

<p>1 Thursday, 11 July 2019 2 (12.00 pm) 3 Statement on publication 4 THE CHAIRMAN: Today, my report concerning the death of 5 Anthony Grainger is published and laid before 6 Parliament. The report is necessarily a long and 7 detailed one, for my terms of reference have required me 8 to examine not just the immediate circumstances of 9 Mr Grainger's death but also the history of the police 10 investigation, known as Operation Shire, that led up to 11 it. 12 That has in turn necessitated a close analysis of 13 certain sensitive matters which, since they cannot be 14 made public, I have had to cover in a separate closed 15 report. I can, however, assure the public that I have 16 included in this published report as much relevant 17 detail as I properly can and the necessary omissions 18 that remain are not such as to affect any of the 19 report's conclusions or the reasoning behind those 20 conclusions. 21 It was in fact precisely the existence of the 22 sensitive matters to which I have referred that made it 23 impossible to hold a conventional inquest and caused the 24 then Home Secretary to set up this Inquiry in 2016. 25 Having gathered, sifted and disclosed an enormous</p> <p style="text-align: center;">Page 1</p>	<p>1 Greater Manchester Police. At the time, Mr Grainger was 2 sitting with two other men in a stolen Audi car in 3 a small public car park in Culcheth. The officers in 4 charge of the operation suspected that they were about 5 to commit a commercial robbery. 6 In summary, I have concluded that Greater Manchester 7 Police is to blame for the death of Mr Grainger because 8 the force failed to discharge its obligation under 9 article 2 of the European Convention on Human Rights, to 10 authorise, plan and conduct the MASTS operation on 11 3 March in such a way as to minimise to the greatest 12 extent possible recourse to the lethal use of force. 13 Firearms commanders authorised and planned the MASTS 14 operation incompetently and without keeping proper 15 records of their decisions. They inaccurately briefed 16 the firearms officers who were to conduct the operation, 17 distorting and in some respects exaggerating the risk 18 presented by Mr Grainger. Firearms commanders failed to 19 maintain contemporaneous records of their decisions, 20 reconstructing their official logs after the event. The 21 inclusion in those logs of material that commanders did 22 not know at the time was not only highly improper, but 23 also masked a fundamental failure to apply the national 24 decision model when they were authorising, planning and 25 conducting the operation.</p> <p style="text-align: center;">Page 3</p>
<p>1 quantity of relevant documentary, digital and other 2 material, the Inquiry conducted a 14-week evidential 3 hearing in 2017, during which it received oral evidence 4 from more than 80 witnesses. Last year, I held another 5 shorter hearing to inform my recommendations. 6 The Inquiry has, I believe, been the thorough, open 7 and fearless investigation that I promised at the 8 outset. It has exposed serious deficiencies in the 9 planning and conduct of the firearms operation that led 10 to Mr Grainger's death, in the procurement of special 11 munitions by Greater Manchester Police and in the 12 training and accreditation of an alarming number of the 13 operation's officers and commanders. The Inquiry's 14 published report contains a detailed explanation of its 15 findings and conclusions, together with some practical 16 recommendations that will I hope be speedily 17 implemented: 18 I must emphasise that no synopsis, including this 19 one, can adequately summarise the report's content. For 20 a proper appreciation of its findings and conclusions, 21 there is no substitute for reading the report itself. 22 On 3 March 2012, Mr Grainger was fatally shot by 23 an authorised firearms officer known as Q9 during 24 a mobile armed support to surveillance, or MASTS 25 operation, conducted by the Tactical Firearms Unit of</p> <p style="text-align: center;">Page 2</p>	<p>1 Firearms commanders failed to subject the MASTS 2 operation of 3 March to forgive oversight and review. 3 They did not reassess the intentions of the men in the 4 stolen Audi as the number of credible robbery targets 5 diminished with the passage of time, nor did they 6 consider whether in the interests of public safety they 7 should disrupt any intended criminal activity without 8 trying to make arrests in Culcheth. Firearms commanders 9 unnecessarily authorised the use of special munitions, 10 including a chemical weapons system known as the CS 11 dispersal canister which Greater Manchester Police had 12 procured some years earlier without the Home Secretary's 13 authority and in flagrant breach of national guidance. 14 Having illicitly acquired the CS dispersal canister, 15 Greater Manchester Police obstinately persisted in its 16 use in the face of well-informed and justified criticism 17 from others and did not finally get rid of its stock 18 until shortly before this Inquiry's evidential hearing. 19 I have made it clear in my report that the proper 20 authorities will need to determine whether any 21 organisation or individual has committed a criminal 22 offence in connection with the importation, acquisition, 23 purported authorisation or use of the CS dispersal 24 canister. 25 Four of the officers involved in the MASTS operation</p> <p style="text-align: center;">Page 4</p>

<p>1 of 3 March, including two of its commanders and 2 a tactical adviser, lacked the necessary degree of 3 professional competence. Partly through his own fault 4 but mainly as a result of the misleading briefing he had 5 received, Q9 made a number of false assumptions. He 6 assumed that the men in the car could be carrying 7 firearms and were intending to commit a hostage robbery 8 on 3 March by kidnapping commercial employees and 9 holding them at gunpoint. He believed that they 10 belonged to a wider criminal group which had a known 11 history of firing guns at police officers. He thought 12 the car had darkened privacy glass fitted to all its 13 side windows, leading him to assume that his colleagues 14 would not be able to see inside the car and would be 15 especially vulnerable to any violent response from its 16 occupants. Those were all serious misconceptions.</p> <p>17 While I am sure that there was no legitimate purpose 18 to any of the visits that Mr Grainger and his companions 19 made to Culcheth, I have concluded that they were 20 probably not intending to commit a robbery on 3 March. 21 They were not planning to take hostages. They were 22 unarmed. There was no intelligence to suggest that they 23 would be armed or would have access to firearms that day 24 and no clear intelligence to suggest that they were 25 intending to commit a robbery that day. They were not</p> <p style="text-align: center;">Page 5</p>	<p>1 range of possible outcomes. In effect, commanders 2 turned the orthodox MASTS methodology on its head. 3 Instead of using MASTS as a means of deploying firearms 4 officers in support of surveillance operations, they 5 treated it as a means of deploying surveillance officers 6 in support of firearms operations.</p> <p>7 It was the same institutional complacency that 8 caused the department to persist with its use of the 9 illicit CS dispersal canister in the teeth of justified 10 criticism and also to underestimate and minimise the 11 significance of training failures among its own 12 officers.</p> <p>13 Before closing, I should like to thank the family of 14 Mr Grainger for the considerable dignity and patience 15 with which they have awaited the publication of my 16 conclusions. I should also like to express my sincere 17 condolences.</p> <p>18 People may talk glibly about closure, but those who 19 knew and loved Mr Grainger will never forget him, nor 20 will they ever be able to forget the brutal 21 circumstances in which he met his death. As I said at 22 the Inquiry's opening session, neither should the rest 23 of us.</p> <p>24 (12.10 pm) 25 (The Inquiry concluded)</p> <p style="text-align: center;">Page 7</p>
<p>1 members of, nor were they actively associating with any 2 wider criminal group. Because the stolen Audi did not 3 have privacy glass fitted to its front side windows, 4 Q9's colleagues in fact had a better view into the car 5 than he himself did.</p> <p>6 When Q9 challenged the men inside the stolen Audi to 7 show their hands, they at first complied but Mr Grainger 8 then unexpectedly lowered his right hand out of sight. 9 Mr Grainger was probably reaching for the door handle in 10 order to get out of the car. However, Q9's misreading 11 of the situation led him to discharge his weapon in the 12 belief that Mr Grainger was reaching for a gun with 13 a view to firing it at Q9's approaching colleagues.</p> <p>14 Although that was wrong, I have concluded that Q9 15 honestly held it. For that reason, applying the correct 16 legal test, I am unable to say that his decision to fire 17 was unlawful. At the root of the events of 3 March 2012 18 was a lack of effective leadership in firearms 19 operations conducted by Greater Manchester Police. 20 I detected a deeply entrenched complacency among certain 21 senior officers who lacked the necessary critical 22 insight to detect, let alone remedy, the deficiencies 23 I have identified. They fundamentally misunderstood the 24 MASTS platform, regarding it as an armed arrest tactic, 25 rather than as a flexible platform leading to a wide</p> <p style="text-align: center;">Page 6</p>	

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