Executive Summary

- On 9th June 2004 Chief Constable Peter Neyroud commissioned a review of the practices and procedures adopted by Thames Valley Police in connection with the fatal shootings at Highmoor Cross on Sunday 6th June 2004. The Independent Police Complaints Commission agreed to oversee this review in the interests of public confidence.

- The purpose of the review was to address public concern about the police response: that it took too long for the police to get to the scene and to get urgent medical help to the victims.

- The review concludes that the delay in attending the scene cannot be justified.

- The reasons for the delay are not due to the failings of the individuals involved in the response. The failings are embedded in Thames Valley Police policy and training in responding to firearms incidents.

- Essentially, current policy seeks to eliminate risk rather than manage it. The direct result of this was that the police priority in response to the emergency calls was to locate the offender rather than get to the victims, and an overly cautious approach to the deployment of armed officers.

- This report recommends that the policy in relation to spontaneous firearms incidents needs to be replaced. The new policy must provide clear direction and guidance on dynamic risk assessment, to respond to situations where people are believed to be hurt. It should include a presumption that unless there are good reasons for not doing so, the command function must take place near the scene. These policies need to be supported by new and better training.

- The review also identifies national issues for firearms policy and training. The IPCC will take these up with the Association of Chief Police Officers to seek to ensure that lessons can be learned at all levels as a result of this tragedy.

The Review

1. INTRODUCTION

1.1 On 9th June 2004 Chief Constable Peter Neyroud commissioned a review of the practices and procedures adopted by Thames Valley Police in connection with the fatal shootings at Highmoor Cross on Sunday 6th June 2004, to facilitate organisational learning.

1.2 The terms of reference were:

- To examine and assess the effectiveness of Thames Valley Police's policies and procedures in relation to its response to firearms incidents

- Using appropriate methodology, skills and analytical tools critically review the widest possible perspective of the police action taken in response to the incident that resulted in the deaths of Vicky Horgan and Emma Walton

- In particular to assess the effectiveness of Thames Valley Police's initial response, command of the incident and our joint working with the Ambulance Service

1.3 Document the findings and recommendations within a report to be submitted to the Chief Constable for oversight by the Independent Police Complaints Commission (IPCC).

1.4 At the invitation of the Chief Constable the review was overseen by Deborah Glass, Commissioner of the Independent Police Complaints Commission.

1.5 Command & Control logs, transcripts of radio transmissions, telephone conversations and policy logs have all been thoroughly examined, and all key personnel have been interviewed.

1.6 A number of structured debriefs were conducted involving staff from Police Area, Abingdon Control Room, the Tactical Firearms Unit and Southern Oxfordshire's Multi-Agency Public Protection Panel.

1.7 Expert opinion was sought, both internally and externally to Thames Valley Police, with regards to firearms tactics, firearms training, firearms policy and firearms command protocols. The views expressed by all of those consulted are consistent with the findings of this review.

1.8 Deputy Chief Constable Joe Edwards (Sussex Police) and his staff have provided invaluable assistance and guidance in relation to all aspects of this review.

2. SEQUENCE OF EVENTS ON 6th JUNE 2004

2.1 On the afternoon of Sunday 6th June 2004 the victims Vicky Horgan (deceased), her sister Emma Walton (deceased) and their mother (seriously wounded) were at a family barbeque in the rear garden of Vicky's home address in Highmoor Cross, Henley. Also present were Vicky's two daughters, aged 7 and 4, and a family friend Gemma Hunter.

2.2 Stuart Horgan, the estranged husband of Vicky, had a long history of domestic abuse towards his wife. The Police were involved on numerous occasions over a considerable period of time. Horgan was arrested on 30th May 2004 for criminally damaging Vicky's car and drink driving. At the time of the incident on 6th June he was subject of bail conditions not to contact Vicky, nor to attend where she lived.

2.3 Horgan had also been registered as a dangerous offender and was the subject of the Multi-Agency Public Protection Panel Arrangements whose risk was managed through the Multi-Agency Risk Management process. This review will not examine these issues, which have been considered elsewhere by Thames Valley Police.

2.4 Approximately 4.35pm Stuart Horgan, who had been drinking heavily, breached his bail. He climbed over a fence into the rear garden where the barbeque was in progress. He was armed with a .410 single-barrelled shotgun. He immediately shot Vicky's mother in the stomach. Vicky ran indoors and Emma ran into the corner of the garden, having grabbed both children. Horgan immediately followed Vicky into the house but, according to witness reports, no shots were heard.

2.5 A few seconds later Horgan returned to the garden and shot Emma in the back. She had been trying to phone the police on her mobile phone. Emma staggered across to Gemma and gave her the phone but after being threatened by Horgan she put the phone down. Stuart Horgan returned to the house where he shot Vicky in the head.

2.6 Horgan then left the scene, still armed, and walked towards the general direction of Nettlebed. He was arrested later that evening in Peterborough still in possession of the .410 shotgun.

2.7 Vicky Horgan was certified dead at the scene and Emma Walton died later that day in the Royal Berkshire Hospital. Dr Chapman, Home Office Pathologist, has stated Vicky would not have survived from the injury she sustained and it was highly unlikely that Emma would have survived had she received specialist medical attention. He is unable to discount the fact that had a surgeon with the necessary specialist skills and resources (organ available for transplant) been available then there was the slimmest of possibilities that her life could have been saved. Their mother was seriously wounded but survived. She continues to make good progress.

2.8 Stuart Horgan was found dead whilst on remand in prison. His death is subject to a separate investigation being carried out by the Prison Authorities.

3. POLICE RESPONSE

3.1 At 4.37pm two 999 calls were made to the police informing them of the shooting. It was very quickly identified that Stuart Horgan was the suspect and that he was in possession of a ‘rifle’. He had left the scene of the attack but was thought to be in the area. He was last seen walking in the direction of Nettlebed.

3.2 At 4.39pm the Control Room Inspector took command of the incident and ordered that no officer attend the scene. The Ambulance Service was also contacted immediately.

3.3 Over the next few minutes the Control Room alerted Armed Response Vehicles, dispatched the force helicopter and informed the duty Silver Commander. Approx. 25 minutes later contact was made with the Tactical Firearms Advisor and duty Gold Commander.

3.4 An initial rendezvous point at Henley Police Station was chosen which was later changed to Emmer Green.

3.5 At 5.41pm armed police enter the house and immediately call for the ambulance and paramedics to attend (64 minutes after initial report).

3.6 At 6.04pm ambulances and paramedics arrive at the scene (87 minutes after initial call).

4. PUBLIC CONCERN OVER POLICE RESPONSE

4.1 During the time period between the report of the incident and police attendance, local residents were left to attend to the victims of the shooting. Georgina Gibson tended to all three victims, attempting to stem the flow of blood and provide first aid as best she could. Her husband, Roy Gibson, provided the Police with a telephone commentary after attending the scene armed with a piece of wood.

4.2 Dawn Clarke, who made the initial call, provided the police with a commentary for approximately 70 minutes, whilst looking after one of Vicky’s children. During this time she demanded police and ambulance attendance in excess of 50 times. She was repeatedly told that the police/ambulance would be with her within minutes.

4.3 Roy Gibson, Georgina Gibson and Dawn Clarke have been highly critical of the police for the way in which this tragedy was dealt with. From their perspective it is the following questions and observations that require serious consideration and explanation:

- Would Emma have died had the police and ambulance responded earlier?
- How can the police justify not coming to the aid of members of the public?
- Why were armed officers not sent to protect the public at the scene whilst the search for the suspect took place?
- Why wasn’t an ambulance sent under armed guard to tend to the victims immediately?

- Did the police prevent the ambulance from attending?
- Why wasn't any first aid advice given over the phone?
- Why did the police lie by continually saying, "We are on our way"?
- Why wasn't someone in charge at Highmoor Cross?
- Why did officers not appear to have any local knowledge?
- Why were the children not attended to by anyone with medical experience?
- Why was there no acknowledgment of the actions taken by neighbours at the scene?

4.4 The incident itself and public outcry attracted a great deal of media interest and a vast amount of criticism being directed at Thames Valley Police. The main thrust of the criticism was the failure of the police to attend the scene of a crime where people had been shot and were in need of urgent medical assistance. No justification could be seen for armed officers not being sent to assist the victims and the residents of Highmoor Cross.

5. INVESTIGATION SUMMARY

5.1 Having interviewed all key personnel involved in this incident, this review has identified many areas of weakness in Thames Valley's response to firearms incidents. Most of these were in the process of being addressed at the time of this incident.

5.2 All of those directly involved genuinely believed that the decisions that they had made were in accordance with the ACPO Manual of Guidance on the Police Use of Firearms (ACPO Manual), Thames Valley firearms policy (Operation Saladin) and the training that they had received. As a consequence of this, the issues facing Thames Valley Police extend further than the decisions made on 6th June 2004. The Force is facing a fundamental challenge to the way in which these incidents are responded to.

5.3 There are two crucial elements at the heart of the delay in attendance at Highmoor Cross: **Command and Policy.** These have been reviewed in turn to explore potential organisational learning with a view to shaping the way that firearms incidents are responded to in the future.

6. REVIEW OF COMMAND

6.1 A number of factors significantly impacted on Thames Valley's ability to take effective command of the situation from the time of initial call through to the time that paramedics tended to the victims.

6.2 The force when operating "normally" relies upon an Inspector, with additional command training to take initial control of significant incidents until such time as a fully formed command structure can be applied. In respect of firearms incidents, the aspirational command structure would be achieved through an on duty Firearms Silver Cadre Officer, and the duty ACPO officer, taking Silver and Gold respectively,

which should be implemented as soon as practicable. Spontaneous firearms incidents are now a predictable occurrence. It follows that the command response should be capable of coping with such incidents, which are often ambiguous in nature and difficult to control in the early stages.

6.3 The structure within the Control Room (Abingdon) is adequate for the vast majority of routine and emergency calls but it cannot and did not cope with a fast-moving critical incident of this magnitude. This is currently being addressed as a matter of urgency.

6.4 The Control Room Inspector took command very early and retained that command for three hours. At the time of the report of the shootings the structure of the Control Room was such that the Inspector was unable to capture all relevant information, analyse it, conduct a risk assessment and then make command decisions. This was due to the number of functions he had to carry out, in addition to briefing other key personnel, as well as the technical limitations in the Control Room. The Inspector can only effectively monitor one radio channel but three were in operation during the crucial stages of this incident. (In future it will be possible to more effectively patch (join) across county boundaries but this is dependent on a national upgrade to the Airwave radio system). Valuable information was also missed as there was no facility to show the video images from the helicopter in the Control Room. There is then a tendency to delay decision making until a clearer picture emerges.

6.5 He made the initial policy decision not to deploy any officer to the scene as it was 'not safe'. The rationale for the decision not to deploy direct to the vicinity of the scene was that there was a 'need to protect all involved in the incident'. The offender was armed with a rifle and was thought to be still in the area. He said that his decision making was in line with policy and in accordance with all the firearms command training that he had received.

6.6 It is the responsibility of the police to safeguard the public. While there is no hierarchy of right to life, protection of the public (specifically and generally) is the priority in every spontaneous firearms incident. The Police Service cannot be reckless in its response to such incidents – but it must respond. Well trained and equipped firearms officers, such as Thames Valley Police Armed Response Vehicle crews, are available to provide a prompt response, well within the margins of acceptable risk. Thus the decision not to deploy armed officers to the vicinity of the scene (forward control point) as quickly as possible was wrong. Furthermore, it remained unchallenged for approximately 35 minutes (and took a further 26 minutes to implement the correct command decision).

6.7 It appears that when faced with a serious firearms threat, Thames Valley Police relies upon process. Coupled with a lack of clarity over authority to act, this compounded the difficulties faced in the early stages of the incident.

6.8 The officer has stated that it was never a consideration to deploy armed officers close to the scene and felt that he would have been criticised had he done so. He is unaware of any training scenario where the recommendation was for armed officers to deploy in this manner.

6.9 The reason for making Armed Response Vehicles available is to urgently reduce risk to the public and unarmed colleagues when facing threats. To then create a process whereby they can never be immediately deployed appears perverse. It is possible that the fear of using undue force may be constraining the proper controlled use of Armed Response Vehicles.

6.10 The Duty Silver Commander was briefed at 4.46pm. He was told that no police officers had been deployed to the scene. He immediately made for Three Mile Cross Roads Policing Base in order to brief himself from Command & Control. As stated, full transfer of command did not occur for approximately three hours. Whilst the Manual of Guidance counsels against taking command too early, there must be an expectation if on duty for that very purpose, to accept responsibility for the actions of the Inspector and add value to the force response.

6.11 By 4.59pm (22 minutes after the initial report) it was reasonably evident that Stuart Horgan was no longer at the scene, nor in the vicinity. Although there could be no guarantee that this was the case, the evidence from witnesses and the helicopter was such that it should have heavily influenced the decision to deploy armed officers at that time. It was clear that people were in the street talking and using mobile phones. Vehicles were also regularly passing the scene in both directions.

6.12 Given that the roads were still open, the public wandering unprotected, repeated pleas for assistance, and several recorded reports that the offender had left the scene, police resources should have been sent forward.

6.13 The Tactical Firearms Advisor was contacted at 5.03pm. He gave advice that the priority was to identify and locate the offender by the safest possible means. He also agreed to call out the 2nd tier response.

6.14 The role of the Tactical Advisor was not clear. The Tactical Advisor should have been given the strategy, threat assessment, and desired outcome, from which to suggest viable tactical options. Had this happened, the priority would rightly have been placed upon the victims first, search for offender second.

6.15 At 5.05pm the second Armed Response Vehicle arrived at the first rendezvous point, Henley Police Station, which is 3.9 miles from Highmoor Cross. There did not appear to be any control over where to locate the rendezvous point and determining a suitable location resulted in some confusion with some units being unaware that the location had changed.

6.16 There appears to be confusion around the use of rendezvous points. This appears to have been set as a place for resources to hold, rather than as would be expected, a place for additional staff to meet, brief and move forward to a scene. The choice of location, management of the rendezvous point, confusion over which premises were in use and extreme distance from the scene caused real problems in the resolution.

6.17 The first Ambulance crew went direct to the ‘old’ Henley Police Station, unaware of the existence of the new station. They arrived at the rendezvous point at 5.05pm.

This confusion was exacerbated by the fact the police and ambulance have different radio systems.

6.18 It was then acknowledged that this location was not suitable, and the rendezvous point moved to Emmer Green, which is 5.2 miles from the scene, but crucially 8 miles from the first rendezvous point. Both rendezvous points were clearly unsuitable as they were too far from the scene. A holding point near to the scene but in the opposite direction to which the suspect was last seen walking would have been preferable.

6.19 The Duty Gold Commander was briefed at 5.07pm and offered Gold support. The Gold Commander was satisfied that this was a silver-led spontaneous firearms incident. Other officers concurred that there was no role for Gold to play whilst the incident was 'live'.

6.20 At 5.15pm the Duty Detective Sergeant for Southern Oxfordshire on his own initiative went in his own vehicle to the scene. He confirms the fact that people were in the street and that the offender did not appear to be present. He had also travelled from Nettlebed and had not seen the offender. He provided a situation report to the Control Room.

6.21 His information appears to have been the catalyst for the eventual deployment of officers to the scene. The officer appears to have carried out the actions which should have been ordered at the outset. The information in his possession when he moved to the vicinity of the house was no better than when the incident was first reported. His personal safety was in no more jeopardy than the general public. His initiative was correct, but he should have been doing so on behalf of the commander.

6.22 After this situation report was provided, it was decided that an ARV crew and Ambulance crew would both be deployed to the scene; however the choice of rendezvous points and the subsequent change of location built in a considerable delay in actually getting them there. It appeared that the priority was to go to the rendezvous point rather than to go direct to Highmoor Cross. It was entirely predictable that at some stage an approach would be made to the address. It was also predictable that it may have to be carried out quickly. To allow resources to remain at remote holding points created significant delay.

6.23 At 5.38pm the second Armed Response Vehicle was deployed to the scene. At the same time, the first Ambulance crew arrived at the Emmer Green rendezvous point. A further Armed Response Vehicle was also making its way directly to the rendezvous point but was experiencing engine problems that limited its speed to 50mph.

6.24 At 5.41pm armed police entered the premises having made a tactical approach. They demanded that paramedics attend the scene immediately.

6.25 At 5.45pm the Ambulance crew initially refused to attend the scene as the police could not confirm that the offender had been located and the area was safe. Several

minutes later they agreed to attend with an armed escort. Providing additional armed support also built in a delay to the Ambulance crew attending. Given the confusion, lack of clarity and actions taken up to that point, a reticence by ambulance staff to move forward is entirely understandable. Had all units been holding together near to the scene, properly briefed by a scene commander, with clear contingency plans in place, this would not have occurred.

6.26 It is difficult to establish the change in circumstances that resulted in the decision to deploy to the scene. The information that was available at the moment of deployment had been available within several minutes of the initial call. Procrastination rather than events appear to have dictated tactics.

6.27 The operators' initial reaction to the calls was that the emergency services would be deployed direct to the scene to attend to the victims, a message they conveyed to the callers. As part of their training they are instructed to keep callers on the line in order to obtain up to date information. During these lengthy calls the operators did their best to provide information and reassurance to the caller. They did not know what the tactical plan was or when it was to be implemented. They provided estimates in the honest belief that the emergency services would be deployed 'without delay'.

7. REVIEW OF POLICY

7.1 The Gold, Silver and Bronze system identifies three command levels, strategic, tactical and operational, through which an operation is controlled and accountability maintained. In very basic terms Gold determines strategy (what to do), Silver determines tactics (how to do it) and Bronze implements the plan (does it). This structure will not fall into place immediately on the report of an incident but it will be something that the person taking command initially (usually the Control Room Inspector) will strive to implement as quickly as possible.

7.2 All officers involved in making command decisions or influencing them have stated that their decisions were in accordance with the ACPO manual. The manual's guidance suggests that Control Room Inspectors will take initial responsibility for command until such time that it is transferred to a more senior officer.

7.3 It is important to note that in relation to the transfer of command it states:

- *It should not be assumed that a trained Silver Commander will immediately take on that role upon being contacted as their ability to perform an effective Command function depends upon:*

  - Knowledge of all intelligence / circumstances
  - Ability to communicate
  - Availability of appropriate tactical advice
  - Being suitably located

- *The transfer of such roles should take place as soon as practicable in accordance with Force procedures.*

7.4 Thames Valley Police would appear to have interpreted this guidance to mean command will not transfer until all four elements of this section have been satisfied to a very high degree. This will inevitably cause considerable delay in transferring command and have an impact on actions taken on the ground. In this case the transfer of command did not take place for 3 hours, which is unacceptable.

7.5 Thames Valley's firearms Commanders, supported through the 'in force' training they receive, have interpreted this section of the manual as meaning that the Commander must have access to Command and Control in order to read the log, have access to their own operators and be suitably located where they can access all of this before they will allow transfer of command to take place.

7.6 Other forces, not all, interpret this section as meaning that the Commander must be verbally briefed, in a position to communicate via their mobile phone, in a location where they can effectively communicate and in a position to speak to a Tactical Firearms Advisor. Clearly this is a more fluid interpretation of the guidance.

7.7 The ACPO manual tends to support Thames Valley's approach to dealing with firearms incidents, however the ambiguity causes inconsistencies in the national approach.

7.8 Transfer of command should ideally take place as soon as a Commander has been briefed and he/she is in a position to effectively communicate with others. This is likely to be when they are in the office, at home or in their vehicle. They will obviously make plans to move to a more suitable location, ideally to the scene, and may have to transfer command back if they are unable to effectively communicate on that journey.

7.9 The initial information will almost inevitably be vague and confusing but this is even more reason for command to transfer to the most appropriate person as quickly as possible. A dynamic risk assessment must be carried out based on the information and intelligence available at that time. It may be that a different picture emerges later on, requiring a reassessment, but this is no reason to delay crucial command decisions being made. Risk assessment is a continual process but waiting to have a 'full' picture is not an option when our priority, as it was at Highmoor Cross, was to protect the public and attend to the victims.

7.10 Operation Saladin, Thames Valley's policy for dealing with firearms incidents, is a satisfactory process for dealing with pre-planned operations or events that are prolonged and therefore need a wide range of services and support. It is inadequate as a policy to deal with spontaneous firearms incidents. It can build unnecessary delays into incidents which require immediate firearms deployment (and where intelligence can be gleaned from those deployments). The policy attempts to eliminate risk rather than manage it.

7.11 Thames Valley Police's 'strategic aim' in all firearms situations, which is stated in Operation Saladin, is always standard: -

Minimise injuries to all persons
Prevent the subject from causing harm
Use no more force than is absolutely necessary

This may best be achieved by identifying, locating and containing the subject thereby neutralising the threat posed.

7.12 As this declared strategic aim is 'standard' there is a tendency not to articulate what the aim is during a specific firearms operation. It is also one of the reasons that the concentration was put solely on locating the suspect and insufficient consideration given to the victims who had been shot. This would have been totally justified had Horgan been sighted or located. The priority would clearly have been to neutralise the threat of further loss of life and injury.

7.13 The Saladin process is aimed at providing an effective decision making forum and a consistency of approach across the force. The policy states that the Saladin process normally starts as an incident moves from spontaneous into pre-planned but that its principles should be applied to all firearms incidents. There is a culture within Thames Valley to manage firearms incidents as if they were pre-planned when clearly there are occasions for which this process is not appropriate.

8. Conclusion

8.1 After comprehensively reviewing all of the evidence in relation to the shooting at Highmoor Cross, this report concludes that the level of delay in both the Police and Ambulance Service attending the scene cannot be justified. The Police have a basic duty to preserve and protect life.

8.2 The staff involved in the decision making process are very dedicated and committed professionals. There is no evidence to support any charges of discipline or misconduct. The weaknesses identified in this review in relation to how the incident at Highmoor Cross was dealt with are fundamental issues for Thames Valley Police and possibly the police service nationally.

8.3 The initial command decision not to deploy any resources to the scene was wrong. The emerging picture should have reinforced the need to send officers to the area. There is little doubt that the initial response fell into a structured routine of finding rendezvous points, briefing commanders, obtaining tactical advice and setting up a command suite, but did not provide an adequate response to a situation in which the public urgently required immediate assistance from the police.

8.4 The priority for the Commander was clearly to identify, locate and contain the offender. The decision to change the priority from the offender to the victims should have been made at 4.59pm at the very latest (22 minutes after first report). This was

the time that a dynamic risk and threat assessment, if carried out, would have identified that the likelihood of the suspect being in the area was slim.

8.5 A Bronze Firearms Commander was available and in a position to respond. He should have been deployed to a suitable location near to the scene of the crime where he could have and performed the role of Ground Commander, a role which his function dictates. He was not utilised appropriately.

8.6 The correct decision to deploy armed resources was made at 5.15pm but the transfer of rendezvous points from Henley Police Station to Emmer Green (8 miles apart) built in a further 25 minute delay for both the Police and Ambulance Service. There appeared to be a lack of faith in the ability of the Armed Response Vehicle staff to act within their training. If that is because the Armed Response Vehicle staff are not trained sufficiently to tactically deploy to get observations on an address, then contain any threat posed, that should be addressed. If there is a fear of undue force being applied by them, then that should be explored and addressed by their commanders.

8.7 At 5.41pm armed police officers arrived at Highmoor Cross and secured the scene. The Ambulance Service refused to attend at this time due to the fact that the whereabouts of the suspect were unknown. The Ambulance Service should have deployed their resources on the advice of the Police. This decision built in a further delay of 14 minutes which could have been avoided through effective scene control.

8.8 Command of this very serious incident should have transferred from the Control Room Inspector to a Silver Commander as quickly as possible. On 6th June this took three hours. The primary reason at the core of this delay is Thames Valley's interpretation of the ACPO Manual of Guidance on the Police Use of Firearms, which has been embraced within Thames Valley's Operation Saladin Policy.

8.9 The wording used in the ACPO Manual in relation to the 'transfer of command' can be interpreted in a number of ways. Thames Valley Police has interpreted it in a way that unavoidably builds in considerable delay in transferring command of a 'spontaneous or live' firearms incident to a Silver Commander and thus increases rather than mitigates risk.

8.10 Silver Commanders, in accordance with guidance and their training, require themselves to be fully briefed, have access to Command and Control and be in a suitable location, prior to taking command. On many occasions this approach will cause little or no problems, but it has inherent weaknesses when dealing with a critical incident that requires a dynamic risk assessment and an early transfer of command.

8.11 Tactical Firearms Advisors are there to provide expert advice on how to tactically resolve a firearms incident. Silver Commanders, prior to contacting the Tactical Advisor, should have made an assessment of the situation, decided what the strategic aim is and formulated a policy in relation to what needs to be achieved. Advice can then be sought in relation to appropriate tactics needed to achieve the aim. All too frequently, as was the case at Highmoor Cross, Tactical Advisors are

being asked to provide advice in relation to command decisions. They, in effect, become the Commander or at best the role of Commander is blurred.

8.12 Thames Valley Police have made considerable progress in relation to how they resource and deal with firearms incidents. The Chief Constable, having identified this as a priority, has invested greatly in the provision of more resources to respond to incidents throughout the Force area. He has also introduced a Firearms Cadre which ensures that fully trained and accredited Silver Commanders are available at times that demand has dictated. Although in its infancy, this system was in place on 6th June and contributed to a Silver Commander being on duty at the time. When fully functional it will have the capacity to take early command of spontaneous incidents from the scene of the incident.

8.13 Vast improvements have also been made in the development of highly sophisticated computer and video-based software, which is used to train all Firearms Commanders. There is a need to ensure that Gold, Silver, Bronze, and Tactical Advisors training is provided within a common programme to ensure consistency of approach across all the roles, and provide a single interpretation of guidance and policy.

8.14 All of these improvements will reduce the likelihood of this occurring in the future but only if it is combined with a change in culture in how Thames Valley Police makes decisions. This review is not advocating that that all firearms incidents are attended immediately, this would be irresponsible and reckless, but Thames Valley Police would appear to have excluded it as an option, which can expose the public and unarmed colleagues to risks which could be more safely mitigated against.

8.15 The causal factors of the criticisms levelled at Thames Valley Police appear to be procedural rather than 'human error'. All personnel involved believed that they had acted in accordance with the ACPO Manual and Operation Saladin. This indicates weaknesses in policies, training and consequently practice that Thames Valley must accept and address in order to learn the lessons from the tragic events that day. Every effort must be taken to prevent the same situation occurring in the future.

8.16 Valuable lessons are being missed, both at a force level and nationally, due to ineffective debriefing and dissemination of learning from firearms incidents. There is a tendency not to thoroughly de-brief firearms incidents which have resulted in a successful outcome, despite the fact that there may have been weaknesses in the way they were handled. There is also no national database where forces can learn from each other.

9. Recommendations

For Thames Valley Police:

9.1 Operation Saladin should be withdrawn and replaced with a new policy to provide clear guidance to commanders dealing with spontaneous firearms incidents, especially where people have been, or are suspected to have been injured. The

policy must highlight the roles and responsibilities of commanders and also provide clear guidance in relation to the transfer of command. It should also stipulate that the command function must, unless there are good reasons for not doing so, be performed near to the scene of the incident. Policy and training needs to provide clear direction and guidance to all firearms commanders in relation to dynamic risk and threat assessing and the making of command decisions under extreme pressure and with limited information or intelligence.

9.2 Firearms training for commanders needs to be co-ordinated across all roles to ensure a consistent interpretation of policy and guidance.

9.3 Establish a Head of Profession to lead and provide consistency within force and to take responsibility for police development and training.

9.4 Technology support in the command and control environment needs to be reviewed urgently to ensure that it is fit for purpose.

9.5 Joint training should take place between Thames Valley Police and the Ambulance Service in order to enhance communication, decision making and command protocols. This recommendation has been welcomed by Royal Berkshire Ambulance Service. The issue of joint control rooms and radio systems should also be pursued.

National

9.6 The ACPO Manual of Guidance on the Police Use of Firearms needs to be amended in relation to the 'transfer of command' during a spontaneous firearms incident. It needs to provide clear and unequivocal guidance on the role of a Silver and Gold Commander, when they should be informed of a firearms incident and what is expected of them in the early stages of an incident. This should be supported by consistent standards in command training.

9.7 Findings from de-briefings of all serious firearms incidents should be disseminated for the benefit of all Commanders and also be used to influence how the police train. This must be a robust process where both best practice and poor practice can be highlighted. Development of a national database of such incidents would greatly assist individual force training and development.

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