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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

KING'S BENCH DIVISION
(JUDICIAL REVIEW)

IN THE MATTER OF AN APPLICATION BY COLETTE McCONVILLE AND CAOIMHE McCANN FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

AND IN THE MATTER OF RULINGS BY THE CORONER

Karen Quinlivan KC appeared with Stuart McTaggart (instructed by O'Muirigh Solicitors) on behalf of the Applicant Colette McConville
Monye Anyadike-Danes KC appeared with Nick Scott (instructed by KRW Law) on behalf of the Applicant Caoimhe McCann
Tony McGleenan KC appeared with Ronan Daly (instructed by Solicitor to the Coroners) on behalf of the Proposed Respondent
Mark Robinson KC appeared with Stephen Ritchie (instructed by the Crown Solicitor's Office) on behalf of the PSNI

COLTON J

Introduction

[1] The applicants seek leave to apply for judicial review of the findings of His Honour Judge Babington sitting as coroner delivered on 11 April 2022 ("the findings") in the matter of an inquest into the death of Neil John McConville ("the deceased"). The applicant, Colette McConville, is the mother of the deceased. The applicant, Caoimhe McCann, was the partner of the deceased at the time of his death.

[2] On 29 April 2003 the deceased was shot by a member of the Police Service of Northern Ireland ("PSNI") and died the same day. He sustained the fatal gunshot wound in the course of an operation named Operation Trill.

[3] The findings of the coroner record the extensive oral and documentary evidence considered by him over the hearing which lasted some 25 days. He heard evidence from 45 witnesses including eyewitnesses to the incident, an engineer,

three ballistic experts, three forensic pathologists, 29 police officers, a military witness and several civilians. He received a large body of documentary material, including the evidence of 18 further witnesses admitted under Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963, maps, plans, photographs, reports, manuals and documents. After all the evidence had been heard, written submissions were provided on behalf of the Properly Interested Parties (PIPs) totalling 383 pages. An oral hearing was convened to deal with oral submissions on 11 October 2021. A further 75 pages of supplementary written submissions were lodged thereafter. The coroner's findings on the verdict were delivered on 11 April 2022. They extend to 462 paragraphs.

[4] The focus of the applicants' challenges relates to an alleged failure by him to express a conclusion on major issues which arose in the inquest.

[5] It is argued that those failures are contrary to:

(a) *R(Amin) v SSHD* [2003] UKHL 51, at para [31] where Lord Bingham noted the purpose of the State's duty to investigate a death is to ensure "full facts are brought to light; that culpable and discreditable conduct is exposed … that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others";

(b) *R(Middleton) v West Somerset Coroner* [2004] UKHL 10 at paras [18] and [20] where the Appellate Committee noted the need to express a "conclusion on a major issue canvassed on the evidence" and noted an uninformative verdict would be unlikely to meet the purpose of an article 2 investigation as noted in *Amin* (see above). The Committee stated:

> "To meet the procedural requirement of article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case."

[6] The application for leave and the substantive judicial review were heard on a "rolled up basis." The court had all the relevant material before it to determine the substance of the applications on the merits. I am very grateful for all the assistance provided by counsel.

Factual background

[7] Paras [73]-[331] of the coroner's findings record in detail the factual background relating to the events giving rise to the shooting of the deceased. The following is a summarised overview.

[8] At 15:10 hours on 29 April 2003 the police received intelligence that a Dee Somers was going to Belfast to collect at least one weapon, a gun, to be used in an attack on a named person. A surveillance operation was mounted with an initial plan that Mr Somers was to be identified whilst collecting the weapon and was to be directed to a vehicle checkpoint ("VCP") to be set up by the Headquarters Mobile Support Unit ("HMSU") on a slip road from or to the M1 motorway.

[9] The operation was given the name Operation Trill at about 17:00 hours on 29 April. It was not planned in advance of that date and lasted from about 15:10 to 19:15 hours. The operation commenced under the control of Regional Command Group ("RCG") South at Mahon Road and became the responsibility of RCG Urban at 17:00 hours when the vehicle suspected of being involved moved from the Craigavon area to the Belfast area.

[10] The suspect vehicle, a Cavalier, was first spotted in Belfast at 16:30 hours. It spent time in the city centre and west Belfast. It later stopped at Agincourt Avenue in the south of the city for about 30 minutes, leaving at 18:04 hours. It returned to west Belfast being driven at speed and stopped at Colinglen Road. A second vehicle arrived at this location and the occupants of both vehicles exited the cars and went to an area of trees. The Cavalier was stationary at this location for about 15 minutes and then proceeded at speed along the Glen Road stopping for fuel at a station at the top of Pond Park.

[11] During the course of the surveillance operation it became clear the Cavalier would not return to Craigavon via the motorway. Thus, the proposed VCP initially mooted was abandoned. A VCP at Pond Park Filling Station was considered but abandoned due to lack of available personnel. It was decided to stop the suspect vehicle by way of an enforced stop, also known as a "hard stop." After refuelling at Pond Park the car then travelled at speed with some erratic movement along the Whitemountain Road, Glenavy Road, Lisburn Road and Crumlin Road where the enforced stop occurred.

[12] The instruction to All Call Signs involved in Operation Trill to conduct an enforced stop was recorded in the HMSU logbook at 18:55 hours. The next entry is at 18:57 hours and records the Cavalier coming towards Sheepwalk Road. There are no further entries until 19:10 hours. No explanation was provided for the gap in the logbook records.

[13] It is accepted that the safest way to conduct an enforced stop is to approach the vehicle from behind, but some police officers could not recall if the specific instruction to stop from behind was given in this case. Police officer GG was a rear seat passenger in the car that attempted the enforced stop. He gave evidence before the inquest that he sought and obtained information that a stop from behind, an enforcement stop, was authorised. The coroner was satisfied that this clarification took place and GG was authorised to stop the vehicle and it was his call as to how the vehicle would be stopped.

[14] When the Cavalier entered a straight section of road, the vehicle GG was in attempted to overtake the Cavalier, turned on the hazard warning equipment, accelerated and pulled alongside the Cavalier. GG gave evidence that he raised his MP5 weapon, shouted "police, stop, pull in" and ensured his police badge was visible to the driver of the Cavalier.

[15] GG stated that the driver of the Cavalier looked at him, accelerated, wrenched the steering wheel to the right causing it to ram the police vehicle. The vehicles travelled side by side for a short distance. An overtaking manoeuvre was impossible because of the presence of a brick wall ahead with the attendant risk of a collision. The Cavalier avoided hitting the wall but went into a spin and travelled sideways eventually coming to a halt facing the opposite direction.

[16] GG's evidence was that the driver of the Cavalier was still trying to drive the car and appeared to drive it in the direction from which it had been travelling. In order to stop this move the police vehicle carrying GG drove into the front off-side of the Cavalier and pushed it into a verge so it was at right angles to the carriageway.

[17] GG left his vehicle and ran towards the driver's door of the Cavalier, smashed the driver's window with the barrel of his MP5 gun while shouting repeatedly "stop police, show me your hands." The driver of the Cavalier revved the engine and the car spun anti-clockwise striking a police officer, Paul Taylor, causing him to be propelled into the air and land on his side where he lay injured on the road in front of the Cavalier. GG stated that the driver of the Cavalier continued revving the engine and attempting to get the car into gear to drive it. He felt there was a real and imminent threat to Mr Taylor's life. He took his weapon off the safety setting, aimed it at the driver and shouted "stop, police, show me your hands or I will fire." His evidence was that he heard three or four shots and realised another police officer HH had discharged his weapon.

[18] The officers removed the driver of the Cavalier from the car. They laid him on the road and administered first aid. Other police units with medics arrived on the scene and took over his care. A police officer, LL, decided to drive the injured driver to hospital in the rear of one of the police cars. On route, the police vehicle met an ambulance. The injured driver was transferred to the ambulance and taken to the Lagan Valley Hospital. Despite best efforts, the driver, who was identified as Mr McConville, died at the hospital as a result of a gunshot wound.

[19] At the inquest HH gave evidence that in the seconds before he opened fire, he exited a police car and moved towards the front of the Cavalier. As he moved, he took the weapon off safety mode to what he believed was semi-automatic mode and brought it to his shoulder. He pulled the trigger and realised the weapon was in fully automatic mode and he immediately released the trigger. When the weapon is in semi-automatic mode a single shot is fired when the trigger is depressed. When it is in fully automatic mode, multiple shots are fired with a press of the trigger. The firing stops when the trigger is released.

The impugned findings

[20] As noted above, the coroner's findings are detailed. They demonstrate a careful, considered presentation and recording of the evidence.

[21] The applicants' grounds of challenge overlap to a large extent. The global grounds of challenge are that the impugned findings:

(a) Are unlawful or contrary to article 2 ECHR in determining "how" or "in what circumstances" the deceased died as they failed to address the culpability of the officer who shot the deceased in selecting the fully automatic mode and failed to conclude whether the second (and fatal) shot fired was justified.

(b) Are unlawful or contrary to article 2 ECHR in addressing "by what means" and "in what circumstances" the deceased died as they failed to address the extent to which, or conclude on how, the PSNI's failure to identify the fault in the type of gun used in the fatal shooting caused or contributed to the death of Mr McConville.

(c) Are unlawful and contrary to article 2 ECHR in failing to both identify persons responsible and address the ways in which the operation was not planned and controlled so as to minimise recourse to lethal force including the impact of a lack of clarity in the thinking of those in control room, apparent gaps in intelligence sharing between RCGs and the decision to abandon the VCP and instead conduct an enforced stop.

(d) Are unlawful and contrary to article 2 ECHR in failing to address the issues relating to the credibility of police officer NN including issues relating to the credibility of his evidence relating to tactical advice.

(e) Are unlawful and contrary to article 2 ECHR in failing to make a finding as to what tactical advice officers NN and/or EE provided during the course of Operation Trill.

(f) The failures noted at (c) and (d) above amount to a failure to take account of material considerations and were irrational.

(g) Are irrational in relation to the conclusion that HH's action in taking the safety setting off before he had decided to fire did not increase the likelihood of opening fire.

The applicants' case

[22] At a general level it is submitted on behalf of the applicants that the central question for the coroner to resolve was whether the shooting of the deceased was "justified." This would involve scrutinising, according to Ms Quinlivan on behalf of

Mrs McConville, "whether the force used … was strictly proportionate to the aim of protecting persons against unlawful violence but also whether the anti-terrorist operation was planned and controlled by the authority so as to minimise, to the greatest extent possible, recourse to lethal force." – Relying on *McCann v United Kingdom* [1996] 21 EHRR 97, para [193].

A. Culpability of HH and justification/necessity of the second shot

[23] The coroner accepted that police officer HH was an experienced, highly trained specialist firearms officer. He found that HH inadvertently selected the fully automatic fire mode as opposed to semi-automatic with the result three bullets were discharged with one single press of the trigger rather than the intended single shot. He found that the evidence indicated the unintended second shot killed the deceased.

[24] The weapon fired by HH was destroyed. There was no evidence of a fault relating to the weapon used and the expert report on the same weapon model as used by HH found no mechanical defect.

[25] In light of this evidence, the applicant submits that the coroner ought to have:

(a) Stated why he concluded that HH inadvertently selected the fully automatic fire mode.

(b) Addressed the culpability of HH given inter alia:

  (i) HH moved the fire selector from safety to fully automatic and raised it to his shoulder when he exited the car at a time when he did not consider himself to be under threat;

  (ii) HH himself gave evidence that the weapon had a fault whereby the user may inadvertently select fully automatic mode instead of semi-automatic mode and he had experienced this error on the firing range;

  (iii) HH failed to conduct a visual check of the weapon before discharging same.

[26] In *Re Jordan's Application* [2014] NICA 76 at para [66], the Court of Appeal referenced "the higher standard of care demanded of a trained and experienced police officer." On behalf of Mrs McConville, Ms Quinlivan submits that despite HH's extensive and regular weapons training the coroner failed to explain why he did not consider HH's inadvertent selection of the fully automatic mode culpable.

[27] In *Bennett v UK* ECtHR Application No 5527/08 the court noted that every fatal shot must be justified. The applicant, Ms Anyadike-Danes on behalf of Miss McCann, adopts Ms Quinlivan's submissions and argues the coroner failed to

make a finding on the key issue of whether each of the three shots, in particular the second fatal shot, was justified. The applicants submit the evidence suggests recklessness on the part of HH in inadvertently selecting the fully automatic firing mode which the coroner does not address.

[28] At para [428] of his findings the coroner expressed concern that officers carry weapons with a tendency to move between safe to fully automatic mode effectively bypassing semi-automatic mode. The applicants submit this finding is an insufficient conclusion relating to the central issue of whether the fatal second shot was justified, and that the coroner must reach a conclusion on this issue in order for his findings to be compliant with his obligations under article 2 ECHR.

B. PSNI's failure to identify the fault in the type of gun and consequences of that failure

[29] The applicants submit that the coroner accepted the evidence relating to the known fault that the selector switch could be easily moved from safe mode to fully automatic, by-passing semi-automatic mode and that a number of officers, including HH, had experienced this fault on the firing range. No weapon fault was reported, recorded or identified by the PSNI. The coroner failed to conclude, however, how that systematic failure in the use of a weapon prone to fault and the failure to report or record this as a fault caused or contributed to the fatal shooting.

[30] The applicants submit:

(a) There was no evidenced procedure for reporting faults in firearms. The weapons armourer failed to identify the fault in the weapon. Further HH did not report the issue he experienced with the weapon to his superiors. Thus, it was argued there was no system of adequate and effective safeguards that guarded against the avoidable accident that resulted in the death of Mr McConville.

(b) The coroner expressed concern that this issue was not brought to the attention of the appropriate authorities at para [428] of the findings but this does not address the matter noted at (a) above and evades the requirement that the coroner must address "by what means" and "in what circumstances" to comply with his obligations under article 2 ECHR.

[31] The applicants cite M*akaratzis v Greece* – Application 50835/99 at para [58] which states:

> "As the text of article 2 itself shows, the use of lethal force by police officers may be justified in certain circumstances. Nonetheless, article 2 does not grant a carte blanche. Unregulated and arbitrary action by State agents is incompatible with effective respect for human

> rights. This means that, as well as being authorised under national law, policing operations must be sufficiently regulated by it, within the framework of a system of adequate and effective safeguards against arbitrariness and abuse of force … and even against avoidable accident."

[32] The applicants submit that the coroner failed to make a finding relating to a system of adequate and sufficient safeguards in relation to the failure to identify and report the fault in the weapon to prevent an avoidable accident such as that which occurred on 29 April 2003.

C. Failures relating to command and control

[33] The coroner was satisfied that "the operation was not planned and controlled in such a way that it minimised to the greatest extent possible the need for recourse to lethal force." (See paras [121] and [460] of the findings).

[34] The applicants' case is that despite these findings the coroner failed to make conclusions as to how such failings caused or contributed to the death of the deceased. The applicants submit that the coroner ought to have stated what actions on the part of the PSNI gave rise to these conclusions and who was responsible for the failings. The impact of this omission is that the PSNI cannot identify lessons to be learned from the failures relating to command and control and the applicants do not have a satisfactory answer as to how such failings caused or contributed to the death of the deceased. It is argued that this fails to meet the "how" and "in what circumstances" requirements of an article 2 compliant investigation as per *Re Jordan's Application* [2014] NICA 76 at para [103]:

> "The essential purpose of such an investigation is to secure the effective implementation of the domestic laws which protect the right to life and in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility."

D. Issues relating to the credibility of NN and tactical advice of NN

Credibility of NN

[35] The applicants submit that, in assessing police officer NN's credibility and evidence at the inquest, it was proper to consider previous adverse judicial findings as to his credibility including the criticisms directed at him in *R v McAuley* where NN admitted to lying in his initial statement and *In the Matter of an Inquest into the Death of Patrick Pearse Jordan* [2016] NI Coroner 1, where the court indicated NN may

have sought to pervert the course of justice or commit perjury. Further, NN gave evidence to the coroner that inter alia he:

(a) Provided tactical advice to Officer BB but the applicant, Miss McCann, disputes this.

(b) Had completed a Firearms Incident Spontaneous Silver Command Course but this does not appear on his training record.

(c) Was familiar with Force Order 64/2002 yet he incorrectly stated that internal Special Operations Branch was not required to document the tactical advice provided because this Force Order does not apply to internal Special Operations Branch. He failed to document tactical advice he allegedly gave in breach of Force Order 64/2002.

[36] The applicants submit the coroner erred in failing to address the issue of NN's credibility. As a result, the requirement that culpable and discreditable conduct is exposed and brought to public notice as per *R(Amin) v SSHD* [2003] UKHL 51 at para [31] remained unmet. Further, the coroner failed to reach a reasoned judgment on the "disputed factual issues at the heart of the case." (*R(Middleton) v West Somerset Coroner* [2004] UKHL 10 at para [20]).

[37] The applicants submit that the history in relation to NN as set out above indicates his evidence is not credible, but if the court disagrees, they submit that the coroner erred in failing to address the credibility of a key witness to the inquiry.

Tactical advice

[38] Police officer NN was officer EE's manager. Both officers had received Firearms Tactical Advisor training and were giving tactical advice to the officers on the ground in Operation Trill (para [168] of the findings). The applicants refer to the error relating to failure to record tactical advice as set out above and as per para [115] of the findings. They refer to the conflicting evidence as to whether there was tactical advice to conduct an enforced stop from behind. EE gave the order to stop the Cavalier at 18:55 hours. The commander on the ground, officer GG, gave evidence that he sought and obtained confirmation that the enforced stop from behind was authorised (see paras [116] to [118] of the findings). However, EE could not recall if officer GG had sought information to stop from the rear.

[39] The coroner stated at para [37] that he "heard evidence about Firearms Tactical Advisors and it is important that their role in this operation is fully understood." The applicants submit, however, that the coroner erred in his conclusion at para [108] of the findings in being "unable to come to any conclusion as to what advice … [NN] or [EE] may have given. This is due mainly to a complete lack of relevant documentation and also by evidence I received from the other officers as set out above."

[40] The applicants submit the coroner erred in failing to make a finding as to what tactical advice, if any, NN and/or EE gave and failed to explain why he was unable to make such a finding. They submit the coroner failed to consider all the evidence relating to tactical advice and failed to strive to make a finding and failed to explain why he could not make a finding in accordance with *Re Jordan's Application* [2018] NICA 34, at para [110].

E.&F. Irrationality grounds

[41] HH gave evidence that in the seconds before he opened fire, he exited the police car and moved towards the front of the Cavalier. As he moved, he took the weapon off safety mode to what he believed was semi-automatic mode (single shot) but was in fact fully automatic mode and brought the weapon to his shoulder (para [431] of the findings). The applicant submits it is relevant that officer GG gave evidence that he would not take a weapon off safety mode until he intended to open fire (para [432] of the findings).

[42] The applicant, Mrs McConville, submits that the conclusion at para [432] of the findings is irrational. The coroner found:

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

[43] The applicants submit that when a gun is in safe mode there is no risk of firing, accidental or otherwise. The selection of a firing mode increases the risk of accidental firing. The applicants record the summation of expert evidence in *Holden* [2022] NICC 29 at para [49], "the golden rules with guns are to always ensure that the gun is safe, never aim unless you intend to fire and never increase the risk of negligent or inadvertent discharge."

[44] The applicants say the coroner's conclusion at para [432] is unsustainable.

Respondent's case

[45] The respondent resists the challenge on four main grounds as follows:

(a) The coroner reached his verdict having examined in detail all available evidence. He exercised the wide discretion afforded to him by section 31 of

the Coroner's Act (Northern Ireland) 1959 and "set forth" the particulars of the death "insofar as those particulars have been proved to him."

(b) The supervisory role of the High Court in relation to the wide discretion afforded to the coroner in relation to his verdict is necessarily limited.

(c) There is no illegality or material error of law or fact in the verdict when it is fully and fairly considered against the evidence adduced at the inquest.

(d) The coroner's verdict and findings fulfil the article 2 obligation and address all the issues in the agreed scope document.

[46] Consequently, the respondent argues:

(a) The application for leave to apply for judicial review does not demonstrate "an arguable case with a reasonable prospect of success" as per *Re Jordan* [2018] NICA 34 at para [3] and in *Re Caoimhe Ni Chuinneagain* [2021] NIQB 79 at para [14].

(b) The grounds of challenge expressed in various ways (ie failed to conclude on, did not strive to make a finding, did not explain, failed to state conclusions) amount to a challenge on the coroner's assessment and evaluation of the evidence.

(c) The coroner addressed all of the issues agreed in the scope document for the inquest dated 4 March 2021 and clearly satisfied the obligations under article 2 ECHR. The coroner at para [5] of the impugned findings noted that he considered "all of the evidence and submissions" and "everything placed before me" and the parties' "arguments have been considered with care although not everything might be commented on in my findings." This approach concurs with para [24] of *Re Jordan* [2018] NICA 34 where it is noted that the whole verdict must be considered as opposed to isolated sections. It is entirely appropriate that every piece of evidence may not be specifically dealt with in the findings, but all arguments have been considered.

[47] The respondent rejects the irrationality grounds of challenge for failure to pass the "extremely high" threshold for such a challenge (see *Re Jordan* [2017] NIQB 135 at para [46]).

[48] It is argued that the coroner carefully and meticulously complied with his duty as per *Re Jordan* [2018] NICA 34 at para [112]:

> "[112] The obligation on a Coroner in an inquest under Section 31 of the Coroners Act (Northern Ireland) 1959 is confined to `setting forth' in his verdict particulars `so far as such particulars have been proved to (him).' The

> statutory obligation on the Coroner is to consider whether a particular has or has not been proved on the balance of probabilities. This must also involve consideration as to whether the Coroner is undecided as to whether the particular did or did not occur …"

[49] The respondent refers to paras [68] and [69] of *Re Ballymurphy* [2021] NI Coroner 6. Keegan J noted the inquest must reach conclusions on major issues canvassed yet:

> "[69] In practical terms, there will be cases where, no matter how thoroughly all relevant primary evidence is secured and available and then comprehensively examined, including by the examination of witnesses (publicly and with the involvement of the next of kin), it is difficult to reach a clear conclusion as to what has occurred or for instance whether the use of lethal force was justified. This might arise by virtue of a lack of evidence or by reason of a conflict of evidence which is simply impossible to resolve decisively one way or the other … The obligation on the State is not to provide a particular result in a given case but to provide a system of investigation which is capable in principle of giving rise to clear findings where they are warranted by the evidence."

[50] The respondent notes the coroner produced a comprehensive and extensive verdict and made findings and conclusions 26 of which are set out at paras [437] to [462]. The conclusions included that the operation was not planned and controlled in such a way that it minimised to the greatest extent possible the need for recourse to lethal force (para [460]) and that HH used a level of force that was no more than absolutely necessary, and he was justified in so doing (para [462]).

[51] It is submitted on behalf of the respondent that it is abundantly clear the State's article 2 procedural duty has been complied with. It is asserted that the challenge amounts to an attack on the assessment and evaluation of the evidence. In essence it constitutes a merits review of the findings and verdict which is not an appropriate approach for the judicial review court.

[52] The respondent argues there is no egregious error of law or fact on the part of the coroner in the impugned findings. Mr McGleenan refers the court to the broad discretion exercisable by the coroner and the reluctance of the High Court to go behind the findings unless there is a compelling reason to do so citing *Jordan* [2017] NIQB 135 at paras [24] to [26] which were affirmed in *Jordan* [2018] NICA 34. At first instance Keegan J noted inter alia:

(a) Judicial review is not an appeal; the reviewing court does not quash a decision simply because it might have reached a different conclusion.

(b) The judicial review court exercises a supervisory function regarding whether:

(i) the inquest was conducted in accordance with the law and proper procedure; and

(ii) given the subject matter, whether it complied with article 2 obligations.

(c) Considerable deference must be made to a fact-finding tribunal. The decision-maker has considerable latitude to decide on the facts having seen and heard witnesses unless the verdict can be categorised as unreasonable in the Wednesbury sense or irrational. This is a high threshold.

(d) The issue of weight to be applied to relevant factors is a matter for the decision-maker and is not to be interfered with at judicial review.

(e) It can be difficult to disentangle issues of law and fact.

(f) It may be relevant that no complaint about procedural fairness was made at the inquest.

[53] In similar vein the respondent refers to *Steponavicine* [2018] NIQB 90 at paras [47] to [52] and [59] where McCloskey LJ stated inter alia:

(a) The coroner is an inquisitor with a broad discretion regarding the inquiry to be conducted.

(b) An inquest does not feature opposing parties unlike civil litigation. Adversarial features of civil litigation such as pleadings and interrogatories, certain strict rules of evidence etc are absent at an inquest.

(c) The public interest dominates inquest proceedings. The inquisitorial process of the inquest balances the interests of the bereaved families and possible perpetrators of the death in a fair and proportionate manner.

(d) Inquest proceedings are governed by statute. A coroner is a judicial officer working on a statutory framework with an obligation to discharge a statutory duty placed upon him.

(e) A challenge to inquest proceedings is via judicial review, invoking the supervisory role of the High Court reflecting the public interest imprimatur in inquest proceedings.

[54] The respondent submits that the threshold for leave to apply for judicial review has not been met and the applications should be refused.

Consideration

[55] The starting point for any consideration of the coroner's findings is the agreed scope of the inquest which was set out in a document dated 4 March 2021 and agreed by all the parties in advance of the inquest.

[56] After setting out the formal preliminaries the coroner commenced his substantive findings with reference to the scope document, which he set out in full.

[57] It is also important to read the findings as a whole. What is clear from the findings is that the coroner considered each of the specific issues raised in the scope document.

[58] True it is as Ms Quinlivan points out the scope document was framed broadly, to include all relevant issues and that the PIPs were entitled to raise particular issues in the course of the hearing.

[59] Having made the general observation that the coroner diligently dealt with each of the issues raised in the scope document I turn to the specific issues raised by the applicants, which as has already been set out, primarily focus on a failure to reach conclusions on certain issues.

[60] I therefore propose to focus on those omissions which allegedly constitute the illegality relied upon by the applicants in this case.

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

[61] These issues are addressed by the coroner in his findings in the following way. In para [236] he recognises the expertise of HH. He goes on to say:

> "[247] I have already referred to the law and I must give consideration to whether HH/U129 was justified in opening fire on 29 April 2003. The law permits an individual to use force, including the use of weapons, when that individual honestly believes that it is necessary to do so to defend himself or another. The level of force used in such circumstances must be no more than is absolutely necessary.
>
> [248] The law has developed in such a way that there are two questions that I must ask myself. The first question is whether HH/U129 held an honest and

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

[62] He goes on to rehearse the evidence in relation to the discharge of the weapon and concludes:

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

[63] Having come to that conclusion he goes on to consider the second question he raised and concludes:

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

[64] In relation to the inadvertent selection of the fully automatic mode the coroner identifies this issue at para [393] as follows:

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

The coroner then summarises the evidence he heard from the experts and sets this out in comprehensive detail in his findings. He also records the next of kin's submissions on this issue. All this evidence is set out in considerable detail in the section on ballistics between paras [385] and [435] of the findings.

[65] At paras [415] to [418] he considers the potential impact of stress on use of the selector switch. He concludes that even well-trained experts can make mistakes in stressful situations. He notes at para [416] that he had the benefit of examining the relevant selector mechanism himself. At para [427] and onwards he records as follows:

> "[427] The evidence of HH/U129 is to my mind very important in considering the mode of fire. Consideration has to be given to every aspect of his evidence relating to the selector switch. HH/U129 was an experienced member of HMSU having served from August 1992 until November 1997. He was then promoted and left the unit returning in November 2002 and thus was back in the unit for approximately 6 months at the time of this incident. His training with this type of weapon commenced in 1991 and even when he was not in the unit he said he often used this type of weapon.
>
> [428] HH/U129 told me that he was aware of problems with the selector switch on some of the older MP5s in that it was very easy to move them from safe to automatic. He thought that in some way the indents on the selector switch might have been worn and therefore the effect was that the weapon went from safety to fully automatic and effectively bypassed semi-automatic or single shot mode. He told me that he had personal experience of this on the range and he was aware that some of his colleagues also had this happen. He was asked how often did this problem occur on the ranges and he said that in his opinion perhaps twice a year and my understanding of what he said was that this related to both himself and his colleagues. He himself had never reported this matter to his authorities or to the armourer although it seems that all weapons would have been maintained by the armourer on a routine basis and there was no issue about maintenance in this matter. I accept what he said about this and am somewhat concerned that the matter was not brought to the attention of the appropriate authorities. This is a matter of concern that at this time police officers were carrying weapons that have the tendency to allow the selector switch to move between safety and fully automatic effectively bypassing semi-automatic or single shot mode. I would therefore endorse Recommendation 5 in the PONI report into Mr McConville's death which recommended removing the

> automatic capability of these weapons save for a very limited number held in the police armoury."

[66] The latter reference is to a Police Ombudsman's report which was published on 4 October 2007.

[67] Having reviewed and summarised all the relevant evidence on this issue the coroner concluded:

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

[68] This conclusion is confirmed in the narrative conclusions in the findings:

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

[69] Importantly, in accordance with his obligations, the coroner came to a conclusion on whether or not the use of lethal force was justified and found:

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

[70] Applying the principles which have been rehearsed above I can find no illegality or irrationality in the coroner's consideration of this issue and in the conclusions he reached. He concluded in accordance with the evidence that the fatal shot was the second one. He accepted the explanation by HH as to how that second shot came to be discharged. He accepted that HH had an honest belief that it was necessary to use force for the purposes of defending another person. He accepted

HH's explanation as to the inadvertent selection of the fully automatic mode for the weapon.

[71] Having regard to the breadth of the discretion available to a coroner and the latitude that must necessarily be afforded in circumstances where he has heard detailed evidence in a manner and form which is not available to this court on judicial review, the applicants have not established an arguable case with a reasonable prospect of success on this issue. They may well be dissatisfied with the coroner's conclusions on the key issue in the inquest. This court is not an appellate court but one exercising a supervisory function. Exercising that function, the court is satisfied that on this issue the inquest was conducted in compliance with the coroner's article 2 obligations and there is no basis for challenging his conclusions.

B. Failure to identify the fault

[72] I return now to the issue of the PSNI's failure to identify the fault in the type of gun used and the consequences of that failure.

[73] In paras [111] to [115] the coroner accurately sets out the submissions from the next of kin on the issue of whether there was a mechanical fault and reviews the evidence on this issue including that the weapon is designed to engage distinctly in different settings in a way that is perceptible to the operator. As stated earlier, the coroner recognised that stress may be a factor in bypassing semi-automatic mode inadvertently. His focus was on determining firstly whether the gun was fired in the automatic mode and whether HH was truthful in his account of what occurred. It is clear from what has already been said that the coroner accepted HH's evidence. In relation to the failure of the PSNI to have a proper system of reporting faults and the consequences of any such failure, I accept that the coroner could have been more explicit in his findings on this issue. That said, he clearly expressed at para [428] that he was "somewhat concerned that the matter was not brought to the attention of the appropriate authorities."

[74] As set out in para [65] above, the coroner went on to say:

> "It is a matter of concern that at this time police officers were carrying weapons that had a tendency to allow the selector switch to move between safety and fully automatic effectively bypassing semi-automatic or single shot mode. I therefore endorse Recommendation 5 in the PONI report into Mr McConville's death which recommended removing the automatic capability of these weapons save for a very limited number held in the police armoury."

[75] In so doing it seems to the court that he was critical of the failure to ensure that the difficulty experienced on the ranges was brought to the attention of the

authorities. By endorsing Recommendation 5 in the PONI report he was addressing the issue of future safeguards so as to prevent a further incident such as that which occurred on 29 April 2003.

[76] I do not consider that the failure to deal with this issue in more detail is sufficient to set aside the findings in this inquest. It does not meet the threshold of establishing an arguable case with a reasonable prospect of success.

C.&D. Planning and control/credibility of NN

[77] The issue of the planning and control of this operation was the second fundamental issue for the coroner to consider in conjunction with whether the force used was justifiable. This is linked to the criticisms made by the applicants in relation to the credibility of NN and in particular in relation to practical advice allegedly provided by him and EE. In the body of the findings the issue of planning and control is dealt with at paras [73] to [121]. The coroner deals with what he refers to as "the surveillance operation" at paras [122] to [162]. He then deals with "the stop" at paras [163] to [256].

[78] On any showing the coroner has set out in detail all the relevant evidence he heard on these issues.

[79] Early on in his analysis he comments:

> "[89] There was evidence that Operation Trill was a so called 'fastball operation' as it developed on the day of the incident. It was not planned in advance of 29 April 2003. It was a specific operation that was mounted on 29 April 2003 as a consequence of specific intelligence received by police on that date. It started in the following way. Police at Mahon Road received intelligence at 15.10 hours that a Dee Somers was going to Belfast to collect a gun to be used in an attack on a named person. That intelligence was subsequently updated a short time later. As a result of this further intelligence AA/5049, who was the Duty Officer in charge, attached to RCG South at Mahon Road PSNI station, Portadown, initiated actions by the police."

[80] He goes on to describe the actions of AA/5049 and states that:

> "[93] I am satisfied that AA/5049 acted appropriately in setting up Operation Trill, and in briefing 8130 as he did. It was a proportionate response to the intelligence that he had received at that time remembering always that there

> is a need to protect the public, prevent criminality and get illegal weapons off the streets."

[81] This was a clear unimpeachable finding in the court's view.

[82] In paras [97] to [107] the coroner specifically addresses the issue as to whether RCG at South and Urban should have appointed/used a Firearms Tactical Advisor. On this issue he concludes:

> "[108] … I am satisfied that there was a complete failure to appoint an FTA in the proper way and I am unable to come to any conclusion as to what advice either of these two officers may have given. This is due mainly to a complete lack of relevant documentation and also by evidence I received from other officers as set out above."

[83] The coroner's reference to the two officers is a reference to EE and NN. In reaching his conclusion about a failure to appoint an FTA in the proper way the coroner refers to the evidence of Superintendent BB who said that during the investigation phase of the incident EE had a designated role as an FTA in the operation and that NN subsequently took over from him. The coroner accepts that both were in the control room during the operation albeit not always at the same time. He accepts that they may well have given some advice but there was nothing by way of documentation to support that.

[84] At paras [104] and [115] the coroner records that BB recalls NN giving tactical advice but could not recall what actual advice was given. Again, the coroner is critical that the advice from both NN and EE was not recorded and concludes at para [115]:

> "… This was a failing that should not have occurred especially as there were a number of documents in existence in the control room. In addition, as already mentioned, the FTA pro forma was not completed."

[85] The issue of what tactical advice was given is further analysed at paras [167] to [170].

[86] On the crucial issue of what order was given to the police officers on the ground the coroner concludes as follows:

> "[116] The order to stop the vehicle was given at 18.55 hours by EE/U118 and was given to all seven call signs that were travelling supposedly in the pattern of something akin to a 'loose box' around the Cavalier. There is obviously no dispute about this and further that

the order was given to all the call signs rather than directed to any particular one. I am satisfied that the order to stop the vehicle was simply that. It went no further than stop in that the method of stop or location of stop was not communicated to the call signs. GG/U137 who effectively became the commander on the ground or if the appropriate command system was being used, the Bronze Commander, says that he sought and obtained information that a stop from behind was authorised – in other words a hard stop was permitted.

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

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

[119] I am further satisfied that all of the officers in the two call signs that were involved in the actual stop were satisfactorily trained and had experience of stopping vehicles in the past with the exception of II/U219. I am also satisfied that all these officers were aware of their legal obligations and in particular their personal obligation to avoid the use of lethal force.

[120] Both RCG South and RCG Urban were aware of intelligence that identified the person or persons against whom the weapon in question was to be used. It was not

> the responsibility of those in the control rooms to ensure that the person or persons at risk were notified of the danger although it was stated that it was the responsibility of someone else. No further evidence was given on this point and I do not know if any such information was communicated to anyone.
>
> [121] I have considered all matters relating to the planning, control and supervision of Operation Trill. I have made various Findings and have drawn various conclusions in the preceding paragraphs in this section. I have given careful consideration to those Findings and conclusions and having done so I am satisfied that the operation was not planned and controlled in such a way that it minimised to the greatest extent possible the need for recourse to lethal force."

[87] This conclusion is confirmed in the conclusions narrative at the end of the findings where the coroner says as follows:

> "[446] No FTA was appointed in RCG South which was contrary to Force Order 64/2002.
>
> [447] There was no documentary evidence to confirm that an FTA was appointed in RCG Urban and no evidence that the appropriate pro forma was ever completed in relation to any advice that was given.
>
> [448] No command structure was put in place in either RCG South or RCG Urban contrary to Force Order 11/98."

[88] This leads to a conclusion that:

> "[460] The operation was not planned and controlled in such a way that it minimised to the greatest extent possible the need for recourse to lethal force."

[89] On the issue of planning and control it seems to the court that the coroner has examined the relevant evidence in detail, set it out in his findings, analysed that evidence and come to rational conclusions. He has set out those facts which he was able to establish on the basis of the evidence before him. He explains the basis for his conclusions. In the court's view it cannot be said that on this issue the applicants have established an arguable case with a reasonable prospect of success.

F.&G. Irrationality

[90] It should be apparent from the above analysis the court does not find any basis for arguing that the conclusions of the coroner are irrational. In particular he accepted that HH made a conscious decision to open fire in circumstances which were justified. Therefore, at some point he had to move the weapon from the safety mode.

Conclusion

[91] It will be seen from the above that the court does not consider this is an appropriate case on which to grant leave and, had it done so, the application would have been refused on the merits in any event.

[92] I recognise that the killing of Mr McConville was a tragedy. His relatives, the applicants in this judicial review, are entitled to an article 2 compliant inquest into his death which occurred at the hands of the PSNI. That requirement also imposes an obligation on this court to carefully scrutinise the conduct of the inquest and the findings of the coroner.

[93] The court reiterates the general principles about the supervisory role of the court in this regard. It is not for the court to rewrite the findings or to substitute its own views on the circumstances that led to Mr McConville's death. The obligation on a coroner in these circumstances is well set out in para [21] of the Court of Appeal's decision in *In the Matter of an Application by Theresa Jordan* [2018] NICA 34 where the court said:

> "In order to comply with the article 2 ECHR procedural obligation to carry out an effective official investigation into the circumstances of the death of the deceased `how' the deceased came by his death meant not only that the coroner had the obligation to investigate `by what means' but also had the obligation to investigate `in what broad circumstances' the deceased came to his death: see *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182. The nature of the article 2 ECHR procedural obligation was considered by the ECtHR in *Jordan v UK* (2003) 37 EHRR 2 and in *Nachova & others v Bulgaria* (2006) 42 EHRR 43. We do not intend to set out all the matters which can be taken from those judgments though we emphasise that the essential purpose of an investigation is `to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility' and that the investigation is also to be effective in the sense that it is

> capable of leading to a determination of whether the force used in such cases was or was not justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. Furthermore, that there must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory." (Emphasis added)

[94] The court's view is that on any fair reading the coroner has complied with the procedural obligations described above. He has determined whether the force used in this case was or was not justified. He has conducted a thorough examination of all the relevant and background information relating to the killing. That examination has been conducted in public and the evidence has been thoroughly tested. The coroner has made findings which are critical of the PSNI operation.

[95] The coroner has complied with his obligation under section 31 of the Coroners Act (Northern Ireland) 1959 in that he has set forth "such particulars as have been proved to (him), who the deceased person was and how, when and where he came to his death" in accordance with the relevant caselaw.

[96] The applications for leave to apply for judicial review are therefore refused.