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IN THE CORONER'S COURT IN NORTHERN IRELAND

**IN THE MATTER OF AN INQUEST TOUCHING UPON THE DEATH OF
NOAH DONOHOE**

**RULING AS TO WHETHER ARTICLE 2 ECHR IS ENGAGED IN THIS
INQUEST**

ROONEY J (*Sitting as Presiding Coroner*)

Introduction

[1] As stated by Lord Stephens in *R (Maguire) v His Majesty's Senior Coroner for Blackpool and Fylde* [2023] UKSC 20 at para [247]:

“247. Until an inquest is underway, and the real issues can be identified, there may be no proper way in which an assessment can be made as to whether there is an arguable breach of the state’s substantive positive obligations so as to engage the enhanced procedural obligation. Accordingly, the Coroner will properly, as in this case, proceed on the basis that there is a need for an expanded verdict and then review the position at the end of the evidence, by which stage most if not all of the additional costs of the inquest have been incurred. Therefore, it is apparent that it will rarely be the case that the positive enhanced procedural obligation will impose an unreasonable or disproportionate burden on the state in relation to the conduct of an inquest.”

[2] The inquest has now reached the point where a determination must be reached on whether there should be an engagement of the enhanced procedural obligation under article 2 ECHR, before questions for the jury can be determined.

[3] Article 2 requires an enhanced investigative duty “where there are grounds for suspecting that a death may involve a breach by the state of one of the

substantive obligations imposed by article 2” (see *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29 at para [70]). Where the procedural investigative article 2 duty is engaged, an inquest must consider not just how, but also “by what means and what circumstances” the deceased came by his death. This has important consequences for the nature and format of the conclusions to be reached at the inquest.

[4] The PSNI and the Department for Infrastructure (“DfI”) submit that, following consideration of the ECHR jurisprudence, it would be entirely impermissible to rule that article 2 is engaged in the circumstances of this inquest. The Next of Kin (“NoK”) and Coroners Service for Northern Ireland (“CSNI”) Counsel remain of the view, based on the evidence discussed below, that the positive operational duty pursuant to Article 2 is activated and there has been an arguable breach of this obligation.

[5] I will deal with the issues under the following headings:

- (a) The Human Rights Act 1998 (HRA 1998”) and its relevance to inquests.
- (b) Article 2 ECHR.
- (c) Duties arising from article 2 ECHR.
- (d) The scope of the positive operational duty.
- (e) The application of the operational duty to the evidence.
- (f) Whether article 2 ECHR is engaged in relation to the PSNI and there is an arguable breach?
- (g) Whether article 2 ECHR is engaged in relation to the DfI and there is an arguable breach?

The Human Rights Act 1998 and its relevance to inquests

[6] There are two aspects of the HRA 1998 which are of particular significance to an inquest. Firstly, is the fundamental principle that it is “unlawful for a public authority to act in a manner which is incompatible with a Convention right” unless required to do so by the terms of primary legislation which cannot possibly be interpreted in any other way (see section 6(2)). For the purposes of section 6, an act includes a failure to act. Section 6(3)(a) provides that the acts of all courts and tribunals, including coroners’ courts, are bound by the HRA 1998.

[7] The second aspect of the HRA 1998 which is particularly relevant to inquests is the obligation on domestic courts, to include the coroners’ courts and tribunals, to “take into account” any judgment, decision, declaration or advisory opinion of the

European Court of Human Rights (ECtHR) which they consider relevant when determining a question which has arisen in connection with a Convention right (see section 2(1)).

[8] There is conflicting dicta by the House of Lords and the Supreme Court as to the content of the obligation imposed by section 2(1) HRA 1998. In *R (Ullah) v Special Adjudicator* [2004] UKHL 26, Lord Bingham stated:

“It is of course open to member states to provide for rights more generous than those guaranteed by the Convention, but such provision should not be the product of interpretation of the Convention by national courts, since the meaning of the Convention should be uniform throughout the states party to it. The duty of national courts is to keep pace with the Strasbourg jurisprudence as it evolves over time: no more, but certainly no less.”

[9] Lord Bingham’s commentary has been referred to as establishing the “mirror principle.” However, in *D v Commissioner of the Police (Liberty and others intervening)* [2018] UKSC 11, Lords Mance and Kerr suggested that Lord Bingham’s approach was too conservative. Lord Mance said at para [153]:

“[153] There are, however, cases where the English courts can and should, as a matter of domestic law, go with confidence beyond existing Strasbourg authority: ... If the existence or otherwise of a Convention right is unclear, then it may be appropriate for domestic courts to make up their minds whether the Convention rights should or should not be understood to embrace it.”

[10] Lord Kerr at para [77] emphasised that in cases following *Ullah* “a departure from the mirror principle can be detected.” Lord Kerr endorsed Lord Wilson’s suggestion in *Moohan v Lord Advocate* [2015] AC 901 that:

“... where there is no directly relevant decision of the ECtHR with which it would be possible (even if appropriate) to keep pace, we can and must do more. We must determine for ourselves the existence or otherwise of an alleged Convention right. ...”

[11] The question as to whether ECtHR jurisprudence should be applied according to a “mirror principle” or whether it is open for the courts to expand the protection provided by the ECHR beyond Strasbourg jurisprudence is relevant in the coroner’s court. Frequently, as in this inquest, coroners find themselves facing arguments from interested persons as to whether the investigative duty under article 2 applies

to a relevant set of circumstances. Plainly, if article 2 is engaged, this widens the scope of the coronial investigation and the conclusions available to the inquest.

Article 2 ECHR – The right to life

[12] Article 2 ECHR provides as follows:

“1. Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary:

- (a) in defence of any person from unlawful violence;
- (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;
- (c) in action lawfully taken for the purpose of quelling a riot or insurrection.”

Duties arising from Article 2 ECHR

[13] In *R (Morahan) v HM Assistant Coroner for West London and others* [2021] EWHC 1603 (Admin), the Court of Appeal in England & Wales helpfully examined the relevant case law and set out the principles to be distilled in respect of the article 2 ECHR obligations. Popplewell LJ (delivering the judgment of the court) outlined the categories of the article 2 ECHR duties imposed upon the states as follows at para [30]:

“Article 2 has been interpreted as imposing three distinct duties on states and those exercising state functions:

- (1) There is a negative duty to refrain from taking life without justification (see, for example, *Rabone v Pennine Care NHS Foundation Trust* [2012] 2 AC 72 at paras 12 and 93). This arises not only at a state level but more commonly, in practice, at an operational level, and includes cases where an individual dies at the hands of an agent of the state, such as a police shooting. This may be labelled the negative operational duty.

(2) There is a positive duty to protect life which has two aspects:

(a) There is a duty to put in place a legislative and administrative framework to protect the right to life, involving effective deterrence against threats to life, including criminal law provisions to deter the commission of offences, backed up by a law enforcement machinery for the prevention, suppression and sanctioning of breaches of such provisions; and in the healthcare context having effective administrative and regulatory systems in place (*Van Colle v Chief Constable of the Hertfordshire Police* [2009] 1 AC 225 at para 28, *Rabone* at paras 12 and 93). This is the framework duty, of which the latter aspect is sometimes referred to as a systems duty.

(b) There is a duty, first articulated in *Osman v UK* [1998] 29 EHRR 245, to take positive measures to protect an individual whose life is at risk in certain circumstances. This is the positive operational duty. In *R (L(A Patient)) v Secretary of State for Justice* [2009] 1 AC 588, Lord Walker of Gestingthorpe observed at paragraph 89 that there is often no clear dividing line between this operational duty, and the systems duty below the national level.

(3) There is an investigative duty to inquire into and explain the circumstances of a death. As I explain below, there are two different investigative duties which have a different scope and different juridical basis. One is a substantive duty to investigate every death as an aspect of the framework duty; the other is a procedural obligation which arises only in some cases and is parasitic on the possibility of a breach by a state agent of one of the substantive operational or systems duties. When the latter arises, it is a duty of enhanced investigation, to initiate an effective public investigation by an independent official body. This is the enhanced investigative duty."

[14] Therefore, article 2(1) ECHR creates a positive duty to take appropriate steps to safeguard the lives of those within the jurisdiction of the state. Article 2(2) places a negative duty on the state not to intentionally take a life.

[15] In *Maguire*, Lord Sales reaffirmed the approach in *Rabone* and identified three different levels of the investigative or procedural duty which he referred to as the “graduated procedural obligation” which may be identified in relation to investigation of a death. Lord Sales referred to “the enhanced procedural obligation (which) applies where there is a particularly compelling reason why the state should be required to give an account of how a person came by their death” (para [15]). This inquest does not involve a consideration of the negative duty pursuant to article 2(2) ECHR. Rather, as agreed by the PIPs, the focus will be on the positive substantive duties, namely the operational duty.

The scope of the operational duty

[16] With specific reference to the operational duty, the dicta of Popplewell LJ paras [38] to [40] in *Morahan* is very relevant:

“38. The positive operational duty arises where the state agency knows or ought reasonably to know of a real and immediate risk to an individual’s life and requires it to take such measures as could reasonably be expected of it to avoid such risk (*Osman* paras 115, 116). In this context:

- (1) Risk means a significant or substantial risk, rather than a remote or fanciful one. In *Rabone* the risk in question was one of suicide and was quantified as being 5%, 10% and 20% on successive days, which was held to be sufficient (see paras 35-38).
- (2) An immediate risk to life means one that is “present and continuing” as opposed to “imminent” (*Rabone* para 39).
- (3) The relevant risk must be to life rather than of harm, even serious harm (*G4S Care and Justices Services Ltd v Kent County Council* [2019] EWHC 1648 (QB), paras 74-75 and *R (Kent County Council) v HM Coroner for the county of Kent* [2012] EWHC 2768 (Admin) at paras 44-47).
- (4) Real focuses on what was known or ought to have been known at the time, because of the dangers of hindsight (*Van Colle* at para 32).

- (5) Overall, in the light of the foregoing considerations viewed cumulatively, the test is a stringent one (see *Van Colle*, per Lord Brown of Eaton-under Heywood at para 115; and *G4S*, paras 71-73). It will be harder to establish than mere negligence, but that is not because reasonableness here has a different quality to that involved in establishing negligence; rather it is because it is sufficient for negligence that the risk of damage be reasonably foreseeable, whereas the operational duty requires the risk to be real and immediate: see *Rabone* at paras 36-37.

39. It is also clear that the existence and scope of the duty must not impose an impossible or disproportionate burden on state agencies in carrying out their necessary state functions and must take into account the individual's rights to liberty (article 5) and private life (article 8): see *Osman* at para 116, *Rabone* at 104 and *Fernandes de Oliveira* at paras 111, 125, 131.

40. In *Osman* it was said at para 115 that the operational duty exists in "certain well-defined circumstances." However, its boundaries have been the subject of developing jurisprudence both in the European Court of Human Rights ("ECtHR" or "Strasbourg") and domestically. For present purposes, the decision of the Supreme Court in *Rabone* can be taken as the point of departure, in which Lord Dyson JSC observed at para 25 that the Strasbourg jurisprudence was young and the boundaries were still being explored; and that they might expand to include new categories of circumstances as giving rise to the operational duty as new factual circumstances were considered."

The application of the operational duty to the evidence

[17] In consideration of the application of the operational duty to the facts of this case, it is clear from the above analysis of the authorities that the critical question is whether the evidence confirms that the PSNI and the DfI knew or ought to have known that Noah faced a real and immediate risk to his life and whether they took such measures as could reasonably be expected to prevent the risk from materialising.

[18] In consideration of this question, I have been provided with written submissions from the PIPs which included an extensive review of the ECtHR jurisprudence. On Friday 19 June 2026, I listened to thought provoking oral submission from each PIP. Due to the urgency of this ruling and its potential impact on the jury questions and verdict, I will not articulate each and every argument contained in the submissions. However, I would like to emphasise that I have carefully considered the submissions which have greatly assisted me in reaching my conclusions.

[19] I will consider seriatim the relevant factual circumstances and evidence in relation to both the PSNI and DfI in relation to the engagement of article 2 duties and the question raised above.

Whether article 2 ECHR is engaged in relation to the PSNI and there is an arguable breach?

[20] The NoK submit that, within a short period of time after Noah was reported missing, the PSNI operated on the basis that the operational duty under article 2 was engaged.

[21] In order to assess whether, based on the evidence, the PSNI knew or ought to have known that Noah faced a real and immediate risk to his life and whether they took reasonable measures to prevent the risk from materialising, it seems to me that the starting point must be the 101 call made by Noah's mother, Fiona Donohoe.

[22] Ms Donohoe rang 101 at 21:44hrs on 21 June to report Noah missing. The call finished at 22:20hrs. In the course of the telephone call, Ms Donohoe made the following statements:

- “(a) Noah has not been himself at all, and I am really concerned for his safety.
- (b) I have just been feeling like he's been going through hormones and then cabin fever, he's constantly by himself. And he's been overthinking ... Oh gosh he's really not been himself ... I have been really concerned about his welfare the whole week.
- (c) Noah has been getting 'really philosophical' and 'so deep in thought about his life.'
- (d) I have been extremely concerned about his mental health ... he's been up and down ... His moods have been really out of character.”

[23] It is abundantly clear from the 101 call that Noah's mother was very concerned about him, particularly in relation to Noah's mental health. It was also clear that Noah's behaviour, and the fact that he had not returned home or communicated with his mother, was totally out of character for him. After the phone call, Control works record that the risk to Noah was assessed as medium "by virtue of age/vulnerability."

[24] Constable Murphy contacted Ms Donohoe shortly after the call. He recorded in the OEL at 00:28hrs the following: "(a) that Noah's disappearance was totally out of character for him and he would usually be home before 10pm; (b) Noah was supposed to be heading to the Cavehill with friends that evening; (c) Noah had been "strange" the last week, hugging his mother and telling her that he loved her a lot; (d) Noah had made no reference to self-harm and was currently not on medication and had no mental health issues; (e) Noah would not have a large number of friends, except Jay and Charlie; and (g) Noah had no access to a vehicle and no access to cash."

[25] It is noted that Ms Donohoe told Constable Murphy that Noah had taken his mobile phone which was fully charged but that the phone was currently turned off.

[26] Within a very short period of time, Noah's status was elevated to "high risk missing person."

[27] Several actions occurred shortly after Noah had been deemed high risk. At 00:52hrs, air support was briefed and later launched. At 01:07hrs a post that Noah was missing was placed on PSNI Belfast Facebook; (c) at 01:14hrs a request for a PolSA (Police Search Adviser) was made and thereafter briefed; (d) by 01:13hrs the Telecoms Liaison Unit (TLU) call out had been authorised; (e) by 01:16hrs a decision had been taken that a CCTV operator would be tasked to review footage to establish if Noah could be seen; (f) searches on foot had commenced before 01:30hrs; (g) at some point between 01:16hrs and 01:43hrs AM600 were tasked to start checking CCTV for Noah.

[28] At 01:16hrs, Inspector Rahilly updated the OEL with his assessment of Noah as a high risk missing person. The rationale was stated as follows:

"The disappearance is completely out of character. Noah has never gone missing before. He was last seen at approximately 1700hrs, 21.6.20 and there have been no sightings or contact since this time. He told his mother he was meeting friends in Cavehill, however, this meeting had been cancelled sometime prior to his disappearance. He has no access to money and whilst he has not been diagnosed or treated for depression etc, his mood has been described as low recently."

[29] The definition of high risk is stated in the PSNI Service Procedure 08/15 as follows:

“The risk posed is real and immediate and there are substantial grounds for believing that the subject is in danger through their own vulnerability or ill health; or may have been a victim of a serious crime involving a real and immediate threat of harm; or the risk posed is immediate and there are substantial grounds for believing that the public is in real and immediate danger. For example, potential murder victims; child abduction; *vulnerable person contemplating suicide and assessed as intending to attempt it*; a detainee under mental health legislation where there are serious concerns of a risk to the public; child of high risk of CSI.”

[30] It is highly significant, according to the NoK, that the said definition of a high risk missing person mirrors the ECtHR and domestic jurisprudence in relation to the interpretation of the positive obligations protected by article 2 ECHR. This is plainly correct. The NoK also highlight that in the PSNI Service instruction on missing persons, under the section “Legal Basis” the following is stated:

“The Human Rights Act (HRA) 1998 places a positive obligation on police officers to take a reasonable action within their powers to safeguard the rights of individuals who may be at risk. Those rights found in Schedule 1 Part 1 that may be relevant to missing persons are - a right to life (article 2).”

[31] The NoK submit that, within a short period of time after Noah was reported missing and particularly after Noah was designated as a High Risk Missing Person, the PSNI operated on the basis that the operational duty under article 2 was engaged. Mr Lunny KC disputes this interpretation.

[32] I agree with Mr Lunny that the fact that the operational duty to protect life and serious threat to harm is expressly stated in the said Service Procedure document, does not lead to the conclusion that, in respect of high-risk missing person searches, article 2 is automatically engaged. The scope of the operational duty and the engagement of article 2 must inevitably be considered carefully in light of the background and developing circumstances of the case.

[33] Reference is made by counsel to *Dodov v Bulgaria* (App No.59548/00, judgment 17 January 2018) a case in which a vulnerable individual had gone missing from a nursing home and was later found dead. In that case, it appears that it was accepted (or at least not contested) that the article 2 operational obligation was engaged. Similarly, in *Goncalves Monteiro v Portugal* (App No.65666/16, judgment

15 March 2022) the applicant's daughter went missing in circumstances where she suffered from mental health problems. Again, no argument appears to have been advanced and certainly the court did not consider whether or not a positive obligation under article 2 arose in these circumstances.

[34] The NoK submit that in *Dodov* and *Monteiro*, cases similar to this case involving vulnerable individuals with mental health problems, the courts appear to have accepted that the article 2 positive obligation was engaged and that the only question was whether the state authorities had failed to take appropriate steps in breach of their article 2 obligations. I am not persuaded by this argument, and I am not convinced that the same acknowledgement should be made in this case. The court's task is still to determine, on the particular facts of this case, whether the PSNI knew or ought to have known of the existence of a real and immediate risk of life to Noah.

[35] Returning to the evidence, I note that OEL log dated 1:54hrs on 22 June, indicates that Sergeant Brown attached a suicide profiling checklist which he considered that the investigating officer (IO) might find helpful in relation to enquiries with Ms Donohoe and Noah's friends. Clearly, the risk of suicide was within the contemplation of the police and ought to have been within the consideration of the investigating officer within a short time after Noah's disappearance.

[36] At 01:49hrs on 22 June, Sergeant Brown (PolSA) recorded on the OEL (14) that although he was keeping an open mind, "there is serious cause for concern and I concur with the SIO's risk assessment reading of "high risk" missing person. I have taken into consideration the missing person's age, vulnerability, state of mind, recent reported behaviour over recent days."

[37] In my judgment, a scrutiny of the OEL logs within the hours after Noah went missing and the high-risk missing person classification, indicates that the police knew or ought to have known that there was a serious and immediate risk to Noah's life. This conclusion can be inferred at least from the above OEL entry from Sergeant Brown and the OEL entry from Inspector Murphy at 09:22hrs on 22 June (OEL 31). The focus was clearly on Noah's age, vulnerabilities, suggestions of depressed mood and the fact that his disappearance was completely out of character. The nature of the specific risk to life will be considered below.

[38] Concerns continued and magnified in relation to the risk to Noah during the early hours of Monday 22 June and thereafter. A TLU map to Inspector Rahilly showed the last known location of Noah's phone was at 20:10hrs on 21 June 2020. At 03:18 a further map was emailed to Inspector Rahilly by TLU showing a small area where Noah's phone had connected to a cell site mast at 19:41hrs on 21 June. Noah's phoned, which had been fully charged, was now turned off. Sean McCarry was the Regional Commander and National Search Manager with the Community Rescue Service (CRS). At 3:40hrs on 22 June, the PSNI contacted CRS requesting their

assistance in the search for Noah. An extensive search commenced, to include the Cavehill area, Belfast Castle, Belfast Zoo and the surrounding area. Sergeant Barry Hutchings (PolSA) confirmed in his evidence that he tasked CRS to the Cavehill area because, as he said in his evidence, “that was the most dangerous place to be. There was a chance [Noah] could have fallen or jumped off the edge.” Contemplation of the risk to Noah’s life is obvious from this statement.

[39] Sean McCarry stated in his evidence that at every point throughout the search, CRS is reliant on the police investigation. The place where the missing person was last seen was regarded by Mr McCarry as “vitally important.” He further said that any “decision or lack of a decision, piece of information or lack of piece of information” could be the “difference between life and death.”

[40] CCTV searches commenced in the early hours of 22 June. It is not necessary for the purposes of this ruling to detail an extensive analysis of the CCTV review. However, it is noted that Noah’s presence was identified on the AM600 CCTV camera at North Queen Street at approximately 11:28hrs. Since this was the last AM600 CCTV camera in the locality, it was not possible for AM600 to progress the place where Noah was last seen beyond North Queen Street heading country wards.

[41] The PSNI continued a CCTV trawl and Constable Day and Constable Craig attended at a Day Today shop further along North Queen Street and Noah was identified on CCTV footage from that shop. They continued to look for CCTV opportunities, reviewing CCTV at the Grove Wellbeing centre and Melville Morgan Funeral Home, which was located opposite the Grove Well-being premises. It is likely that the review of the footage took place between 12:03hrs and 12:38hrs on 22 June. The officers failed to identify Noah during their review of this CCTV footage. Clearly, it is arguable that this constitutes a missed opportunity.

[42] Noah’s mobile was found by Adelaide Armstrong at approximately 15:55hrs on 22 June in Castleton Park, which is located off North Queen Street. The PSNI seized the phone at approximately 16:30hrs. The PSNI decided to triage the phone in order to discover any information contained within it which could provide an insight into Noah’s state of mind or who he was contacting in the relevant period (see log entry 67).

[43] At 18:10hrs on 22 June, Sinead Quinn informed the PSNI that, a person she recognised as Noah, had fallen off his bike on North Queen Street. At 19:12hrs on 22 June, Karen Crooks reported a bike, which matched the description of Noah’s bike, to be lying on the ground outside her house.

[44] Constable Tim Wilson was tasked at 19:57hrs to attend at 89 Northwood Road. He saw the bike and also found a black skateboard helmet on the pavement outside 29 Northwood Road. He took photographs of the bike and helmet in situ. He also found a blue hooded jumper hanging over railings and a pair of blue Nike trainers on the ground outside 63 Northwood Road. According to Constable

Wilson's statement, the items of clothing were placed in an evidence bag to protect them from rain and then placed into the boot of a patrol vehicle.

[45] At 21:36hrs on 22 June, Sergeant Adams made the following OEL entry (log 81):

"AT call signs have attended a report of a black bike abandoned in Northwood Street. They have spoken to the reporting person and a few neighbours. They have stated that they observed a 'black male child naked' cycling past them at 17:00hrs. The AT crew have located all the MISPERs clothing and his helmet. I have confirmed with his mother that it is his bike. I have asked the AT crew to knock a few more doors and see if they can get any further information. It is highly likely that the MISPER is still in the local area *as a naked black child would likely lead to members of the public phoning the police*. I have asked Comms to task ASU to look for the MISPER in the local area. I have also asked for a dog call sign. I have spoken to AT Duty Sgt and briefed him."

[46] The information that Noah, a black male child, had disposed of his clothing and was now naked and last seen entering waste ground in the proximity of a culverted river, undoubtedly, in my judgment, increased the PSNI's concerns that there was a real and immediate risk to Noah's life. The immediate risk to his life remained present and continuing. Indeed, until Noah was found on Saturday 26 June, I have no difficulty in concluding that the police were aware of the present and continuing risk to Noah's life.

[47] DCI Phillips became the investigating officer on Wednesday 24 June. In the OEL log entry (221) on 24 June 2020 and log entry (239) on 25 June, DCI Phillips put forward a number of hypotheses ranging from a head injury, disappearance of his own accord and third party coercion and involvement.

[48] During the course of DCI Phillips evidence, the following exchange took place (Day 70, page 20, 6-10):

"Q: You explained to Mr Quinn and Ms Campbell that your absolute priority when conducting this review is finding Noah, isn't that right?

A: Oh, 100%, it is a high risk missing person, high risk because the life is considered at immediate risk. The first priority of the police officer as a human being [is to] find a person, find them alive."

[49] I also refer to the evidence of Detective Sergeant Sam McCallum when questioned by Mr Coll KC (Day 60, page 15 L25). The following exchange took place:

“Coroner: I’m just thinking Mr Coll, we all know, all the lawyers know what article 2 means, but a jury may not know what article 2 means.

A: Yeah, I think that is a very fair point My Lord. With reference to article 2, I take it that’s reference to article 2 of the European Convention on Human Rights and the right to life?

A: It is, yes.

Q: And this is a reference to Noah’s article 2 right to life?

A: It is, that’s correct.

Q: And the police conducting an investigation into him being missing in order to respect and guard his article 2 right to life?

A: It is, that’s correct. So we know Noah is missing, we need to find Noah as soon as possible. With every passing minute, as you know there is potential that Noah could come to harm so we need to find him as soon as possible, so he has a right to life.”

[50] When further questioned by Ms Campbell KC, as to whether, when Noah went missing, there were real article 2 considerations and his life needed to be protected, DS McCallum unreservedly agreed.

[51] As stated above, the classification of Noah as a high risk missing person is not sufficient per se to engage article 2 for the purpose of these inquest proceedings. However, the classification placed the PSNI on high alert that there may be a real and immediate risk to Noah’s life. The decisive stage on which Noah’s article 2 rights were activated was, as detailed above, when they became aware that they were dealing with a 14-year-old child with vulnerabilities to include depressed mood, disturbed state of mind and whose disappearance was completely out of character. In my view, this was the decisive stage in the sequence of events. At that point PSNI knew or ought to have known that there was a real and immediate risk to Noah’s life. Unquestionably, the concerns of the PSNI were heightened when they received reports that a young child had discarded his clothes, abandoned his bike

and was last seen naked walking in the direction of waste land and a culverted river. In my judgment, the police knew and were correct, that there was a real and immediate risk to Noah's life from early Monday morning on 22 June, which continued and was always present until Noah's body was discovered. If I am wrong about the police knowing that, then they ought to have known.

[52] In *Maguire*, Lord Sales stated that the court must identify a specific risk to life for the operational duty to be engaged:

"191. I agree with Popplewell LJ's comment in *Morahan* (para 48), that:

'[t]his is consistent with principle because the article 2 operational duty is not one to take steps in the abstract, but rather to take steps to avert a specific risk to life; until the specific risk to life has been identified, it is impossible to answer the duty question. Just as in the domestic tortious law of negligence it is not sufficient merely to ask, 'Is there a duty' but rather, 'Is there a duty not carelessly to inflict a particular type of damage?', so too the article 2 operational duty must be examined and defined as a duty to take reasonable steps to avoid the specific risk to life which is relevant in the circumstances of a given case.'

[53] Turning to the facts of this case, and the analysis above, the specific risk to life is a risk of suicide. The risk of suicide, although not expressly stated, can be reasonably inferred from all the circumstances, to include the classification of Noah as a high risk missing person, the contents of the OEL and the Control works logs, the briefing, advice and directions of PolSA and the considerable actions taken in response to Noah's disappearance. The risk to life through suicide remained within the contemplation of the PSNI from the earliest stages of the missing person investigation and the facts known to the PSNI. At all times, the risk to Noah's life remained real and immediate and continued until Noah was tragically found deceased. The PSNI cannot be criticised for their consideration of various hypotheses to include "disappearance of his own accord" and "disappearance orchestrated/instigated by a third party." Plainly, in my view, the hypothesis "disappeared of his own accord" can clearly encompass a risk of suicide, supported by the said factors in the knowledge of the PSNI as highlighted above.

Whether the PSNI took reasonable measures to prevent the risk of life from materialising and, consequently, to find Noah alive?

[54] The second aspect of the operational duty under article 2 is that at the point when the risk to life crystallised, did the PSNI take such measures as could reasonably be expected to avoid the risk. In other words, at the point when the PSNI became aware that there was a real and immediate risk to Noah's life, did they react

properly and appropriately take steps to prevent that risk from materialising and, consequently, to find Noah alive.

[55] The PSNI Service Instruction on missing persons states that the “Human Rights Act places a positive obligation on police officers to take a reasonable action within their powers, to safeguard the rights of individuals who may be at risk.”

[56] The NoK state that, on the basis of the evidence, the PSNI have failed to take reasonable steps to prevent the risk to Noah’s life materialising. In particular, it is submitted that the police failed. Inter alia, (a) to use the TLU map to direct use of AM600 cameras; (b) failed to identify Noah on CCTV footage captured at the Grove Well-Being Centre or at Melville Morgan Funeral Directors. If article 2 is engaged, these are matters for the jury.

Engagement of the investigative duty under article 2 ECHR

[57] In *R (Smith) v Oxfordshire Asst DP Coroner* [2011] 1 AC at para [70], Lord Phillips stated as follows:

“70. The duty to hold an article 2 investigation arises where there are grounds for suspecting that a death may involve breach by the state of one of the substantive obligations imposed by article 2 ... The requirement for an article 2 investigation will only arise if the preceding stage of the investigation disclosed that there is a possibility that the state has not complied with a substantive article 2 obligation.”

[58] The threshold for the engagement of the investigative article 2 duty is low. The rationale for this was summarised by Popplewell LJ in *R (Skelton) v West Sussex Senior Coroner* [2021] QB 525 at para [63]:

“63. The threshold is a low one because to impose a more onerous burden would run the risk of the Coroner determining, in advance of the full evidential picture, what the outcome of any inquest might be. ‘Arguable’ in this context means anything more than fanciful (see *R (Palmer) v HM Coroner of Worcestershire* [2011] Inquest LR 50, per Hickinbottom J, at para [60].”

[59] Mr Lunny submits that, in the circumstances of this inquest in which all the evidence has now been heard, the coroner is well placed to make an informed decision as to whether or not there are grounds for suspecting that the death may involve a breach by the PSNI of its operational obligation imposed by article 2. The NoK argues that if the coroner carries out this exercise, it will supplant the role of the jury. Mr Lunny disagrees. He submits that this is a legal question, which can

properly be determined in advance of a jury being sworn and also in advance of any evidence. In an inquest where the evidence has been heard, the coroner is well placed to assess the legal question of the engagement of article 2. It is submitted that there is nothing different in principle in this exercise than in the application of the *Galbraith* plus test.

[60] Mr Lunny argues that the evidence as to *when* Noah died is patently relevant to this question. He states that the pathologists agree that they could not say on the balance of probabilities that Noah was still alive by midnight on the night of Sunday 21 June. He states that the only other evidence upon which the jury might rely in deciding when Noah was still alive is, as suggested by the NoK, evidence of activity during the night in the area around the culvert entrance. In this regard, the NoK is referring to screams heard by some residents and other overnight activity.

[61] Both the PSNI and counsel for the CSNI argue that reference to screams (or attempts to turn a door handle or banging on a letter box) amount to speculative claims of attribution to Noah.

[62] Mr Lunny further argues that, even if the jury accepts that Noah was alive at 03:30 hrs, the “overnight activity” evidence cannot safely lead to a finding on the balance of probabilities, that Noah was still alive any later than around 04-4:30hrs on Monday morning. Mr Lunny also refers to the evidence of the pathologists who indicated that the most likely source of Noah’s head injury was from within the culvert and that such an injury could possibly have dazed him or even caused him to lose consciousness and, furthermore, that only a shallow depth of water is required for a person to drown. Accordingly, he submits, there is no basis for any finding that the police investigation could realistically have located Noah by the early hours of Monday morning. Or, to put it another way, the coroner cannot conclude that there are grounds to suspect that any act or omission by PSNI breached any such article 2 duty by causing or contributing to Noah’s death, when the PSNI had no knowledge whatsoever of Noah until several hours after he was last seen alive.

[63] Clearly, if the timing of Noah’s death is determined to be in on late Sunday evening or the early hours of Monday morning, there is considerable force in this argument.

[64] The NoK submit that the jury is likely to consider that the evidence of activity during the night in the area around the culvert entrance related to Noah. They state that the evidence suggests that Noah had been outside the culvert until at least 03:30hrs which is long after the PSNI were informed that Noah was missing and would suggest, at the least, that Noah survived into Monday. The NoK submit that there is no reason at all to conclude that Noah entered the culvert and headed quickly directly towards the outlet. Accordingly, there are good grounds to suspect that PSNI failings in the search operation may have caused or contributed to Noah’s death. But for these alleged failings as identified above, it is submitted that Noah

would have been found alive and that this is a conclusion the jury would be entitled to reach.

[65] Mr Coll, senior counsel on behalf of the CSNI, submits that the time of death is a question that must be asked of and decided by the jury since it is a statutory question. Secondly, the evidence of the pathologist was that the window of time during which death must have occurred was between midnight Sunday 21/Monday 22 June and possibly Wednesday 24 June or part of it. Mr Coll states that it is for the jury to decide the question of the time and date of Noah's death and, depending upon their answer to this question, they may have the opportunity to comment on any failings that they consider relevant as to whether Noah's death could have been prevented, to include the timing and pace of the PSNI search of the culvert.

[66] It is my decision that the determination of the time of death is fundamentally a question for the jury. Once the time and death have been determined by the jury, it will be for the jury to consider whether the measures and steps taken by the police following the report that Noah was missing, more than minimally, negligibly or trivially contributed to his death.

Decision in respect of PSNI

[67] For the reasons given, it is my decision that the PSNI's operational duty under article 2 has been engaged. The threshold for engagement of the investigative article 2 duty is low. What is required is an "arguable" breach of a substantive duty. "Arguable" is anything more than fanciful: it is a low threshold, and one that is reached when there is an issue which required investigation, not just where the evidence before the court demonstrates something is wrong.

[68] For the reasons given, it is arguable that the PSNI, having been made aware that there was a real and immediate risk to Noah's life, failed to take reasonable measures and to react promptly and appropriately to prevent the risk to life from materialising, and consequently, to find Noah alive. The relevant failings arguably include the following:

- (a) failing to identify Noah on CCTV footage at the Grove Well-Being Centre and Melville Morgan and thereafter identifying the place last seen at an earlier stage.
- (b) failing to commence the search of the culvert earlier;
- (c) failing to adequately and promptly search the entirety of the culvert; and
- (d) failing to conduct the search of the culvert from the inlet at PDS and the outlet at Belfast Lough.

Whether article 2 ECHR is engaged in relation to the DfI and there is an arguable breach?

[69] In order for the article 2 operational duty to apply to the DfI, it seems to me that the critical question is whether the evidence satisfies me that Noah fell within a identified class of persons (namely children) who the DfI knew ought reasonably to have known faced a real and immediate risk to their life if they entered and proceeded down the culvert and that the DfI failed to take all reasonable measures to prevent the risk from materialising.

[70] Ms Murnaghan KC, senior counsel for the DfI, has provided me with well researched written submissions which were supplemented by thought provoking oral submissions.

[71] Ms Murnaghan submits that no allegation has been made within the course of this inquest that the DfI directly caused Noah's death. This is plainly correct. The issues explored in the evidence related to the DfI's application of nationally accepted guidance (viz, the EA09 and CIRIA 786) and the DfI's policies and practices in place regarding the management of the PDS inlet. In essence, it is submitted that the questions for consideration are whether a debris or security screen should have been in place and whether the debris screen that was in place caused or contributed to Noah's death. It is submitted that the jury can only consider these questions if article 2 is engaged.

[72] As stated above, article 2 encompasses two positive substantive duties, namely the systemic duty and the operational duty. The systemic duty requires the state to put in place a legislative and administrative framework which protects the right to life. As stated by Ms Murnaghan, there has been no evidence of specific and serious deficiencies in the frameworks in place for the culvert management, namely CIRIA 2019 and the EA09 guidance, read in conjunction with the CDM Regulations and the Health and Safety Work Regulations. Properly analysed, I agree with DfI's submission that there is no evidence of a breach of the systemic duty.

[73] The focus therefore turns to the operational duty to protect an individual whose life is at risk in certain circumstances. As provided in the ECtHR jurisprudence, the trigger for the obligation is the state authority's awareness of the real risk.

[74] Following an extensive review of the ECtHR jurisprudence, Ms Murnaghan states that the following principles can be distilled and applied to the facts of this case:

- (a) The operational duty under article 2 is only triggered if there is a real and immediate risk to the life of a particular individual or particular individuals and that this is known to the relevant authority.

- (b) In respect of this inquest, the operational duty is only triggered if the DfI was aware or ought to have been aware of a real and immediate risk to the life of Noah Donohoe.
- (c) There is no evidence that the DfI knew or ought to have known of a real and immediate risk to Noah's life. The relevant risk must be to life rather than of harm, even serious harm. Risk means a significant or substantial risk rather than a remote or fanciful one.
- (d) The exercise to be carried out must be what was known or ought to have been known to the DfI at the relevant time and must not be infected with hindsight bias.
- (e) The existence and scope of the positive duty must not impose an impossible or disproportionate burden on state agents in carrying out the necessary state functions.
- (f) It is not known, and may never be known, what caused Noah's death over the distance of 600 metres down the culvert. The culvert is tidal. However, the tide rises slowly, which permits an individual in the culvert the opportunity to move backwards towards the non-tidal section, or out of the outlet, if the tide is not high.
- (g) The DfI could not have been aware of a real and immediate risk to Noah's life when he entered the culvert or at the location at which his body was recovered.
- (h) If a person is capable of getting through the screen, that person is capable of coming back out again without going further into the culvert. Consequently, a distinction must be drawn between the inlet and the location at which Noah was found.
- (i) Noah could only have entered the wasteland in which the PDS culvert is located as a trespasser, either by climbing over the 1.8 metre palisade fence topped with barbed wire, or through the back garden of one of the houses that backed onto the waste ground. Whilst, ultimately, it will be a matter for the jury, it is submitted that the evidence suggests that Noah most likely entered the waste ground through the driveway of 89 Northwood Road and, thereafter, through the garden. It cannot be correct that the article 2 operational duty applies to the circumstances in this case, particularly since Noah was a trespasser.

[75] In response to the above, counsel for the NoK submit that, on the analysis of the evidence, had knowledge in 2016/2017 of the following:

- (a) that the culvert presented a risk of death from drowning;

- (b) that the culvert was a confined space;
- (c) that the lower reaches of the culvert were tidal and flowed full twice a day;
- (d) that the culvert inlet was located in an urban and densely populated residential area;
- (e) that the culvert inlet was at the rear of residential gardens;
- (f) that the area around the culvert inlet was accessible to, at the very least, local residents, their children, their friends, their families, their guests;
- (g) that no public safety risk assessment had been carried out in relation to the inlet and choice of grille;
- (h) that a grille which had been installed prior to the 2016 grille, had 11 bars and therefore had characteristics akin to a security screen;
- (i) that a security screen was capable of preventing access to the inlet and therefore the culvert itself;
- (j) that a debris grille, with bar spacing greater than 180mm, would not have prevented access, including by children, to the inlet and therefore the culvert itself.

[76] The DfI submit that they had no knowledge of trespassers at the culvert. They emphasised that there is a lack of graffiti or vandalism at the inlet. According to the NoK, the lack of such evidence does not detract from the fact that the DfI should have been aware of the risk of access by children. The 2009 Guidance includes a "Local and Accessibility" factor affecting the extent to which a culvert presents a hazard: "A culvert entrance that is near a residential area, yet which cannot readily be seen by passersby, is likely to attract children."

[77] As addressed by Mr Pope in his evidence, he stated that the DfI should have been on notice that the culvert posed a risk of attracting children. Dr Cooper states that the DfI failed to carry out any or any adequate risk assessment, which would have taken into consideration the risk of accessibility to the culvert and, in relation to children, the risk of entry into the culvert through the bars of the debris screen.

[78] The NoK submit that the DfI's failure to carry out a public safety risk assessment at a time is critical.

[79] Mr Coll submits that it has never been argued that the DfI could not have erected a security screen following 2017. Rather, it was the DfI's position during the

course of the inquest that the relevant guidance did not merit a review of the screen in 2017 and, even if, it had, a security screen would not have been erected.

[80] Mr Coll argues that the DfI's flood gates argument is not justified. He states that if article 2 is engaged, then this is due to the specific and narrow set of circumstances of the particular case. The existence of the operational duty to a specific set of circumstances does not impose an impossible or disproportionate burden on the DfI.

Decision in respect of DfI

[81] I have carefully considered the written and oral submissions and, as stated above, the urgency of this ruling prevents me from articulating and debating each and every argument.

[82] I am persuaded by the arguments advanced by counsel for the NoK and counsel for the CSNI. In my judgment, the article 2 positive obligation has been engaged. On the evidence, the DfI knew, or ought reasonably to have known, of a real or immediate risk to the life of a child, such as Noah, in the event that the child gains access to the culvert.

[83] The specific risk to life is by drowning. The class of persons to whom the duty is owed is not trespassers or indeed riparian owners or their adult visitors. Rather, the duty is owed to children, who remain vulnerable to the risk of injury or death due to their age, propensity for exploration and adventure, lack of knowledge or appreciation of dangers associated with the culvert, the allurements of the stream and the location and the inherently dangerous nature of the culvert if accessed through the debris screen.

[84] Where the nature of an activity or location is hazardous and the risk is context specific, states can nonetheless owe article 2 duties to a broader class of persons. In *Zinatullin v Russia* (App No.10551/10) 28 May 2020 at para [27], the ECtHR stated as follows,

“In the context of activities carried out on construction sites, which may pose risks to human life due to their inherently hazardous nature, States are required to take such reasonable measures to ensure the safety of individuals as are necessary, including through regulations geared to the special features of the activity in question (see *Cevrioğlu v. Turkey*, no. [69546/12](#), § 57, 4 October 2016). In the absence of the necessary safety precautions, any construction site, especially one in a residential area, has the potential for life-endangering accidents that may impact not only professional construction workers, who are more familiar with the

possible risks, but also the public at large, *including vulnerable groups such as children*, who may easily become subject to those risks (ibid., § 67)". [Emphasis added]

[85] In *Rabone* [2012] 2 AC 72 at para [25], Lord Dyson observed that the ECtHR jurisprudence in respect of the operational duty is relatively young and that the court has been inclined to extend its remit. In *Rabone*, the key factor militating towards the recognition of the duty was the control assumed by the state over the patient. However, Lord Dyson observed at para [23]:

"In circumstances of sufficient vulnerability, the ECtHR has been prepared to find a breach of the operational duty even where there has been no assumption of control by the state."

[86] In support of this contention, Lord Dyson gave the example of the protection of children from abuse in *Z v UK* (2001) 34 EHRR 97.

[87] In *Maguire*, Lord Sales stated at para [186]:

"The issue of assumption of responsibility raises the question, assumption of responsibility for what? The authorities show that the degree to which assumption of responsibility is a factor relevant to the operational duty under article 2 depends upon the specific risk to life of which the authorities were aware and which they understood had to be guarded against."

[88] In this case, the specific risk to life of which the DfI was aware or should have been aware was the risk of drowning if access was gained to the culvert. The DfI was aware or should have been aware that it was possible for children and, indeed young teenagers, to access the culvert through the debris screen.

[89] Once the child (in this case Noah) was able to access the culvert through the debris screen, the risk was significant, present and continuing, particularly due to the fact the culvert was in darkness, was a confined space and the lower reaches of the culvert were tidal and flooded twice per day.

[90] As stated above, the threshold for engagement of the investigative article 2 duty is low. What is required is an "arguable" breach of a substantive duty.

[91] For the reasons given, it is arguable that the DfI failed to take any reasonable measures to prevent access by a child, to include Noah, to the culvert and to prevent the risk of death by drowning from materialising. The engagement of the positive obligation and the investigative article 2 duty have been satisfied.

[93] Since it is my decision that article 2 ECHR has been engaged in respect of both the PSNI and DfI, it is not necessary for me to consider the purported extension of the common law in respects as stated by the Court of Appeal in *Bradley and Duffy v Ministry of Defence* [2025] NICA 30.