. Constable JJ was on the ground in this gap. Constable KK was also now standing in the path of the vehicle. The Vauxhall car was revving highly and the driver was attempting to engage the gears.

2.19 Constable JJ states, *“I knew that I was in extreme danger with the Cavalier still apparently at maximum revs. I knew that if the Cavalier moved forward it would have to run straight over me to get away. I attempted to get on my hands and my knees and up onto my right leg, however I could not put any weight on it and I collapsed”*. He describes being very frightened and concerned about self-preservation. Constable KK also felt in fear, and aimed his gun at the driver and had decided he would shoot the driver if the car began to move to *“prevent me being seriously injured or killed”*.

2.20 Sergeant GG had moved back into a position by the driver's door, slightly behind it and about four feet from the driver. He was aware that Sergeant HH was out of his sight, to his right and about six feet from the driver. He had observed Constable JJ being knocked in the air and knew that he was lying on the ground in front of the vehicle. He also saw that Constable KK would be in the path of the vehicle if it were to move forward. The red Vauxhall Cavalier was at maximum revs and the driver was still trying to engage the gears. Sergeant GG had noticed Constable JJ try to get to his feet and collapse. He decided that something had to be done and took his weapon off the safety catch. Sergeant GG shouted a warning. He then heard three to four shots and realised that Sergeant HH had discharged his weapon. Sergeant GG described how he would have fired had his colleague not done so. He immediately saw that the driver had a bullet wound to his arm. He slumped back in the car seat away from the steering wheel. Throughout this activity various officers describe loud noises

of officers shouting, wheels spinning, the engine revving and police warning sirens blaring.

- 2.21 Sergeant HH stated in interview that he feared for the life of Constable JJ, and other officers, and fired what he believed to be an aimed shot at the driver. He felt that there was no other course of action open to him. Upon pulling the trigger Sergeant HH realised the fully automatic position on the weapon had inadvertently been selected and, as a result, he believed that three or four bullets were discharged.
- 2.22 The car was just rolling forward and Constable II stopped it by placing his foot on the front bumper. Sergeant GG opened the driver's door and found the driver conscious with his eyes open. He took him by the arm and helped him from the vehicle. He walked with the driver for about two metres and then sat him on the road. He continued to talk to the driver to try to ascertain the extent of his injuries. The driver was conscious but did not respond. The Sergeant shouted for medical support and was joined by two officers from Call Sign 7. These officers were officers trained to provide medical support, and they gave first aid. It was quite apparent to those officers that the driver was seriously injured. They were not aware of the identity of the driver at this stage, and an officer asked Man 'A' who the driver was. He refused to tell them saying, "*ask him yourself*".
- 2.23 By this time there were twenty-one officers at the scene, several of whom were qualified advanced first aiders. Sergeant LL arrived at the scene at 1912 hours, with other officers, and undertook the role of Medical Manager and Triage. He assessed Mr McConville and found that he was reacting to pain stimulus, but that other vital signs were diminishing. That officer believed that evacuation to hospital was urgent, and instructed that a police vehicle be used for this purpose as no ambulance had arrived. Four officers accompanied Mr McConville, and first aid was continued in the vehicle. Constable JJ went with the vehicle as he required hospital treatment for his injuries.

- 2.24 Mr McConville was placed in a Mitsubishi Gallant Estate police vehicle which had arrived at the scene. The rear seats had been placed in the prone position to facilitate this. The driver, Constable MM, said that it was obvious that the man needed to get to hospital as soon as possible, and it was evident to all present at this stage that he was seriously injured. Officers QQ, YY, JJ and SS accompanied Mr McConville. The vehicle was then driven away by Constable TT. Constables SS and JJ provided mouth to mouth resuscitation on the journey. At the junction with the Soldierstown Road an ambulance on the way to the call was stopped as it travelling towards them, and the patient was transferred into the ambulance. Constables QQ and YY stayed with the patient and assisted the paramedic in providing treatment. The police vehicle followed the ambulance to Lagan Valley Hospital where it arrived at 1941 hours. By this time cardio-pulmonary resuscitation was being performed and, whilst there was no feeling of a pulse, there was cardiac activity. Mr McConville did not revive and death was pronounced at 2007 hours in Lagan Valley Hospital.
- 2.25 Constable FF had approached the passenger door of the vehicle. He noted that there was something concealed under a light jacket between the passenger seat and the gearstick. At no time did he see Man 'A' attempt to take control of this. Man 'A' was screaming. Constable FF instructed him to get out but he did not do so. The officer tried the door, but found that it was damaged or locked and he was unable to open it. He saw that there was blood on the arm of Man 'A' and realised that he had been injured. He then reached in and pulled him out through the passenger door window. He was taken to the grass verge and sat down. First aid was provided. Sergeant LL assessed Man 'A' after Mr McConville left the scene and found he was fully conscious and had good vital signs. He was transferred to Craigavon Hospital where he was treated for two superficial bullet wounds, one to his upper and one to his lower left-arm. It was later confirmed that the injuries identified were caused by

a single bullet. Officer LL then gave treatment to Sergeant GG in respect of the injury to his finger.

2.26 As other officers had arrived on the scene and were assisting with first aid, Sergeant GG had gone to the passenger door of the Vauxhall Car and saw a long thin item wrapped in a nylon windcheater between the front seat and the gear stick, pointing in the direction of the roof. He loosened the windcheater enough to see the contents. He also had to peel back some newspaper in which the item was wrapped and saw the barrel of what appeared to be a shortened ("sawn off") single barrel shotgun. He did not touch it further and left it there. He shouted a warning to his colleagues that there was a weapon in the vehicle.

2.27 Man 'A' was despatched to the Craigavon Hospital by a police vehicle and accompanied by Constables UU, VV, WW and XX. This vehicle left the scene about two to three minutes after the vehicle taking Mr McConville left the scene. Man 'A' was able to walk into the hospital with little assistance. The details of Man 'A' had been confirmed at the scene and passed to the police control room.

3.0

COMPLAINTS MADE BY MR PAUL McCONVILLE AND PERSON 'P'

- 3.1 On 15 May 2003 a statement was taken from Mr Paul McConville, the father of the deceased in which he complained that the officers shot dead his son unlawfully and without good reason.
- 3.2 Mr Paul McConville also complained that the police did not notify his family of the death and delayed in taking his son to the hospital.
- 3.3 A complaint was also made by Person 'P', the mother of Mr McConville's child, that Mr McConville had told her, two weeks before his death, that he had been chased by police who threatened to shoot him. She also alleged that he was chased by police in November 2002 when they again threatened to shoot him. She also alleged that she was stopped on 24 May 2004 by three officers. She states she said to them, *"it is not good enough for you to shoot my child's dad dead"*, and one of the policemen said, *"so fuck, he deserved it anyway. Didn't shoot him quick enough the wee bastard"*.

4.0

NATIONAL PROCESSES FOR THE COMMAND AND CONTROL OF FIREARMS OPERATIONS – HOW A FIREARMS OPERATION SHOULD BE MANAGED

- 4.1 Sections 4,5 and 6 of this Statement provide information to enable the reader to understand the context applicable to the investigation conducted by the Police Ombudsman for Northern Ireland.
- 4.2 The Association of Chief Police Officers (ACPO) is the collective body of chief police officers (those officers of Assistant Chief Constable, Deputy Chief Constable, Chief Constable and equivalent ranks within the Metropolitan Police Service) for England, Wales and Northern Ireland. ACPO have a number of business areas which include committees, sub-committees and working groups which consider various issues of national importance to policing, and issue guidelines where appropriate to chief officers. One such Working Group relates to the police use of firearms. The group considers best practice, and lessons learnt from incidents in England, Wales and Northern Ireland, and has issued the **Manual of Guidance for the Police Use of Firearms**. The committee is dynamic, meets several times a year, updates the guidance where necessary, and issues briefing notes to chief officers in between meetings if circumstances direct. The Manual of Guidance takes into consideration the United Nations Code of Conduct for Law Enforcement Officials and Human Rights Law.
- 4.3 The status of the Manual of Guidance is advisory, however, the subject matter of the manual includes the police use of lethal force, and thus compliance with its contents is seen as highly desirable and

an abrogation from it by a Chief Officer should only take place after careful consideration, when a clear strategic decision(s) has been taken to that effect. The status of the Manual of Guidance has been further strengthened, since the death of Mr McConville, as the Home Secretary issued a Code of Practice on Police Use of Firearms and Less Lethal Weapons in December 2003. This Code, issued to chief officers of England and Wales under the provisions of Section 2, of the Police Reform Act 2002, (the Home Secretary does not have jurisdiction in respect of Scotland and Northern Ireland), places a duty on chief officers to have regard to the Manual of Guidance.

4.4 The PSNI (and RUC previously) have taken an active part in formulation of national policy. The Manual takes cognisance of the fact that the PSNI is an armed service and makes special accommodation for that. The ACPO Working Group allows for a police service to seek an abrogation from aspects of the Manual if it feels it cannot comply with it. It has been confirmed that no abrogation had been sought by the PSNI (who are represented, at a senior level, on that group).

4.5 The Manual sets out a command structure for operations such as the operation which is the subject of this Statement. The Manual states, *“Command is an integral and immediate consideration within any police response to (a firearms) incident. The possibility of potentially lethal force being used by the police service places an obligation on them to ensure that an operation is controlled through effective command”*. The Manual states, *“in normal circumstances an effective command structure has three levels, Strategic, Tactical and Operational. These command functions are commonly referred to as Gold, Silver and Bronze respectively and the Commanders performing these roles need to be carefully selected, trained and updated on a regular basis”*.

4.6 The Manual offers the following explanation of those roles:

Gold Strategy The overall intention is to combine resources towards managing and resolving an event or incident.

Silver Tactics The way that resources are used to achieve the strategic intentions within the range of approved tactical options.

Bronze Operational Organises the groups of resources to carry out the tactical plan.

4.7 The Manual outlines the responsibilities placed on those roles as follows:

4.8 **The Gold Commander:**

- a) Is the officer in overall strategic command and has responsibility and accountability for the operation;
- b) Is required to resource the operation;
- c) Chairs meetings of the strategic co-ordinating group when they are held, in the event of a multi-agency / multi-discipline response to an incident;
- d) Is required to set, review and update the strategy – which may include some tactical parameters;
- e) Should be in a position to maintain an effective strategic command of the operation;
- f) Is required to consult with partners involved (if any) when determining strategy;
- g) Should maintain a strategic overview, and should not become drawn into tactical level decisions.
- h) Should remain available to the Silver Commander if required;
- i) Should ensure that the strategy for the operation / incident is documented in order to provide a clear audit trail, including any changes to that strategy;
- j) Is responsible for ensuring the resilience of the Command structure and the effectiveness of the Silver Commander.

4.9 **The Silver Commander:**

- a) Should make a full and detailed assessment of the information available and consult a Tactical Advisor;
- b) Is responsible for developing and co-ordinating the tactical plan in order to achieve the strategic intention of the Gold Commander within any tactical parameters set;
- c) Is responsible for ensuring that all officers / staff are fully briefed;
- d) Should be so located as to be able to maintain effective tactical command of the operation;
- e) Should ensure that all decisions are documented in the Command Log in order to provide a clear audit trail;
- f) Provides the pivotal link in the command chain between Bronze Commanders and the Gold Commander. This ensures all other Commanders are kept apprised of continuing developments;
- g) Must constantly monitor the need for firearms (i.e. the information can change at any time);
- h) Has the responsibility to review, update and communicate changes in the tactical plan to Bronze Commanders and, where appropriate, the Gold Commander;
- i) Must hold a full and thorough de-brief on conclusion of appropriate incidents.

4.10 **The Bronze Commander:**

- a) Should have knowledge and clear understanding of the Silver Commander's tactical plan and their role within it, ensuring that staff are appropriately briefed;
- b) Is responsible for the implementation of the Silver Commander's tactical plan within their geographical or functional area of responsibility;
- c) Keeps the Silver Commander updated on current developments including any variation in agreed tactics within their geographical or functional area of responsibility;

- d) Should be so located as to be able to maintain effective tactical command of their area of responsibility;
- e) Should be available to those under their Command. However, they should allow them sufficient independence to carry out their specific role in accordance with the strategy and tactical plan;
- f) Should record decisions taken (where possible) to ensure a clear audit trail exists.

4.11 The Manual emphasises the need to document all plans, including consideration of options rejected or progressed. The Manual also highlights the importance of tactical advice stating:

“A Firearms Tactical Advisor should always be contacted at an early stage where there is an incident involving the actual or potential deployment of AFOs (Authorised Firearms Officers), spontaneous or pre-planned.”

“While the need for tactical advice will always exist at the level of Silver Commander as a priority, Gold Commanders may wish to seek the advice of a Tactical Advisor concerning the potential operational effect of setting tactical parameters.”

“The advisors do not make any decisions or take independent action. The responsibility for the validity and reliability of the advice lies with the Advisor, but the responsibility for the use of the advice lies with the Commander.”

4.12 The issues of command, documentation and tactical advice were to have particular relevance to this enquiry. The ACPO Manual of Guidance has taken into consideration the various legal provisions which govern the police use of potentially lethal force. They are outlined in the following chapter.

5.0

LEGAL AUTHORITY FOR THE POLICE USE OF FORCE

5.1 Police officers must act lawfully in their use of force, and particularly lethal force. There are various provisions which authorise the police to use force.

5.2 Section 3 (1) of the Criminal Law Act (Northern Ireland) 1967 which states;

“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”.

5.3 Article 2 of the European Convention on Human Rights requires that lethal or potentially lethal force can only be used if it is “absolutely necessary.” It states:

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 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.

5.4 The European Court of Human Rights has laid down certain standards for law enforcement organisations planning operations where lethal force may be used. In their judgement on **McCann and Others v The United Kingdom (1995)**, the judges held that, *“it must consider the security force’s actions in question but also the manner in which they were planned and controlled”*. In **Ergi v Turkey (1998)**, the European Court concluded that the application for an effective enjoyment of the right to life, could, *“also be engaged where they (agents of the state) failed to take all feasible precautions in the choice of means and methods of a security operation mounted against opposing groups, with a view to avoiding and, in any event, minimising, incidental loss of civilian life”*.

5.5 Article 88 of the Police and Criminal Evidence (Northern Ireland) Order states:

Where any provision of this Order—

- (a) confers a power on a constable; and
- (b) does not provide that the power may only be exercised with the consent of some person, other than a police officer, the constable may use reasonable force, if necessary, in the exercise of the power.

5.6 There is also a defence which exists at Common Law for the use of force where an individual has to defend himself from attack, defend another from attack or defend property. In such circumstances Common Law would support the use by an individual of reasonable force.

6.0

INSTRUCTIONS ISSUED BY THE CHIEF CONSTABLE OF THE PSNI IN RELATION TO THE USE OF FIREARMS

- 6.1 Whilst the Manual of Guidance offers national advice to the PSNI, orders are also issued by the Chief Constable, with which officers have to comply, or they will be in breach of police discipline. These instructions were notified to officers of the PSNI through General Orders. The PSNI also, uniquely within UK policing, has a Code of Ethics. A breach of the standards articulated in the Code amounts to a disciplinary transgression.
- 6.2 On 29 November 2001, the Chief Constable issued General Order Number 61/2001 on “Human Rights and the Police Use of Firearms”. This instruction emphasised that *‘Firearms are only to be fired by police officers when their use is absolutely necessary, after conventional methods have been tried and failed, or must from the nature of the circumstances be unlikely to succeed if tried.’* The instruction outlines matters that must be considered in order to ensure that the force used is no more than absolutely necessary. These include considering all other options before lethal force is used. The instruction complements another General Order (34/2001) on “Human Rights and Police Use of Force” issued on 14 June 2001 which also alluded to the European Court case of McCann and stated, *“The McCann case also asserts that strict control must be exercised over operations, which may involve the potential use of lethal force. Planners must consider all tactical options e.g the choice of weapons or equipment to establish that a lesser degree of force was intended.*

- 6.3 On 27 June 2002 General Order Number 43/2002 was published relating to the ACPO Manual of Guidance on Police Use of Firearms. This order included the paragraph, *'The introduction of the Human Rights Act 1998 resulted in a review of ACPO policies. The Manual has been audited for compliance with The Human Rights Act 1998 and other international Human Rights instruments. The review of the ACPO Manual of Guidance on Police Use of Firearms coincided with the review of police use of force and firearms being undertaken in Northern Ireland. Subsequently the ACPO Manual was subject to a further strategic review in 2001. This ensured that the position of the Police Service of Northern Ireland was acknowledged within the Manual.'* The Order stated that the purpose of the Manual is to act as a central reference document, and to provide guidance on matters relating to the deployment of police officers to situations which may require the intervention of armed police.
- 6.4 This General Order further stated, *'The Manual has and will continue to inform relevant policies, practices and procedures within policing in Northern Ireland. It provides advice and guidance for officers of all ranks and disciplines. The Manual will be of particular relevance to those officers who are involved in the planning or command and control of firearms related operations/incidents. It will also be applicable to operational officers who are deployed to an operation or incident that requires an armed police response.'* The order was circulated to all officers in the PSNI. The ACPO Manual of Guidance was also circulated to various departments including the Assistant Chief Constable responsible for the Regional Co-ordinating Groups.
- 6.5 On 18 October 2002, General Order Number 64/2002 was issued dealing with Firearms Tactical Advisors. The order stated that *'to meet the Service's obligations regarding human rights legislation, the use of firearms tactical advisors will be crucial in both the planning and implementation stages of any planned operation or prolonged spontaneous incident.'* The Order states that the advisors are on-call 24 hours a day. It states, *"Firearms Tactical Advisors must be*

contacted at the earliest possible opportunity regarding any planned operation or spontaneous incident where an armed response is required". The order states that the Tactical Advisor will complete a Tactical Options Proforma. It states, *'This proforma highlights all the options that are available to the relevant commander in charge, including the preferred option. The Tactical Options Proforma will be signed by the Firearms Tactical Advisor, and should be countersigned by the receiving commander in charge of the operation or incident.'*

6.6 The Order then states, *'Officers are reminded of the importance of record keeping, and any use of firearms tactical advisors should be documented within policy files, journals and official notebooks as applicable'*. Again this Order was issued to all officers of the force, including each Superintendent.

6.7 On 20 February 1998, the Chief Constable issued General Order number 11/98 headed Command Structures – Police Operations / Events. This order outlines the Gold, Silver and Bronze command structure for dealing with public order, firearms incidents and major incidents. It states, *"Notwithstanding the difference in the nature of the incidents, specific command structures have been approved or are recommended for handling same"*. An appendix to the Order outlines the functions of the various commands, broadly in line with the ACPO Manual of Guidance.

6.8 On 14 March 2003, the PSNI issued a Code of Ethics which articulates a standard of conduct and practice for police officers. The Code states that, *"police officers are required at all times to carry out their duties in accordance with the provisions of the Code"*. Of particular relevance in the Code are the following Articles:

(4.1) Police officers, in carrying out their duties, shall, as far as possible, apply non-violent methods before resorting to the use of force or firearms. They may use force or firearms only if other means

remain ineffective or without any realistic promise of achieving the intended result.

(Sourced from: Article 4 United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials.)

(4.2) Police officers responsible for the planning and control of operations where the use of force is a possibility, shall so plan and control them to minimise, to the greatest extent possible, recourse to force and, in particular, potentially lethal force.

(Sourced from: European Court of Human Rights, McCann –v- UK (1995) 21 EHRR paragraph 194.)

(4.3) Whenever police officers resort to the lawful use of force or firearms, they shall:-

- (a) exercise restraint in such use and act in proportion to the seriousness of the offence and the legitimate object to be achieved;*
- (b) minimise damage and injury, and respect and preserve human life;*
- (c) ensure that assistance and medical aid, where possible, are secured to any injured person at the earliest possible opportunity;*
- (d) ensure that relatives or close friends of the injured or affected person are notified at the earliest possible opportunity;*
- (e) where force or firearms are used, report the incident promptly to their supervisors;*
- (f) comply with any instructions issued by the Chief Constable.*

(Sourced from: United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Official, Article 5(A)-(C), Article 6.)

(4.4) A police officer shall discharge a firearm only where the officer honestly believes it is absolutely necessary to do so in order to save life or prevent serious injury, unless the discharge is for training purposes or the destruction of animals.

*(Sourced from: European Court of Human Rights, Andronicou and Constantinou -v- Cyprus (1997) 25 EHHR page 554;
Article 9 United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials).*

(4.5) Whenever police officers resort to the use of firearms, they shall identify themselves as such and shall give a clear warning of their intent to use firearms, with sufficient time for the warnings to be observed, unless to do so:

- (a) would unduly place any person at a risk of death or serious injury;*
- or*
- (b) would be clearly inappropriate or pointless in the circumstances of the incident.*

(Sourced from: Article 10 United Nations Basic Principles on the Use of Force and Firearms by Law Enforcement Officials).

7.0

THE POLICE OMBUDSMAN'S INVESTIGATION

- 7.1 The Police Ombudsman's Senior Investigator on-call was contacted at 8.10 pm and informed of the shooting by the PSNI. He made arrangements for investigators from the Office of the Police Ombudsman for Northern Ireland to attend various locations to commence the necessary investigation. A total of 37 investigators attended different locations and were involved in various aspects of the investigation through the night. This included the scene of the shooting which had been secured and preserved by police. The Police Ombudsman's investigation took primacy of that scene from the police and it was fully forensically examined and searched. This concluded around lunchtime the next day.
- 7.2 Investigators also attended Lagan Valley Hospital to deal with issues relating to Mr McConville, and the vehicle in which he was conveyed; the police premises to which the officers involved had returned, and Craigavon Hospital to deal with issues relating to Man 'A'. The Executive Director of the Office of the Police Ombudsman dealt with media enquiries, and made a media appeal that night in which he provided the facts as they were understood at that time.
- 7.3 Police weapons and clothing were taken, and initial accounts were received from the police officers involved. The scene was photographed and relevant records were secured. A sawn-off shotgun was found adjacent to the front passenger seat of the vehicle. The weapon was unloaded and there was no ammunition for the gun found in the vehicle. The PSNI were responsible for investigating any offences which may be relevant in respect of that

weapon. The vehicles used to transport injured parties were also seized by Police Ombudsman staff, for possible forensic examination.

7.4 There were some homes and a public house nearby, and enquiries were made. An appeal for witnesses was also made. The Police Ombudsman identified a number of witnesses, who gave statements of their evidence.

7.5 Witness B heard a siren and a vehicle skidding. The witness then looked into the road and saw a red coloured Vauxhall Cavalier car boxed in by what the witness realised were police cars. Witness B stated that the driver of the Cavalier was driving backwards and forwards ramming the police cars in an attempt to get away. Witness B saw armed, uniformed police officers get out of their vehicles and the Vauxhall car still trying to get away. Witness B heard someone shout, "*Armed police get out of the car*". Witness B saw police trying to open the Vauxhall Cavalier car doors and saw a policeman standing by the driver's side front wing of the vehicle.

7.6 As Witness B saw the officer try to open the driver's door the witness noted that the officer had to jump out of the way. Witness B then saw the same police officer pointing what he described as a rifle at the driver. The witness said there was shouting and the police were telling the two occupants to get out of the car. The witness then heard two or three shots very close together, and saw the red Vauxhall Cavalier stop. Witness B describes the police as then getting the doors open and believes that the passenger was removed from the vehicle first and put on the ground. The police then removed the driver and the witness noted that the driver was bleeding from his right shoulder/chest area and arm. He was put on the ground and given first aid. The witness describes the driver as being in a 'trance'. The witness then heard an officer shout, "*Weapon in the vehicle*".

7.7 Witness B saw both occupants being taken away in police vehicles. The witness believed this all occurred at about 1935 hours or

thereabouts. The witness states, *“I would add that I am adamant that I heard the police give proper warning several times and from what I saw of the actions of the Cavalier it was clear to me that he would have driven over anybody to get away, he was not for stopping”*.

7.8 Another Witness, C, was drawn to look upon hearing the sound of emergency sirens. The witness saw the red Vauxhall Cavalier travelling from the direction of Crumlin towards the Horseshoe Inn. Witness C described the vehicle as being ‘out of control’ and heard it making loud engine noise. The witness lost sight of the vehicle shortly afterwards but heard *“two or three loud thuds”* which sounded like vehicles colliding. Witness C then heard a male voice clearly saying, *“there is a weapon in the vehicle”* and then immediately heard four or five shots. Witness C heard two shots in quick succession, followed by a gap and then three further shots. Witness C states that his vision of the scene was not entirely clear.

7.9 Witness D’s attention was attracted to the sound of emergency sirens at about 7 pm. The witness saw a red saloon vehicle which had two occupants in the front, and an unmarked green vehicle behind it which had sirens sounding. The witness then saw the red car reversing into a building site at the side of the road, then going backwards and forwards, and then driving off towards the public house and colliding with the green police vehicle which was in the middle of the road. The witness then saw the red car reverse and try to force its way past the police car several times. The car engine was revving loudly and the screaming engine could be clearly heard. The witness formed the impression that the occupants of the red car *“were not car thieves and were not going to give themselves up”*, and then heard car doors banging which the witness thought were police officers getting out.

7.10 The witness then clearly heard a voice shouting, *“Police, remove yourself from the vehicle, we are armed, get out of the vehicle now”* or words to that effect. The witness states that the warning was clear.

The two occupants did not get out of the vehicle or react to the shouts. After a brief time Witness D heard another officer shout, *“there’s a weapon in the vehicle”*. Soon after this the witness heard three, four or five shots. These shots were fired soon after a clear warning being given. The witness thus assumed that a police officer had fired the shots but did not see who did. Witness D, accompanied by Witness C saw a lot of police activity which included the provision of first aid treatment.

- 7.11 Witness E, described hearing at least two bangs soon after 7 pm. The witness also heard sirens but cannot remember if this was before or after the bangs. The bangs sounded like a car accident. The witness then saw police activity and someone lying on the ground. Witness E saw a red car in between two other cars. Witness E did not see anything else of evidential value.
- 7.12 Witness F was with Witness E and looked down the road and saw police activity and officers providing first aid. The witness did not see anything of evidential value.
- 7.13 Witness G was driving on the Aghalee Road and heard a screech of brakes and then saw a number of police officers with machine guns. The witness’s view was obstructed by a police car, which was parked on the road, but the witness saw a Vauxhall car which had stopped ahead of the police car, and before that had heard sirens and the sound of two vehicles crashing into each other. Witness G also heard three shots in quick succession but did not see who fired the shots or where they came from.
- 7.14 Other witnesses were traced who heard shots, or saw events after the shooting, but whose evidence took the investigation no further forward. Statements were taken from them.
- 7.15 The general accounts of these witnesses broadly support the police version of the events to the extent that warnings were given and the

driver of the red Vauxhall Cavalier was not prepared to stop or get out of the vehicle. There are some minor contradictions in the accounts, which is not unusual given that the incident would have been quite frightening and occurred very quickly.

- 7.16 Witness H and Witness J were ambulance personnel based at Lagan Valley Hospital. The transcript of the emergency call to that service and the radio messages were recovered during the course of the investigation. On 29 April 2003, at 19.14 hours they received a call to attend a shooting scene at Upper Ballinderry. The message was ambiguous and the crew believed that a police officer had been injured. They were assigned at 19.15 hours. They were mobile at 19.16 hours. Whilst travelling down Glenavy Road, Moira they were flagged down by an unmarked police car. There were a number of police officers in the car performing CPR on a patient. The patient was transferred to the ambulance with the assistance of the police officers. Witness H was in the rear and confirmed that the two officers assisted in providing first aid on the journey to Lagan Valley Hospital, where Mr McConville was taken immediately to the resuscitation room. Witness H stated that there were no delays on their journey.
- 7.17 Witness J stated that they met the police officers at 1927 hours and left the scene some minutes before 1932 hours. The witness stated that there is a button to hit which records the time when the ambulance left the scene, but that the button was not activated until a minute or two after they left. The time was recorded as being 1932 hours. Witness J thus left with the patient at about 1930 hours. The witness described the journey to Lagan Valley Hospital as taking 8-10 minutes. They arrived at the hospital at 1941 hours.
- 7.18 The hospital had been advised by ambulance control that a male was en route with serious gunshot injuries and a resuscitation unit was summoned and awaiting his arrival. Dr K examined Mr McConville and found him to be unresponsive, not breathing and that he had no central pulse. Dr K found no feeling of pulse at the neck but cardiac

activity was positive on the cardiac monitor. The doctor noted a gunshot wound on his left axilla (underside of armpit). The left side of his chest was hyper resonant (there was air leak from his lungs into the chest cavity). Drugs and treatment were provided but cardiac activity ceased. Also present with Dr K was a surgical senior house officer, a medical senior house officer and a consultant anaesthetist. A fifth doctor was also present who took no part in the examination. Death was pronounced at 2007 hours. This was a team decision. At this stage the police were not certain of the identity of Mr McConville, and the hospital authorities were also not aware of his details.

- 7.19 Mr L, a Consultant in Accident and Emergency Medicine, was on call for Lagan Valley Hospital that night and received a call that there had been a shooting. He began to make his way towards the hospital and kept telephone contact with the staff there. The patient was pronounced dead prior to his arrival. He later met Mr McConville's mother and other family members, and, using medical notes and a briefing he had received, he told the family that in his view Mr McConville was almost certainly dead when he got into the ambulance and that he had been shot at least four times. He based this on the four wound marks shown in a diagram in the notes. It was established in post mortem that only three shots had been fired and that Mr McConville had five wounds, which were three bullet entry wounds, and two exit wounds (one bullet was found in the body and did not exit).
- 7.20 As Mr McConville's identity was not known, he was shown as a 'male anon' upon reception, in hospital records, and there was some delay in confirming the identity of Mr McConville and informing his next of kin.
- 7.21 A post mortem examination was conducted on Monday 30 April 2003 by the state pathologist, Professor Jack Crane, MB, Bch, FRCPath, DMJ (Clin et Path), FFPPathRCPI. He found three entrance wounds to the right shoulder, the first centred about 7 cm below the top of the

shoulder blade, the second 2 cm below that and the third on the outer side of the right upper arm, centred about 11.5 cm below the top of the shoulder blade. He found two exit wounds - to the front of the right upper arm, and to the left side of the chest.

7.22 His examination found extensive haemorrhaging of the larynx, beneath the vocal cords. He also found that a bullet had passed diagonally across the upper lobe of the left lung. The left lung was rather collapsed. He found bruising on the left side of the chest below the collarbone and bisection here revealed a copper-jacketed bullet lodged in the left shoulder area. He found a bullet hole in the left chest cavity between the fifth and sixth ribs.

7.23 He concluded that Mr McConville was a healthy young man who had died due to a bullet wound to the chest. His conclusion was that he had been struck by three bullets, one of which had passed through the upper arm, fracturing the underlying humerus bone but, apart from this, did no serious injury. Another bullet had passed through the upper arm into the chest, fracturing the inner end of the right collar bone, then passing across the chest, right to left, horizontally, to lodge in the left shoulder from where it was recovered in the post mortem. The fatal bullet had also gone through the right arm and then into the chest, causing slight bruising of the top of the right lung. From there it had passed diagonally through the left lung and between the fifth and sixth left, rib 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 haemorrhaging which was responsible for Mr McConville's death in hospital shortly after admission. His view was that the fatal wound would have been inflicted by the second bullet discharged. The pathologist's opinion was that Mr McConville's life could have only been saved by emergency surgery to stem the bleeding, which would have had to have taken place within thirty minutes. He stated that the extent of the bleeding would not have been evident at the scene, as he was bleeding internally.

- 7.24 A toxicological examination of body fluids showed that there was no alcohol in the body. An analysis for the presence of drugs revealed a therapeutic concentration of the tranquilliser diazepam and its metabolites in the bloodstream. A metabolite of cannabis was also detected in the blood indicating that he had been using this drug some time prior to his death.
- 7.25 Man 'A' was taken to Craigavon Area Hospital where he was taken to an operating theatre, and his wounds were cleaned by Dr M. It was noted that he had two superficial bullet wounds to the upper and lower left arm. It was thought there may be ulnar nerve damage and he was transferred to the Ulster Hospital, Dundonald.
- 7.26 Computerised representation technology was employed in respect of the shooting, the trajectory of the bullets, and the injuries suffered by Man 'A'. It was established that the injuries to the upper and lower arm of Man 'A' were equidistant from the elbow, and it was concluded that the arm was folded upwards as a single bullet passed through. This is consistent with Man 'A's' account that he had his arms bent and his hands raised above his head. Professor Crane's opinion was sought on this, and he was of the view that it was quite feasible for the wounds to have been caused by a single bullet.
- 7.27 Constable JJ attended the Accident and Emergency Department of Lagan Valley Hospital on 29 April 2003, and then his doctor's surgery on 30 April, as a result of injuries he received from being knocked over by the red Vauxhall Cavalier. A statement has been taken from his General Practitioner in which he stated that the officer had injuries to his lower back and right buttock, superficial abrasions to both knees and upper shins, a deep abrasion to the posterior aspect of the right elbow, bruising to the posterior scalp area, decreased flexion and extension of the neck with decreased rotation to the right, tenderness over the lower back and buttock areas. He had been provided with mild analgesic tablets at Lagan Valley Hospital. His doctor provided strong anti-inflammatory tablets and strong analgesic

tablets. He also dressed the deep abrasion to his right elbow. The injuries were consistent with being struck by a vehicle as described.

7.28 The weapon and magazine of bullets were seized from Sergeant HH. It was established that he was issued his weapon at 7 am that day, along with two magazines each containing twenty-eight bullets. A full magazine of twenty-eight bullets was taken from him along with a second magazine containing twenty-five bullets. His training record was inspected. He had passed training on the MP5 weapon on 25 April 2003. He was thus authorised to use the weapon. Magazines issued to other officers involved in the incident were inspected by the Police Ombudsman's Investigator and rounds counted in each magazine in order that the ammunition could be audited. All rounds were accounted for.

7.29 Forensic Scientist M was called to the shooting scene where three spent 9 mm cases were recovered from rough ground adjacent to the front nearside wheel of the red Vauxhall Cavalier. The Forensic Scientist examined the vehicle and could see no obvious bullet damage. The Forensic Scientist was able to conclude that the location where the three spent cases were found was consistent with the police officer standing and firing from the driver's side of the red Vauxhall Cavalier car.

7.30 The Forensic Scientist confirmed that the weapon recovered from the vehicle was a sawn-off shotgun and was viable. He confirmed it was a prohibited weapon by virtue of Section 3(2)(ac) Firearms (Amendment) (Northern Ireland) Order 1989.

7.31 Sergeant HH stated that he had accidentally placed his gun into automatic mode, thus resulting in three shots rather than a single shot being discharged. This is effected by moving a lever from the safety position to semi-automatic and then automatic modes. At position "0" the weapon is safe and cannot be fired. The lever is moved to position "1" to be in the semi-automatic mode (when single shots are

discharged each time the trigger is depressed) and to “25” for fully automatic (where bullet discharge continuously whilst the trigger is pressed). The total movement from “0” to “25” is approximately 30 mm. Forensic Scientist M stated that, whilst there are detents to identify each position by feel, it is quite possible, in a stressful situation, when wishing to select “1” to push from “0” to “25” inadvertently. This means that instead of firing a single shot each time the trigger was pressed a burst of fire would result.

- 7.32 One used bullet was recovered from inside the vehicle; a second from the ground, which it was believed may have fallen from the clothing of the injured passenger, and a third from Mr McConville’s body. Those bullets were examined by Forensic Scientist M and compared with the firearm used by Sergeant HH. It was confirmed that they were discharged from that gun. The Forensic Scientist concluded, from partially burned material on the sweatshirt being worn by Mr McConville, that the officer was within four feet of the driver’s door when he fired the three shots.
- 7.33 Three live rounds were also found at the scene. It was established that these rounds had come from the MP5 weapon of Constable JJ who was knocked to the ground, as his magazine had three rounds missing. All other ammunition was accounted for.
- 7.34 Forensic Scientist N was asked to examine the police vehicle and the Vauxhall car which were alleged to have collided. He concluded that the green police Ford Mondeo and the red Vauxhall Cavalier had made contact by virtue of the damage to the nearside wing mirror of the Ford Mondeo. The scientists also concluded that the second police vehicle, a green Omega had been in contact with the red Vauxhall Cavalier. The police vehicles were also examined for mechanical defects and none were found.
- 7.35 The clothing of Officer JJ was examined. Whilst no damage was found, an area of light watery soiling was present on the back of the

shirt. This soiling was over an area to the right, running from the right shoulder to near the waist. Traces of blood were found on the clothing and skin scales were found on the inside surface of the trousers.

7.36 A full debrief of the incident took place on 30 April 2003. It was attended by twenty-eight of the officers involved in the operation, and was led by an Inspector. All the main officers involved in the operation were present except Constable JJ, who was sick from work following the injuries which he had received the previous day. Two Investigators from the Office of the Police Ombudsman were also present. The whole incident was talked through, in a manner which was consistent with the police officers' accounts outlined in this Statement.

7.37 Man 'A', initially refused to co-operate with the Police Ombudsman's investigation. However, he later agreed to speak to Investigators and was interviewed. He described how he became aware of a police vehicle, with sirens sounding, passing them with another car behind. He claimed the police car "rammed them off the road". He described how their car went into a spin and they ended up between two police cars. He stated that Neil McConville was trying to drive off, but the car wheels were spinning and then another police car collided with them knocking them around again.

7.38 Man 'A' then looked to his left and saw a police officer with a gun, and put his hands up above his head. He states that an officer was injured but believes this was caused by another police vehicle. He said police were all around them and Neil McConville was trying to drive the car but the wheels were spinning. He saw a police officer to his right holding a machine gun. He stated that the window was smashed and he got shot in the arm. He was then pulled out through the window. He claimed he was beaten by the police on the ground.

- 7.39 He said that police asked him the name of the driver and he told them to, "*Ask him yourself*". He confirmed that first aid was given to him and that he was transferred to hospital.
- 7.40 Officers who had a key role in the incident were interviewed under caution (either misconduct or criminal, as appropriate). When criminal matters are alleged, or apparent, in respect of an officer, a criminal caution is used and the interview is conducted under the provisions of the Police and Criminal Evidence Order 1989. When the interview relates to a breach of the officer's Code of Ethics only, a misconduct caution is given.
- 7.41 Police Ombudsman Investigators advised Special Branch they would require access to the intelligence on which the operation was based. It was seen as essential to scrutinise the details of the information available to ensure that police action was appropriate and proportionate to the detail that intelligence revealed. This was followed on 09 May 2003 by a formal written request to secure access to the intelligence.
- 7.42 The intelligence was sensitive and there were considerable delays in responding to the Police Ombudsman's request for access. The Executive Director of Investigations spoke to the Assistant Chief Constable 'Crime' who had responsibility for Special Branch on 24 June 2003. The Assistant Chief Constable stated that he was minded to refuse access, on the basis of advice received. The Police Ombudsman has statutory authority to obtain information necessary for an investigation under Regulation 8 of the RUC (Complaints etc.) Regulations 2000 and Section 66 of the Police (Northern Ireland) Act 2000. There is no qualification to that power and this law is written unambiguously. It is imperative to the independence of the Police Ombudsman that such power exists. On 25 June 2003 the Executive Director of Investigations wrote to the Assistant Chief Constable 'Crime', pointing out the delays in granting access, reminding him of the legal provisions, and insisting on access within seven days.

- 7.43 The Chief Constable then intervened and access to the material was then agreed. The material was contained on a computerised record within Special Branch. On Friday 27 June 2003, a meeting took place between investigators from the Office of the Police Ombudsman and the Head of Special Branch to facilitate that access. The Head of Special Branch informed them at that meeting that the material had been accidentally deleted from the system. An investigation then took place into how this occurred, which included seizing the relevant hard drive and exploring all technical options to recover the material. Expert assistance was secured for this purpose.
- 7.44 The material could not be recovered. It was established that it was deleted in the beginning of June 2003 and the space that the file would have occupied had been overwritten. Human error was blamed, as a member of staff had allegedly deleted the file by mistake. This was of considerable concern and was investigated, but no evidence was found to, either support or contradict the explanation. Details of the intelligence had been recorded elsewhere by Detective Superintendent AA. It will never be known how complete or accurate that record is, or whether he was provided with the complete picture available.
- 7.45 The pilot of the helicopter was interviewed, and a statement taken from him confirming that the view of the red Vauxhall Cavalier was clear and unobstructed from before 1855 hours. The pilot confirms that the operator / observer in the helicopter was in constant radio contact with the control room.

8.0

THE ROLES, FUNCTIONS AND CONDUCT OF THE OFFICERS INVOLVED IN THE TWO RCG CONTROL ROOMS

DETECTIVE SUPERINTENDENT AA

- 8.1 Detective Superintendent AA was served a Discipline Notice under Regulation 9 RUC (Conduct) Regulations 2000 alleging that he failed to take tactical advice for the operation, as required by PSNI instructions, failed to have a tactical plan and failed to make a detailed assessment in terms of health and safety. Detective Superintendent AA was subjected to a disciplinary interview in which he described his role, in respect of the operation of 29 April 2003, as being in charge of the operation within the South Region.
- 8.2 Detective Superintendent AA was in charge of the Regional Co-ordinating Group for the South Region of the PSNI (the PSNI was, at that time, divided into three regions, South, North and Urban Belfast). He described how he was passed intelligence, which was scant in detail, but indicated that Man 'A' was to travel to Belfast to collect a gun with which he intended to attack an individual. The Superintendent took the view that there was inadequate intelligence at this stage to mount an operation, and told the Inspector who brought the intelligence to research and identify the potential target, in order that they could be warned that they were subject to threat and any other necessary action could be taken.
- 8.3 Further intelligence was later received with much greater detail which enabled an operation to be mounted. By this time it was believed that Man 'A' was already mobile and on the way to Belfast. Detective

Superintendent AA tasked an Inspector to make urgent enquiries to establish if there were surveillance and police resources available to mount the operation. The Detective Superintendent explained that the Inspector to whom he was speaking was a qualified Tactical Firearms Advisor, and he discussed options for the operation with him. These discussions and options were not recorded in written form.

- 8.4 He said that he considered the risks to the public, the risk to the police who were carrying out the operation, the intended victim and the targets of the operation. He considered three basic options; stop the vehicle on way to Belfast; stop the vehicle leaving Belfast or to let it go back to the Craigavon area and recover the gun with a house search. He felt that they may be too late with the first as they were behind the individuals who may have set off to Belfast. He thought that there was a risk with the third option as the gun could already have been used. He also recognised that they did not know where Man 'A' was at that stage. He said that his favoured option was to conduct a Vehicle Check Point (VCP) in South Region, and plan this for when the target of the operation left Belfast and returned south. He discussed his plans with Detective Chief Superintendent CC. He favoured an arrest with the weapon, as the individual might just collect it on another day when the police were unaware and unable to intervene.
- 8.5 The Detective Superintendent described himself as very experienced in these types of operation, with over three years' service as a Superintendent, and ten years experience of working with Regional Co-ordinating Groups. He was of the view that he ran the operation perfectly and that nothing could have been carried out any differently.

9.0

DETECTIVE CHIEF SUPERINTENDENT CC

- 9.1 Detective Chief Superintendent CC (with whom Detective Superintendent AA had discussed his plans) had been served with a Disciplinary Notice under Regulation 9 RUC (Conduct) Regulations 2000 which alleged that he failed to set, review and update strategy in respect of the operation which resulted in the death of Mr Neil McConville. He had replied that he had nothing to say “*at this stage*”. Detective Chief Superintendent CC had been an officer for thirty-one years, the majority of which time he had been a detective within the CID of the PSNI. He had transferred to Special Branch in September 2002 and was given regional responsibility for Special Branch in the South Region of the PSNI, where this operation was instigated. He had not had extensive experience in managing firearms operations, his major experience being in investigating crime. He had received no training in special operations. He had also had no training in the roles of Gold, Silver and Bronze commands for firearms operations.
- 9.2 Detective Chief Superintendent CC was interviewed and stated that he was consulted by Detective Superintendent AA at about 1700 hours as police had received intelligence that a named individual was going to Belfast to pick up a gun to carry out an attack. Detective Superintendent AA was in charge of the Regional Co-ordinating Group in South Region. He stated that the Regional Co-ordinating Groups complied with the ACPO Manual of Guidance for the Police Use of Firearms.
- 9.3 Detective Superintendent AA told Detective Chief Superintendent CC that as the operation was travelling to Belfast it was being coordinated from Belfast. He said that he would have resources available in case the operation came back into South Region. Detective Chief

Superintendent CC confirmed that “everything was ok” and then decided that he did not need any further involvement. He said that he was told about the shooting soon after 7 pm when he was about to leave his office. The Detective Chief Superintendent states that he did not adopt or accept any command role as Belfast were coordinating the operation. He also felt that an Assistant Chief Constable need not be involved as the two Detective Superintendents (AA and BB) “*were experienced, senior and highly paid and could sort it out between them*”.

10.0

DETECTIVE SUPERINTENDENT BB

- 10.1 Detective Superintendent BB, who was in charge of the Belfast Regional Co-Ordinating Group, was served a Discipline Notice under Regulation 9 RUC (Conduct) Regulations 2000 alleging that he failed to take tactical advice for the operation, failed to have a tactical plan and failed to make a detailed assessment in terms of health and safety. He replied when given the notice, "*Detective Superintendent requests that his full name be used, the name used is for friends and colleagues only*" (an abbreviated first name was included on the discipline notice). The Detective Superintendent reported that he had been certified sick with stress, claiming this was induced by being placed under investigation, and remained sick for four months following the service of this notice. This, and his subsequent sickness significantly delayed the investigation.
- 10.2 Detective Superintendent BB was interviewed under disciplinary caution on 09 December 2003. He was not legally entitled to a solicitor present for such an interview, but requested the presence of a solicitor. This was permitted on the basis that the solicitor was there as a 'friend' and not a legal adviser. The friend challenged the basis for the interview, on behalf of Detective Superintendent BB, in a very forceful way claiming the investigation had caused Detective Superintendent BB great stress and that he objected to being treated as a 'suspect' and felt he should be treated as a 'witness'. This was rejected as it would have been wholly inappropriate and the interview continued. The Detective Superintendent confirmed that he was in charge of the Belfast Regional Co-ordinating Group. On 29 April 2003, he was briefed by Acting Inspector RR about the details of an individual who was travelling to Belfast to collect a gun for use in a

criminal enterprise. He then spoke to Detective Superintendent AA and agreed that an operation would be mounted to trace Man 'A' and that his vehicle and activities would be monitored in Belfast. He stated that he formed the view that the intelligence would suggest that once the vehicle left Belfast towards Craigavon, there would be a weapon or weapons on board the vehicle and the police would then be required to stop it to search for weapons. The police units were briefed regarding the intelligence available and Detective Superintendent BB remained in the Belfast Regional Co-ordinating Group room throughout the operation.

10.3 He was told at 1700 hours that a Vauxhall Cavalier had been spotted with Man 'A' and another inside. The vehicle and occupants were observed in Belfast. Meetings, various stops and other activity were observed. The number of occupants in the Vauxhall car varied at various stages. An assessment was made that, by 1855, there was probably a weapon(s) on board as the car was leaving Belfast. Detective Superintendent BB then instructed Sergeant EE, who was in the control room with him, that he wanted the vehicle to be stopped by the police. He wanted to ensure that the vehicle was not lost on the country roads, as that would have presented the real possibility of the weapons being used which could result in serious injury or loss of life. He was then told at 1909 hours that the vehicle had been stopped and at 1910 hours that two persons were wounded, and a police officer was injured at the scene. Acting Inspector RR immediately tasked an ambulance to attend the scene. Detective Superintendent BB said that Acting Inspector RR kept a log of the operation.

10.4 Detective Superintendent BB confirmed that he formulated a plan to identify the vehicle, assess whether the weapon was on board and then have it stopped upon leaving Belfast. He said that they only got the information after 1600 hours and did not have much time. They were aware of where the meeting was to take place to collect the gun. He then contacted his immediate supervisor, Detective Chief Superintendent DD and neither of them could contact the Acting

Assistant Chief Constable. Detective Chief Superintendent DD sanctioned his plan.

- 10.5 He was asked about the ACPO structure for decision-making outlined in the Manual of Guidance i.e. the Gold, Silver and Bronze Command roles. He said he was aware of it but that it was mainly written for a *“uniform type of scenario but this type of work that I do is fairly unique but I’m aware of it and we do it”*. He was asked about his training for commanding these types of operations and said, *“well I would say probably I’m the most experienced officer, without bumming myself up, in this type of operation. I’ve been involved in these types of operations since 1989”*. He said that he had run such operations in Northern Ireland, other parts of the UK and overseas, and that he had worked with intelligence agencies and police forces throughout the world. He said that he knew the ACPO Guidelines.
- 10.6 He confirmed that there was air support for the operation. He confirmed that the details of who was in the control room were not documented and that operational decisions taken were not documented. He confirmed that he did not consider the intended targets of the attack. He said he was not aware as to whom the targets were intended to be. He said that his main operational objective was to take the weapon(s) out of circulation so they could not be used. He said that stopping the vehicle earlier involved the risk that the weapon was not on board and thus he wanted to assess the intelligence and when he was reasonably sure that the weapon(s) were in the vehicle to have the vehicle stopped outside Belfast. He stated that he consulted on options with the Inspector and Sergeant who were in the control room and were trained Tactical Advisors for firearms operations.
- 10.7 Detective Superintendent BB stated that he did not record the tactical advice given as *“it was a live operation and I was more concerned with the operation, what’s happening on the ground than writing down notes”*.

- 10.8 Towards the end of the investigation it was decided to interview Detective Superintendent BB again to clarify some matters. The Detective Superintendent was notified of this. A further lengthy period of certified sickness followed, and, as a result, he could not be interviewed until 19 July 2005. In this interview the Detective Superintendent stated that he had never received training but had vast experience. The Detective Superintendent maintained that, given the circumstances again, he would not change one part of the operation so far as his role was concerned.
- 10.9 In the interview the Detective Superintendent claimed that he discussed tactical decisions with Officers NN and EE who were Senior Tactical Advisors and positioned in the operation room. This included consideration of stopping the vehicle before the meeting in Belfast. He dismissed a 'stinger' type of device to stop the car saying they had found *"drug dealers etc. drive over them and then we've ended up with a whole scenario on the motorway where dangers to the public etc, these guys will drive on the rims, so that was not an option"*.
- 10.10 Detective Superintendent BB said that Sergeant EE was posted in the control room as a Firearms Tactical Advisor for the operation and then this role was taken over by Inspector NN. The Detective Superintendent was asked if he conducted any risk assessment and replied, *"Yeah, well I mean the risk assessment is obviously where we are going to actually do the tactical stuff and also the risk assessment of loosing this weapon, and the potential dangers to the public"*. He accepted that he had not conducted a formal and documented risk assessment. He considered that it was not his role to risk assess how the stop was done, that was for the officers on the ground.
- 10.11 Detective Superintendent BB said that the method of how to stop the vehicle was for the Bronze Commander on the ground. He stated that, *"it was one of the Sergeants"*. He confirmed that he did not know

and did not enquire into the details of any potential victim and said, *“if I’d known it wouldn’t have changed what my plan was”*. The Detective Superintendent dismissed other options suggested and said the vehicle had to be stopped as he had received certain information and *“it was not hard to work out that they were going to lose this”*.

- 10.12 Detective Superintendent BB rejected the suggestion that Mr McConville might be alive today if greater control was placed on the operation, and other options taken. He went on to say, *“I would not have changed ... one iota, I had all the expertise, I had all the information I needed and whenever I asked for the vehicle to be stopped I was aware of what was going to happen, it was going to be a tactical stop. You know the only reason that this gentleman’s life was lost is that he attempted to murder a police officer and that’s it, it’s as simple as that there”*.

11.0

DETECTIVE CHIEF SUPERINTENDENT DD

- 11.1 Detective Chief Superintendent DD who was Detective Superintendent BB's Senior Officer, was served with a Discipline Notice under the provision of Regulation 9, Royal Ulster Constabulary (Conduct) Regulations 2000. The allegation on that notice was that the officer failed to set, review and update the strategy in respect of the operation which resulted in the death of Neil McConville. It also alleged he neglected his duty in that he failed to ensure that there was an appropriate command structure for the operation and failed to minimise the recourse to lethal force. When served this notice he stated that he had nothing to say at that stage.
- 11.2 Detective Chief Superintendent DD had been a police officer with the PSNI for nearly twenty-five years at the time of the incident. He had been a uniform, CID and Traffic Officer during the course of his career. In 2002 he had been transferred to C4 as a Detective Chief Superintendent with responsibility for surveillance resources and authorisations. In March 2003, he was given regional responsibility for Special Branch resources in the Belfast Urban area with the title of Regional Intelligence Adviser.
- 11.3 He was interviewed under disciplinary caution and described how he had a good knowledge of Gold, Silver and Bronze command structures and the ACPO Manual of Guidance for the Police Use of Firearms. Detective Chief Superintendent DD describes how the system which was instigated that day should work. He said that the intelligence would come in and the Regional Co-ordinating Group would then bring all relevant parties together and prepare a plan to exploit the intelligence, which would effectively be a tactical plan. The Superintendent in charge would then go to the Regional Assistant

Chief Constable if he/she was available, or to the Detective Chief Superintendent if the Assistant Chief Constable was not available. The Assistant Chief Constable would then set the strategy and be the Gold Commander. He explained that whilst the Superintendent may have set a strategy, the Assistant Chief Constable may not agree that strategy, and that was the important role that is performed by the Gold Commander.

11.4 He said that the leader of the Regional Co-ordinating Group is the Silver Commander and the team leader on the ground the Bronze Commander. Thus the Assistant Chief Constable decides what's going to be done (strategy), the Regional Co-ordinating Group decides how they are going to achieve that objective (tactics) and the team then does it. The Detective Chief Superintendent referred to a Force Order which he stated explained this, and which did apply to officers employed in Regional Co-ordinating Group Operations.

11.5 Detective Chief Superintendent DD explained that on 29 April 2003 he finished work and left his office at about 5 pm. At about 5.20 pm he received a telephone call from Detective Superintendent BB who described intelligence that had been received. He told Detective Chief Superintendent DD that he had put an operation in place. The Detective Chief Superintendent stated that the purpose of the operation was very simple, to identify those involved and to stop, search and arrest them if they had a firearm. He described that as the strategy for the operation. He said that the Detective Superintendent had tried to speak to the acting ACC, but was not able to contact that officer. He then discussed the operation in some detail. He described how he had been involved in many dangerous operations in the previous few years, and how he had asked the Detective Superintendent relevant questions which satisfied him that the operation was legal, proportionate and necessary and that those matters had been catered for. The Detective Chief Superintendent made no detailed notes of this conversation.

- 11.6 The Detective Chief Superintendent stated that he then tried to contact the acting Assistant Chief Constable but he received no reply. He then spoke to the staff officer who said that the ACC was in a meeting with the Chief Constable and other senior officers. He left a message for the ACC to ring him and then contacted Detective Superintendent BB and told him he had not managed to contact the ACC, but that he was content with his plan and authorised him to continue with it. He accepts that he was then in the position of Gold Commander for the operation.
- 11.7 The Detective Chief Superintendent described Detective Superintendent BB as a “*very, very capable officer*” who had years of experience in this type of operation. He said the operation was already up and running when he was contacted, as it had had to start because they were unable to contact the acting Assistant Chief Constable. He said then effectively he had two options, either to agree to the operation as it was going, or to say stop. He said it was not the case of setting a new strategy as *‘that is how things go wrong’*. He said that people had been briefed and deployed, and things could not be changed mid-stream. He accepted responsibility for the plan which had been devised by Detective Superintendent BB.
- 11.8 He said that he had discussed with Detective Superintendent BB where the car was to be stopped, and the Detective Superintendent had said that the stop was to be effected on one of the roads which lead to the motorway, after the weapon had been collected. The Detective Chief Superintendent said that he was happy this was not to be done in a built up area. The Detective Chief Superintendent was asked if he had considered the safety of the intended victim and whether control of that person had been considered, which would have removed the immediate risk to life and given more options. The Detective Chief Superintendent was not aware that the details of the intended targets were known. The Detective Chief Superintendent suggested that this may not have been passed as he was on a mobile

telephone. He had, however, been provided with all the other sensitive details of the operation.

11.9 He also said that such information would not have changed his authorisation, particularly as the officers had already been briefed and were aware of what they were trying to do. He commented that it wasn't a case of *"let's come up with another bright idea here"*. It was pointed out to him that the ACPO Manual of Guidance, to which he was referring, stated that there were risks attaching to it. He stated that he was aware of the capabilities of the HMSU and that they were involved in such stops on a regular basis. He did not believe that anything else could have been done particularly as the operation was up and running.

11.10 Other suggestions which appeared not to have been considered, were put to the Detective Chief Superintendent, which included disrupting the individuals involved (by, for example, flooding the area where the meeting was to take place with uniform officers), stopping the car en-route, stopping those with the firearm prior to the handover as their details were known, and guarding the intended victims. The Detective Chief Superintendent dismissed all those options as, he asserted, they were not certain to have recovered the weapon, would not have prevented a criminal enterprise and would not have allowed the officers to bring the individuals before a court.

11.11 The Detective Chief Superintendent then said he continued home and had no further involvement until he was telephoned after 7 pm to be told about the shooting that had occurred, and he had not made any further enquiries during that time. He stated that he did not want to interfere and knew the Silver Commander to be very experienced. The Detective Chief Superintendent said he would not have done anything differently if the circumstances presented again, as his view was that he either endorsed the strategy or stopped the operation, and they were the only options available to him.

12.0

BELFAST REGIONAL CO-ORDINATING GROUP OPERATIONS CONTROL ROOM: RESPONSIBILITY FOR FIREARMS TACTICAL ADVICE

- 12.1 There were at least four officers with the Detective Superintendent in the Belfast Control Room. Sergeant EE ran the operation desk, and operated the radio, passing and receiving information to and from the units involved in the operation. He was accompanied by Inspector NN who was the senior officer in charge of the HMSUs. Sergeant PP completed a log of activity transmitted from the team. Acting Inspector RR assisted the Detective Superintendent, by recording some decisions and managing the Control Room.
- 12.2 A statement, dated 21 May 2003, was provided by Inspector NN, who is attached to the PSNI's Tactical Firearms Unit at Force Headquarters. He is a trained National Firearms Tactical Advisor and states that he has under his command a large number of officers, who have been accredited and who are on call 24 hours a day to give tactical advice. He explained that the officers were not on call to Specialist Operations Branch, and thus an on-call adviser was not sought on 29 April 2003 for this operation. He stated that the majority of officers involved in the operation were trained as Firearms Tactical Advisors, that the briefing was undertaken by Sergeant EE, a trained and accredited Firearms Tactical Advisor, and that both he and Sergeant EE were in the Police Operations Room and *available* to give necessary firearms tactical advice. The officer did not state that any advice was asked for or given.

- 12.3 A statement was provided by Sergeant EE dated 20 May 2003 in which he stated that he was briefed regarding the operation at 1645 hours on 29 April 2003 and transmitted details of the red Vauxhall Cavalier car to all vehicles in the Greater Belfast area. No registration number was known. He became aware a short time later that a red Vauxhall Cavalier car had been identified as being probably the vehicle in question. He transmitted all relevant messages from the surveillance units to the HMSU officers.
- 12.4 He stated that at 1723 hours he was joined in the control room by Sergeant PP who assisted him by opening an operations log. He stated that at approximately 1855 hours, Detective Superintendent BB directed him to tell the police officers to stop the vehicle. He stated that at that time there were seven police vehicles involved in the operation. He passed this message on and was then told that a stop had taken place and shots had been fired. He stated that he continued controlling the operations desk until all the police personnel had been relieved from the relevant scenes. Sergeant EE did not make any mention of having a role to provide tactical advice or indeed providing such advice.
- 12.5 The issue of tactical advice became of importance to the enquiry as a clear contradiction was emerging between what Detective Superintendent BB was stating and the statements of Officers NN and EE. Letters were sent, through the PSNI, on 14 October 2004, stating that Police Ombudsman's investigators wished to interview officers NN, PP, EE and RR with a view to clarifying some issues and to take further witness statements from them. No response was received to this request from any of the officers, and further letters were sent on 06 January 2005. Sergeant EE and Inspector NN then refused to be interviewed, or make a further statement, but agreed to respond in writing to questions asked. Sergeant PP had retired from the Police Service at this time and Acting Inspector RR ultimately refused to co-operate.

- 12.6 This was wholly unsatisfactory, as witnesses need to be interviewed and probed in order that relevant issues can be identified and thorough witness statements taken. However, given their refusal, written questions were provided. In the response then provided, to the questions asked, dated 28 February 2005, Inspector NN stated that the, *“..officers present were also required to offer Firearms Tactical advice.”* He said that the *“Gold/Silver/Bronze command structure was used and the strategy intentions of the operation were relayed by RCG staff, with the tactics required to achieve these objectives having been agreed and approved by the ... officer in the operations and control room and the senior RCG member. The Sergeant in charge on the ground ensured that the tactical plan was carried out”*.
- 12.7 He also said, *“On my arrival at the operations and control room I took overall command of all personnel involved in the operation, making myself available to offer Firearms Tactical advice”*. He confirmed that the on-call Firearms Tactical Adviser was not called as it was a Specialist Operations Branch operation and that both himself and Sergeant EE *“were in the operations and control room, and available to give the necessary Firearms Tactical advice”*. Again, Inspector NN did not state that advice was requested or given and provided no such details.
- 12.8 Sergeant EE stated that he was responsible for the HMSU Vehicle Desk in the Control Room, passing and receiving information to/from the call signs involved in the operation. He too stated that the Bronze/Silver/Gold structure was utilised. He stated, *“I was the first officer to arrive at the Operations Room. I was briefed by RCG staff, gave them tactical advice, then briefed my own personnel as the operation was already running. I am a nationally trained Tactical Advisor, as is NN. Advice was given throughout the operation”*. He did not state who gave the advice throughout the operation, what the advice was or to whom it was given. Whilst he stated advice was

given to RCG staff, he did not state whether he gave any advice to Detective Superintendent BB who was in charge of the operation.

- 12.9 In the interview of Detective Superintendent BB of 19 July 2005 he stated that Inspector NN and Sergeant EE were the appointed Tactical Advisors for the operation. PSNI instructions indicated that the appointed advisor should complete a proforma indicating the advice requested and given. Inspector NN and Sergeant EE were thus served a disciplinary notice outlining the allegation that they failed to complete the proforma as required.
- 12.10 Inspector NN was interviewed under disciplinary caution on 19 August 2005. The officer refused to answer the vast majority of the questions and would not confirm or deny if he was the appointed Tactical Firearms Advisor for the operation. He did state that the instruction regarding completion of the proforma applied to all the PSNI except Specialist Operations Branch (SOB). It was pointed out to him that the instruction did not provide for any exemption.
- 12.11 During the course of the interview Inspector NN volunteered the comment, *"The first time, the very first time, tactical advice was given to an RCG during an SOB operation was 29 May 2003"* (i.e. a month after this fatal shooting). He refused to elaborate or answer questions relating to this. The comment seemed to indicate such advice was not given on 29 April.
- 12.12 During the course of the interview, the contents of his written response to questions, dated 28 February 2005, was read to him. This was on a computerised typed PSNI report form, bearing his typed rank and designated number at the end. This had been sent through his line manager, to the PSNI Police Ombudsman Liaison Officer within the PSNI at their Headquarters, where it was handed to the Police Ombudsman's Investigator. Inspector NN claimed the version the Investigators had read was not his original statement but had been altered, and words deleted. He also said that his report was

dated 20 February 2005, not 28 February 2005. He had a copy of the report he said he had submitted.

- 12.13 Following the interview, a letter was received from his solicitor dated 06 September 2005 addressed to the Police Ombudsman in which it said, *“it appeared that certain information which our client had supplied in the course of this enquiry had been altered. We hereby apply on our client’s behalf for copies of the altered questions and answers. We further request information as to why the questions and answers were changed, who changed them and who authorised the changes”*.
- 12.14 Sergeant EE was interviewed under disciplinary caution on 18 August 2005. He too refused to answer the majority of questions posed but stated that whilst he gave tactical advice, he was not designated as the Tactical Firearms Advisor for the operation. He refused to answer questions as to the advice for which he was asked, or the advice he gave. The officer also claimed that the Force Order did not apply to Specialist Operations Branch.
- 12.15 Sergeant EE also alleged that his typed response to questions had been altered after his submission. The response received by the Police Ombudsman was dated 03 March 2005, and the response to question two started with, *“The Gold / Silver / Bronze Command Structure was implemented”*. Sergeant EE stated that the response he submitted stated, *“The Silver / Bronze structure was present”*. He stated that he had not authorised these changes.
- 12.16 As a result a meeting was held on 29 September 2005 with the Head of C4 Branch of the PSNI, who has responsibility for the officers in question. He stated that it was his belief that the officers themselves submitted the original reports, and then amended them. He was quite sure that the reports forwarded to the Police Ombudsman were written entirely by Inspector NN and Sergeant EE.

- 12.17 The following day, 30 September 2005, the Police Ombudsman's Office was contacted by the Head of the Branch and informed that both Inspector NN and Sergeant EE accepted that they had made the amendments in question. Both Inspector NN and Sergeant EE withdrew any allegations they were making in writing.
- 12.18 Acting Inspector RR had been in the control room and completed the log of the operation on behalf of the Detective Superintendent. The officer had assisted Detective Superintendent BB and was situated next to him in the Control Room. The officer had recorded details of the intelligence made available and objectives of the operation, which both the officer and Detective Superintendent BB signed. Acting Inspector RR had provided a witness statement on 16 May 2003. The officer was permanently attached to the Regional Co-ordinating Group and remained in the Control Room throughout the operation. The officer was there at 1855 hours when Detective Superintendent BB ordered that the suspect vehicle should be stopped as soon as possible. The officer made no mention of any tactical firearms advice being sought or given.
- 12.19 Given the uncertainty in what had occurred, a letter was sent to the PSNI on 14 October 2004 seeking to take a witness statement from Acting Inspector RR to clarify outstanding issues. The letter asked the officer to contact the investigators, but the officer did not respond. In January 2005 a further letter was sent which resulted in a meeting with the officer on 25 January 2005. The officer was accompanied by a supervising officer. The officer was asked for a further statement and the reasons it was required were explained. The officer refused to make a statement that day.
- 12.20 The Police Ombudsman's investigator provided Acting Inspector RR with a list of questions on which clarification was required, in an attempt to secure co-operation. The officer requested time to consider making a statement and took those questions away. The officer then left a message on 02 February 2005 refusing to make a

statement. Following the interview of Detective Superintendent BB on 18 July 2005, it was apparent that there were contradictions in the evidence and accounts provided by members of the Control Room and it was essential that a statement was obtained from Acting Inspector RR.

12.21 Weekly Order 26/03 of the PSNI provides that officers can be ordered by a senior officer to make a witness statement to the Police Ombudsman. Accordingly on 09 August 2005 a letter was sent to the PSNI requesting that the officer be ordered to take part in an interview and make a further statement. On 18 August 2005, the officer attended the Office of the Police Ombudsman, again accompanied by a senior officer.

12.22 The procedure and need for a statement were explained to the officer, who again refused to make a further statement or answer any questions. The seriousness of the investigation, involving a death, was pointed out to the officer, as was the need for the investigation to be thorough to comply with Article 2 of the European Convention on Human Rights. The officer stated that no-one had done anything wrong and *“that the person had died because he tried to kill a police officer”*. The General Order was pointed out to the officer, as was the fact that refusal to co-operate may be a disciplinary offence. The officer still refused to make a statement and said, *“Discipline me, I’m not making a statement”*.

13.0

THE ROLES AND FUNCTIONS OF OFFICERS INVOLVED IN STOPPING MR McCONVILLE'S CAR AND THE SUBSEQUENT EVENTS

- 13.1 Sergeant HH was interviewed under the provisions of the Police and Criminal Evidence Order 1989 on 18 June 2003. He stated that on 29 April 2003 he had commenced duty at 0700 hours. At that time he had been issued a Heckler and Koch MP5 sub-machine gun and two magazines of twenty-eight rounds. He also had his Personal Protection Weapon. At 1645 hours that day he was tasked in relation to the operation. He was dressed in police overalls. He describes the operation as a 'fastball' operation (a term used by officers to indicate a spontaneous rather than pre-planned operation,) and said there was no formal briefing in a briefing room because of the immediacy of the operation. He and others were told that there would be two persons in a red Vauxhall Cavalier, the details of a road in which Man 'A' was to meet an individual to take possession of a weapon in Belfast and the name of that person. There was no certainty where the car would then go, so they were told to position themselves in Belfast and wait for Surveillance Units to identify the red Vauxhall Cavalier until *"such times as we directed any action as required"*.
- 13.2 Sergeant HH described how resources were being pulled together, and how they would operate. Call Sign 10, containing Sergeant HH, was a Belfast based unit. It was joined by Call Sign 7, a South Region vehicle.
- 13.3 Sergeant HH said, *"Basically we discussed, GG discussed with KK, the tactics that were to be used if we were called to stop the target"*

vehicle itself. And the tactic discussed was if it was a road stop, then ourselves, myself in particular, would actually stop the Cavalier and then Call Sign 7 would be further on deployed and they would have been in a position if they did crash through our actual checkpoint they could deploy a stinger. And then the other tactic was if we had to have approached the vehicle from behind then our vehicle would pull alongside the target vehicle and bring it to a halt whilst Call Sign 7 would be behind it to prevent it from reversing out of any stop". As the operation was occurring in Belfast, it was decided that Call Sign 10 would act as the principal vehicle.

- 13.4 Sergeant HH confirmed that he had been told that the objective was to arrest the occupants when the police were quite sure that a gun was onboard. He said that he had been given the name of Man 'A' and the person whom he was to meet in Belfast. He was not provided the details of Mr McConville. He described how they had a 'rolling sort of brief', and were updated as information became available.
- 13.5 He confirmed that the order to stop the vehicle was relayed by Sergeant EE in the Control Room. He stated that Sergeant GG asked how they (i.e. the Control Room) wanted the stop achieved and that the *"RCG were happy enough for us to stop the vehicle and pull it, what we call, pull it from behind"*. He stated that the two-tone horns and blue lights on their car were activated as they caught up, turned them off when the red Vauxhall Cavalier was in sight and switched back on as they finally approached the vehicle.
- 13.6 Sergeant HH was in uniform and positioned in the rear seat behind the passenger seat in Call Sign 10. He described how they caught up with the red Vauxhall Cavalier when instructed to do so, and overtook the car. He estimated the speed of their vehicle then to be 40-50 mph. He confirmed that a helicopter had advised of the progress of the red Vauxhall Cavalier. The Vauxhall Cavalier then swung into their car causing a collision. He described how Sergeant GG had wound his window down, and indicated to the driver to pull over, and how he was

in the process of putting on his police cap. The collision dislodged their wing mirror. The vehicles locked together and the red Vauxhall Cavalier came to a stop eventually, facing towards Crumlin, the way from which it had just travelled. The other police vehicle had passed them and the Vauxhall Cavalier started to move. Constable FF, the driver, closed the gap and the nearside front of the police vehicle collided with the offside front of the red Vauxhall Cavalier.

- 13.7 He then got out of the vehicle with Sergeant GG. He said he was carrying his Heckler and Koch MP5 sub-machine gun and, as he approached the front of the red Vauxhall Cavalier car, he brought the gun into his shoulder and removed the safety catch off the weapon to *“cover the occupants of the Cavalier”*. He said, *“I was aware of Officer GG breaking the side driver’s door window with his MP5 and shouting, ‘armed police’ or words to that effect on several occasions”*.
- 13.8 The driver of the car was revving the car loudly and appeared to be *“getting or attempting to get the vehicle into gear”*. The vehicle suddenly started to reverse at speed and knocked Sergeant GG out of the way and knocked another officer into the air. Sergeant HH then described how he ran towards the driver’s window and shouted, *“Armed police stop”* several times. He saw the driver working the gear stick and saw that Constable JJ was lying in front of the Vauxhall car, about eight to ten feet from it. He was directly in what would be the path of the Vauxhall car. He was also aware of another uniformed officer to his right in the general path of the Vauxhall car.
- 13.9 Sergeant HH then said, *“Fearing for the life of Constable JJ and other police I fired what I considered to be an aimed shot at the driver of the Cavalier as there was no other course of action open to me to prevent the Cavalier driving over Constable JJ. On pulling the trigger I immediately realised my fire selector was on fully automatic and I immediately released the trigger. As a result I believe I fired three or possibly four aimed shots at the driver”*. He stated that he was in no doubt at the time that if the driver drove the vehicle forward that

Constable JJ would be either killed or seriously injured. He said that the driver was *“bent on getting away, he would have driven over the top of that police officer”*.

- 13.10 In respect of the fire selector / safety catch the officer stated that he had placed it in the automatic firing opposition in error and claimed that this can be easily done, particularly with the older type of MP5s. He said that this had happened before, and had happened on the range (in training). He stated that once a position had been selected and the gun was in aim position it had to be taken out of aim position to change it.

14.0

CONCLUSIONS OF THE POLICE OMBUDSMAN FOR NORTHERN IRELAND IN RELATION TO THE INVESTIGATION OF THE CIRCUMSTANCES SURROUNDING THE DEATH OF MR NEIL McCONVILLE

- 14.1 Police officers have to face extremely difficult and dangerous situations which are often imprecise and uncertain. Any subsequent assessment of actions has to take into consideration the speed at which operational situations can develop and the personal stress and fear that officers may experience when confronted by potentially violent situations. Northern Ireland has suffered more than its fair share of violent incidents and there have undoubtedly been high demands on the Police Service of Northern Ireland to respond to incidents such as that which presented itself on that day. The operation which had to be mounted was, however, not unique, and similar situations are encountered by all major police services in the United Kingdom, albeit possibly not as often.
- 14.2 This operation has been described by the officers involved in the incident as a 'Fastball' operation in that the intelligence received indicated a need for immediate action, without the luxury of quality time to plan a response in advance. These police units are well trained for such operations. They are the equivalent of a Tactical Firearms Team, which may be found in other large policing services. Detective Superintendent AA initially assessed the intelligence as being insufficient to mount an operation, and re-assessed that decision in the light of information as it emerged. He was required to act with considerable speed but documented his decisions and the rationale for them. He also ensured appropriate authorisation for the

operation under the Regulation of Investigatory Powers Act 2000. The computerised intelligence record was not made available to the Police Ombudsman's Investigators, and was deleted from the system either accidentally or deliberately. **It is accepted that the intelligence did indicate the need to mount an operation and the actions of Detective Superintendent AA in so doing were appropriate and proportionate.**

14.3 He informed his supervisor, Detective Chief Superintendent CC, who was satisfied with the actions taken and did not see a further role for himself, given that the operation was being passed to another region for which he had no responsibility. **Given the urgency and importance of the events unfolding this decision also seems appropriate.**

14.4 The operation was passed to Detective Superintendent BB, who recorded in the initial contact with Detective Superintendent AA that the HMSU would stop the vehicle as it left Belfast. It is apparent from all the evidence available that this strategy was selected without detailed consideration of any other option. Detective Superintendent BB did not record all his policy decisions, which is a requirement of PSNI Orders and the ACPO Manual of Guidance for the Police Use of Firearms. He stated that this was because of the speed of the operation and the lack of opportunity. This is not accepted as he had over two hours in which to record decisions, he had significant support in the operations/control room and a record was essential given the seriousness of this operation and the potential deployment of lethal force.

14.5 When initially interviewed the officer described himself as "*probably the most experienced in this type of operation*" and maintained throughout that he did not feel he would change any decision he made given the same circumstances again. His overwhelming consideration was taking a weapon out of circulation, an understandable objective.

14.6 Detective Superintendent BB has claimed that he took tactical advice from Sergeant EE and Inspector NN who are trained tactical advisers. **It is not accepted that they each had the role of Tactical Firearms Advisor as claimed by Detective Superintendent BB.** Had advice been requested, a form should have been completed, which should have been signed by the Advisor, and the officer in charge of the operation, Detective Superintendent BB. **No such Form was completed and no other written record exists.** It is also clear that the Detective Superintendent made his decision immediately and Sergeant EE and Inspector NN had distinct roles in the Control Room, other than being there as Tactical Firearms Advisors. The other two identified members present in the Control Room, Sergeant PP and Acting Inspector RR, have not co-operated with the investigation. Acting Inspector RR initially provided a statement, which did not include any details relating to tactical advice, or the directions of Detective Superintendent BB. The officer refused to co-operate any further in contravention of PSNI General Orders and Code of Ethics. Sergeant PP declined to make a Statement and retired before the matter could be pursued. The Detective Superintendent claimed in interview that he considered the risks. There is no documented risk assessment. He would be aware of the importance of such a document which is advocated in the ACPO Manual of Guidance for the Police Use of Firearms. **The Police Ombudsman has concluded on the evidence available, that the Detective Superintendent did not make use of a Tactical Firearms Advisor and did not assess tactical options as required.**

14.7 Inspector NN had a supervisory role and force-wide responsibility for Tactical Firearms Advisors and thus should have been well aware that Tactical Firearms Advisors should be independent of the chain of command for the operation mounted. Neither Inspector NN nor Sergeant EE had that independent advisory function. They were involved in the operation. The PSNI Instruction and Manual of Guidance for the Police Use of Firearms distinguished between the

command functions and the advisory role. Obviously initially the operation had to be started with urgency, but time did then allow for independent Tactical Firearms Advisors to be employed. The PSNI, as an organisation, accepted that the instruction did apply to all sections of the organisation. **The PSNI Policy did not exclude the Special Operations Branch from the requirement to use Tactical Firearms Advisors as alleged by Inspector NN and Sergeant EE. It is also a matter of serious concern that the Inspector in charge of Tactical Advisors does not recognise that the Advisors have to be independent of the operation.**

14.8 In addition to this there is serious concern about the management of this operation, and the lack of proper consideration of other options. Detective Superintendent BB did not know the name of the intended victims and had not sought such details. Neither had he checked whether Detective Superintendent AA had allocated resources to ensure the safety of the intended victims. He stated that it would not have made a difference to his planning. This indicated that he did not consider deploying resources to ensure those individuals were safe (either covertly or overtly). Had he done so, he would have had more options available to him, knowing that the victims were safe. **This should have been a consideration.**

14.9 The police officers had Stinger devices and there were significant resources available to the Detective Superintendent to deploy. A Vehicle Check Point could have been organised, and was in fact a documented early plan, which would have been inherently safer than the option chosen. In his second interview the Detective Superintendent claims that the officers on the ground chose the option of a stop from behind. The evidence clearly shows the Control Room directed the tactic and that those officers twice questioned the decision to stop the vehicle from behind.

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14.11 Stopping a vehicle from behind is a high-risk tactic which should only have been used when other options had been excluded. If, as suspected, the suspects were armed, they would be highly unlikely to be compliant with a police command. As they were ordered to overtake the vehicle at speed those officers were exposed extreme danger. They would inevitably be close to, and in the firing range of, the potentially armed occupants of the vehicle. This tactic also inevitably leads to a 'stop' at speed, where loss of control of vehicles and collisions are highly likely. In the context of armed occupants of the target vehicle, and the necessity for police to present an armed challenge to them, this created considerable uncertainty as to the outcome. The roads were wet on the night in question which would have exacerbated the risks. There are occasions when such tactics are necessary, but only after careful consideration of other options. There is no evidence in this case that such careful consideration took place.

14.12 Detective Superintendent BB claimed that the vehicle had to be stopped, as the helicopter assistance might well become ineffective. **The evidence of the pilot shows that not to be the case, the red Vauxhall Cavalier was visible as it left Belfast, at least 10-15 minutes before the stop was executed, and the Control Room had direct contact with the aircraft.** The resources on the ground did not have such contact. Surveillance from the air would have been a great asset in seeking to direct a vehicle into a Vehicle Check Point had that action been considered.

- 14.13 Some comment was made by Detective Superintendent BB that everything was running fast. However there was also an option to disrupt the operation through a uniformed police presence in the identified location in Belfast where the meeting was to take place in connection with the weapon. In truth, the police units were on the ground, and in strength, and able to cope with the challenges. **Detective Superintendent BB had clearly not given this option any consideration.**
- 14.14 Detective Superintendent BB was aware that there were further resources available in South Region. Detective Superintendent AA had noted that his favoured plan was to mount a Vehicle Check Point in South Region when the car returned to that area. **Detective Superintendent BB did not factor this option into his planning.**
- 14.15 Detective Superintendent BB placed considerable importance, in forming his strategic aims, on the need to remove the firearm from the streets. The Detective Superintendent would also have been aware during this operation that other firearms still remained in the hands of known criminals whom Man 'A' and Mr McConville had met, yet he had no strategy to try and recover those weapons and no such action was taken. **This seems to be in conflict to his overall aim.**
- 14.16 Detective Superintendent BB did communicate with his supervisor, Detective Chief Superintendent DD and discussed his plan. Both state that the acting Assistant Chief Constable was not available because a meeting was being held. **It has been confirmed that at least one other Assistant Chief Constable was available in force, and on duty, at the time but no effort was made to contact them. This should have been done.** Detective Chief Superintendent DD identified himself as the Gold Commander. **Given his assessment that he was fulfilling that role, his response and involvement was totally inadequate.** The Detective Chief Superintendent stated more than once when interviewed that, as the operation was running, new strategies could not be set as that is how things go wrong. As the

Gold Commander he had a duty to continuously review the strategy as events unfolded. **He should have had a much greater involvement and been available to provide much better support to the Detective Superintendent.**

14.17 Detective Chief Superintendent DD made inadequate notes of the role he took and the decisions he made. **He did not review the strategy and did not place himself in a position to maintain effective strategic command of the operation.**

14.18 Detective Superintendent BB was entitled to better leadership from his supervisor, but he was very experienced, and this no doubt was a factor playing on the mind of Detective Chief Superintendent DD. The Detective Superintendent should have taken and documented tactical advice, and considered the matters outlined in this Report. He should have made enquiries regarding the potential victim(s) to increase his options. He should have documented his actions and a risk assessment in a professional way. It will never be known whether another option may have produced a different outcome but such a possibility cannot be excluded. It is always easy in hindsight to criticise decisions which are made in pressurised operational situations. However, Detective Superintendent BB was a very experienced officer, had access to manuals and advice and at least two hours to consider his different options. He had significant resources in terms of the number of specialist officers and equipment at his disposal. **It is concluded that he did not plan and control the operation to minimise the possibility of recourse to lethal force as required by the PSNI Code of Ethics and Article 2 of the European Convention of Human Rights. His failure to properly consider the options available, failure to communicate proper decisions and to document clearly his actions was a serious deficiency.**

14.19 The police officers involved on the ground were briefed but there is no record of the actual briefing. The ACPO Manual of Guidance for the Police Use of Firearms would articulate as good practice the keeping of a record of the briefing. The Manual of Guidance for the Police Use of Firearms states, *“Officers providing briefings should stress the aim of any operation including specifically the individual responsibility of officers and legal powers anticipated to be used in all aspects of the operation. Such briefings should be recorded in a manner prescribed by local policy having regard to the Criminal Procedure and Investigations Act, 1996”*. Whilst this was a hastily organised operation, the police units are frequently called upon for such tasks and should be equipped to make such records at a short notice. **There is no evidence that during the briefing officers were advised of the relevant legal provisions, or of their individual responsibilities. Whilst it could be argued that they should be fully aware of this, given their extensive experience, research indicates that all firearms teams of other UK Forces would receive such warnings whatever their experience. Most seriously, no Bronze Commander was appointed.**

14.20 There has been a significant lack of co-operation from officers in the Control Room. Neither Inspector NN or Sergeant EE were appointed as Tactical Advisors, although they did seek at one stage to indicate that they had given tactical advice as Tactical Advisors, and their lack of co-operation is inexplicable. As it is accepted they did not fulfil the Tactical Advisor role it was not appropriate to subject them to disciplinary action for failures in this respect. **Their lack of co-operation and attitudes could undermine public confidence in the PSNI, particularly as they are employed in such a sensitive department of the organisation.**

Further, having refused to be interviewed, they alleged that their written answers to questions had been tampered with, but subsequently withdrew these allegations, when they were challenged.

- 14.21 Acting Inspector RR also failed to co-operate with the investigation. **Appropriate action was recommended against the officer in respect of the refusal to write a witness statement. The officer retired soon after and cannot now be subjected to disciplinary action. Sergeant PP did not fully co-operate with the inquiry, but retired during the latter stages of this investigation before this could be pursued.**
- 14.22 The impact of this overall resistance to the investigation was that no clear and objective assessment could be made, and individuals could not be held accountable for the decisions and advice given in the Belfast Control Room. A graphic example of this was evidenced when critical draft paragraphs of this Report were sent to those officers in the Control Room for factual comment. Inspector NN indicated that there were six officers in the Control Room supporting Detective Superintendent BB. No information was provided by Inspector NN as to the identity of the sixth officer. Sergeant EE indicated there were more than four officers. There had been no record of the staffing of this Control Room. Only officers BB, EE, NN, RR and PP had been mentioned in any Report, response to questions or interviews of officers.
- 14.23 The police units on the ground responded with speed, and quickly had control of the suspect vehicle. The evidence indicates that the officers twice sought confirmation of the strategy to be adopted i.e. a stop from behind. The police units are trained in this tactic but it is recognised as a high-risk strategy, particularly when it is desired to bring a vehicle to a stop from speed. The forensic, medical and witness evidence supports the version of events given by the officers as to what happened at the scene. It is clear from all the evidence collected during the course of the investigation that the officers reasonably anticipated that they may face violent criminals armed with firearms who would have had every reason to avoid detection. It is accepted that officers had every justification to have their weapons

drawn when they left their vehicles and their response was thus proportionate and justified.

14.24 The evidence supports the fact that the officers were telling Neil McConville to get out of the vehicle and shouting that they were armed police officers. Mr McConville was not compliant with these commands. Sergeant GG did try to physically restrain the driver without recourse to firearms when the vehicle knocked an officer over. Mr McConville could have been in no doubt that his vehicle was surrounded by armed police officers and that it was a serious situation. The evidence supports the fact that an officer was injured and lying on the ground. Clearly a vehicle driving over him at speed was likely to cause serious injury and possibly death. It is not difficult to imagine how quickly these events were unfolding, with the whole incident probably more easily counted in seconds than minutes.

14.25 Several warnings were given and three officers were preparing to discharge their weapons at the driver, having come to identical independent views of the life threatening situation that they were facing. Sergeant HH then discharged his weapon. It is tragic that three shots were discharged rather than the one aimed shot intended. The Pathologist has stated that only one of the three bullets caused the fatal injuries to Mr McConville. This fatal bullet entered Mr McConville through the middle of the three entry wounds on his upper right arm. The FSNI ballistics expert notes that in his professional opinion this middle wound was probably caused by the second of the three shots that struck Mr McConville, and accepted that the automatic mode could be inadvertently selected in a stressful situation. It is therefore likely that Mr McConville would have survived if only the first shot had been fired. **This is not the first time that the Police Ombudsman has investigated a situation when a Heckler and Koch MP5 was accidentally engaged in the fully automatic mode, and on 17 January 2005 the Police Ombudsman recommended that this function be disabled on the weapon.**

- 14.26 The investigation conducted supports the Sergeant HH's contention that he believed that his colleague's life was in danger, and that the use of a firearm was, in his view at the time, necessary to address that threat. It was stated by Detective Superintendent BB and other officers, in interview, that Neil McConville was intending to murder a police officer. The evidence does not support that black and white analysis of the situation. The evidence would indicate that Neil McConville was determined to get away and had he driven forward would have driven over the officer. His intention was probably never to kill the officer, but it was a fact that such a consequence could have occurred.
- 14.27 There is evidence to support the officers' claims that they rendered first aid to the driver and passenger in the vehicle. Evidence of the bandages etc. used by the officers was present at the scene, members of the public witnessed first aid being given and the ambulance crew also confirm the efforts of the officers in keeping Neil McConville alive. Some members of the HMSU were highly trained in paramedic care. A decision was taken to remove Mr McConville to hospital in a police vehicle given their assessment of the extent of his injuries. The evidence of the pathologist would support that decision, as speed of medical intervention was the only factor which would have been likely to save his life. As such intervention was not possible, he died from the injuries he had sustained.
- 14.28 **Sergeant HH and all other officers at the scene cooperated fully with the Police Ombudsman's investigation** and were supportive of investigators from the Police Ombudsman's Office being present for the de-brief the next day, which allowed the investigators to achieve a comprehensive overview at an early stage of the investigation. **Such a presence at a de-brief is unusual but was supported by those officers. It is quite usual for officers to go sick following such traumatic incidents but, with the exception of Constable JJ who was injured, the officers remained on duty and assisted the investigators.**

- 14.29 Sergeant HH was forthcoming in interview, and all officers involved on the ground in the investigation were interviewed promptly and provided the investigators with comprehensive statements. A file of evidence in this case was forwarded to the Director of Public Prosecutions who directed no prosecution against any police officer.
- 14.30 **Whilst the Police Ombudsman has had access to other intelligence in this investigation, the Police Ombudsman has not been able to view all the original intelligence on which the operation was based.** Readers of this Report may have great difficulty accepting the explanation offered of an accidental erasure of the material, particularly following the resistance offered to granting access to the material. The PSNI, at a senior level within Special Branch, were aware that access was required and of the importance of this particular investigation. The resistance was at Assistance Chief Constable level, albeit as a consequence of advice received. When access granted, following intervention by the Chief Constable, the intelligence was found to be missing.
- 14.31 The Police Ombudsman regularly receives full co-operation when requirements are made for intelligence material. Resistance has been previously met on more than one occasion in respect of access to sensitive information held by Special Branch, and legal action was threatened before this incident was resolved. Following such resistance, the absence of the material required is all the more suspicious. All other avenues were pursued to check the provenance of the intelligence and the Police Ombudsman is satisfied that intelligence did exist which justified the operation. It will never be known whether the full content would have justified any other courses of action. The erasure was investigated but no evidence found to prove or disprove the explanation offered. **The PSNI must take action to ensure this never happens again. It is crucial to public confidence in the system that the Police Ombudsman has quick and unrestricted access to all material on which police base**

actions. The Police Ombudsman will take any legal action necessary to ensure this legal requirement is complied with.

- 14.32 An unloaded sawn-off shotgun was found in the vehicle. No ammunition was found with it. The officers at the scene have never indicated that it was used in an aggressive way in their presence.
- 14.33 It is of concern that senior officers interviewed gave different answers regarding whether the PSNI operation complied with the ACPO Manual of Guidance for the Police Use of Firearms, and the recommended command structure for such an operation. This is an area where absolute clarity is required. Although the RUC adopted the Gold, Silver and Bronze Command roles in 1998, when the force published a General Order to that effect, no officer was trained in any of these command disciplines for firearms operations until 2005.
- 14.34 In December 2002 the police were involved in another shooting incident which did not prove fatal. The investigation of that incident also showed that there was considerable uncertainty as to the status and application of the ACPO Manual of Guidance for the Police Use of Firearms within the PSNI. Recommendations were made to the Chief Constable on 03 July 2003, prior to the final Report being issued, and three months after the shooting of Mr McConville. Reference was made to the fact that similar issues were emerging during the investigation of the shooting of Mr McConville. One of the recommendations was, *“That a general review of Firearms Policy and Practice takes place to standardise compliance with the ACPO Manual of Guidance, or to publish policy if in variance with the Manual of Guidance”*. It is absolutely vital that officers are very clear as to the procedures required on occasions such as this.
- 14.35 The PSNI was asked on at least five occasions to identify those aspects of the ACPO Manual of Guidance for the Police Use of Firearms with which it considers itself in compliance, and whether any policy decisions had been taken, with reasons provided, for

departures from the Manual of Guidance for the Police Use of Firearms. No response was received. The PSNI had not advised the Association of Chief Police Officers or Her Majesty's Inspector of Constabulary of any desired abrogation from the Manual.

- 14.36 It is accepted that the PSNI is an armed service, and in that way is different to the vast majority of other UK police forces. This has been specifically catered for in the Manual of Guidance for the Police Use of Firearms. It is also accepted that there has historically been a different context to policing in Northern Ireland. However, no operational reasons were articulated as to why the Manual, in its entirety, could not be adopted by the PSNI. Other investigations conducted by the Police Ombudsman have identified concerns in the use of firearms by the PSNI, their training regime and a failure to comply with many aspects of the Manual of Guidance for the Police Use of Firearms. There have been many 'near misses' - occasions on which firearms have been operationally discharged with an attendant risk of injury to people.

15.0

THREATS TO MR McCONVILLE TWO WEEKS BEFORE HIS DEATH

15.1 Person 'P' had also alleged that, two weeks before his death, Mr McConville had been chased by police who threatened to shoot him. Extensive checks were made of police intelligence records, both locally and centrally, where any police interest or stops of Mr McConville would be recorded. No trace could be found of any incident in the time period given when Mr McConville was allegedly chased by police. Attempts were made to interview two of his friends who may have been with him but all attempts to secure their assistance failed. This matter cannot therefore be taken any further.

16.0

ALLEGATION OF ABUSE BY OFFICERS TO “PERSON P” ON 24 MAY 2004

- 16.1 Person ‘P’ alleged that she was driving her Volkswagon Golf vehicle at 2.54 pm on 24 May 2004 when her vehicle was stopped by police. She had her two young children in the vehicle with her. She states that police had followed her previously and she was angry. She thus immediately said to the officer who approached her, *“why the fuck are you harassing me? Is it not enough for you to shoot my child’s dad dead?”* She states the officer replied, *“so fuck, he deserved it anyway. Didn’t shoot him quick enough the wee bastard”*. There was another male officer and a female officer present. Person P took the officer’s number and said she was going to report him and he again allegedly swore at her.
- 16.2 Enquiries were made of the number Person P had taken which identified the officer as Sergeant ‘X’. A discipline form was then served on him stating he was being investigated for abusive and offensive language towards Person ‘P’.
- 16.3 The other two officers from the police vehicle were subsequently identified as Constable X1 who was the driver and Reserve Constable X2. On 10 August 2004, Constable X1 was interviewed and a witness statement was taken from him. He stated that the Sergeant did a check on the vehicle and found it was not registered in the area. He was a local officer and did not recognise the vehicle and had earlier seen it outside a known drug dealer’s house. He decided to stop it.
- 16.4 He stated that Sergeant X left the vehicle and spoke to the occupant and he did not pay much attention as he saw it was a female and that there was a child in the car. He did not hear the conversation or raised voices. When the Sergeant returned to the vehicle he told

Constable X1 who was driving the car. Constable X1 knew Person 'P' and did know that she was the former girlfriend of Neil McConville.

- 16.5 On 10 August 2004 Reserve Constable X2 was also interviewed and a witness statement was taken. Reserve Constable X2 confirmed the basis for the stop and had stood by the passenger side of the police car whilst Sergeant X approached the driver, a female who got out of the vehicle. Reserve Constable X2 did not hear the conversation but did hear that the female driver had raised her voice. The Sergeant returned to the police car. Reserve Constable X2 did not recognise the driver, did not know Person P and was unaware of any link between Person P and Neil McConville, until told of this when interviewed by the Police Ombudsman's investigator. Reserve Constable X2 considered it a routine stop.
- 16.6 On 27 August 2005 Sergeant X was interviewed under disciplinary caution. He confirmed the reason for stopping the vehicle and speaking to Person 'P', the driver. He asked for the documents to the vehicle as it was not registered locally. She then produced her insurance details. He said there was a child in the car and decided that there was no need to search the vehicle. He said that he had had previous dealings with Person 'P' but denied that Neil McConville featured in the conversation at all. The Sergeant had noted the stop in his pocket book.
- 16.7 There were no other available witnesses to the incident. Person 'P' accepts that the officer had told her that the vehicle was not registered locally, and thus it is clear that some enquiry had been made about the vehicle before it was stopped. Details of the alleged drug dealer have been verified, and it has been established that Person 'P's' vehicle was in the vicinity of that property, albeit for an innocent purpose. Whilst Person 'P' was known to two of the officers they were unaware that she was associated with Neil McConville. Checks of police records would support that.

16.8 The Police Ombudsman is satisfied that there were justified grounds to stop the vehicle and that the officers were unaware as to who was driving it when they stopped it. There is a complete conflict on what was said between the Sergeant and Person 'P'. Having carefully considered all the evidence the Police Ombudsman does not find the complaint substantiated.

17.0

RECOMMENDATIONS OF THE POLICE OMBUDSMAN FOR NORTHERN IRELAND PURSUANT TO THE INQUIRY INTO CIRCUMSTANCES SURROUNDING THE DEATH OF MR NEIL McCONVILLE

17.1 This investigation has reinforced the importance of clear policies, training and command for operations involving potentially lethal force. The PSNI has been working on policy development in these areas and has introduced a number of changes since this incident. They engaged in a full review of their firearms training, have sought a review from Her Majesty's Inspector of Constabulary and have consulted the Office of the Police Ombudsman on those developments. The changes made by the PSNI are contained in the following responses from the PSNI, which demonstrate that necessary change has occurred, and should continue to occur. Since this incident occurred structural changes have been made within the PSNI. The PSNI response to the recommendations made by the Police Ombudsman are incorporated in this Statement, and use current terminology in relation to PSNI structures.

17.2 **Recommendation 1**

That urgent attention is given to Firearms Policy to bring the PSNI in line with the nationally identified good practice and training standards articulated in the Manual of Guidance for the Police Use of Firearms .

PSNI Response

The implementation of the new PSNI Firearms Policy and introduction of Armed Response Vehicles (ARVs) will further align PSNI Firearms Policy with National Standards. However, the provision of a further less lethal option - TASER - will be essential to allow PSNI to mirror best practice in GB. TASER allows Police to incapacitate immediately a subject, and if available to PSNI officers working in pre-planned firearms operations, such as this incident, it could in the right circumstances, prevent the need to recourse to the use of lethal force. This is currently subject to discussion with the Policing Board.

- 17.3 This investigation has highlighted the fact that experience alone, without training, is not adequate. The PSNI have recently trained officers in the Silver and Gold Command roles. In England and Wales only officers trained and accredited in these roles are permitted to command firearms operations. This is not the case in Northern Ireland.

17.4 **Recommendation 2**

It is recommended that the command functions of Gold/Silver/Bronze disciplines are employed in such roles in the future. If the PSNI fully embraces the Manual of Guidance this will follow as the Manual specifies that these standards should be utilised for all firearms operations, and that only officers who are trained and accredited in these should be appointed to such roles.

PSNI Response

This is in respect of the command functions at Gold/Silver/Bronze level for firearms operations and these will be

fully implemented as per the ACPO Manual of Guidance on the Police Use of Firearms to coincide with the deployment of ARVs. PSNI is currently developing a Silver Firearms Commanders' Course that will be nationally accredited.

Additional interim arrangements are being put in place prior to the introduction of ARVs. C4 Special Operations Branch (SOB) has fully embraced this recommendation. Since March 2005 C4 Gold/Silver Commanders have been trained and accredited to national standards by Kent and Sussex Police. All C4 SOB operations are commended by accredited and operationally competent Silver and Gold Firearms Commanders. Refresher training is ongoing. Bronze Commanders and Firearms Tactical Advisors have already been given Command Structure Awareness Training. All elements of SOB HMSU Training reflect this Command structure and these standard operational procedures are currently being signed off as being nationally curriculum compliant by NPIA.

17.5 HMSUs operate in a specialised area of policing. This investigation established that in the minds of the officers within that unit there was considerable uncertainty that a General Order issued to the whole PSNI applied to them in respect of the requirement to use independent Tactical Firearms Advisors during firearms operations. There may be other areas where specialists do not feel instructions apply to their working environments and complete clarity is required.

17.6 **Recommendation 3**

That it is made clear to all specialist areas of policing within the PSNI that General Orders and Instructions issued to the force, apply to all Departments other than those specifically excluded.

PSNI Response

It is already the case that Policy Directives, General Orders and instructions issued to the Service apply to all departments other than those that are specifically mentioned and excluded.

17.7 When a fatal incident such as this occurs, and an investigation takes place, it is essential that all officers co-operate with the investigation. Inspector NN, Acting Inspector RR and Sergeant EE resisted the investigation in respect of their roles in the Control Room to the point of near obstruction. Their behaviour was particularly stark in comparison with those who were involved on the ground, who co-operated fully. Acting Inspector RR has retired. The two other officers remain employed in controversial and highly sensitive areas of the PSNI. They are supervisors in a position to influence others. It is essential that the public can have faith in the integrity and ethics of the police service.

17.8 **Recommendation 4**

It is thus recommended that the Chief Constable considers the suitability of their current postings given the findings of this investigation and transfers them to a less contentious area of policing. It is further recommended that they be advised with regard to their obligations under the Code of Ethics.

PSNI Response

Some officers identified have since retired. In relation to the two officers remaining in service, both were transferred post this incident. Both were also subject to training, including Human Rights Standards, and have recently resumed HMSU duties.

17.9 Investigations conducted by the Police Ombudsman have twice found that multiple discharges have taken place with MP5 weapons, when a

single bullet was intended to be fired. Officers have also informed the investigation that this regularly happens in training and a Forensic Scientist had confirmed this error can easily occur with the weapon. On this occasion, a man died. **There is a significant risk of a similar situation occurring in the future.** The PSNI currently have weapons which discharge a continuous flow of bullets on automatic mode, and others which discharge three bullets on automatic mode. It is not accepted that their general use is necessary, and they significantly increase the risk of serious or fatal injuries. The previous PSNI response that they are considering other weapons is not adequate given the weakness identified in this weapon.

17.10 **Recommendation 5**

It is recommended that all operational weapons be immediately adapted to remove the automatic capability with the exception of a number of weapons kept in an armoury for which specific authorisation for their use should be given (if it were felt that capability was required).

PSNI Response

PSNI currently has a number of weapons capable of automatic fire and of firing bursts of three rounds. All H&K 36s issued to SOB officers were purchased with a fully automatic trigger group, as recommended by PONI. This trigger mechanism was specifically designed for PSNI by H&K and means the officer has to consciously move the fire selector to the fully automatic position.

The second aspect of Recommendation 5 is that automatic capability weapons are to be kept in an armoury for which specific authorisation for their use should be given. This is the case for the issue of the H&K 36s that are signed out when

required on a daily basis on authority of the Duty Gold Commander.

All automatic weapons now have selector mechanisms that cannot be selected by accident.

Although the role of the ARVs is not to replace the long arms on issue for personal protection purposes while officers are on duty, PSNI considers the introduction of ARVs to be an opportune time to conduct a full review of the issue and deployment of long arms.

17.11 Operational channels of the PSNI are routinely tape recorded. The channel used by the HMSU is not. This would provide enhanced accountability to their role. It is accepted that the HMSU are often engaged in highly sensitive operations but there are legal arrangements to cater for the sensitivity of such material within the criminal justice system. A recommendation has previously been made to the PSNI in the light of this investigation that routine taping of that channel is adopted to provide greater accountability in the event of similar investigations in the future. A response is awaited to that recommendation.

17.12 Officers subject to disciplinary investigations can retire or resign at any stage, and are then beyond the scope of disciplinary action (but not criminal proceedings). Disciplinary action is related to the employer / employee relationship, which ends when the officer leaves the service.

Detective Chief Superintendent DD has retired from the PSNI since this incident occurred. The actions of Detective Superintendent BB fell below those articulated by the Code of Ethics of the PSNI and disciplinary action was recommended in respect of the officer. The officer retired before this could be conducted.

17.13 The final conclusion of the Police Ombudsman is that the management of this operation by Detective Chief Superintendent DD and Detective Superintendent BB, Gold and Silver Commanders was totally inadequate. In effect, officers on the ground were left to manage the process as they thought best. There was no identified Bronze Commander. It will never be known whether, had adequate leadership been provided, and had the ACPO Manual of Guidance for the Police Use of Firearms been complied with, the outcome may have been different. The PSNI must learn lessons identified in this Statement

17.15 Whilst this investigation was concluded in August 2005, the publication of the Statement had to be delayed to allow judicial processes connected to the events of that day to take place.

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