

Neutral Citation No. [2014] NIQB 11

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*(subject to editorial corrections)\**

IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

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QUEEN'S BENCH DIVISION (JUDICIAL REVIEW)

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Jordan's Applications (13/002996/1), (13/002223/1) (13/037869/1) [2014] NIQB 11

IN THE MATTER OF THREE APPLICATIONS BY HUGH JORDAN FOR  
JUDICIAL REVIEW

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STEPHENS J

**Part One: Introduction**

**The applications**

[1] The evidence at the inquest into the death of Patrick Pearse Jordan, ("the deceased") was heard before the Coroner, Mr Sherrard with a jury between 24 September 2012 and 26 October 2012 (2/1).

[2] This judgment is in respect of three applications for judicial review brought by Hugh Jordan, the father of the deceased.

[3] The first application (13/002996/1) is for judicial review of various rulings of the Coroner. In that application the Coroner is the respondent and the Police Service of Northern Ireland ("PSNI") is a notice party. One of the applicant's grounds of challenge includes the contention that the anonymity afforded to jurors and the requirement for a unanimous jury verdict, are incompatible with the applicant's article 2 rights and that section 6 of the Human Rights Act 1998 required the Coroner not to apply section 31 of the Coroners Act (Northern Ireland) 1959 which requires that the jurors are unanimous but rather to accept a majority verdict. The applicant also seeks a declaration that section 31(1) of the Coroners Act (Northern Ireland) 1959 and article 26 of the Juries (Northern Ireland) Order 1996 (as amended by section 10 of the Justice and Security (Northern Ireland) Act 2007) are incompatible

with the applicant's Article 2 rights. A notice pursuant to Order 121, rule 3A of the Rules of the Court of Judicature (NI) 1980 was served on the Department of Justice for Northern Ireland and the Department responded by notice seeking to be joined as a party to the proceedings.

[4] The first application (13/002996/1) is based on 38 grounds specified in the amended Order 53 statement. The grounds encompass the following issues:

- (i) Non-disclosure of the Stalker/Sampson reports (1/2/8/i-ix).
- (ii) Non-disclosure of underlying material from a Police Ombudsman's investigation into the death of Neil McConville in 2003 (1/2/11-12/x-xii).
- (iii) The Coroner's decision to sit with a jury (1/2/12/xiii-xiv).
- (iv) The Coroner's decision not to discharge a particular juror (1/2/12-13/xv-xvi).
- (v) The manner in which the Coroner framed the questions which were posed to the jury (1/2/13/xviii-xix).
- (vi) The content of the Coroner's directions to the jury (1/2/13-14/xix-xx).
- (vii) The decision by the Coroner to accept the verdict of the jury (1/2/14/xxi-xxiii).
- (viii) The Coroner's decisions on the anonymity of and on the screening of witnesses (1/2/15-16C/xxiv-xxxvii).
- (ix) The response of the Coroner to the involvement of former RUC Special Branch Officers in the disclosure process (1/2/16c/xxxviii).

[5] In relation to the challenge to decisions on anonymity and screening of witnesses which are contained in paragraphs (xxiv) to (xxxvii) of the applicant's amended Order 53 statement it was conceded by Ms Quinlivan that this court was

bound to find against the applicant in relation to grounds (xxiv) and (xxv) by virtue of the decision of the Court of Appeal *In the matter of an application by Officers C, D, H & R* [2012] NICA 47; the Supreme Court having refused to grant leave to appeal.

[6] In the second application (13/002223/1) the first ground of challenge relates to a decision of the PSNI refusing to disclose to the applicant two statements made by Officer AA to the Police Ombudsman for Northern Ireland relating to her investigation into the death of Neil McConville, which statements were given by the Chief Constable to the Coroner. The applicant contends in this judicial review application that he had a legitimate expectation that “all documents” disclosed by the Chief Constable to the Coroner, whether relevant or irrelevant to the issues in the inquest, except for any document which is subject to legal professional privilege or to a valid public interest immunity claim, would also be disclosed to him by the PSNI (9/2/3-4/i-v). The applicant seeks an order of mandamus compelling the PSNI to provide the applicant with disclosure of the two statements (9/2/3/iv). This ground of challenge closely relates to the ground of challenge in the first judicial review application in which the applicant challenges the decision of the Coroner not to disclose these two statements to him on the basis that the Coroner has an obligation to disclose potentially relevant documents to the next of kin and that these documents were potentially relevant. It also closely relates to the ground of challenge that the failure to disclose the documents breached article 2 inasmuch as the next of kin were prevented from participating in the inquest to the extent necessary to protect their legitimate interests (1/2/11/x-xii). I will deal with these issues together in part five of this judgment.

[7] The second ground of challenge relates to the involvement of RUC Special Branch Officers and a former RUC intelligence Officer in the process of complying with the Chief Constable’s obligations under Section 8 of the Coroners Act (Northern Ireland) 1959 (9/2/5/vi-vii). The applicant seeks a declaration that this involvement compromised the independence of the disclosure process and meant that the inquest was not compliant with Article 2 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (9/2/3/v). This ground of challenge closely relates to the ground of challenge in the first judicial review application in which the applicant challenges the role of the Coroner in that it is contended that he should have concluded that the involvement of RUC Special Branch Officers in the disclosure process compromised the independence of his enquiry and that he should have directed the Chief Constable to utilise different personnel. That the Coroner bears ultimate responsibility for the integrity of the conduct of the inquest over which he presides and it is contended that he failed to take any or any adequate steps to ensure that the independence of the disclosure process was not compromised by the Chief Constable (1/2/16C/xxxviii). I will deal with these issues together in part six of this judgment.

[8] In the third application (13/037869/1) for judicial review the applicant seeks a declaration that further delay between 4 May 2001 and 24 September 2012 in commencing the inquest was incompatible with Article 2 ECHR and/or that as a result of this further delay the inquest was not held as soon as practicable after the Coroner was notified of the death contrary to Rule 3 of the Coroners (Practice and Procedure) (Northern Ireland) Rules 1963. On 4 May 2001 the ECHR delivered judgment in *Jordan v United Kingdom* (2003) 37 EHRR 2. That judgment established a violation of Article 2 ECHR had taken place, *inter alia*, by reason of delay in the holding of an inquest prior to that date. The ECHR granted a declaration and awarded damages of the sum of £10,000 as just satisfaction for feelings of frustration, distress and anxiety.

### **Layout and organisation of documents**

[9] I divide this judgment into distinct parts.

- (a) Part one contains this introduction.
- (b) Part two contains the factual background in relation to the death of the deceased and also in relation to the other deaths in relation to which the applicant contends evidence was admissible as similar fact evidence or as to the credibility of the witnesses.
- (c) The other parts deal with the distinct areas of challenge as developed in argument and as set out in the previous paragraphs.

I seek to deal with all the diverse issues raised by the applicant but if in the event I have not expressly dealt with any issue then I make it clear that I decide that issue against the applicant on the basis of the evidence or on the oral or written submissions of the respondent or notice party or in the exercise of discretion.

[10] Voluminous documents have been produced in relation to these applications with a number of different files being lodged in court by the applicant, the respondent, and the notice parties. As a consequence there were no clear numbers or letters attributed to the files. In order to give structure to this judgment I set out below the number which I give to each file together with the original label given to that file by the party that lodged it.

- (a) File 1 which was lodged on behalf of the applicant labelled "Part A. Pleadings."
- (b) Files 2 and 3 which were lodged on behalf of the applicant labelled "Part B. Exhibit FS1 pp 1-460" and "Part B. Exhibit FS1 pp 461-680."

- (c) Files 4 and 5 which were lodged on behalf of the applicant labelled "Exhibit FS2 Volume 1 pp. 681-1158" and "Exhibit FS2 Volume 2 pp. 1159-1361." These files contained closed materials consisting of parts of the Stalker/Sampson reports. Those reports have been redacted and I was informed that a PII certificate has been signed by the Minister in relation to the Stalker/Sampson inquests but that certificate has not as yet been considered by the Coroner with responsibility for the Stalker/Sampson inquests. A copy of that certificate has not been made available to me. The Stalker report was an interim report. The Sampson report was a final report. None of the reports have been published. At the instigation of the PSNI and when these files were sent to the court a request was made that additional precautions should be put in place to maintain confidentiality and that they should not be read by anyone except the assigned judge.
- (d) Files 6 and 7 which were lodged on behalf of the applicant labelled "Inquest Transcripts Bundle. Volume 1" and "Inquest Transcripts Bundle. Volume 2."
- (e) File 8 which was lodged on behalf of the applicant containing authorities.
- (f) File 9 which was lodged on behalf of the applicant labelled "In the matter of decision taken by the PSNI."
- (g) File 10 which was lodged on behalf of the Coroner labelled "Hugh Jordan Judicial Review Coroner File 1."
- (h) File 11 which was lodged on behalf of the applicant under the number 13/037869/1 which are the documents relating to the applicant's application for leave to apply for judicial review on the ground of delay.
- (i) File 11A which was lodged on behalf of the applicant which are the documents relating to the substantive hearing of the applicants third application for judicial review on the ground of delay.
- (j) File 11B which was lodged on behalf of the Coroner labelled "Hugh Jordan (Delay Issue). The Respondent Coroner's bundle."
- (k) File 11C which was lodged on behalf of the PSNI labelled "Jordan Dealy JR PSNI Affidavits"

- (l) File 11D which was lodged on behalf of the applicant labelled "Applicant's Book of Authorities for Leave Application."
- (m) File 12 which was lodged on behalf of the Department of Justice labelled "Incompatibility issue."
- (n) File 13 which was lodged on behalf of the PSNI labelled "PSNI 1."
- (o) File 14 which was lodged on behalf of the applicant labelled "Book of Skeleton Arguments."
- (p) File 15 which was a lever arch file in which I placed various documents that were handed in during the hearing of the applications.
- (q) File 16 which was lodged on behalf of the PSNI containing a number of authorities.
- (r) File 17 which was lodged on behalf of the applicant containing a number of authorities in relation to the standard of review.
- (s) File 18 which was lodged on behalf of the Department of Justice containing a number of authorities.
- (t) File 19 which was lodged on behalf of the applicant containing a number of authorities in relation to the issue of anonymity.

[11] In this judgment I will identify documents by reference to the number of the file in which they are contained, followed if there are dividers, by the divider number or letter, and then by the page number. On some occasions I identify the paragraph number or line number and that will follow the page number.

### **Anonymisation**

[12] One ground of challenge relates to the decision of the Coroner not to discharge a particular juror. Article 26(C)(4) of the Juries (Northern Ireland) Order 1996 provides for the anonymity of jurors. In consequence jurors are referred to by number rather than by name. In order to maintain the anonymity of the particular juror concerned I will further anonymise by referring to him or her as "Juror J".

[13] Orders were made by the Coroner granting anonymity to various police witnesses who were referred to by cipher. I set out a list of the ciphers together with a short summary of the roles played by each witness.

Witnesses	Summary of the role of each witness
Sergeant A	Shot and killed the deceased. Most senior officer of the officers on the ground at the time of the shooting and issued instructions on the ground. In radio contact with Officer M. Front seat passenger in Call Sign 8, the car which was involved in forcing the deceased's car off the road and which was positioned in front of that car when the shooting occurred.
Officer B	Rear seat passenger in Call Sign 8
Officer C	Driver of Call Sign 8.
Officer D	Front seat passenger of the second police car (Call Sign 12), which was also involved in the pursuit of the deceased's car and was positioned to the rear and right of that car. The precise position of the car is unclear because it was removed from the scene before CID arrived.
Officer E	Driver of Call Sign 12
Officer F	Rear seat passenger of second police car (Call Sign 12)
Officer H	HMSU Sergeant who arrived at the scene after the shooting. Apparently directed HMSU Officers to Arizona Street in Call Sign 12 (the second police car), but there is also evidence that this decision was taken by A. Did not attend the inquest to give evidence although summonsed. Officer H was working abroad but all parties were made aware on 15 October 2012 that H was available to attend the Inquest on 29 October 2012.
Officer M	HMSU Inspector based at TCG headquarters and in radio contact with officers on the ground. Issued instructions to officers on the ground based on decisions made by TCG Officers. Also responsible with Officer V for the debrief.
Officer Q	HMSU Officer based at TCG headquarters,

	responsible for the radio-log, which apparently only commenced shortly prior to the shooting. Also took notes at the debriefing.
Officer R	Sergeant in HMSU who briefed HMSU Officers earlier in the afternoon and attended the debrief after the shooting.
Officer V	Head of HMSU. Off duty on the day the deceased was shot but notified of the shooting and came in to attend the debrief. Took notes of the debrief. He gave evidence at the inquest that having learnt from the experiences of 1982, he carried out this debrief to ensure that his Officers were not instructed to give a false account of the events that had occurred.
Officer AA	A Detective Inspector in E Dept and the second most senior TCG Officer at TCG headquarters. Along with AB had overall responsibility for the planning and control of the operation.
Officer AB	Det. Superintendent in E Dept and most senior TCG Officer at TCG headquarters. Along with AA had overall responsibility for the planning and control of the operation.
Soldier V	Army Liaison Officer responsible for liaison in TCG between Army surveillance and E Dept.
Soldier X	Undercover soldier who was driving a vehicle which was located 2 cars behind Call Sign 12 (the 2 <sup>nd</sup> police car). He saw a man (the deceased) as he was running across the road, heard a shot and then saw him lying on the ground.
Soldier Z	Undercover soldier on general surveillance duties at 4-6 Arizona Street, purported to identify the deceased as a look-out at Arizona St.

[14] Some of the police witnesses were involved in other incidents involving lethal force and in the reports into those incidents or in court proceedings in relation to those incidents they were anonymised by the use of different ciphers. I set out the ciphers used in other lethal force incidents.

(a) Officer M otherwise known as P24 or Officer NN.



- i. Officer M is referred to in the Stalker/Sampson reports as *P24*. He was involved in three incidents involving lethal force the subject of the Stalker Sampson inquiry which incidents occurred in November and December 1982.
  - a. The first operation was one in which Gervaise McKerr, Eugene Toman and Sean Burns died at Tullygally Road East, Craigavon, on 11 November 1982. Officer M was then a sergeant in HMSU and he conducted the first debrief of officers involved in the shooting.
  - b. The second operation was one in which Michael Tighe died and Martin McCauley was wounded at the hayshed at Ballynerry Road North, Lurgan, on 24 November 1982. Officer M was the sergeant in charge of a two vehicle patrol. He claimed to have seen an armed man walking towards the hayshed but later admitted that this was untrue and claimed that he been instructed not to disclose the fact that he was acting on Special Branch information.
  - c. The third operation was one in which Seamus Grew and Roddy Carroll died at Mullacreevie Park, Armagh on 12 December 1982. Officer M signed a false claim for overtime payments made by Constable Brannigan which facilitated a false account that Constable Brannigan had been on duty thereby enabling it to be recounted that another officer had not been present.
- ii. Officer M was also involved in the events surrounding the death of Neil McConville on 29 April 2003 and was referred to in the Police Ombudsman's report in relation to that incident as *Officer NN*. On 29 April 2003 he was an Inspector in HMSU. He was in the control room and was the most senior HMSU Officer there. He controlled the operation desk along with Sergeant EE radio operator passing and receiving information to and from units involved in the operation.

*(b) Officer V otherwise known as P8.*

- i. Officer V is referred to in the Stalker/Sampson reports as *P8*. He was involved in three incidents involving lethal force the subject of the Stalker Sampson inquiry which incidents occurred in November and December 1982.

- a. The first operation was one in which Gervaise McKerr, Eugene Toman and Sean Burns died at Tullygally Road East, Craigavon, on 11 November 1982. Officer V was then head of the Special Support Unit which was an operational arm of Special Branch, later renamed HMSU. He briefed the Special Support Unit Officers involved in the operation prior to deployment and was present at a subsequent debriefing of the officers involved prior to CID interviews when those officers were advised that they were not at liberty to disclose Special Branch involvement or that the operation was pre-planned.
- b. The second operation was one in which Michael Tighe died and Martin McCauley was wounded at the hayshed at Ballynerry Road North, Lurgan, on 24 November 1982. Officer V as head of the Special Support Unit briefed officers involved prior to deployment. He held a debrief in the form of "general conversation" with officers involved and he was present at subsequent meetings with officers involved when a cover story was formulated. The purpose of the meeting was "to get the story right before seeing the CID". He subsequently gave instructions about the cover story to officers not directly involved.
- c. The third operation was one in which Seamus Grew and Roddy Carroll died at Mullacreevie Park, Armagh, on 12 December 1982. Officer V was the head of the Special Support Unit. He briefed officers prior to deployment warning them to expect armed resistance. He was present at a debriefing at Gough Barracks when cover stories were formulated. He was present at a further meeting the next day at Lisnasharragh when actions of officers involved were rehearsed and V is said to have "schooled" officers in what they were to say. It is alleged that he told an officer injured by an army surveillance unit in a separate road traffic accident to attend the place where it had been falsely stated that Messrs Grew and Carroll had driven through a checkpoint and to impregnate his clothes with dirt at that scene to lend support to the suggestion that he had been injured by Messrs Grew and Carroll breaking through the checkpoint.

(c) Sergeant A otherwise known as P47.

- i. Sergeant A is referred to in the Stalker/Sampson reports as P47. He was involved in one of the incidents in 1982 the subject of the Stalker Sampson inquiry. That operation was one in which Seamus Grew and Roddy Carroll died at Mullacreevie Park, Armagh, on 12 December 1982. In that incident he was a radio operator monitoring transmissions and in direct contact with the three crews involved. He was present at a debrief in Gough Barracks when a false account of the incident was fabricated.

(d) Officer AA otherwise known as Officer BB.

- i. Officer AA was also involved in the events surrounding the death of Neil McConville on 29 April 2003 and was referred to in the Police Ombudsman's report as *Officer BB*. On 29 April 2003 he was a Detective Superintendent in the Tasking and Co-ordination Group. He was the Silver Commander for the operation during the course of which he was in the control room. Accordingly *Officer AA* otherwise known as *Officer BB* was involved in the planning and control of both police operations.

### **Officer AA and Officer M**

[15] I also set out the method by which the involvement of Officer AA and Officer M in the circumstances surrounding the death of Neil McConville became known to the next of kin and to the Coroner.

[16] The hearing of the inquest was due to commence on 12 September 2012. Three sets of judicial review proceedings in relation to decisions of the Coroner concerning anonymity were heard by Deeny J on 28 August, 5, 6, 7 and 10 September 2012. Two applications were by officers who were not content with a ruling of the Coroner in relation to anonymity. One application was by Hugh Jordan, who challenged the Coroner's decision to grant anonymity. Deeny J gave an extensive judgment on 17 and 18 September 2012 under citation [2012] NIQB 62. Officer AA was one of the officers to whom anonymity had been granted by the Coroner and accordingly during the course of Hugh Jordan's application for judicial review submissions were made on his behalf to Deeny J. One of the submissions was that Officer AA not only had to give evidence in this inquest but also that he would have to give evidence at other legacy inquests. This was the first occasion on which the next of kin were aware that Officer AA was involved in other legacy inquests and Ms Quinlivan made this clear to Deeny J during the course of submissions. At paragraph [123] of his judgment Deeny J stated in relation to Officer AA as follows:

“It was submitted on his behalf that he will have to give evidence at other legacy inquests but Ms Quinlivan complains that no disclosure of that has been made to the next of kin. I remind those advising the Chief Constable that he is under a duty of continuing disclosure in these inquests. If it has not already been done a competent person or persons must ensure that relevant information is provided to the Coroner and not lost because an officer has a different cypher in one fatal instant from another one.”

[17] On 24 September 2012, the first day of the hearing of the inquest, counsel for the Chief Constable advised that Officer AA had a role in the Neil McConville case and was referred to by the cypher BB in the Police Ombudsman for Northern Ireland’s report (A/6/56/130).

[18] On 4 October 2012 when Officer M attended to give evidence at the hearing of the inquest, it was revealed that he had a role in the Neil McConville case and was referred to in the Police Ombudsman for Northern Ireland’s report under the cypher NN (A/6/57/138).

### **Private hearings**

[19] These judicial review applications were heard and determined in open court. However, for a period of approximately 1½ days when reference was being made to the material in files 4 and 5 the court was requested, and all the parties proceeded on the basis, that the public, the next of kin, and the court staff should be excluded. The request was made despite the fact that the materials in those files had been redacted. No party objected to that course of action being adopted. The explanation that was proffered by Dr McGleenan was that the process of considering all the material underlying the Stalker/Sampson reports for the purposes of redaction on the grounds of public interest immunity had not been completed. That this process could lead to further redactions being necessary in the Stalker/Sampson reports in order to prevent jigsaw identification. This proposition was not challenged by any party however it is for the court to be satisfied before it sits in private, see *Al Rawi and others v Security Service and others (Justice and others intervening)* [2012] 1 A.C. 531 and *In re Guardian News and Media Limited* [2010] 2 AC 697 at 708 paragraph 2. I could not form a view without first considering the material in files 4 and 5 in private session. It transpired that a lot of the closed material in its redacted form is already within the public domain. Indeed, a question may arise as to the extent of some of the redactions, for instance a comment made by Lord Justice Kelly in open court at the trial of *R v McCauley* has been partially redacted. However having considered the closed material I did consider that there may be substance in the

suggestion that unwittingly jigsaw identification could occur if the reports as presently redacted were combined with subsequent disclosure of the material underlying the reports. Experience has shown that the ways in which jigsaw identification can occur should not be underestimated. The risks if they materialised could be catastrophic. Given the volume of the underlying material it is not possible for this court to consider all of that material to determine whether the propositions advanced on behalf of the PSNI for not sitting in open court were correct. However, though I was minded to accept the submission on behalf of the PSNI, I required an affidavit to be sworn by a responsible officer on their behalf confirming what I had been informed by counsel.

[20] Colin Stafford in his second affidavit addressed that issue setting out the sequence in relation to the private hearings. He adverted to paragraph 16 of the judgment of Deeny J [2012] NIQB 64 from which it appears that it was the PSNI who suggested that part of the hearing before that court was in closed session. In his affidavit Mr Stafford states that the PII process in the Stalker/Sampson cases is ongoing and there is a need to adopt a cautious approach until the PII hearings have taken place and the position is formalised. Mr Stafford did not confirm what I had been informed but rather stated that

“Having considered the issue afresh PSNI does not now consider that it is necessary for the reference to the redacted Stalker Sampson narrative reports to be heard in closed session. If an issue arises in the course of a hearing that could potentially infringe a PII certificate counsel instructed on behalf of the Chief Constable can take appropriate action to protect the national security interest.”

[21] I have been provided with transcripts of the submissions of counsel to Deeny J and of his ruling that part of the proceedings before him should be held in private. Mr Macdonald correctly stated that it was an exceptional step to conduct a hearing in private. That it was a matter for the court to be satisfied that it was a proper step. It was explained by Mr Macdonald that he had given an undertaking and that he had applied to the Coroner to be released from it but that the PSNI had objected. There was no attempt by the PSNI to explain why they had objected or to justify why the documents, despite all the redactions, should be secret. Given that the documents were redacted the question as to why they required not to be referred to in open court, was not addressed. There was no substantive attempt by the PSNI to justify sitting in private.

[22] There are a number of matters which I take from the second affidavit of Colin Stafford:-

- (a) It does not confirm what I had been told.
- (b) It refers to national security interest and raises the potential for the redacted contents of files 4 and 5 adversely affecting national security. It does not seek to explain how the redacted documents could affect national security.
- (c) It envisages that nevertheless the documents can be referred to in open court. I have difficulties in understanding how if national security interests could be adversely affected what action could be taken by counsel to protect that interest once the information has been publicly disclosed in open court.
- (d) It does not address the question as to whether the next of kin may have access to files 4 and 5. At present, despite the concession during the course of these proceedings that the contents are potentially relevant, but because of the undertakings required of his counsel by the PSNI, the applicant cannot have access to them. However it now appears that he may hear about the contents of them in open court.
- (e) It does not state when the change of attitude on behalf of the PSNI occurred so it is not possible to arrive at a view as to whether there was any need for a private hearing during the judicial review application before Deeny J or during the course of the inquest.

[23] In view of the contents of the affidavit I now consider that it was not appropriate to sit in private during the course of these judicial review applications whilst the contents of files 4 and 5 were being considered. The public, including the press and the next of kin should not have been excluded from the hearing.

[24] The steps that I take to correct the position are that:-

- (a) I direct that the copies of the CD recordings of the private hearings be made available to the PSNI.
- (b) The PSNI will then have a period of a week, that is until 12 noon 7 days from now to consider what was said during the private hearings and to indicate one way or the other in writing to the court office with copies to the other parties whether they wish to make any application to the court to maintain the confidentiality of any part of the private hearings.
- (c) If the PSNI do not make such an application or if it is not acceded to, then I will direct that copies of the CD are made available to the legal representatives of the next of kin and the legal representatives of the

Coroner and that the recording be placed on the ordinary court FTR system. That those parties are at liberty to play the recording on one occasion to the press provided that it is done by arrangement and in the presence of a legal representative of the PSNI. The parties are not at liberty to provide a copy of the CD to the press. The object of that exercise is to allow the press to report a hearing which ought to have been held in open court, if they so wish, and to replicate as far as possible what would have occurred in open court if they had been allowed to be present.

[25] I do not have the jurisdiction to deal with what should occur in relation to the private hearing before Deeny J and there is no judicial review application in relation to the decision of the Coroner to conduct a small part of the inquest in private. It is now accepted that the approach adopted by the PSNI before me was not appropriate. If it is also accepted that the approach before either the Coroner or Deeny J was not appropriate then there would be an obligation on the PSNI to bring the matter to the attention of one or other or both of them so that consideration can be given as to what, if any, steps should now be taken to correct the position.

[26] The closed material was referred to by counsel and some of it is referred to in this judgment. In view of the fact that there is still a reference to national security in the context of files 4 and 5 the procedure that I will adopt is that I will give judgment to the parties legal representatives but not in open court and with an embargo on any further dissemination for a period of a number of days except in so far as is necessary to enable the PSNI to consider whether they wish to contend that any part of the contents of this judgment adversely affect National Security or the Article 2 or Article 8 rights of any individual. This will enable the PSNI to determine whether they wish to make any application to me to deliver any part of the judgment as a closed judgment. Absent any such application I will then sit in open court and deliver the judgment publicly.

### **Appearances, the Coroner and the role of counsel to the Coroner**

[27] In the first two applications Mr Macdonald, QC, SC and Ms Quinlivan QC appeared on behalf of the applicant. In the third application Ms Quinlivan QC and Ms Doherty appeared on behalf of the applicant. In the first two applications Mr Simpson QC and Mr Doran appeared on behalf of the Coroner, Mr Montague QC and Dr McGleenan QC appeared on behalf of the PSNI. In the first application Mr Scoffield QC and Mr Coll appeared on behalf of the Department of Justice for Northern Ireland. In the third application Mr Doran appeared on behalf of the Coroner. I acknowledge the great debt that I owe to all sets of Counsel together with their supporting solicitors for the meticulous way in which these judicial review applications have been prepared, the efficiency with which they have complied with

the timetable and the clarity, economy and impressive command of detail with which the applications have been presented in Court.

[28] As will become apparent submissions were made to the Coroner at the inquest and repeated on affidavit in these proceedings which counsel has subsequently conceded. I emphasise that the decisions of the Coroner have to be seen in the context of those earlier submissions which are no longer relied upon in this court. I pay tribute to the experience, industry and commitment of the Coroner. He was faced with a complex and demanding task in this inquest. The complexities are amply demonstrated by the fact that the legal issues in relation to the inquest have been litigated at all judicial tiers on numerous occasions. Those complexities were also faced by counsel. I make it clear that I have read a substantial portion of the transcripts of the inquest and any comments about the role of counsel and counsel for the coroner is not to be taken as implying any criticism of any of the counsel involved in this particular case. All counsel have undertaken their duties to the highest professional standards. Rather my comments are only meant to assist in relation to future inquests. It is incumbent on counsel, particularly counsel for the Coroner, to assist the Coroner to identify the correct legal principles and to assist him in carrying out his duties, see *Ashmore v Corporation of Lloyds* [1992] 2 All ER 486 at 488 g. It is incumbent on counsel, particularly counsel for the Coroner, to set out in writing the correct legal principles and to identify between them whether the legal principles are agreed and if not what are the precise areas of disagreement. It is also incumbent on counsel for the Coroner to inform the Coroner whether in his view a ruling in the inquest is incorrect or whether inadequate reasons have been given and why or whether alternative reasons have not been considered. This will afford the Coroner an opportunity during the inquest to revisit his decision. The role and duty of counsel to the Coroner involves appreciating exactly all aspects of the role and duty of the Coroner, see for instance *R v Coroner for Inner London West District ex parte Dallaglio* [1994] 4 All ER 139 at 162 and *R v Coroner for Northumbeshire and Scunthorpe, ex parte Jamison* [1995] QB 1 page 26. Counsel for the Coroner should replicate that role and that duty but as counsel proactively assisting the Coroner. For instance assertions on behalf of the PSNI that documents are irrelevant should be analysed and if appropriate challenged by counsel on behalf of the Coroner. Similarly, if it is suggested that any part of the proceedings should be in private, that should be analysed and if appropriate challenged. The analysis should be in relation to the stance adopted by all those represented at the inquest. Another instance is that the investigation into in what broad circumstances the deceased died is not a one sided investigation. The police are called to give a public account for their actions. A form of words was agreed as to the deceased's involvement with a terrorist organisation and as a consequence the applicant was not asked any questions in relation to, nor was he called to give a public account in relation to, the deceased's involvement and the actions of the deceased. That is also a part of the broad circumstances and one of the central issues at the inquest as would be the nature of any terrorist bombing campaign being conducted at the time.



### **Hearing of these applications**

[29] At paragraph [20] of my judgment dated 4 July 2013 (STE8935) I set out some of the logistical difficulties in fixing a date for the hearing of the leave application. I granted leave and fixed separate hearing dates for the various issues included in these applications. I was unavailable to deal with the issue in relation to the Stalker/Sampson reports in September 2013. Mr Macdonald due to commitments in the Court of Appeal was unable to deal with those issues in November 2013. It was relisted in December 2013. I also record that the applicant expressly takes no point in relation to the length of time it has taken to bring these judicial review applications to judgment.

## **Part Two: Factual background**

[30] In this part of the judgment I first set out the factual background to the death of the deceased together with the central issues and the factual matters which arose for consideration at the inquest. I then set out the factual background in relation to the other deaths which the applicant contends are relevant as either going to the credibility of the witnesses giving evidence at the inquest or as similar fact evidence. The factual descriptions in relation to the other deaths, except in relation to the events surrounding the death of Neil McConville, are taken from descriptions formulated on behalf of the applicant. There is considerable controversy surrounding the exact circumstances of those deaths. The factual descriptions are not meant to be definitive nor have they been agreed with the PSNI. I include the descriptions so that the suggestion that similar fact evidence should have been introduced in this inquest can be put into context.

### **(a) Factual background to the death of the deceased on the Falls Road Belfast on 25 November 1992**

[31] The factual background has been taken from the evidence adduced at the inquest but it is not meant to summarise all the evidence. Rather it is to be read together with the identification of the central issues, the broad facts which were not in dispute and the factual issues which arose for consideration. The overall purpose is to enable the issues which arise in these judicial review applications to be put in context.

[32] On 25 November 1992 the deceased was shot and killed at Falls Road, Belfast, by an Officer of the Royal Ulster Constabulary (“the RUC”) later identified as Sergeant A. Sergeant A was a member of the RUC’s Headquarters Mobile Support Unit

[33] At the inquest, Detective Superintendent AB and Detective Inspector AA gave evidence that they were part of the Tasking and Co-ordinating Group (TCG) responsible for co-ordinating a joint police/Army surveillance operation mounted in West Belfast on 25th of November 1992 to monitor activity at Arizona St., which was thought to be a location for IRA bomb-making for the city centre and throughout the province. On 22<sup>nd</sup> November 1992, three days earlier, a bomb had been defused in the city centre, in Chichester Street. TCG were in radio communication with HMSU officers who were at the scene. The arrangement was that the HMSU would act in support of the surveillance personnel, and might be tasked to stop a vehicle or perform searches. That afternoon, both AA and AB were in the operations room at Castlereagh. At around 3.40 pm there was a report that a red Ford Orion, BDZ 7721, was being driven in the area of Whiterock Leisure Centre and appeared to be on IRA business. AB said that the information was that the car was delivering or collecting IRA munitions. The Orion had been hijacked outside the community centre,

Monagh Road, Belfast between 3.15pm and 3.30pm by two men who told the driver, Mr Cullen, that they were "Irish Republican Army". One of the men in the back seat gave Mr Cullen the impression that he had a gun. He was told to drive to Whiterock Leisure Centre and ordered to go to, and remain at, the swimming pool viewing gallery. One of the men sat behind him. At approximately 7pm he was told to wait 10 minutes then report the car to the police as being hijacked. Following the fatal shooting, a statement was released which claimed the deceased to be a member of the IRA and stated that the car had been hijacked.

[34] At 4.30pm the Orion was observed leaving Arizona Street. It was seen to travel in the direction of Upper Springfield Road and then went unsighted for a period. At 5pm the Orion was observed returning to Arizona Street. At approximately eight minutes past five the Orion left Arizona Street. It headed towards Andersonstown. In view of the previous activity around Arizona Street, and the fact that the car had defective rear lights, AB instructed M, a HMSU officer in the operation room, to have the car stopped. The defective rear lights were to be used as a reason for checking the vehicle out. He said that because of the earlier reports they couldn't let the vehicle go without checking that it was okay. At its height, it was a suspicious vehicle. He said that he didn't know who was driving it at that time.

[35] AA said that once a decision had been made to have the vehicle stopped the task and tactics then passed to the HMSU officers on the ground. HMSU would not have been instructed in how to stop the car. AA said he could not recall if there had been any assessment of the risk of stopping. AA said that the overriding concern was whether a car bomb was going to the City Centre. That the priority was to ensure a bomb didn't go to the City Centre and that the IRA was hell bent on a bombing campaign. AA recalled that a few days after 25 November 1992 a bomb had exploded in Upper Queen Street, Belfast, in which 27 people were injured.

[36] At around 5.18 pm HMSU reported that they had rammed the car after it had failed to stop, that one person had run off and been shot by police.

[37] Officer M's specific role on that day was to direct communications and to coordinate the HMSU units on the ground. He said that HMSU gave effect to TCG decisions and that the rear stop was the safest way to stop the vehicle. He said he didn't anticipate a high speed chase and if he had he would possibly then have put crews into a different location. He accepted that he could be seen as being at fault for not anticipating that particular eventuality.

[38] Sergeant A was the most senior HMSU officer on the ground in the operation that day. He was in the front passenger seat of Call Sign 8. C was the driver of Call Sign 8 and B was the rear seat passenger sitting behind Sergeant A. Call Sign 12 was working in support of Call Sign 8. E was its driver, D was the front seat passenger and F was the rear seat passenger.

[39] Sergeant A gave an account of the pursuit of the car on the Falls Road, and that account broadly matches the accounts given by the other officers in Call Sign 8. Sergeant A directed the driver of his vehicle to drive alongside the Orion and he signalled for Mr Jordan to stop. Mr Jordan slowed down and then accelerated city bound on Falls Road. He described ramming the Orion. He said they tried a soft stop, which then became a forcible stop when Mr Jordan's car failed to stop.

[40] Sergeant A's account of the shooting was that when the cars had stopped he burst out of his vehicle from the passenger door and then moved back towards the Orion. He said that he saw the driver of the Orion on the road. He stated in evidence that the driver had already got out of the Orion at the time he got out of his vehicle. He described him as running at an angle from left to right away from him. He said that the driver had turned his head to the right, looking in his direction. He said in his evidence that he could see the driver's upper body but could not see the bottom part of his arms. He described the man's arms as being straight down, but said he could not see his hands. He said that the driver of the Orion, Mr Jordan, turned towards him in a clockwise direction. In his account to the police, he used the word "spun". He said that at this moment he feared that his life, or the life of the driver of his car, was in danger. He fired a short burst from his firearm, a Heckler and Koch MP 5. Sergeant A maintained that he fired the shots as the man was facing him.

[41] All the officers were debriefed after the incident and before they were interviewed by CID officers. The debrief was conducted by Officer M under the supervision of Officer V, who had come in from leave for the purpose. They denied that the purpose of the debrief was to fabricate an account of the incident that would protect Sergeant A from prosecution. Sergeant A gave his account in the presence of the other officers and they then gave their accounts, which were noted by Officer M and Officer Q.

[42] The case on behalf of the applicant is that his son, who was unarmed, did not turn but rather was running away presenting no threat when he was shot in the back and killed by Sergeant A. In brief, that the account of Sergeant A is false. Alternatively, that if his son did turn in the manner indicated then that subjectively Sergeant A did not believe that his life or the lives of others were in danger and/or that the use of lethal force was not an appropriate response in the circumstances. Again, in brief, that Sergeant A's evidence as to his subjective belief was not only unreasonable but false.

### **The central issues at the inquest**

[43] The broad facts were not in dispute.

- (a) The deceased was the driver of a hijacked car stopped by police involved in an anti-terrorist operation.
- (b) He was running away and trying to escape from police when he was shot dead.
- (c) He was unarmed, made no attempt to pretend that he was armed and had nothing in his possession that could have been mistaken for a firearm.
- (d) He was shot twice in the back and once in the back of the left arm.
- (e) He was shot by Sergeant A, who emerged from his car with a round in the breech and fired 5 shots on automatic.
- (f) At the time he was shot he was about 3 yards from the hijacked car and 6 yards from Sergeant A.
- (g) Sergeant A agreed that he had failed to comply with the RUC Code of Conduct governing the discharge of firearms and which he accepted applied to him in the situation.

[44] The *central* issue was whether his killing was justified. There were issues about the debriefing which essentially went to the credibility of the accounts given about how the deceased was shot and were therefore relevant to the *central* issue which was whether the killing was justified. An issue also arose as to whether the operation had been planned and controlled so as to minimise recourse to lethal force, the 'planning and control' issue.

[45] In determining these issues, a number of factual questions arose for consideration at the inquest.

[46] In relation to the shooting of the deceased those matters were as follows:

- (a) why Sergeant A had a round in the breech before he got out of his car;
- (b) whether Sergeant A shouted "police, halt" before he fired;
- (c) whether Sergeant A issued any warning that he was going to fire;
- (d) whether the deceased did anything that, as a matter of objective fact, posed a threat to Sergeant A or any other police officer;
- (e) whether Sergeant A's view of the deceased's hands was obstructed;

- (f) whether the deceased turned around to face towards Sergeant A;
- (g) whether the deceased was facing Sergeant A when Sergeant A fired at him;
- (h) whether Sergeant A honestly believed that the deceased did anything that posed a threat to him or any other police officer;
- (i) whether Sergeant A selected automatic fire rather than single shot deliberately or accidentally;
- (j) whether Sergeant A was justified in firing in breach of the RUC Code of Conduct governing the discharge of firearms;
- (k) whether Sergeant A could have taken another course of action, such as using the protection of his armoured vehicle as an alternative to firing at the deceased;

[47] In relation to the debrief those factual issues were:-

- (a) whether it was appropriate to conduct a debrief prior to the interviewing of witnesses by CID;
- (b) whether the primary purpose of the debrief was to facilitate the exoneration of Sergeant A;

[48] In relation to planning and control those factual issues were:-

- (a) whether there was a clear line of command within the operations room;
- (b) whether the TCG exercised any or any adequate control and supervision over the conduct of officers on the ground;
- (c) whether TCG officers or Officer M gave any advice, guidance or directions to the police officers on the ground in relation to stopping the car and the importance or otherwise of stopping the driver;
- (d) whether the decision to stop the vehicle by way of a casual stop, as opposed to a vehicle check point, and the absence of any clear direction as to what should happen in the event that the driver ran away caused or contributed to the death of the deceased; and
- (e) whether, therefore, the planning and control of the police operation was such as to minimise recourse to lethal force.

**(b) Factual background to the deaths of Gervaise McKerr, Eugene Toman and Sean Burns at Tullygally Road East, Craigavon, Co. Armagh on 11 November 1982**

[49] At approximately 9.40 p.m. on 11 November 1982, a motor vehicle containing three suspected IRA members breached an RUC vehicle check point (VCP) that had been established on the Tullgally East Road, Craigavon, Co. Armagh. Police opened fire on the fleeing vehicle and a chase ensued involving police officers who were members of a uniformed unit within Special Branch called the Special Support Unit (since re-named as Headquarters Mobile Support Unit). During the pursuit the SSU Officers discharged further shots at the vehicle, which failed to negotiate a slip road and crashed into a grass bank. SSU Officers again opened fire on the suspect vehicle. All three occupants, Gervaise McKerr, Eugene Toman and Sean Burns, were shot dead. No firearms, explosives or other materials of significance were discovered in the vehicle.

[50] Following the shooting, the SSU Officers involved, together with other members of the unit, including Officer V (in the Jordan inquest) who was the head of the unit, took part in a debriefing prior to their interviews with the CID Officers tasked to investigate the shootings. At that debriefing, senior officers required the SSU Officers involved not to disclose the involvement of Special Branch or the fact that the interception of the suspect vehicle had been a planned operation. Alternative explanations for the involvement of police at the scene were suggested by those senior officers. All the officers involved made false statements in accordance with the cover story.

[51] Three members of the SSU were charged with, but acquitted of, the murder of Eugene Toman.

**(c) Factual background to the death of Michael Tighe and the wounding of Martin McAuley at Ballynerry Road North, Lurgan, Co. Armagh on 24 November 1982**

[52] At approximately 4.30 p.m. on 24 November 1982, an SSU patrol consisting of a sergeant (Officer M in the Jordan inquest) and 6 Constables approached a hayshed at the rear of 12 Ballynerry Road North, Lurgan, Co. Armagh. The officers claimed that they challenged two armed men within the hayshed and on being confronted by them fired in self-defence. Michael Tighe was killed and Martin McCauley was injured. When the shed was searched, three dated rifles were found. No ammunition was recovered and no shots were fired at the police officers.

[53] Officer M, a witness in the Pearse Jordan inquest, was one of the officers who fired shots into the hay-shed in which Michael Tighe was killed and Martin McCauley seriously injured. He fired 33 shots in total. The SSU Officers involved in the shootings were debriefed prior to interview by the CID Officers tasked to

investigate the incident. At the debrief, attended *inter alia* by Officers V and M, a cover story was formulated, purportedly to conceal aspects of Special Branch involvement. All the officers involved made false statements in accordance with the cover story.

[54] The cover story formulated suggested that the SSU Officers had approached the hay-shed because Officer M had seen a gunman at the hayshed. This was not true. The officers, including Officer M, had gone to the hayshed because they were directed to do so by other officers. There was a listening device in the hayshed and it is the applicant's case that it was as a result of noises heard in the hayshed that the SSU Officers were directed to investigate.

[55] At the subsequent trial of Martin McCauley, the trial judge, Lord Justice Kelly, declined to rely on the evidence of Officer M and other police officers at the scene. He acquitted Martin McCauley of possession of firearms with intent to endanger life and convicted him of possession of the firearms in suspicious circumstances. He imposed a sentence of three months' imprisonment suspended for two years.

**(d) Factual background to the deaths of Seamus Grew and Roddy Carroll at Mullacreevie Park, Armagh, Co. Armagh on 12 December 1982**

[56] On 12 December 1982, nine members of the HMSU were deployed in the Armagh area on an anti-terrorist operation. At about 8.15 p.m. a motor vehicle driven by a suspected terrorist was pursued into the Mullacreevie Park housing estate and stopped by officers of this unit. The police opened fire. The driver, Seamus Grew, and the front seat passenger, Roddy Carroll, were killed. No shots were fired from within the car and no firearms or explosives were found in the car. A police officer was prosecuted for, but acquitted of, the murder of Seamus Grew.

[57] The HMSU Officers involved in the shootings were debriefed prior to interview by the CID Officers tasked to investigate the incident. At the debriefs, attended *inter alia* by Officers V and M, first at Gough Barracks and then the following day at HMSU HQ at Lisnasharragh, a cover story was formulated, purportedly to conceal aspects of Special Branch involvement in the incident. All the officers involved made false statements in accordance with the cover story, which involved, *inter alia*, fabricating an account of the deceased breaking through a fictitious police check point, injuring a police officer (who had in fact been injured in a collision involving an Army surveillance vehicle), and then driving away from the scene at speed. It also involved an officer who had in fact been on leave at the time being inserted into the account in order to take the place of another Special Branch Officer whose involvement and role it had been decided to conceal altogether. This required the officer to make a false claim for overtime.



[58] At the inquest, Officer V accepted that he told the Stalker Sampson team that his role was to “plug” holes in the cover story as and when they appeared. He accepted that he and the other officers involved in that episode had weaved a “web of deceit” and that, in relation to the “build-up and what happened afterwards”, he was “one of the main weavers of this web of deceit”.

**(e) Factual background in relation to the death of Neil McConville on the Aghalee Road near Ballinderry, Co. Antrim on 29 April 2003**

[59] Neil McConville died on 29 April 2003 having been shot by a police Officer who was a member of HMSU. The circumstances of his death were set out in the investigative report of Mrs Nuala O’Loan, the Police Ombudsman for Northern Ireland, which was published pursuant to Section 62 of the Police (Northern Ireland) Act 1998 in October 2007. The Ombudsman had concluded her investigation when she submitted a file to the Public Prosecution Service on 6 January 2005. However publication of her report took place after the conclusion of the prosecution of an individual referred to as man A. The published report was available to the next of kin in the Jordan inquest. However the identity of all of the police officers involved, whether on the ground or in planning and control of the operation, was anonymised in the Police Ombudsman’s report by the use of ciphers. Accordingly, it was not possible for the next of kin or the Coroner in the Jordan inquest to determine whether any of the police Officers involved in the Jordan inquest had also been involved in the events surrounding the death of Neil McConville.

[60] I summarise parts of the Ombudsman’s report. In doing that I will use in bold the same ciphers as used in the Jordan inquest in respect of any officer who was also involved in the events surrounding the death of Neil McConville.

[61] On 29 April 2003 the PSNI learned that an individual (man “A”) was to travel to Belfast in a Vauxhall Cavalier motor vehicle and collect a gun, which may subsequently be used in an attack on an individual. An operation was mounted, directed by HMSU Officers. The car was identified and traced in Belfast, and followed to various locations. Police suspected that a gun had been collected at one of these locations.

[62] At 1630 hours Officers from the HMSU attended a briefing, where they were given details of the intelligence available, and were told that they would be in support of the surveillance operation, with a role to stop the suspect vehicle if necessary. The briefing advised the officers that the occupants of the vehicle would be likely to have a firearm. Two police vehicles containing crews from the HMSU armed with MP5 sub-machine guns were identified to take the principle role of, if necessary, stopping the suspect vehicle. The two principle police vehicles from the HMSU met in central Belfast where the two crew commanders discussed the options for stopping the vehicle, should it be necessary. They considered a vehicle

checkpoint and discussed the fact that Call Sign 7 had a “stinger” (a device that can be stretched across a road and which would puncture car tyres in an attempt to immobilise a vehicle) which they could use and they also considered the option of stopping the vehicle from behind. This would involve activating their audible warning equipment when following with the possibility of overtaking the vehicle and indicating that it should stop. No decision was actually taken at this time. The police officers were aware that a helicopter was also involved. At 1855 hours **Officer AA** was advised that the vehicle had left the Belfast City area and was heading towards Stoneyford (a rural village to the South West of Belfast). At this point **Officer AA** directed Sergeant EE to tell the call signs to stop the red Vauxhall Cavalier. This instruction was relayed to the police. The officers were told to stop the vehicle from behind. They applied their blue lights and audible warning equipment and travelled at speed to take visual control of the red Vauxhall Cavalier. They were aware at this stage that there were two occupants. On the Crumlin to Aghalee Road they caught up with the red Vauxhall Cavalier and turned off their warning equipment so as not to alert the driver. They waited until they were on the Aghalee Road near Ballinderry which seemed a suitable location. By now the red Vauxhall Cavalier was driving at speed. Sergeant GG instructed the driver, Constable FF, to overtake the red Vauxhall Cavalier and he commenced that manoeuvre. A collision took place before the vehicle was brought to a stop. Officers then approached the vehicle and challenged the driver, Neil McConville, to turn the engine off. He reversed the car at speed and spun it round. The front wing of the vehicle caught an officer and threw him to the ground in front of the car, where he lay injured. The driver then tried to engage the gears to drive forward. The injured officer was directly in the vehicle’s path. At least three of the officers present feared that, if the car drove forward, this officer would be killed or seriously injured and challenged the driver to stop, shouting that they were armed police. Mr McConville did not stop and continued to try to get away. An Officer then discharged his MP5 at Neil McConville. The Officer had inadvertently selected the “automatic” mode on the weapon, rather than “single shot” and three bullets were discharged. These caused fatal injuries to Neil McConville, who was pronounced dead at Lagan Valley Hospital at 2007 hours. The front seat passenger, man “A”, suffered less serious injuries, when a bullet passed through Neil McConville and struck him. An unloaded “sawn-off” shotgun was found wrapped in a nylon windsheeter in the front of the vehicle. No ammunition was found in the vehicle.

[63] I set out what subsequently occurred by way of investigation to illustrate the differences in investigations between 2003 as compared to 1982 and 1992. Section 55(2) of the Police (Northern Ireland) Act 1998 requires the Chief Constable to refer to the Ombudsman any matter which appears to the Chief Constable to indicate that the conduct of any member of the police force may have resulted in the death of some other person. Where any matter is referred to the Ombudsman under Section 55(2) he shall formally investigate the matter in accordance with Section 56. In accordance with these provisions the Police Ombudsman’s senior investigator on

call was contacted at 8.10 pm on 29 April 2003 and informed of the shooting by the PSNI. He made arrangements for investigators from the office of the Police Ombudsman for Northern Ireland to attend various locations to commence the necessary investigations. A total of 37 investigators attended different locations and were involved in various aspects of the investigation through the night. This included the scene of the shooting which had been secured and preserved by the police. The Police Ombudsman's investigation took primacy of that scene from the police and it was fully forensically examined and searched. Vehicles involved and other evidence were seized for necessary forensic examination. House to house enquiries were conducted and an appeal for witnesses was made. A number of witnesses were identified and interviewed including officers involved in the operation, ambulance and hospital personnel, civilian witnesses, a forensic scientist and a helicopter pilot.

## Part Three: Legal Principles

### Legal principles: Self-defence

[64] In *Bennett v UK* Application no. 5527/08 the European Court of Human Rights considered a complaint that a Coroner had not given a sufficient direction to the jury as to the legal test for self-defence. The Coroner had directed the jury that in determining whether it was self-defence or defence of another, the first question was whether the individual believed, or may have honestly believed, that it was necessary to defend himself or another, having regard to the circumstances which he honestly believed to exist (subjective test), although the reasonableness (objective) of the belief was somewhat relevant because, if the belief on the facts was unreasonable, it might be difficult to decide that it was honestly held. The second question, which arose if the first question was answered favourably to the individual, was whether the force used was reasonable having regard to the circumstances which were believed to exist (objective test). The High Court and the Court of Appeal found that this direction was consistent with English law. It was contended that the direction which she had given under domestic law was not accurate having regard to Article 2(2) of the Convention on Human Rights, which provides that "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...". The applicant complained that the definition in domestic law of self-defence and therefore the Coroner's direction to the jury did not include an instruction that it would have been unlawful for the police officer to have shot Mr Bennett unless he was satisfied that it was "absolutely necessary" for him to do so and that the Coroner had erred in refusing to incorporate the test of "absolute necessity" into her direction to the jury on lawful killing. It was held by the domestic court that the domestic test had been considered by the European Court who had not suggested any incompatibility with Article 2 (*McCann and Others v. the United Kingdom*, 27 September 1995, §§ 134-200, Series A no. 324; and *Bubbins v. the United Kingdom*, no. 50196/99, §§ 138-140, ECHR 2005-II (extracts)). When the complaint came before the European Court it referred to the general principles set out in the decision in *Bubbins v. the United Kingdom* including the following paragraph

"135. In the light of the importance of the protection afforded by Article 2, the Court must subject deprivations of life to the most careful scrutiny, taking into consideration not only the actions of State agents but also all the surrounding circumstances, including such matters as the planning and control of the actions under consideration. Any use of force must be no more than 'absolutely necessary' for the achievement of one or more of the purposes set out in

sub-paragraphs (a) to (c). This term indicates that a stricter and more compelling test of necessity must be employed from that normally applicable when determining whether State action is 'necessary in a democratic society' under paragraphs 2 of Articles 8 to 11 of the Convention. Consequently, the force used must be strictly proportionate to the achievement of the permitted aims (McCann and Others, cited above, p. 46, §§ 148-149). ..."

[65] The European Court in its judgment in *Bennett v UK* went on to recall that a similar domestic provision and complaint was considered in the *McCann* case and that the Court in that case had found that, while the Convention standard appeared on its face to be stricter than the national one, the difference between the two standards was not "sufficiently great" for a violation of Article 2 § 1 to be found on this ground alone (at §§ 154-155). The European Court gave careful consideration to the application of the domestic test on the facts in *Bennett v UK* and concluded that "while it might be preferable for an Inquest jury to be directed explicitly using the terms "absolute necessity", any difference between the Convention standard, on the one hand, and the domestic law standard and its application in the present case, on the other, could not be considered sufficiently great as to undermine the fact-finding role of the Inquest or give rise to a violation of Article 2 of the Convention."

[66] Accordingly a domestic law direction in relation to self-defence omitting the words "absolute necessity" can be compliant with Article 2 depending on the particular facts of this case. The distinction between the court's role and the role of the Coroner needs to be emphasised. The Coroner decides what direction to give to the jury. The court's role is supervisory and limited. It is for the applicant to demonstrate to the court how it was inadequate on the particular facts of this case for the Coroner to have given a direction which omits the words "absolute necessity."

### **Legal principles: Disclosure of documents by the Coroner and the obligation on the police to give documents to the Coroner**

[67] In the *Chief Constable of the PSNI's Application* [2010] NIQB 66 Gillen J reviewed the legal principles as to the approach to be adopted to the disclosure of materials in coronial inquests by a Coroner. The decision of Gillen J was appealed by the PSNI but the appeal was withdrawn. In his decision Gillen J adopted the description of the Coroner's role given by Sir Thomas Bingham MR in *R v Coroner for Inner London West District ex parte Dallaglio* [1994] 4 All ER 139 at 162 which description included the function of gathering relevant evidence and acting in a role closer to that of a judge d'instruction than to that of a judge presiding over contested

proceedings between adversaries. Gillen J went on to adopt the description of the duty of the Coroner given in *R v Coroner for North Humbershire and Scunthorpe, ex parte Jamieson* [1995] QB 1 p. 26 as a duty

“to ensure that the relevant facts are fully, fairly and fearlessly investigated ... he must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul play, abuse or inhumanity. He fails in his duty if his investigation is superficial, slipshod or perfunctory.”

[68] So in accordance with these functions and duties the Coroner gathers relevant evidence but as Gillen J recorded there is no statutory provision, instrument or rule governing the Coroner’s approach to disclosure of the evidence which he has gathered. That remains a matter of discretion for the Coroner but in exercising that discretion there should be a presumption in favour of as full disclosure as possible, see *R (on the Application of Smith) v Oxfordshire Assistant Deputy Coroner* [2008] 3 WLR 1284 and *R (Bentley) v HM Coroner for Avon* (2001) 166 JB 297.

[69] Gillen J held and I respectfully agree, that the Coroner is obliged to direct disclosure of “potentially relevant material.” The reasons for this obligation include a number of factors:

- (a) The purpose of coronial investigations which purpose includes confirming or allaying public suspicion and in that sense one is looking not only at the inquest but beyond, see the remarks of Scott Baker LJ recorded by Gillen J at paragraph [30] of his judgment and see also *Re Hemsworth* [2009] NIQB 33 paragraphs 33-36 and *Re Ramsbottom* [2009] NIQB 55 at paragraph 11.
- (b) Fulfilling the requirement that the next of kin can participate in an informed, open and transparent fashion on an equal footing with all other parties.
- (c) Allowing the next of kin to make informed submissions as to the scope of the inquest.
- (d) Allowing the next of kin to make informed submissions as to the admission of similar fact evidence.
- (e) Allowing the next of kin to make informed submissions as to permitted lines of cross examination as to the credit of witnesses or as to the admission of evidence to contradict answers on cross examination as to credit.

[70] The test of potential relevance requires that a Coroner should not refuse disclosure on the basis that he has decided to limit the scope of the inquest and on

that basis documents which might otherwise have been subject to disclosure are no longer relevant to the limited scope of the inquest and therefore not disclosed. If a document is potentially relevant it should be disclosed so that all those interested in the inquest may make submissions as to actual relevance. After receiving such submissions the Coroner can rule on actual relevance and as to the control stage: that is what if any use he will make or allow others to make of the document at the hearing.

[71] In the *Chief Constable PSNI's Application* [2008] NIQB 100 and in respect of the obligation for the police to disclose information to the Coroner under section 8 of the Coroners Act (Northern Ireland) 1959 Morgan J stated that:

“there is no basis for limiting the information to which the Coroner is entitled by reference to whether it is factual, opinion or assessment.”

Again with respect I agree that even though documents may contain matters of opinion, comments, assessment, conclusions or recommendations such analysis of the relevant evidence is likely to be extremely helpful to the Coroner in defining the issues which he can expect to emerge on the hearing of the inquest. Similarly such information is likely to be extremely helpful to the next of kin in forming their submissions as to the proper scope of the inquest. In *Chief Constable PSNI's Application* [2008] NIQB 100 Morgan J went on to state that in so far as such information was made available by the police to the Coroner then in turn in so far as it is relevant, and I would add potentially relevant, the Coroner should provide it to the interested parties to obtain their assistance on the question of the scope of the inquest so as to enable the interested parties to participate effectively in the inquest proceedings.

[72] The disclosure of information by the police to the Coroner is the subject of section 8 of the Coroners Act (Northern Ireland) 1959. That section provides that

“Whenever a dead body is found, or an unexpected or unexplained death, or a death attended by suspicious circumstances, occurs, the [Superintendent] within whose district the body is found, or the death occurs, shall give or cause to be given immediate notice in writing thereof to the Coroner within whose district the body is found or the death occurs, together with such information also in writing as he is able to obtain concerning the finding of the body or concerning the death.”

In *McCaughey v Chief Constable of the Police Service of Northern Ireland* [2007] UKHL 14 Lord Bingham stated that the obligation on the police under section 8 is a continuing obligation. The House of Lords declared that section 8 of the 1959 Act requires the Police Service of Northern Ireland to furnish to a Coroner to whom notice under section 8 is given such information as it then has or is thereafter able to obtain (subject to any relevant privilege or immunity) concerning the finding of the body or concerning the death.

[73] The Coroner has an obligation to provide potentially relevant documents to the next of kin. The information which the police are obliged to give to the Coroner under section 8 of the Coroners Act (Northern Ireland) 1959 must include potentially relevant documents otherwise the Coroner would not be able to discharge his obligation to direct disclosure of potentially relevant documents to those interested in the inquest.

[74] It would be most exceptional if any document brought into existence by the police in relation to their investigation of a death was not potentially relevant and accordingly as a matter of practice all those documents will be made available to the Coroner. In addition in this case potentially relevant documents include any documents potentially relevant to the credibility of witnesses at the hearing and any documents potentially relevant as similar fact evidence.

[75] To discharge the obligation which rests on the police to make available potentially relevant documents to the Coroner the police have to obtain the documents and form a view as to their potential relevance. For instance in this case proactively the police have to obtain any document potentially relevant to the credibility of witnesses at the hearing and any document potentially relevant as similar fact evidence and that involves forming a view. It is not part of the Coroner's function to undertake an obligation which rests on the police. The practice that has been adopted of the police asserting that documents are not relevant but in any event making them available to the Coroner so that he can form a view is to misunderstand the obligation which is on the police to obtain documents and to form a view in relation to them. It also contains the seeds of delay because it is combined with an approach by the police that the documents will not be subject to PII or Article 2 redaction unless and until the Coroner makes a decision that the documents are relevant or potentially relevant. If the Coroner so decides then he is faced with the potential consequence of having to adjourn the inquest in order to allow for PII or Article 2 redactions. Just such a proposition was advanced to the Coroner for instance in relation to the Neil McConville statements of Officer AA.

[76] The Coroner is not to assume an obligation that rests on the police but he has his own separate duty to gather relevant evidence which duty he performs with assistance from amongst others the next of kin. The Coroner is not restricted in that he can obtain documents from other persons or bodies and is not restricted to



obtaining documents from the police. If the documents are not made available in response to a direction then he can summons a witness to attend with the documents. In relation to the PSNI if it is asserted that a particular category of documents is not potentially relevant the Coroner can require a police witness to attend and to provide an explanation. If the Coroner identifies a category of potentially relevant documents and those documents are not being made available by the PSNI then again the Coroner can require a witness from the PSNI to attend. The Coroner has power to require a police witness to attend to give evidence in advance of the inquest itself as to what steps have been taken by the police to obtain documents.

### **Legal principles: Article 2 ECHR compliant inquest**

[77] In *McCann v United Kingdom* (1995) 21 EHRR 97 the Strasbourg court held that Article 2 by implication gave rise not merely to a substantive obligation on the State not to kill people but, where there was an issue as to whether the state had broken this obligation, a procedural obligation on the State to carry out an effective official investigation into the circumstances of the deaths (“the procedural obligation”). In an inquest which does not have to comply with the procedural obligation, “how” means only “by what means” whereas in an Article 2 compliant inquest it must also encompass “in what broad circumstances”: see *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182. The question has previously arisen as to whether an inquest had to comply with the procedural obligation if the death pre dated the coming into force of the Human Rights Act 1998 on 2 October 2000. In *re McKerr* [2004] 1 WLR 807 the House of Lords held that it did not. In 2009 the Grand Chamber of the Strasbourg court took a decision in *Silih v Slovenia* (2009) 49 EHRR 996 which further extended the effect of Article 2. The Grand Chamber ruled that Article 2 imposed, in certain circumstances, a freestanding obligation in relation to the investigation of a death which applied even where the death itself had occurred before the member state ratified the Convention. In *Re Brigid McCaughey & Anor for Judicial Review* [2012] 1 AC 725; [2011] UKSC 20 the Supreme Court found that the decision of the Grand Chamber of the European Court of Human Rights in *Silih v Slovenia* had extended the effect of Article 2 of the Convention so that it now imposed a freestanding and autonomous procedural obligation in relation to the investigation of a death, which could arise where the death had preceded the court's assumption of jurisdiction if a significant proportion of the procedural steps which Article 2 would require took place after that date. Accordingly, if the United Kingdom authorities decided to hold an inquest into a death which had occurred before 2 October 2000 the Convention imposed an international obligation to ensure that it complied with the procedural obligations of Article 2, at least in so far as that was possible under domestic law. In the words of Lady Hale:

“if there is now to be an inquiry into a death for which the State may bear some responsibility under

Article 2, it should be conducted in an Article 2 compliant way.”

The Jordan inquest is such an inquest and it has to have been conducted in an Article 2 compliant way.

[78] The nature of an Article 2 compliant investigation was considered by the Strasbourg Court in *Jordan v UK* (2003) 37 E.H.R.R. 2 and in *Nachova & others v Bulgaria* (2006) 42 EHRR 43. A number of matters can be taken from those judgments.

- (a) The essential purpose of an investigation is “to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility.”
- (b) The form of such an investigation may vary in different circumstances. The Strasbourg Court did not specify in any detail which procedures the authorities should adopt in providing for the proper examination of the circumstances of a killing by State agents. The aims of fact finding, criminal investigation and prosecution can be carried out or shared between several authorities, as in Northern Ireland, and the requirements of Article 2 may nonetheless be satisfied if, while seeking to take into account other legitimate interests such as national security or the protection of material relevant to other investigations, they provide for the necessary safeguards in an accessible and effective manner. However the available procedures have to strike the right balance.
- (c) Whatever mode of investigation is employed, the authorities must act of their own motion, once the matter has come to their attention. They cannot leave it to the initiative of the next of kin either to lodge a formal complaint or to take responsibility for the conduct of any investigative procedures.
- (d) For an investigation into alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for and carrying out the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence. That in order for the investigation to be effective, “the persons responsible for and carrying out the investigation must be independent and impartial, in law and in practice” (paragraph 112 of *Nachova*).
- (e) The investigation is also to be effective in the sense that it is *capable of leading to a determination* of whether the force used in such cases was or was not

justified in the circumstances and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including inter alia eye witness testimony, forensic evidence and, where appropriate, an autopsy which provides a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard. (emphasis added)

- (f) A requirement of promptness and reasonable expedition is implicit. It must be accepted that there may be obstacles or difficulties which prevent progress in an investigation in a particular situation. However, a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts.
- (g) There must be a sufficient element of public scrutiny of the investigation or its results to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case.
- (h) In all cases the next-of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests. In respect of this matter I would add that the next-of-kin must be involved regardless as to their personal circumstances or attributes.

[79] It is clear that the requirement that the investigation is capable of leading to a determination is not an obligation of result, but of means. In practical terms there will be cases where, no matter how thoroughly all relevant primary evidence is secured and available and then comprehensively examined, including by the examination of witnesses (publicly and with the involvement of the next of kin), it is difficult to reach a clear conclusion as to what has occurred or for instance whether the use of lethal force was justified. This might arise by virtue of a lack of evidence or by reason of a conflict of evidence which is simply impossible to resolve decisively one way or the other. The European Court of Human Rights has recognised that “there may be cases where the facts surrounding a deprivation of life are clear and undisputed and the subsequent inquisitorial examination may legitimately be reduced to a minimum formality”; but that, “equally, there may be other cases, where a victim dies in circumstances which are unclear” see *Taylor, Crampton, Gibson and King v United Kingdom* (1994) 79-A DR 127 at 136. The jury verdict questionnaire in the inquest in relation to the death of Jean Charles de Menezes, in England and Wales, included provision for a jury response to each

question that they “cannot decide” (2/417-419). The obligation on the State is not to provide a particular result in a given case but to provide a system of investigation which is capable in principle of giving rise to clear findings where they are warranted by the evidence.

### **Legal principles: The test for judicial review in respect of decisions of the Coroner**

[80] It was submitted on behalf of the Coroner that in the absence of manifest irrationality this court should refuse to interfere with “certain” determinations made by the Coroner. The Coroner contended that an example of a decision to which the *Wednesbury* test applied was a decision as to whether material concerning an incident that occurred 10 years after the death of the deceased should be disclosed to the next of kin and as to whether the report on that later incident could be deployed in the questioning of witnesses. The Coroner accepted that an example of a decision where the standard of review was not limited to the *Wednesbury* test was whether the Coroner’s directions to the jury on the use of force was in compliance with Article 2 ECHR. Another example was whether the decision to conduct the inquest with a jury was compliant with Article 2.

[81] In support of the proposition that certain decisions were subject only to the *Wednesbury* test I was referred to references to the wide element of discretion available to the coroner in *Regina (Middleton) v West Somerset Coroner and another* [2004] 2 AC 182, *R v Inner West London Coroner, ex parte Dallaglio and another* [1994] 4 All ER 139 and *In the matter of an application by Officers C, D, H & R and other appeals* [2012] NICA 47.

[82] The question of the discretion of a Coroner was addressed by Sir Thomas Bingham MR in *R v Inner West London Coroner, ex parte Dallaglio and another* [1994] 4 All ER 139. In that case he gave consideration to an argument that an inquest should not be resumed because in relation to the question “how” as narrowly defined the only proper answer would be, as was already known, that the deceased died by drowning following the collision between the Marchioness and the Bowbelle. Sir Thomas Bingham rejected that contention. He stated that the verdicts which the Coroner could properly leave open to the jury at the end would be both limited and predictable but this did not mean that the investigation into the means by which the deceased came by his death should be limited to the last link in the chain of causation.

“That would not be consistent with the court's conclusion in *R v North Humberside and Scunthorpe Coroner, ex p Jamieson* [1994] 3 All ER 972 at 991, [1994] 3 WLR 82 at 101 (para 14) which emphasised the need for full, fair and fearless investigation and the exposure of relevant facts to public scrutiny, and it

would defeat the purpose of holding inquests at all if the inquiry were to be circumscribed in the manner suggested.”

The question then arose as to how far back from the last link in the chain the enquiry would go. Sir Thomas Bingham held that this was a matter for the discretion of the Coroner. He stated that

“It is for the Coroner conducting an inquest to decide, on the facts of a given case, at what point the chain of causation becomes too remote to form a proper part of his investigation. That question, potentially a very difficult question, is for him. If these inquests were to be resumed, and I emphasise if, the question would have to be answered by the new Coroner, exercising his judgment as best he can on all the information available in the knowledge that, wherever he drew the line, his ruling would be unwelcome to some.”

[83] Subsequently in *Regina (Middleton) v West Somerset Coroner and another* [2004] 2 AC 182 the now Lord Bingham of Cornhill emphasised the element of discretion available to the Coroner when considering how best in the particular case to elicit the jury’s conclusions on the central issue or issues. For instance he could choose

- (a) to invite the jury to give a narrative form of verdict in which the jury’s factual conclusions are briefly summarised or
- (b) he could invite the jury to answer factual questions put to them by the Coroner.

Lord Bingham also stated that if the Coroner invites either a narrative verdict or answers to questions, he may find it helpful to direct the jury with reference to some of the matters to which a sheriff will have regard in making his determination under section 6 of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976: where and when the death took place; the cause or causes of such death; the defects in the system which contributed to the death; and any other factors which are relevant to the circumstances of the death. However the choice must be that of the Coroner and his decision should not be disturbed by the courts unless strong grounds are shown.

[84] The question of the discretion of a Coroner also arose *In the Matter of an Application by Officers C, D, H & R and other appeals* [2012] NICA 47 before the Court of Appeal in the context of procedural errors. Girvan LJ indicated that in deciding whether there has been a procedural mistake the High Court should accord to the

Coroner a wide margin of appreciation given the generous width of discretion which is vested in him. I set out what Girvan LJ stated at paragraph [8]:

“[8] In his conduct of the inquest the Coroner will be called on from time to time to make procedural rulings. Unless it is apparent that a procedural ruling should not have been made the High Court exercising its supervisory jurisdiction should not intervene. It is not the function of the High Court to micromanage an inquest or to act as a forum for a de facto appeal on the merits against a Coroner’s procedural ruling. A Coroner will have only acted unlawfully if he has exceeded the generous width of the discretion vested in him to regulate the inquest in the interest of what he considers to be a full, fair and fearless inquiry. The Coroner will have much greater awareness of the issues involved and the evidence likely to emerge in the course of the inquest. He must, accordingly, be accorded a wide margin of appreciation and the High Court must recognise that aggrieved parties alleging procedural unfairness will have an ultimate remedy at the end of the inquest if there is a case that the verdict should be quashed because the inquest has fallen short of proper standards to such an extent as to call into question the lawfulness of the resultant verdict. Any other approach would encourage the proliferation of wholly undesirable judicial review challenges to Coroner’s procedural rulings in the course of an inquest. As experience shows in relation to any disputed procedural ruling it is frequently possible to produce plausible arguments to support a complaint that the Coroner has got it wrong. Different Coroners might decide the same procedural question differently, each one acting within the parameters of his powers and discretions. This applies equally in the course of procedural rulings in the course of civil and criminal trials. In the context of civil and criminal litigation it is recognised that it would be a recipe for chaos if there was a general right for litigants to seek to stop a trial mid flow to take a procedural question on appeal. It would be contrary to the interests of justice which can be properly protected and vindicated at the end of the process. Taken to its logical conclusion if a party in inquest proceedings can challenge by judicial review any and every procedural ruling or, since a Coroner will be keeping all his rulings under review in the course of the inquest, any and every revised ruling made in the course of the inquest there would

be no end to the matter. The case would become, to use Dickens' words, "perennially hopeless."

[85] Girvan LJ referred to de facto appeals and to the position in relation to civil trials. The domestic law in relation to appeals in civil trials is straightforward. It has long been recognised that an appeal will not be entertained from an order which it was within the discretion of a judge to make, unless it be shown that he exercised his discretion under a mistake of law (*Evans v Bartlam* [1937] AC 473) or in disregard of principle (*Young v Thomas* [1892] 2 Ch 134) or under a misapprehension as to the facts or that he took into account irrelevant matters (*Egerton v Jones* [1939] 3 All ER 889 at 892) or the conclusion which the judge reached in the exercise of his discretion was "outside the generous ambit within which a reasonable disagreement is possible" (*G v G* [1985] 1 WLR 647).

[86] I also seek to apply the principles at paragraphs [15] to [17] of Girvan LJ's judgment in *Officers C, D, H & R*.

[87] I consider that the appropriate principles are as follows

- (a) A distinction should be drawn between the decision under challenge and the verdict. The Coroner made many decisions during the course of the inquest and if it is apparent that a particular decision should not have been made then it is a question of discretion as to what, if any order should be made in relation to that decision. The verdict will only be quashed if the inquest has fallen short of the proper standards to such an extent as to make that outcome appropriate.
- (b) The Coroner's decisions should not be *Wednesbury* irrational, he has to take into account all relevant matters in arriving at his decision, he has to leave out of account all irrelevant matters, and he should not misdirect himself as to the law. There is no exercise of discretion in relation to the application of correct legal principles and accordingly it has been said that there is no discretion to get the law wrong.
- (c) There is an obligation for the inquest to be conducted in accordance with the rules of procedural fairness. Those rules differ depending on the context. I set out in this judgment the principles in relation to a number of different areas including for instance the admissibility of similar fact evidence. The domestic law procedural test involves a two stage inquiry. First whether the evidence is relevant. Second the control stage. The control stage involves the exercise of discretion and balance. It is in relation to discretion at the control stage that judicial review is limited to the conventional *Wednesbury* grounds, see by analogy *O'Brien v Chief Constable of South Wales Police* [2005] 2 AC 534.

- (d) There is an obligation for the inquest to be conducted in such a way as to constitute an Article 2 compliant investigation into the death of the deceased. What is an Article 2 compliant investigation *may* also involve the exercise of discretion and may vary from case to case. For instance if a positive operational duty arises to protect the life of a witness under Article 2 then the response is to be proportionate taking into account the many relevant considerations including the impact of the measures on the fairness of the proceedings at the inquest. That is an example of discretion. There must be a sufficient element of public scrutiny but the degree of public scrutiny may vary from case to case. That is an example of variations from case to case and those variations will be influenced by discretionary decisions. The concept of proportionality requires the reviewing court to assess the balance which the decision-maker has struck not merely whether it is within the range of rational or reasonable decisions. Along with the concept of proportionality goes that of the margin of appreciation, frequently referred to as deference or perhaps more aptly latitude. The primary decision-maker on matters of proportionality is the Coroner. The Coroner should be left with room to make legitimate choices. To adopt what Girvan LJ stated “Different Coroners might decide the same procedural question differently, each one acting within the parameters of his powers and discretions.” So the width of latitude and the intensity of the review which it dictates can change depending on the context and the circumstances of the particular procedural decision under consideration. In many areas the width of the discretion is generous but in other areas there is no margin of appreciation. For instance there is no margin of appreciation to get the law wrong.
- (e) The decision maker is the Coroner and it is only when the outcome of the exercise of discretion is inevitable that this court should direct the Coroner to give a particular ruling.

### **Legal principles: Similar fact evidence**

[88] The rules governing the admission of similar fact evidence were considered by the House of Lords in *O'Brien v Chief Constable of South Wales Police* [2005] 2 AC 534. The facts of that case were that on 12 October 1987 Mr Phillip Saunders was attacked and robbed. He sustained injuries from which he died five days later. In July 1988 three men, including Mr O'Brien, were convicted of his murder. Eleven years later Mr O'Brien's appeal against conviction was allowed. He had spent 11 years in prison. He brought a civil action alleging that the police had framed him for Mr Saunder's murder. At the hearing of the civil action he wished to introduce evidence of impropriety by the police in relation to a criminal investigation which



had commenced in July 1982 some five years prior to the death of Mr Saunders. He also wished to introduce evidence of impropriety by the police in relation to a criminal investigation which commenced in February 1990, some 2 ½ years after the death of Mr Saunders. The judge permitted the admission of that evidence. The Chief Constable appealed unsuccessfully to the Court of Appeal and to the House of Lords. The decision in the House of Lords was that for similar fact evidence to be admitted there is a two stage enquiry.

- (a) The first stage of enquiry is common to both criminal and civil cases, being an enquiry as to whether the evidence which it is proposed to adduce is relevant to one or more issues in the trial. Any evidence, to be admissible, must be relevant. Relevance must, and can only be judged by reference to the issue which the court (whether judge or jury) is called upon to decide. "Evidence is relevant if it is logically probative or disprobative of some matter which requires proof .... Relevant (ie. logically probative or disprobative) evidence is evidence which makes the matter which requires proof more or less probable" see *Director of Public Prosecutions v Kilbourne* [1973] AC 729, 756, per Lord Simon of Glaisdale.
- (b) The second stage of the enquiry is the application of the control test, which is different in civil cases from that which is applied in criminal trials. I will confine my summary to civil cases. The control test involves the trial judge making what will often be a very difficult and sometimes a finely balanced judgment as to whether evidence or some of it (and if so which parts of it), which ex hypothesi is legally admissible, should be admitted. The trial judge balances the factors for and against admitting such evidence.

[89] In relation to the first stage of the enquiry it is entirely rational to consider other events of an apparently similar character as perhaps throwing light on and helping to explain the event which is the subject of the current enquiry. So in *O'Brien* the primary evidence must relate to how Mr O'Brien and his co-defendants were treated. But if he were able to establish that these same officers had, in other cases resorted to the same or similar methods in order to try and obtain admissions and convictions, his hand would be significantly strengthened. The similar fact evidence was relevant. It was logically probative of some matter which required proof.

[90] In relation to the second stage the factors for admitting such evidence are set out in paragraph 5 of the speech of Lord Bingham of Cornhill as follows:-

"For the party seeking admission, the argument will always be that justice requires the evidence to be

admitted; if it is excluded, a wrong result may be reached. In some cases, as in the present, the argument will be fortified by reference to wider considerations: the public interest in exposing official misfeasance and protecting the integrity of the criminal trial process; vindication of reputation; the public righting of public wrongs. These are important considerations to which weight must be given. But even without them, the importance of doing justice in the particular case is a factor the judge will always respect. The strength of the argument for admitting the evidence will always depend primarily on the judge's assessment of the potential significance of the evidence, assuming it to be true, in the context of the case as a whole."

[91] The factors against admitting such evidence are set out in paragraph 6 of the speech of Lord Bingham of Cornhill as follows:-

"While the argument against admitting evidence found to be legally admissible will necessarily depend on the particular case, some objections are likely to recur. First, it is likely to be said that admission of the evidence will distort the trial and distract the attention of the decision-maker by focusing attention on issues collateral to the issue to be decided. This is an argument which has long exercised the courts (see *Metropolitan Asylum District Managers v Hill* (1882) 47 LT 29, 31, per Lord O'Hagan) and it is often a potent argument, particularly where trial is by jury. Secondly, and again particularly when the trial is by jury, it will be necessary to weigh the potential probative value of the evidence against its potential for causing unfair prejudice: unless the former is judged to outweigh the latter by a considerable margin, the evidence is likely to be excluded. Thirdly, stress will be laid on the burden which admission would lay on the resisting party: the burden in time, cost and personnel resources, very considerable in a case such as this, of giving disclosure; the lengthening of the trial, with the increased cost and stress inevitably involved; the potential prejudice to witnesses called upon to recall matters long closed, or thought to be closed; the loss of documentation; the

fading of recollections. It is, I think, recognition of these problems which has prompted courts in the past to resist the admission of such evidence, sometimes (as, perhaps, in *R v Boardman* [1975] AC 421) propounding somewhat unprincipled tests for its admission. But the present case vividly illustrates how real these burdens may be. In deciding whether evidence in a given case should be admitted the judge's overriding purpose will be to promote the ends of justice. But the judge must always bear in mind that justice requires not only that the right answer be given but also that it be achieved by a trial process which is fair to all parties."

[92] The factors to be taken into account at the second stage of the enquiry were also considered at paragraphs [54] - [56] and [73] - [77].

[93] As is apparent from paragraph [6] and at the control stage of the enquiry a factor to be taken into account is whether the trial is before a jury, see also paragraphs [55] and [77].

[94] The second stage of the enquiry involves the exercise of judicial discretion. The power of an appellate court to interfere with the exercise of that discretion is limited to misdirection or demonstrable error. Lord Bingham stated that

"In the absence of misdirection or demonstrable error that is not a judgment with which an appellate court should interfere, and the Court of Appeal was right not to do so save in a very limited way."

Lord Rodger of Earlsferry, whilst acknowledging that it would not be appropriate to differ from the exercise of discretion by the judge at first instance, expressly stated that in relation to some of the similar fact evidence that if he had been exercising the initial judgment he would have been inclined to exclude that evidence on the ground that its potential significance would not justify the time and expense of exploring it at the trial.

[95] An illustration of a successful challenge by way of judicial review to the exercise of the second stage discretion by a Coroner to exclude similar fact evidence is the decision of Weatherup J in *McCaughey's (Brigid) Application (Leave Stage) (No 2)* [2012] NIQB 23. In my view that case is an example of demonstrable error by the Coroner. The inquest was into the death of Martin McCaughey and Dessie Grew who died on 9 October 1990. The application for judicial review was brought during the hearing of the inquest. Evidence was given at the inquest by soldier A, a

member of the SAS. The applicant sought a declaration as to the admissibility at the inquest of evidence from soldier A concerning his involvement in another operation that led to the death of a Francis Bradley on 18 February 1986. The Coroner decided that the evidence was potentially relevant in effect deciding in favour of the applicant on the first stage of the enquiry. Turning to the second stage of the enquiry he decided to exclude the evidence for two reasons. The first was unfairness to soldier A of admitting the evidence. The second ground for ruling inadmissible the evidence of soldier A in relation to the Bradley incident concerned the implications of introducing the evidence. Weatherup J identified the central issues in the inquest as:

“That broader ‘how’ concerns the background circumstances and whether the deaths were unnecessary in that they were brought about by a shoot to kill policy. That is the effective central issue. The circumstances of the Bradley incident may inform that central issue in the present case. The Bradley incident cannot be described as a distraction. It is an important aspect of a proper inquiry into whether or not there was a shoot to kill policy. It is recognised as potentially relevant to that issue. If the case of a common soldier in two similar incidents cannot permit examination of the shoot to kill policy by reference to the other incident then it would seem that there will never be an inquest that extends beyond the facts of the particular case. There is a public interest in inquests serving to allay suspicion and rumour about how deaths occur. One suspicion or rumour that arises in relation to this shooting is that the approach of the soldiers resulted in unnecessary deaths.”

Weatherup J analysed both reasons and held that the Coroner was in error in relation to both reasons for excluding the similar fact evidence. He referred the ruling on the evidence of soldier A in connection with the Bradley incident back to the Coroner for reconsideration in the light of the comments that he had made.

### **Legal principles: Evidence as to credibility of a witness**

[96] Some questions in cross examination and some evidence that a party seeks to have admitted which goes to the credibility of the witness can also be similar fact evidence. For instance if a witness has been found to give an untruthful account or accepts that he has given an untruthful account on another occasion that goes to his credibility. However if the other occasion was a similar occasion to the one under primary consideration then the untruthfulness can also be relevant as tending to

establish for instance a cover up of what occurred on that other occasion, or a preparedness to fabricate evidence in relation to that other occasion.

[97] In *O'Brien v Chief Constable of South Wales Police* Lord Phillips of Worth Matravers referred to the decision of Lord Lane CJ in the criminal case of *R v Edwards* [1991] 1 WLR 207 which considered the question of cross examination as to credit and the admission of evidence to contradict answers on cross examination as to credit. Lord Phillips quoted a number of passages including:

"The test is primarily one of relevance, and this is so whether one is considering evidence in chief or questions in cross-examination. To be admissible questions must be relevant to the issue before the court. Issues are of varying degrees of relevance or importance. A distinction has to be drawn between, on the one hand, the issue in the case upon which the jury will be pronouncing their verdict and, on the other hand, collateral issues of which the credibility of the witnesses may be one. Generally speaking, questions may be put to a witness as to any improper conduct of which he may have been guilty, for the purpose of testing his credit."

He also stated that "After citation of a case dealing with cross-examination as to credit Lord Lane CJ continued, at p 215:

"The distinction between the issue in the case and matters collateral to the issue is often difficult to draw, but it is of considerable importance. Where cross-examination is directed at collateral issues such as the credibility of the witness, as a rule the answers of the witness are final and evidence to contradict them will not be permitted: see Lawrence J in *Harris v Tippett* (1811) 2 Camp 637, 638. The rule is necessary to confine the ambit of a trial within proper limits and to prevent the true issue from becoming submerged in a welter of detail."

In paragraph [38] of his judgment Lord Phillips went on to set out exceptions allowing for the admission of evidence as to credit in a criminal trial.

[98] *R v Edwards* was a criminal case. In civil proceedings I consider that the two stages of enquiry that apply to the admission of similar fact evidence also applies to cross examination and the admission of evidence as to credit. The first stage is

whether the question is relevant. The second stage is the control stage where it is a matter of discretion as to whether the questions in cross examination are permitted or the evidence should be admitted to contradict answers of the witness in relation to credit.

**Legal principles: Actual and apparent bias, the common law obligation of procedural fairness and the Article 2 requirement of an impartial investigation.**

[99] The concepts of bias and apparent bias are an aspect of procedural fairness. In considering procedural fairness and therefore any question of bias or apparent bias the court has first to apply the relevant substantive and procedural rules of domestic law. The legal analysis shall not begin and end with the Strasbourg case law, see *Osborn v The Parole Board* [2013] UKSC 61 at paragraphs [54]-[63].

[100] In relation to that aspect of procedural fairness which relates to bias or apparent bias the domestic law is that the verdict of the jury should be set aside if a juror was biased or apparently biased.

[101] The question as to whether the Coroner ought to have discharged a juror on the basis of actual or apparent bias, which is an aspect of procedural fairness, is a matter for this court to determine for itself. The function of this court is not merely to review the reasonableness of the decision-maker's judgment of what fairness requires, see *Osborn v Parole Board* at paragraph 65.

[102] Actual bias was considered in *Davidson v Scottish Ministers* [2004] UKHL 34. In that case Lord Bingham stated that:

“The rule of law requires that judicial tribunals established to resolve issues arising between citizen and citizen, or between the citizen and the state, should be independent and impartial. This means that such tribunals should be in a position to decide such issues on their legal and factual merits as they appear to the tribunal, uninfluenced by any interest, association or pressure extraneous to the case. Thus a judge will be disqualified from hearing a case (whether sitting alone, or as a member of a multiple tribunal) if he or she has a personal interest which is not negligible in the outcome, or is a friend or relation of a party or a witness, or *is disabled by personal experience from bringing an objective judgment to bear on the case in question*. Where a feature of this kind is present, the case is usually categorised as one of actual bias. But the expression is not a happy one, since

"bias" suggests malignity or overt partiality, which is rarely present. What disqualifies the judge is the presence of some factor which could prevent the bringing of an objective judgment to bear, which could distort the judge's judgment." (emphasis added)

Accordingly in order to establish actual bias the applicant has to establish on the balance of probability the presence of some factor which could prevent the bringing of an objective judgment to bear, which could distort the juror's judgment.

[103] The test which I seek to apply in deciding whether the juror ought to have been discharged on the basis of apparent bias is that set out in *Porter v Magill* [2002] 2 AC 357. It is a two stage test; see *Brigid McCaughey's application* [2012] NIQB. The first stage is for the court (that is this court) to ascertain all the circumstances which have a bearing on the suggestion that the juror was biased. It was accepted by the parties and I agree that the circumstances would include matters which occurred both before and after the Coroner made his decision not to discharge the juror. For instance the presence or absence of further incidents involving that juror or any juror would be part of the circumstances. In arriving at a decision as to what circumstances have been established in this court it is appropriate for this court to evaluate the evidence. For instance hearsay evidence from an individual who has been inaccurate in other material aspects may be of less value than the observations of an impartial judicial officer. The next stage is for this court to determine whether the fair-minded and informed observer, having considered those circumstances, would conclude that there was a real possibility that the juror was biased. That test has been considered in a number of authorities such as *R (Condrón) v National Assembly of Wales* [2007] 2 P & CR 4 at paragraphs [38] & [39].

[104] In this jurisdiction the governing principles in relation to apparent bias have been considered by McCloskey J in *R -v- Jones* [2010] NICC 39, *Re Belfast International Airport's Application* [2011] NIQB 34 and *Quinn Finance & others v Lyndhurst Development Trading SA & others* [2013] NICH 13.

[105] Mr Macdonald on behalf of the applicant submitted that directions as to the application of the domestic law test for bias or apparent bias in *Porter v Magill* given the particular circumstances of jury trials in Northern Ireland is to be found in the decision of the Divisional Court in *R v McParland* [2008] NIQB 1 (8/6). That case involved a challenge to the compatibility with Article 6 of the European Convention on Human Rights and Fundamental Freedoms of various jury provisions introduced by the Justice and Security Act (Northern Ireland) 2007. The applicant referred to paragraph [46] of the decision in which the court adverted to a requirement for a trial judge in accordance with his duty to ensure that the trial is conducted in "a fair and even handed way" to an admonition to potential jury members that they should not serve if there is *any possibility* of conflict arising (emphasis added). The applicant

also referred to paragraph [47] in which Kerr LCJ referred to the duty on prosecutors to be:

“astute to detect *any possibility* of a lack of impartiality on the part of a member of the jury panel. If there is *doubt* about the independence or neutrality of any juror, this should be communicated to the defence and steps should be taken (conventionally, one would expect by an agreed exercise of the Crown’s standby power) to *make sure* that such a person does not serve on the jury” (emphasis added).

Accordingly, it is submitted on behalf of the applicant that the application of the test of *Porter v Magill* in Northern Ireland is different in relation to jury trials. The *Porter v Magill* test involves the concept of a real possibility of bias. It was submitted that as applied in Northern Ireland to jury trials and since *McParland* the test would include the concept of “any possibility of conflict arising” or “if there is doubt about the independence or neutrality of any juror.”

[106] It is inherent in the decision in *Porter v Magill* that if the test for apparent bias is not met then the proceedings are procedurally fair. I do not consider that the Divisional Court in *McParland* was considering altering the test for apparent bias or attempting to bring definition to a new test of procedural fairness. Also I do not consider that the Divisional Court was altering the application of the test in *Porter v Magill* in relation to jury trials in Northern Ireland. The point at issue in *McParland* was different. I consider that the test for apparent bias is that set out by the House of Lords in *Porter v Magill*. I will apply that test which complies with the domestic test of procedural fairness and with the Article 2 requirement of an impartial investigation.

[107] The applicants contend that an impartial jury cannot be guaranteed by giving clear directions to the jury as that relies on the self-assessment of potential jurors as to their suitability to act as jurors. In support of this contention the applicant refers to other inquests in which it is suggested that a juror has disregarded the Coroner’s directions (1/41/78-83). However the particular jurors concerned in those other inquests did bring the matters to the attention of the Coroner and were discharged. As Kerr LCJ stated in *McParland* at paragraph [46]:

“Of course, it might be suggested that no instruction to the jury on this theme, however phrased, can guarantee the elimination of every biased juror but this has always been the position. In the United Kingdom we have not adopted the practice of in depth inquiry into the views and attitudes of



potential jurors that has been deemed in other jurisdictions to be an essential concomitant of a fair trial procedure. But it is not suggested that the absence of such inquiry has produced an unfair system of trial. Ultimately, a measure of trust must be reposed in the conscientiousness and sense of civic duty of those who serve on juries in this jurisdiction. Happily, in the vast majority of cases that trust has not been betrayed.”

I would add that factors such as the jury oath, the on-going trial process, the repetition of instructions and admonitions to the jury, all lead to jurors taking their duties extremely seriously and in a most conscientious way. I do not consider that the instances of delay on the part of one or two jurors can undermine the proposition that the combination of safeguards including directions and admonitions to jurors are *ordinarily* effective in securing an impartial tribunal. There is a high degree of confidence in the jury system. It is demonstrably an important part of our constitutional arrangements and overwhelmingly provides effective impartial justice. It is the ideal by which the courts operate, not to be undervalued.

[108] The overwhelming majority of cases mean unfortunately that there is a minority of cases. What is *ordinarily* effective in securing an impartial tribunal has always to be seen in context. In *Sander v The United Kingdom* [2000] ECHR 194 the court considered that, generally speaking, an admonition or direction by a judge, however clear, detailed and forceful, would not change racist views overnight. The Justice and Security (Northern Ireland) Act 2007 was enacted because in the context of certain criminal trials in Northern Ireland there is a real risk that what is ordinarily effective in securing an impartial jury will not be effective. Accordingly that Act allows for non-jury criminal trials in certain cases.

[109] If a real possibility of bias arises prospectively before the inquest commences on behalf of a juror or the jury then it was contended on behalf of the applicant that the Coroner should have made more inquiries of the potential jurors during the process of jury selection. That has not been a feature of our justice system. The list of questions suggested on behalf of the applicant illustrates a number of potential difficulties in the context of this case. It was suggested on behalf of the applicant that all the jurors should be asked as to whether they had ever been a member of any sectarian organisation (including the Loyal Orders). Mr Macdonald in response to a question from the court stated that membership of any lawful political party should not lead to automatic exclusion from the jury. The Loyal Orders are lawful organisations. Some of the lawful political parties in Northern Ireland have emerged from the status as political wings of terrorist organisations.

[110] It was contended on behalf of the applicant that the Coroner should have made more inquiries of Juror J when the issue arose in relation to the apparent bias of that particular juror. In November 2012 Sir John Thomas, President of the Queen's Bench Division published a protocol entitled "Jury Irregularities in the Crown Court" [2013] 1 WLR 486. The protocol distinguishes between irregularities during the course of the trial and irregularities after verdicts have been returned. After verdict a trial judge has no jurisdiction in relation to enquiries about jury irregularities. During the course of the trial a judge may make enquiries as to any irregularities that are drawn to his attention. The protocol states that:-

"7. The trial judge should try to establish the basic facts of what has occurred. This may involve questioning individually the juror(s) involved. Unless there is good reason, ... this should be in open court in the presence of the defendant(s). ... The hearing should be held in court sitting in chambers, not in the judge's room.

8. The judge's inquiries should be directed towards ascertaining whether the juror(s) can remain faithful to their oath or affirmation; the trial judge shall not inquire into the deliberations of the jury. The inquiry should only be to ascertain what has occurred and what steps should be taken next. It may be appropriate for a judge to ask the juror(s) whether they feel able to continue and remain faithful to their oath or affirmation."

The law and practice in relation to investigations during the course of a trial are set out in Blackstone's Criminal Practice 2014 at D13.69. There is scope for enquiries to be made of a particular juror. An example is to be found in *Farhi v France* [2007] ECHR 5562. That case involved an allegation of an unlawful communication during a criminal trial between certain members of the jury and the Advocate General during an adjournment when the judges had withdrawn to deliberate leaving the jury in the courtroom. The Domestic Court did not investigate this allegation. The European Court held that "it was the duty of the Domestic Court to use all the means in its power to dispel any doubts as to the reality and nature of the alleged offence" and that "in particular that only a hearing of the jurors would have been likely to shed any light on the nature of the remarks exchanged and the influence they might have had, if any, on their opinions."

## **Legal Principles: Positive operational duty to protect life under Article 2 and actions in response such as granting anonymity and screening**

[111] The decision of the Court of Appeal *In the Matter of an Application by Officers C, D, H and R* [2012] NICA 47 sets out the circumstances in which prospectively the positive operational duty to protect life under Article 2 arises. If that duty does arise then appropriate steps are required to be taken to safeguard the individual's life and there is an obligation to take preventative operational measures to protect an individual against risks of criminal acts from others. The positive operational duty arises where there is a real and immediate risk to the life of an identified individual or individuals. A real risk is a risk which is neither fanciful nor trivial and which would be present if a particular course of action is or is not taken. An immediate risk is one which is present and continuing. If the positive operational duty arises then that does not necessarily mean that action or any particular action needs to be taken. Rather the nature of the action depends on the nature and degree of the risk and what, in the light of the many relevant considerations, the authorities might reasonably be expected to do to prevent it. The response is to be proportionate taking into account the many relevant considerations. In this case the many relevant considerations include the nature and extent of the risk and the impact of the measures on the fairness of the proceedings at the inquest. The nature and extent of the risk is to be seen in context. The context is that the inquest is addressing a legacy of communal violence unparalleled in any other part of the United Kingdom and police officers have been subjected to threats, targeting and attacks by well organised and resourced terrorist organisations using lethal force for many years.

[112] It is for the Coroner to carry out the balancing exercise and he must evaluate the fairness of the inquest as it proceeds. The Coroner has power, if he concludes that there is such unfairness that he should intervene. This he can do by revoking the anonymity order or stopping the inquest, whichever is the more appropriate step to take in the circumstances.

[113] In relation to those officers who had been refused anonymity the Court of Appeal held that on the evidence the need for operational action and Article 2 was in play and the Coroner in acting as public authority was required to address the issue of what proportionate response was required in the circumstances. The decisions to refuse anonymity and screening were quashed and the matter remitted to the Coroner for reconsideration. The Coroner's decision that the need for operational action under Article 2 was in play in respect of the officers to whom he had granted anonymity and screening is not capable of challenge.

[114] Once the operational duty is engaged and in the context of an inquest there are various actions which the Coroner can take including:

- (a) Granting anonymity to the individual.

- (b) Screening the individual whilst he or she is giving evidence. In this context there can be varying degrees of screening including from the public or from the next of kin.
- (c) Enabling the individual to enter and exit the court building covertly at a particular time and/or in a particular way.
- (d) Arrangements can be made within the court building to separate the individual from the public in a restricted area.
- (e) Arrangements can be made for the witness to enter the courtroom by a door not available to the public immediately before the Coroner sits and before the jury, if there is one, comes into court
- (f) Removing all mobile phones and/or cameras from any person attending the inquest.
- (g) An order might be made permitting the searching of those who come into the courtroom.
- (h) Sketching and note taking is forbidden under the usual rules of court but consideration might be given to making further orders that no one is to reveal, reduce to writing or to reduce on to a screen any kind of description of the witness.
- (i) An order might be made that all electronic devices other than the ones that are required for transcription will be switched off.
- (j) Enabling a device to be used to distort the voice of the witness.

[115] In practice some or all of these actions may be agreed between the parties but there is still an obligation on the Coroner to decide whether they are appropriate see *in Re Guardian News and Media Ltd* [2010] AC 697 at 708 paragraph 2.

[116] Each of these actions is distinct. If anonymity is a proportionate response to the risk then this does not inevitably lead to screening of the individual.

[117] Some of these actions are ordinary and are deployed in other circumstances not involving Article 2.

[118] In carrying out a balance a precautionary approach was adopted by Weir J in his decision dated 29 October 2013 in the inquest into the death of *Roseanne Mallon* (20/5/5). A similar approach was adopted by Deeny J in his judgments dated

17 and 18 September 2012 [2012] NIQB 62 at paragraph [101]. A precautionary approach is not acting without evidence or good reason but rather involves recognition that:

- (a) on one side of the balance the public authority is dealing with the potential for a catastrophic loss of life and/or
- (b) the public authority is having to anticipate prospectively in circumstances where events at the inquest and the consequences as a result may not be predictable from all the subjective perspectives in play including those who would carry out murderous attacks.

### **Legal principles: Jury questions**

[119] In *Jordan v Lord Chancellor and Another* [2007] UKHL 14, Lord Bingham stated that:-

- (a) A jury in Northern Ireland may not return a verdict of unlawful or lawful killing: see Rule 16 of the Coroner's (Practice and Procedure) Rules (Northern Ireland) 1963. This is in contrast to the position in England and Wales where such a verdict is permissible provided no person is named.
- (b) A jury may find facts, either as primary facts or as inferences from primary facts, directly relevant to the cause of death which may point very strongly towards a conclusion that criminal liability exists or does not exist.
- (c) If the central facts are not contentious or if a draft is agreed by the parties there may be advantages to the Coroner giving the jury in draft a detailed factual summary. The advantage may be that the jury's attention will be concentrated on, or questions may be framed as to, the factual issues which they must decide. On the other hand there is a danger, if a Coroner gives the jury in draft a detailed factual summary, that he may appear or be felt to dictate their conclusion.

[120] An illustration of permissible factual findings which point very strongly towards a conclusion that criminal liability did not exist is contained in *Re Bradley and Others Application* [1995] NI 192 see paragraph 39 of *Jordan v Lord Chancellor and Another*. In *Bradley* the jury had found that:-

- (a) Given that the men were dressed in balaclavas, combat jackets and gloves and carrying arms, it would be natural to believe it was a terrorist operation.

- (b) As soldier A approached we believed that one of the deceased made a movement towards his feet and as such the soldier had no alternative but to take the action he did.

Carswell LJ stated at first instance that these were findings of justifiable homicide. In *Jordan* the House of Lords stated that they were facts tending to exonerate the soldiers.

[121] An inquest which does not have the capacity to reach a verdict “leading to a determination of whether the force used ... was or was not justified” would not comply with the requirement of Article 2. Accordingly whilst it is not permissible in Northern Ireland to put to the jury the direct question of lawful or unlawful killing it is a requirement to put all the constituent elements to the jury from which such a conclusion can be drawn. In this case it is a requirement to put the issue of self-defence to the jury and/or to deconstruct all the component parts of the issue of self-defence and to put all those parts as questions to the jury. By that method there is the capacity for verdicts or findings which are capable of leading to a determination of whether the force used was justified. In short it is necessary that the questions are designed to provide the capacity to elicit whether the force used was justified.

#### **Legal principles: The requirement of promptness and reasonable expedition in the investigation/inquest**

[122] An express requirement of promptness in conducting an inquest is to be found in rule 3 of the Coroners (Practice and Procedure) (NI) Rules 1963 which states:

“On being notified of any death the Coroner shall, without delay, make such inquiries and take all such steps as may be required to enable him to decide whether or not an inquest is necessary, and *every inquest shall be held as soon as is practicable after the Coroner has been notified of the death.*” (emphasis added)

[123] A requirement of promptness and reasonable expedition is also implicit in an Article 2 compliant inquest. In *Jordan v United Kingdom* it was stated by the ECHR at paragraph 108 that a prompt response by the authorities in investigating a use of lethal force may generally be regarded as essential in maintaining public confidence in their adherence to the rule of law and in preventing any appearance of collusion in or tolerance of unlawful acts. The court recognized that there can be exceptions

“because it must be accepted that there may be obstacles or difficulties which prevent progress in an investigation in a particular situation.”

In *Hemsworth v UK* (Application 58559/09, Judgment of 16 July 2013) at paragraph 74 the ECHR stated that:

“Whatever the individual responsibility, or lack of responsibility, of those public officials involved in the investigation process, these delays cannot be regarded as compatible with the State’s obligation under Article 2 to ensure the effectiveness of investigations into suspicious deaths, in the sense that the investigative process, however it be organised under national law, must be commenced promptly and carried out with reasonable expedition.”

[124] The requirement of promptness and reasonable expedition was considered in this jurisdiction by Weatherup J in *Julia Mongan’s Application for Judicial Review* [2006] NIQB 82.

[125] I consider that the following legal principles are applicable and the following procedures are appropriate:

- (a) An inquest has to be conducted promptly and with reasonable expedition. This is one aspect of an effective investigation into a death required by Article 2 ECHR.
- (b) The requirement of promptness and reasonable expedition gives rise to a right under Article 2 the breach of which can lead to the grant of relief in the form of a declaration of a violation and/or the award of damages by way of just satisfaction under section 8 of the Human Rights Act 1998.
- (c) There is no standard period within which an inquest should be completed. Each case depends on the character of the investigation required by the circumstances of the case. Accordingly one cannot form a view as to whether there has been delay without some initial regard to the circumstances of the case. The onus is on the applicant at this stage to establish on a *prima facie* basis that there has been delay.
- (d) If it is established on a *prima facie* basis that an inquest has not been conducted either promptly or with reasonable expedition then it is for the State authorities to satisfy the court that there were obstacles or difficulties which prevented progress. So at this stage the onus is on the State authorities to justify the period that has elapsed. At this stage it is not appropriate or necessary for the State authorities to have to justify every detail of an investigation. Rather any significant period of

delay by an investigating agency will require explanation and justification. The circumstances which can justify delay are open ended and specific to the facts of each individual case.

- (e) The aims of fact finding, criminal investigation and prosecution can be carried out and shared between several authorities, as in Northern Ireland. The requirement of promptness and reasonable expedition under Article 2 rests on each of the State authorities that are in fact concerned with a particular death. Accordingly
  - i) each State authority has a duty under Article 2 to assist in the investigation carried out by the Coroner. The only statutory obligation to obtain and to give documents and information is on the PSNI under section 8 of the 1959 Act but other State authorities, if they are concerned with the death, have a similar continuing obligation to obtain and to provide information and documents to the Coroner. That obligation is not dependent on a request or a direction from the Coroner. In practice in order for one State authority to comply with that obligation they may need another State authority, such as the PSNI or the Security Services, to consider the documents, for instance, for the purposes of PII or Article 2 redactions. If that is so, then the other State authority will have its own free standing obligation to consider those documents for that purpose in accordance with the requirement of promptness and reasonable expedition.
  - ii) it is appropriate to attribute specific responsibility for component parts of delay to the various State authorities involved. This was done in *Julia Mongan's Application for Judicial Review*.
- (f) A particular State authority should not itself create obstacles or difficulties to the progress of an investigation. If it does then declaratory relief and/or an award of damages may follow.
- (g) If obstacles or difficulties preventing the progress of an inquest are established by a State authority and if the particular State authority which is a notice party is not responsible for those obstacles or difficulties and has no power to remedy deficiencies, then that particular State authority will not be in breach of the requirement of promptness and reasonable expedition and cannot be held responsible.



- (h) If obstacles or difficulties preventing the progress of an inquest are established by a State authority and these have not been created by that particular authority then that authority will not be responsible unless its response to those difficulties is outside the wide ambit of appropriate responses or it is culpable in the way that it has reacted to the obstacles and difficulties.
  
- (i) The only State authority which has a statutory obligation to provide information to the Coroner is the PSNI by virtue of section 8 of the 1959 Act. Other State authorities have a similar obligation under Article 2 ECHR. In relation to all State authorities the investigator is the Coroner and he has authority to summons witnesses and by that method to obtain information and documents. He can deploy a range of case management techniques to secure those objectives. For instance in advance of a directions hearing he can require the interested parties to meet in order to attempt to agree proposed directions in relation to the future conduct of the inquest and by 12 noon on a specified date prior to the preliminary hearing that one of the interested parties is to send to his office in writing any agreed proposed directions together with any details of any matter in relation to which the parties cannot reach agreement. He can at the preliminary hearing not only direct disclosure of documents by the PSNI or direct disclosure of documents from other state authorities in compliance with their Article 2 obligations, but also he can direct that the documents are to be disclosed by 12 noon on a specified date so that there is no equivocation as to by when disclosure is to occur. He can require the parties to make available to him drafts of letters to be sent to the PSNI or to other State authorities directing disclosure of documents or the provision of information. Standard forms of draft directions can be developed and utilized. Specifying 12 noon on a particular date enables the Coroner and any of the other interested parties to immediately bring the matter back if there is a failure to comply. If there is a failure to comply then the Coroner can summons a witness to attend either to provide an explanation or to produce the documents to the Coroner. The range of case management techniques available means that if any State authority does not comply with any direction from the Coroner for documents or for information then questions may arise as to that State authority's compliance with the requirement of promptness and reasonable expedition. However if the Coroner does not react to the failure to comply then questions may also arise as to whether the Coroner ought to have required, either at all or timeously, the attendance of a witness from that state authority to give an explanation and also ought to have required the witness to provide the documents to the Coroner by the technique of summoning a witness.

In civil litigation a potential consequence of failing to comply with directions is that judgment can be entered against the party in default. Such a sanction is not available to a Coroner. An adjournment of an inquest is not a sanction against the persons in default. There are other techniques that can be utilised.

- (j) A justification that the particular State authorities were acting within national law may still lead to a finding that there has been a breach of Article 2 by the State on the basis that national law was not structurally capable at the relevant time of providing an effective investigation which would commence promptly and be conducted with due expedition, see *Hemsworth*. It was contended on behalf of the applicant that as a result of the decision in *Hemsworth* that a breach of Article 2 can be found *not only* where there are periods of unjustified delay but *also* where the overall delay in holding the inquest is such that it “cannot be regarded as compatible with the State’s obligation under Article 2”. If by that contention it is asserted that justified delay can lead to a finding of a breach of Article 2 then I do not consider that to be the basis of the decision in *Hemsworth*. Rather that justification by a State relying on its own inadequate national laws is not justification within the implicit obligation of promptness and reasonable expedition in Article 2.
- (k) The requirement of promptness and reasonable expedition is breached even if it has not been established that the delay actually impacted on other aspects of the effectiveness of the investigation. Accordingly breach of Article 2 will arise if there has been unjustifiable delay even if it has not been established that the efficacy of the investigation has been impeded by, for instance, failing to obtain evidence until after memories have faded. In this sense the requirement of promptness and reasonable expedition is a free standing right.
- (l) At the level of the ECHR the cases have been against the United Kingdom as the State responsible for all its various State bodies. In this case the notice parties are the Coroner and the PSNI. To obtain relief against either of them the applicant has to establish that either one or other or both of them created obstacles or difficulties or reacted to obstacles or difficulties created by others outside the wide ambit of appropriate responses or is culpable in the way that it has reacted to obstacles or difficulties.
- (m) A finding that there has been a breach of the implicit obligation of promptness and reasonable expedition does not require the court to grant any remedy. Remedies remain discretionary.

- (n) No award of damages may be made against the Coroner see section 9 (3) of the Human Rights Act 1998.
- (o) The following are some of the factors which are relevant to the exercise of discretion as to whether to grant relief in the form of a declaration.
  - i. A declaration may be appropriate if an investigation into a death has not been concluded or a supposedly concluded investigation is liable to be re-opened, as such a declaration may impact on the further investigation.
  - ii. A declaration may also be appropriate where it may impact on investigations into other deaths.
  - iii. The fact that there have been findings in the ECHR and in the domestic courts, of delay or unjustified delay in other cases and also findings of deficiencies in domestic coronial law are factors to be taken into account in the exercise of discretion as to what, if any, relief to grant. In some circumstances it may be that the grant of a declaration is unnecessary given the previous findings. However previous findings on their own cannot be determinative because the relief has to accommodate the individual facts of each case and the individual legitimate rights of the particular applicant.
  - iv. The fact that structural deficiencies identified by the ECHR in *McCaughey* and *Hemsworth* will be subject to the determination of the Committee of Ministers as to what is required of the United Kingdom government in order to address the issues identified by the Court is also a factor to be taken into account in the exercise of discretion as to what, if any relief to grant (see paragraph 145 of *McCaughey*). The strength of that factor will depend on the quality of the evidence as to the steps that have subsequently been taken. So for instance if major reform of coronial law and practice is well underway or shortly to be implemented then declaratory relief may be unnecessary.
  - v. The fact that further litigation seeking to establish delay and the pursuit of individual awards of damages and costs may divert resources and limited personnel and expertise to handling public law challenges rather than organizing inquests is another factor that may be taken into account in the exercise of discretion. In order for this factor to carry significant weight it

would have to be clearly established that the problem is going to be exacerbated rather than resolved by litigation. The strength of this factor might be influenced by whether the State authorities have established that resources applied at an earlier stage will not conserve resources overall and in the long term. A countervailing factor is that individuals who have legitimate grounds of complaint together with an entitlement to damages and costs cannot be deprived of a remedy to which they are entitled.

- (p) If it is found that a particular State authority, which is a notice party, has not complied with any aspect of the requirement of promptness and reasonable expedition, but there is another State authority or other State authorities who have also not complied who are not notice parties, then the particular State authority who is a notice party, may have orders made against it involving a declaration and/or all of the damages. The court will not seek to reduce the award to the applicant on the basis that only a proportion is attributable to the State authority which is a notice party. It is for that State authority, if it so wishes, to seek a contribution from the other State authority.

### **Legal principles: jury verdicts**

[126] In an Article 2 compliant inquest that part of the jury's verdict which relates to "how" the deceased came to his death must also encompass in what broad circumstances he came to his death. Where all members of the jury at an inquest fail to agree upon such a verdict then the Coroner has discretion to discharge the jury. On the facts of this case the jury did not reach a unanimous verdict as to "how" the deceased came to his death. The question in relation to planning and control was withdrawn from the jury as they could not agree. The jury was unable to agree any fact in relation to whether the force used was or was not justified. Accordingly the Coroner had discretion under Section 31(2) of the Coroners Act (Northern Ireland) 1959 as to whether to accept the jury verdict. The factors to be taken into account in the exercise of discretion would include matters such as whether the verdict had addressed the central issues and whether a further inquest, either with or without a jury, could arrive at a conclusion in relation to those issues.

## **Part Four: Stalker/Sampson**

### **Non-disclosure of the Stalker/Sampson Reports and an inability to use the contents of the reports in cross-examination of Officers M and V at the inquest.**

[127] The applicant contends that:

- (a) The Stalker/Sampson reports ought to have to been disclosed in this inquest (subject to any PII claim).
- (b) The Coroner ought to have permitted the use of part of those reports during the course of the inquest in relation to issues of credibility and also as similar fact evidence.

[128] A distinction was drawn during the course of the inquest between on the one hand the statements made by M and V to the CID in relation to the investigations into the deaths that were subsequently investigated by Stalker/Sampson (“the 1982 deaths”) together with those officers’ statements to the Stalker/Sampson inquiry team (“the statements of M and V”) and on the other hand the Stalker/Sampson reports. The position in relation to the statements of M and V is that they were disclosed in redacted form by the police to the Coroner and by the Coroner to the applicant, (2/150-2/294). The police contended that the Stalker/Sampson reports were not relevant. Whilst maintaining that contention they made them available to the Coroner, in un-redacted form, so that he could form his own view as to relevance. The applicant contended that the reports were relevant and ought to be disclosed. It is apparent that there is a considerable volume of material underlying the reports such as all the statements made and all the evidence gathered by the Stalker/Sampson team and all the statements recorded by that team. As a pragmatic step the applicant did not seek disclosure of any of the materials underlying the reports except the statements of M and V. The applicant also contended that he should be permitted to deploy parts of the reports in cross examination of witnesses at the inquest. The Coroner considered the reports and decided that they were not relevant.

[129] Ms Quinlivan, one of the counsel who appears on behalf of the applicant, was also instructed on behalf of the next of kin in relation to the outstanding inquests into the 1982 deaths. The Coroner in those inquests had ordered the disclosure of a redacted version of the Stalker/Sampson reports to the legal representatives of the next of kin on their undertakings to keep the documentation safe and confidential and only to use it for the purposes of the Stalker/Sampson inquests. The legal representatives in those inquests could disclose the documentation to and discuss it with the members of the families of the deceased in those inquests provided that prior to discussing or disclosing such a document that person had also given an

undertaking, (2/94). As a pragmatic response to the fact that Ms Quinlivan had access to those documents in the Stalker/Sampson inquests and was also instructed in this inquest, the PSNI agreed to the disclosure to her of the redacted Stalker/Sampson reports and to the other legal representatives of the next of kin in this inquest whilst maintaining that the reports were not relevant to any of the issues in this inquest. The deceased's next of kin were not permitted to have access to that material and were required to leave court on every occasion that reference was made to those documents. The legal status of the documents remained that they had not been disclosed in this inquest but rather that this was a pragmatic response to the circumstance that the same counsel was instructed in this inquest and in the Stalker/Sampson inquests.

[130] Prior to the hearing of the inquest commencing and by letter dated 17 August 2012 the Coroner ruled that the contents of the Stalker/Sampson reports were not relevant "to the determination of the issues in the Jordan inquest" (2/300). Accordingly, he stated that:

"It would not therefore be appropriate to order that those reports be disclosed to interested parties for the purpose of the Jordan inquest."

In the same letter the Coroner gave his decision in relation to the statements of M and V. The letter stated that:

"The Coroner is satisfied that that material is relevant to the credibility of those officers and that it can be deployed by counsel in examining the witnesses in question in the course of the Jordan inquest."

Accordingly, the Coroner drew a distinction between the Stalker/Sampson reports which he held were not relevant to the determination of the issues in the Jordan inquest and the statements of M and V which he held were relevant to the credibility of those officers.

[131] In relation to the decision dated 17 August 2012 the applicant sought leave to apply for judicial review which was refused by Deeny J on 26 September 2012, see *Jordan's (Hugh) Application (Disclosure of Stalker/Sampson Report)* [2012] NIQB 64. The applicants have appealed that decision to the Court of Appeal and a hearing of that appeal is awaited. This judicial review application does not seek to impugn the decision dated 17 August 2012 which was the subject of the judgment of Deeny J but rather seeks to impugn the subsequent decision of the Coroner taken during the course of the hearing not to order disclosure of the Stalker/Sampson report and not to permit the deployment of material contained in the Stalker/Sampson report. The applicant contends that as the evidence developed parts of the Stalker/Sampson

report were relevant and accordingly the reports ought to have been disclosed and in the exercise of discretion the Coroner ought to have permitted the use of those parts of the reports in cross-examination.

[132] Written submissions were made to the Coroner on behalf of the applicant on 8 October 2012 (2/307). The Coroner held an oral hearing in camera on 11 October 2012 at which reference was made to the material in files 4 and 5. The next of kin were excluded from that hearing (1/6/55/128). The Coroner refused disclosure in an oral ruling given on 19 October 2012. The inquest concluded on 26 October 2012. The Coroner subsequently gave his written reasons on 7 November 2012 (2/311).

[133] In his written reasons and in relation to the statements of M and V the Coroner stated that he “regarded that material as relevant to the credibility of those officers”. In relation to the reports the Coroner referred to the extent of the material previously disclosed and to the terms of the ruling of Deeny J [2012] NIQB 64. The Coroner then stated he was not persuaded to depart from his “original decision that the reports were *not relevant (or potentially relevant)* to the issues to be determined in Jordan” (emphasis added). He also said:

“The submissions on behalf of the next of kin also directed me to specific passages within the reports on the basis that the evidence given by M and V at the inquest had clearly demonstrated the relevance of those passages. I reviewed those passages with particular care in the light of the evidence given by the officers, but I was not persuaded on that basis to depart from *my decision on relevance*. Nor was I persuaded that there was anything in those passages that might justify the recall of Officers M and V for further questioning in relation to the Stalker/Sampson episodes. I remained of the view that the underlying material provided to the next of kin and deployed by counsel for the next of kin represented the totality of Stalker/Sampson material that was properly subject to a duty of disclosure in the context of Jordon” (emphasis added)

[134] The reference by the Coroner to the extent of the material previously disclosed and to the judgment of Deeny J could be seen as a reference to the control stage which would have involved individual consideration of a number of factors in relation to deployment of each of the parts of the reports that were relevant. Those factors would have included whether the particular matter contained in the reports could also be taken from the statements of M and V and as to whether the reports did not add anything of probative value to the particular matter. I consider however

that the decision of the Coroner was based entirely on relevance rather than a conflation of the concepts of relevance and the control stage. His original decision dated 17 August 2012 was that the reports “are not relevant” (2/300). His further decision dated 19 October 2012 for the reasons given on 7 November 2012 was not to depart from his “original decision” namely “that the reports were not relevant (or potentially relevant) to the issues to be determined in Jordan” (2/31/12).

**The parts of the Stalker/Sampson reports which the applicant contends were relevant**

[135] It was not contended that any part of the Stalker/Sampson Report was relevant to the evidence of Officer A.

[136] The applicant contends that parts of the Stalker/Sampson Report were relevant to the evidence of Officers M and V. Those contentions were addressed by all counsel under a number of distinct headings which I will adopt and follow in this judgment. Mr Macdonald on behalf of the applicant stated that he was not contending that any expression of opinion in the Stalker/Sampson Report was admissible though he contended that expressions of opinion in the reports were not a bar to the disclosure of the reports, see *Chief Constable PSNI's application* [2008] NIQB 100.

**(a) An understanding of the investigations conducted by the Stalker/Sampson team in relation to the matters contained in the statements of M and V**

[137] The applicant contended that the reports were relevant allowing an understanding of the investigations conducted by the Stalker/Sampson team in relation to the matters contained in the statements of M and V. For instance the statements of M and V which were disclosed referred to senior officers. The reports identified those officers. A worked example is that M in relation to the Ballynerry Road North incident in which Michael Tighe died, asserted in his original statement after caution dated 25 November 1982 that on 24 November 1982 he was on a routine patrol and that:

“he looked to his left across a field and ... saw what he took to be a man armed with a rifle and walking towards the outbuilding.” (2/152)

On 15 August 1983 M made a further statement stating that the reference to seeing a gunman moving towards the outbuilding was “not the case” and that he had been directed to the outbuilding on Special Branch information that there were gunmen there. That after the incident:



“It was stressed most strongly to me by senior police officers that it was imperative that no mention of Special Branch information should be used in my statement.” (2/156)

[138] The applicant contends that in order to identify the senior officers either by name or by cypher reference has to be made to the Stalker/Sampson Reports. Also that reference has to be made to those reports to determine whether the senior officers accept that they did or did not give any such instruction to Officer M. Accordingly, that the reports are relevant.

[139] There was no response by the respondent or by the PSNI to that contention.

[140] In relation to this heading I consider that the reports were both potentially relevant and relevant.

**(b) To protect the life of a source, whether senior officers denied the instructions to fabricate and whether a correct account was initially given**

[141] At the inquest the explanation proffered by Officer M for giving false information in his statement under caution dated 25 November 1982 as to seeing an armed gunman was that he lied on the instruction of senior officers and “to protect the life of the person who had given the information and solely to protect the life of that person” (6/4/56/23). He also asserted that he had given a truthful account to senior police officers immediately after the incident on his return to Gough Barracks, (6/4/60/30 et seq). The explanation for lying in his statement and his assertion that he had told senior officers the truth remained unchallenged and was repeated by the Coroner in his charge to the jury. The applicant contends that the jury were left with evidence from which they could conclude that the immediate and only reason for Officer M being at Ballynerry Road North was information received from an individual whose life would have been at almost certain risk if Officer M had not been prepared to follow instructions and give false information in his statement.

[142] The applicant contended to the Coroner that material in the Stalker/Sampson’s reports indicated that the reason or the immediate reason why Officer M was deployed to Ballynerry Road North was what was heard on a covert listening device in the hayshed rather than information received from an individual whose life might be at risk (4/803/13.26-4/807/13.53). Metallic sounds had been heard over the listening device from which it was concluded that two men were in the barn cocking and possibly cleaning rifles and this led to the deployment of Officer M and his fellow officers to the hayshed. The applicants’ legal representatives wished to cross-examine Officer M as to the credibility of his assertion that he gave false information to protect the life of a source. That application was refused by the Coroner.

[143] The applicant recognises that because the immediate reason was what was heard over the listening device does not rule out the potential for the listening device having been placed on the basis of information provided by the source whose life had to be protected. They also accept that even if the only reason why Officer M was deployed was what was heard over the listening device this does not mean that he was not told by senior officers that the reason was to protect the life of a source.

[144] The Stalker/Sampson team investigated the suggestion that Officer M had:

- (i) told senior police Officers the truth on his return to Gough Barracks; and
- (ii) that he had been instructed by D/Superintendent Anderson, now deceased, and P2 to give the account referring to the gunman in the field.

The report indicates that Anderson denied that allegation saying that he could not remember having that conversation with Officer M. He also denied that Officer M had told him that he had not seen anyone with a rifle; "nobody said that to me" (4/836/13.182 see also 4/840/13.198)

[145] In relation to this heading I consider that the reports were both potentially relevant and relevant.

**(c) Information provided by Constable Brannigan to Officer M as to the events at Tullygally Road East on 11 November 1982.**

[146] Arising out of the incident which occurred on 11 November 1982 Constable Brannigan was prosecuted for and acquitted of the offence of the murder of Mr Toman. The prosecution case was that after the car driven by Mr Toman had come to a halt Constable Brannigan fired fatally wounding the driver. It was part of Constable Brannigan's defence in the criminal trial that he had not or that there was no evidence that he had fired after the car had come to a halt.

[147] At the inquest Officer M stated that he was not aware of the exact case against Constable Brannigan (6/5/39) and that he did not know exactly what was going on in the trial (6/5/40).

[148] Mr Macdonald wished to put to Officer M part of the Stalker/Sampson Reports which dealt with a meeting which had occurred at Gough Barracks attended by, amongst others, Officer M and Constable Brannigan. The meeting was upon the return of those involved in the shooting to Gough Barracks on the day of the incident. The report records that at that meeting Constable Brannigan stated that after the suspect car had crashed that he heard sounds emitted from the vehicle

which resembled the cocking of a weapon and that he had fired at the vehicle (4/954/14.121-14.123 and 4/983/15.7). Mr Macdonald submits that the report is potentially relevant and ought to have been disclosed and that the disclosed statements of Officer M were insufficient to allow him to effectively cross-examine Officer M on this issue as to credibility. Furthermore, that the issue also relates to Officer M's willingness to stand by irrespective of the truth of what had occurred. That he wished to put to Officer M that he had been told by Constable Brannigan that he had fired after the car came to a halt and that despite knowing that is what he had been told, Officer M had not alerted the investigating police officers or the prosecuting authorities to vital evidence that Constable Brannigan had fired at Toman after the car had come to a halt.

[149] The trial of Constable Brannigan had opened on 29 May 1984. On 5 June 1984 Lord Justice Gibson delivered his reasons for acquitting Constable Brannigan. On 20 September 1984 Officer M made a statement to the Stalker/Sampson Team. That statement is one of the disclosed statements. It records that on the day of the incident Officer M had been told by Constable Brannigan that Constable Brannigan had fired at the vehicle after it had crashed in response to a sound which resembled the cocking of a weapon. At the end of that interview Officer M states that:

"I have never been seen by any investigating officer about this incident or asked to make a statement until now."

[150] The respondent and notice party contend that the disclosed statement could have been used in cross-examining Officer M in relation to this point. It clearly establishes that he was told by Constable Brannigan that he had fired at the car after it had crashed. Accordingly they contend that there was no need for the Stalker/Sampson Report to be deployed in cross-examination as opposed to the statement which had been disclosed and could have been taken into account by the Coroner at the control stage.

[151] In relation to this heading I consider that the reports were both potentially relevant and relevant and that the issue raised in the previous paragraph is appropriate to be considered at the control stage.

**(d) Stalker/Sampson recommendations in relation to debriefs prior to CID investigations**

[152] After the death of the deceased, Officers M and V participated in a debrief prior to the CID investigation. Debriefs prior to a CID investigation had been a feature of the 1982 incidents. Those earlier debriefs had been participated in by Officers M and V. It was acknowledged that in 1982 uniformly false accounts had then been given to CID Officers following those debriefs. In relation to the debrief

following the death of the deceased Officer V had been off duty and had come in specifically to carry out that debrief. He asserted during the inquest that having learnt from his experience in 1982 that the reason for coming in to conduct a debrief was to ensure that his men were not persuaded to put forward a false account (6/6/73). At the inquest Mr Macdonald asked Officers M and V whether this practice of conducting HMSU debriefs prior to CID interviews had ever been criticised to their knowledge. They replied that to their knowledge it had never been reviewed or commented on (6/5/51/21-22 and 6/6/83/3).

[153] Mr Macdonald wished to have an order disclosing the Stalker/Sampson Reports and to put to Officers M and V those parts of the report which recommended that those debriefs should not occur. For instance in the report dated 10 April 1987 under the heading "Dubious Procedures of Investigations" it was stated:

"When such shooting incidents occur, there should be no debriefings of Officers before interviews with the CID unless on the explicit instruction of a Chief Officer who will later accept responsibility."  
(5/1/1352 see also 5/1361/19 and 5/1343-1344).

[154] In relation to this heading I consider that the reports were both potentially relevant and relevant.

**(e) Officer P42**

[155] In Officer V's written statement after caution dated 23 February 1983 in relation to the death of Seamus Grew and Roddy Carroll he stated that he had travelled to Gough Barracks where he debriefed all of the patrols who had been operating in the area. That he learned later that the deceased were Seamus Grew and Roddy Carroll. He also learned that one of his men had been injured at the vehicle checkpoint on Keady Road which Grew's car had earlier breached (2/233).

[156] At the inquest Officer V accepted that there was no checkpoint and no officer had been knocked down (6/6/29). That he had been instructed by senior Officers that he could not disclose a very sensitive source of intelligence (6/6/30). That accordingly a story had been made up about a checkpoint and an officer being hurt at the checkpoint. In fact the Officer, P42, had been injured when a collision had occurred between an HMSU vehicle and an army surveillance vehicle (6/6/31). Officer V stated that his only involvement was to instruct that P42 should be taken to hospital and that is as much as he knows about it. That he did not instruct P42 to go to scene where it was suggested that a checkpoint had been set up and to roll around in the dirt (6/6/31). "That certainly did not happen on my instructions because it is too ludicrous." (6/6/32/10)

[157] Mr Macdonald contended that the Stalker/Sampson Report was relevant to the credibility of this assertion and ought to have been disclosed and that the applicant ought to have been permitted to deploy the Stalker/Sampson Report in cross-examination of Officer V. The Stalker/Sampson Report records the account of P42. It states:

“P42 asserts that he had little involvement with the subsequent debrief but was approached by Inspector V later that night and told that ‘in order to toe the party line it would be necessary to change the circumstances’. To give credence to the cover story P42 was told by Inspector V to go to Papermill Bridge and to impregnate his clothing with dirt from that area before that clothing was sent for forensic examination. This he did prior to attending Craigavon Area hospital which was, according to him, about 2 am on the Monday morning.

...

On the 17<sup>th</sup> of December (P42) was told to return to work for the purposes of being interviewed by the investigating officers. Immediately prior to that interview he was seen by Inspector V who told him what he was to say during the course of that interview. He made a statement which accords with the instructions given to him by his Inspector. P42 was throughout assured that there was no likelihood that anybody would have to attend court other than the Coroner’s court.” (4/1120-1121).

[158] Mr Macdonald also contended that the accounts of P41 and P11 to the Stalker/Sampson team were relevant or potentially relevant. P41 had stated to the Stalker/Sampson Team that he had accompanied P42 to the Papermill Bridge whilst that officer contaminated his clothing with debris from the scene (4/1122). P11 stated that he had taken P42 to hospital and was aware of what he had told the doctor who treated him (4/1122).

[159] In relation to this heading I consider that the reports were both potentially relevant and relevant.

(f) **Officer V - Correction of his statements**

[160] Officer V gave an account at the inquest as to how he came to correct his statements. He accepted that he had made statements to the CID which he knew were inaccurate and that he was aware that those statements were to go to the DPP for a decision (6/6/43). He stated:

“At the same time I made a further statement to the DPP under secret cover ... for the DPP’s eyes only, outlining everything that had taken place in these instances so that the DPP knew exactly what was happening.”

[161] His evidence was to the effect that the reason he gave the true account was misgivings that he and his other officers had about the false statements. He was asked whether the true statements were made at the same time as the false statements and he said that they were not (6/6/44). He could not remember what the timescale was between the false statements and the statements in which the entire truth had been disclosed to the DPP (6/6/46). He was asked whether it was hours, days, months or weeks and he replied:

“It could have been days, but yes days probably, I don’t know.”

[162] Mr Macdonald contends that the Stalker/Sampson reports were relevant to the timescale between the false statements and true statements and also relevant to the issue as to why Officer V came to make the true statements. Mr Macdonald contends that the real reason was that the DPP was not satisfied and required further statements.

[163] The dates of Officer V’s initial statements were as follows:

- (a) 13 January 1983 in relation to Tullgally Road East (2/221)
- (b) 17 January 1983 in relation to Ballynerry Road North (2/229).
- (c) 23 February 1983 in relation to Mullacreevie Park (2/232).

There is then a statement dated 20 May 1983 in relation to Mullacreevie Park (2/239) but it does not say, for instance, that the deceased had not driven through a checkpoint injuring P42. It could not be described as a statement outlining everything that had taken place. There is then a statement of 20 July 1983 in relation to Tullygally Road East and that statement refers to a secret file (2/241) and an

earlier statement. The existence of an earlier statement in relation to Tullygally Road East can also be discerned from what Officer V said at interview on 1 October 1984 in which he refers to a statement of 20 May 1982 (*sic*) in relation to Tullgally Road (2/249). The statements of Officer V disclose the existence of another statement of V which when combined with his evidence was a statement to the DPP. That statement has not been disclosed. That analysis does not rely on the Stalker/Sampson reports but that does not make the reports irrelevant or potentially irrelevant in relation to this issue.

[164] Mr Macdonald contends that those parts of the Stalker/Sampson Report which record the serious concerns of the DPP expressed in his letter of 22 June 1983 (4/1057/10.27) and the direction given on 8 July 1983 that each officer be individually given the opportunity to alter or add to his previous statements (4/1058/11.2) was relevant to the issue as to whether any corrections came about at the instigation of Officer V and misgivings on his part or at the instigation of the concerns expressed by the DPP.

[165] In relation to this heading I consider that the reports were both potentially relevant and relevant to the number of statements made by Officer V, the dates of those statements and the circumstances in which the statements came to be made.

**(g) Ballynerry Road North and Officer V**

[166] At the inquest Officer V was asked as to whether he played a passive or active role in developing and promoting the false account in relation to Ballynerry Road North (6/6/71). That false account was that Officer M had seen a gunman going to the hayshed. Officer V prefaced his reply by stating that he could hardly remember and the reply itself was not entirely clear. He said:

“I have no doubt that I had been involved in not formulating the story, but certainly if the story was going to be put to the men, I would have been there.”  
(6/6/71)

The construction placed upon that by the applicant is that Officer V asserts that he was not involved in formulating a story but that he was there.

[167] Mr Macdonald contends that the Stalker/Sampson Report is relevant to how the false account came to be fabricated. P33 gave his account to the Stalker/Sampson Team and a summary of that account is contained in the Report. It is stated that P33 remembered being gathered together with the three crews involved and given the cover story by Officer V (4/819/13.102).

[168] In relation to this heading I consider that the reports were both potentially relevant and relevant to the question as to when, by whom and in what circumstances the false account was fabricated.

**(h) False statements to the Coroner's Court**

[169] In his evidence at the inquest Officer V stated that he would not make a false statement in any court. That he saw no distinction whatsoever between the Coroner's Court and any other court (6/6/41).

[170] Mr Macdonald wished to put to Officer V the summary of the account given by P42 to the Stalker/Sampson Team. The Report records that immediately prior to P42 being interviewed by the investigating officers he was seen by Officer V who told him what he was to say during the course of that interview. That he made a statement which accords with the instructions given to him by his Inspector (ie Officer V) and that:

“P42 was throughout assured that there was no likelihood that anybody would have to attend court other than the Coroner's Court.” (4/1121/13.141).

[171] The juxtaposition of that assertion with the instructions given by Officer V gives rise to the inference that Officer V had envisaged that there would be an inquest and was countenancing that the false account would be given in the Coroner's Court by P42.

[172] In relation to this heading I consider that the reports were both potentially relevant and relevant to the credibility of Officer V.

**(i) Officer V and manipulation of other officers**

[173] At the inquest Officer V asserted that he did not have a history of getting other officers to lie (6/6/75/21-22).

[174] Mr Macdonald asserts that the Stalker/Sampson Reports were relevant to the issue as to whether Officer V got other officers to lie. In the Report there is for instance a description of a debrief at which Officer V at the instigation of Superintendent Anderson asked Constable Brannigan to assume the role of the driver of the additional police vehicle. Officer V is recorded as denying playing any active part in formulating the cover story, that was the responsibility of senior officers. His function was to ensure that all the accounts were tailored to substantiate the fabricated story. The Report then goes on to say:



“(Officer V) accepts fully the responsibility of manipulating his officers and providing false accounts of their roles but says that it was undertaken at the behest of 3 principles, Anderson, P2 and P13.” (4/1115/13.124).

[175] It is not clear whether this was an opinion arrived at by the Stalker/Sampson team or whether there was an express written or oral acceptance in these terms by Officer V. The statements of Officer V, which have been disclosed, do not contain such an acceptance and on that basis I am of the view that this was an opinion arrived at by the Stalker/Sampson Team. Indeed, while Officer V did deny on one occasion at the inquest having a history of getting other officers to lie that was entirely inconsistent with his earlier repeated admissions of doing exactly that.

[176] The other parts of the Stalker/Sampson Report to which I was referred in relation to the suggestion of manipulation of other officers by Officer V are to be found at 4/1095/13.64, 4/1150/14.13, 4/1151/14.15-14.16.

[177] In relation to this heading I consider that the reports were both potentially relevant and relevant to the issue as to the role played by Officer V in the fabrication of false accounts.

**(j) Overtime claim by Constable Brannigan**

[178] The false account that was given in relation to the deaths of Seamus Grew and Roddy Carroll involved switching officers so that one particular Officer, Constable Brannigan, would say that he was driving a particular motor vehicle when he had not been and when he had in fact been off duty. This in turn required Constable Brannigan to make a false claim for overtime. At the inquest Officer V accepted that he had asked Constable Brannigan to do that on direction of senior officers (6/6/33). He then asserted that:

“I made it very clear to Constable Brannigan and he readily accepted it, that there would be no personal gain in it for him and indeed monies that he had earned through overtime or whatever it may be, was subsequently either returned to the Police Authority or given to a charity. I am not one hundred per cent sure which but I know that it was made clear that he could not benefit from it.”

[179] The applicant contends that the Stalker/Sampson Report was relevant to the credibility of that assertion. That report contains a summary of the account of Constable Brannigan to the Stalker/Sampson Team in relation to the Constable’s

false account that he was the driver of a vehicle and his false claim for overtime. Constable Brannigan states that he was instructed to do this by Officer V. That was accepted by Officer V at the inquest. The summary of what Constable Brannigan stated makes no mention of it being made very clear to him by Officer V and he accepting that the overtime money should either be returned to the Police Authority or given to a charity. (4/1124/13.152)

[180] Mr Macdonald wished to put that summary of a hearsay account of Constable Brannigan to Officer V in cross-examination to test the credibility of Constable V's assertion that he had instructed Constable Brannigan and the Constable had agreed to and did in fact divest himself of, any personal gain.

[181] It is important not to conflate relevance with the control stage. It may be that in relation to the control stage a number of factors will be relevant. The extract from the Stalker/Sampson Report is a summary. It is hearsay. Constable Brannigan is dead. In fact Officer V in his own statements to the Stalker/Sampson Team made reference to the claim for overtime not being for any gain. Officer V was interviewed on 2 October 1984 by the Stalker/Sampson Team. He described the switching of the officers and the vehicles and the reason for this (4/266). He stated that he was told to ask Constable Brannigan to be the driver of the Cortina and he said:

“Brannigan agreed to do this, not for any gain, ...  
(there is then a redaction) and the operation and he  
was of the opinion it was merely a paper exercise.”

Officer V returned to the lack of personal gain in his latest statement to the Stalker/Sampson Team see 4/270.

[182] In relation to this heading I consider that the reports were both potentially relevant and relevant to the credibility of the assertion made by Officer V.

### **Submissions on behalf of the Coroner and the PSNI**

[183] Mr Simpson on behalf of the Coroner accepted the relevance of each of those parts of the reports. He submitted that it was perfectly appropriate for the Coroner to limit the extent of cross-examination in relation to questions of credibility and similar fact evidence. He demonstrated the considerable time that had been taken during cross-examination dealing with issues other than the specific incident leading to the death of the deceased. He submitted that the question as to whether further evidence in relation to the credibility of M and V should be permitted had to be seen in the context of the admissions during the inquest that both of them made that they had lied, see (6/4/56/19, 6/4/56/19, 6/4/58/23, 6/4/60/22, 6/4/69/12, 6/4/70/23, 6/6/56, 6/6/71 and 6/6/77). For instance Officer V admitted a web of

deceit, that it could be interpreted as a conspiracy to pervert the course of justice and dishonesty on a spectacular scale.

[184] Dr McGleenan, on behalf of the PSNI, accepted that the reports were relevant or potentially relevant but contended that “certain” of the points to be taken out of the reports could be addressed by use of the statements of M and V. He contended that the Coroner was correct not to disclose the reports not because they were not relevant or potentially relevant but because of the fact that –

- (a) M and V’s statements had been disclosed.
- (b) The Stalker report was only an interim report.
- (c) The reports contained opinion and conjecture.
- (d) There was confusion in the reports as to the attribution of statements.
- (e) The reports were of no assistance in any event.

#### **Conclusion in relation to this part of the judgment**

[185] Mr Simpson on behalf of the Coroner accepted that all the extracts from the Stalker/Sampson reports referred to by Mr Macdonald are relevant to the issue of credibility of M and V. Dr McGleenan made a similar concession stating that all the extracts were potentially relevant but contended that it was correct not to disclose the reports given that the underlying statements of M and V have been disclosed.

[186] The test for disclosure is potential relevance. I consider that the concessions now made by Mr Simpson and Dr McGleenan that parts of the report were relevant or potentially relevant to the issue of credibility were correctly made. Furthermore if the statements of M and V which were part of the material underlying the reports were relevant to credibility then it is hard to understand why the reports which referred to and analysed that material should not also be relevant. I have analysed each of the categories of documents identified and I consider that they are all relevant or potentially relevant. I also consider that the reports were relevant in order to put the statements of M and V in context. For instance absent the reports there would be un-contradicted assertions in the statements of M and V that they were acting on the instructions of senior officers in putting fictitious material into their original police statements. In fact there was a dispute that they were acting on the instructions of senior police officers. I also consider that the reports were relevant so as to enable the applicants to make submissions to the Coroner as to the scope of the inquest and the extent to which similar fact evidence should or ought to be permitted. The Coroner did not rule that the reports were relevant but in the exercise of his discretion they ought not to be disclosed. Rather the Coroner ruled

that the reports were not relevant. I consider that that decision was Wednesbury irrational and should be quashed.

[187] The applicant contends that the inquest findings should also be quashed on the basis that the reports were not disclosed. The respondents contend that whatever the strict legal position was in fact the applicants' legal representatives had access to the reports. The legal representatives could make and did make submissions in relation to them to the Coroner. The legal representatives were able to use the reports to place the statements of M and V in context. That in fact the only person who did not have access to the reports was the applicant and that he would be entirely dependent on his legal advisors to analyse and deploy the reports. I asked Dr McGleenan on a number of occasions during the hearing of the judicial review applications why it was that the applicant could not have access to the reports whilst the next of kin in the Stalker/Sampson inquest could. Initially I was informed that the disclosure of the Stalker/Sampson reports to the legal advisors of the next of kin was purely a pragmatic response to the fact that the same counsel had been instructed but that the reports were not relevant to the Jordan inquest. That there was no pragmatic problem to be resolved in relation to the applicant. He unlike counsel, had not seen the reports and because the reports were not relevant there was no need for a pragmatic solution in relation to him. Later when it became apparent that the contents of the reports were relevant it was suggested by Dr McGleenan that all that needed to have happened during the inquest was for the applicant to have applied to the Coroner and the reports would have been disclosed to him on the same terms as they had been disclosed to the next of kin in Stalker/Sampson inquests. Finally that was corrected on the basis that Dr McGleenan had no authority to disclose the reports to the applicant. The position was and remains that the reports could not be disclosed to the applicant. I consider that no reason has been advanced to me as to why the distinction continues to be made between the applicant and the next of kin in the Stalker/Sampson inquest.

[188] The applicant contends that it is a requirement of Article 2 that the next of kin have access to all the material so that they can be fully informed. That the appropriate remedy is to quash the verdict unless the material is peripheral and/or of marginal significance.

[189] The next of kin must be involved in the coronial procedure to the extent necessary to protect his legitimate interest. This involves the next of kin participating in an informed open and transparent fashion. The purpose of the coronial investigation includes confirming or allaying public suspicion and that includes suspicion on the part of the next of kin. I am prepared to accept, without deciding, that non-disclosure did not affect how the case was presented by the legal representatives. However that leaves out of the equation the other effects. For instance as a consequence the applicant was informed that there was confidential material that he could not see. That he was not allowed access to the Coroner's

Court or to this court when the material was being discussed. That he could not follow the arguments as to why lines of cross-examination were not being permitted or indeed what were the lines of cross-examination. Those effects are also to be seen in the context that no reason is now being advanced as to why the applicant could not participate in the same way as the next of kin in the Stalker/Sampson inquest. I consider that given the absence of any reason for the distinction between the applicant and the Stalker/Sampson next of kin these effects are inconsistent with a requirement to hold an Article 2 compliant inquest. Accordingly on that ground I quash the verdict.

[190] The next issue relates to the deployment of those parts of the Stalker/Sampson reports at the inquest. For material to be admitted there is a two stage inquiry. The first stage is relevance and the second stage is the control stage. The Coroner never ruled on the control stage but rather held that the reports were not relevant. It is conceded that the decision as to relevance was incorrect. The respondents and the notice party contended that there was ample material upon which the Coroner could have exercised discretion at the control stage to exclude the material. The applicant submits that is to impute to the Coroner reasons that he never expressed. The control stage in this case involves a difficult and finely balanced judgment. The factors for and against are not obviously against the materials being admitted. For instance to leave a jury with the impression that there was no dispute that M and V had been instructed by senior police officers to fabricate when in reality there was a dispute is a matter of consequence. Similarly to leave the evidence that the fabrication was to protect the life of a source when there could be other explanations is also a matter of consequence. It is incumbent on the Coroner to investigate the suggestion that to allow this material to be admitted would cause injustice to the witnesses in that other statements or other parts of the reports would then become relevant. That may be so but exact definition would have to be brought to the difficulties in order to evaluate them. I do not consider that the outcome of the control stage was inevitable. This is a matter for the Coroner to decide. He failed to do so, given the contentions on behalf of the police that the reports were not relevant and therefore did not pass the first stage of the test. I quash the decision not to permit the deployment of parts of the Stalker/Sampson reports. I also quash the verdict on this ground given that this evidence might have been admissible and that its potential impact could have been significant. It is a matter for the Coroner at the inquest which will now have to be held to rule on the control stage.

## **Part Five: McConville**

**Non-disclosure of two statements made by Officer AA to the Police Ombudsman for Northern Ireland relating to her investigation into the death of Neil McConville, which statements were given by the Police to the Coroner and deployment of the Ombudsman's report in cross examination of Officers AA and M**

[191] Two issues arose during the course of the inquest.

- (a) The first issue was disclosure of two statements made by Officer AA to the Police Ombudsman for Northern Ireland relating to her investigation into the death of Neil McConville ("the statements"). The statements were documents underlying the Ombudsman's report. The applicant sought an order from the Coroner on the basis that the statements were potentially relevant as similar fact evidence going to planning and control or evidence going to credibility. The applicant also sought the statements from the PSNI on the basis of a legitimate expectation that the documents would be disclosed.
- (b) The second issue was whether the contents of the Ombudsman's report, and the statements if they were disclosed, could be deployed in cross examination of the witnesses at the inquest.

[192] In these proceedings the applicant:

- (a) challenges the decision of the Coroner not to disclose the statements;
- (b) challenges the decision of the PSNI not to disclose the statements to him relying on a legitimate expectation that they would be disclosed; and
- (c) challenges the decisions of the Coroner in relation to the deployment of the report and the statements in cross examination of Officers AA and M.

### **Factual background to this part**

[193] The deceased died on 25 November 1992. The issues in the inquest in relation to his death include the planning and control of the operation by those in the control room, the interaction between those in the control room and those on the ground and the circumstances on the ground involving the use of lethal force. On 25 November 1992 Officer AA, then an Inspector in the Tasking and Co-ordinating Group, was in the control room and he together with another officer were in overall

charge of the operation being responsible for planning and control. Also on 25 November 1992 Officer M was the senior HMSU Officer involved in the operation being stationed at the TCG headquarters and being in radio contact with officers on the ground. He was responsible for directing the officers on the ground as to what action they should take on foot of instructions that he was given by Officer AA. Accordingly Officer M also played a significant role in relation to the planning and control of the operation.

[194] It is the applicant's case that events surrounding the death of Neil McConville on 29 April 2003 were relevant or potentially relevant to the inquest into the death of the deceased in 1992. On 29 April 2003 Officer AA was the Silver Commander in the control room during the operation responsible for planning and control and Officer M was the most senior HMSU Officer in the control room. He controlled the operation desk along with Sergeant EE, a radio operator passing and receiving information to and from units involved in the operation.

[195] Accordingly Officers AA and M were involved in planning and control on both 25 November 1992 and 29 April 2003 and on both occasions lethal force was deployed.

[196] The Police Ombudsman for Northern Ireland, Mrs Nuala O'Loan, had investigated the death of Neil McConville and her report was published in 2007 ("the report"). The report was available to the applicant but not the underlying documents.

[197] In relation to Officer AA the report concluded that:

- (a) The strategy of stopping the red Vauxhall Cavalier was elected without detailed consideration of any other option.
- (b) Officer AA did not record all his policy decisions which is a requirement of PSNI orders and the ACPO Manual of Guidance for the Police use of Firearms (2/385/14.4).
- (c) That Officer AA's explanation as to the lack of a record, namely the speed of the operation and the lack of opportunity, should not be accepted as he had over two hours in which to record decisions and he had significant support in the Operation/Control Room and a record was essential given the seriousness of the

operation and the potential deployment of lethal force (2/385/14.4).

- (d) That Officer AA's claim that he took tactical advice from Sergeant EE and Officer M who were trained tactical advisors was not accepted as neither Sergeant EE nor Officer M had the role of tactical firearms advisors as claimed by Officer AA (2/386/14.6).
- (e) That there was no documented risk assessment and that Officer AA would have been aware of the importance of such a document which is advocated in the ACPO Manual of Guidance for the Police use of Firearms (2/386/14.6).
- (f) That Officer AA did not make use of a tactical firearms advisor and did not assess tactical options as required (2/386/14.6).
- (g) That Officer AA's claim that the vehicle had to be stopped as the helicopter assistance might well become ineffective was shown to be incorrect by the evidence of the pilot (2/388/14.12).
- (h) That Officer AA did not plan and control the operation to minimise the possibility of recourse to lethal force as required by the PSNI Code of Ethics and Article 2 of the European Convention of Human Rights. His failure to properly consider the options available, failure to communicate proper decisions and to document clearly his actions was a serious deficiency (2/390/14.18).
- (i) The police Officers had stinger devices and there were significant resources available to Officer AA to deploy. A vehicle checkpoint could have been organised, and was in fact a documented early plan, which would have been inherently safer than the option chosen. In his second interview Officer AA claims that the officers on the ground chose the option of a



stop from behind. The evidence clearly shows the control room directed the tactic and that those officers twice questioned the decision to stop the vehicle from behind (2/387/14.9).

- (j) That stopping a vehicle from behind is a high risk tactic which should only have been used when other options had been excluded. If, as suspected, the suspects were armed, they would be highly unlikely to be compliant with a police command. As they were ordered to overtake the vehicle at speed those officers were exposed to extreme danger. They would inevitably be close to, and in the firing range of, the potentially armed occupants of the vehicle. This tactic also inevitably leads to a “stop” at speed, where loss of control of vehicles and collisions are highly likely. In the context of armed occupants of the target vehicle, and the necessity for police to present an armed challenge to them, this created considerable uncertainty as to the outcome. The roads were wet on the night in question which would have exacerbated the risks. There are occasions when such tactics are necessary, but only after careful consideration of other options. There is no evidence in this case that such careful consideration took place (2/388/14.11).

[198] In relation to Officer M the report concluded that:-

- (a) There was a significant lack of co-operation from, amongst others, him in the investigation. That when a fatal incident such as this occurs, and an investigation takes place, it is essential that all officers co-operate with the investigation. Officer M resisted the investigation in respect of his role in the control room to the point of near obstruction. His behaviour was particularly stark in comparison with those who were involved on the ground, who co-operated fully. The Police Ombudsman recommended that the Chief Constable considers the suitability of his posting given the findings of the investigation and transfers him to a less contentious area of policing (2/386/14.20 and 2/405/17.7).

- (b) That his lack of co-operation and attitudes could undermine public confidence in the PSNI particularly as he is employed in such a sensitive department of the organisation (2/391/14.20). In the view of the fact that he had a supervisory role and force wide responsibility for tactical firearms advisors that he should have been well aware that tactical firearm advisors should be independent of the chain of command for the operation. That as he was involved in the chain of command of the operation he could not act as a tactical firearms advisor in that operation. That he failed to recognise the tactical advisor should be independent of the operation (2/386/14.7 and 2/320/20).
- (c) He refused to be interviewed and incorrectly alleged that his written answers had been tampered with (2/391/14.20).
- (d) He failed to identify the sixth officer who was in the control room (2/392/14.22).

[199] An application was made to the Coroner at the inquest on behalf of the next of kin for permission to deploy the report in cross examination of Officer AA. The Coroner deferred ruling on this issue and Officer AA was advised that he should make himself available for recall if required. The Coroner indicated that he wished to consider the content of the report and would then hear further submissions on the matter (1/57/137).

[200] On 4 October 2012 Officer M gave evidence at the inquest. He was asked whether he recognised the importance of co-operating with investigations into police conduct to which he replied yes. Thereafter, he was asked whether he had always co-operated with such investigations to which he also replied in the affirmative. On that date an application was made orally supported by written submissions for permission to deploy the report in cross examination of Officer M, (1/59/146 and 2/409-413). It was contended on behalf of the applicant that the report was relevant in three respects namely:-

- (i) to Officer M's assertion before the jury that he had always co-operated with investigations into police conduct;
- (ii) to Officer M's credibility generally lending support to the contention that Officer M is a dishonest witness; and
- (iii) to the methodology used to carry out the stop on the deceased's car and the manner in which that stop was affected.

[201] On 5 October 2012 further submissions were made and the Coroner permitted questioning of Officer M on the issue of his non co-operation with the Ombudsman's investigation but refused to permit questioning of Officer M in relation to other aspects of the report (1/59/147 and 6/5/27).

[202] In these judicial review proceedings the Coroner has stated in relation to Officer M that he permitted questioning of that witness by reference to the report concerning the issue as to whether he had properly co-operated with the Ombudsman's investigation. That this was directly relevant to an assertion made by Officer M in his evidence at the Jordan inquest that he would always co-operate with an investigation into police conduct. The Coroner went on to state that "I did not accept that a report by Police Ombudsman report (sic) into the death of Mr McConville, which occurred a decade after the death of Mr Jordan, was *relevant* to the other matters brought to my attention, namely to the officer's credibility generally or to the methodology used to stop Mr Jordan's vehicle" (10/8/26) (emphasis added).

[203] A ruling remained outstanding in relation to the use of the report in cross examination of Officer AA. On 8 October 2012 counsel for the Chief Constable advised that papers had now been obtained from the Ombudsman and provided by the Chief Constable to the Coroner (1/60/148). The applicant's solicitor understood that the documentation included the statements made by Officer AA to the Ombudsman although the precise nature of the documentation was then unknown because the applicant was neither provided with disclosure of the documents nor was he provided with a description of the nature of the documents. It subsequently transpired that the documentation provided to the Coroner comprised the transcript of interviews between Police Ombudsman investigators and Officer AA (10/8/25 and 10/2/22/2).

[204] In these judicial review proceedings it is stated that the Chief Constable did not and does not, consider the information contained in the Ombudsman's report or the underlying statements and materials relating to the report to be "information ... concerning the death of the deceased" in 1992. That the Chief Constable determined that he would provide certain materials relating to the death of Mr McConville to the Coroner notwithstanding his view that the section 8 obligation was not engaged. That he did this so that the Coroner could determine whether those documents were relevant to the scope of the inquest into the death of the deceased (13/2/6-7). The Chief Constable did not make those documents available to the applicant.

[205] In a written ruling entitled "Relevance of AA's involvement in the death of Neil McConville" (10/2/22-24) dated 10 October 2012 the Coroner stated that he had asked the question as to whether "the material", that is the "material contained in or informing the report" is relevant or potentially relevant to the issues to be addressed at the inquest. He stated that the question might also be expressed as follows:

“is evidence relating to the other incident *capable* of being logically probative of an issue to be determined by the jury at this inquest.”

He then stated that having considered the above questions he had concluded “that there is nothing in material concerning Mr McConville’s death in 2003 that *meets the test of relevance or potential relevance*” (emphasis added). He also stated that “the report into the death of Mr McConville is incapable of properly assisting this jury in its determination of the question of how Mr Jordan met his death in 1992”. He went on to say:-

“Part of the jury’s function is to assess the planning and execution of the operation that led to Mr Jordan’s death. The jury is not concerned with events that took place after the death except to the extent that those events are informative of the death. I have concluded that introduction of evidence concerning the planning and control of an operation some ten years after Mr Jordan’s death can tell the jury nothing useful about that earlier incident. Quite apart from the lack of temporal relevance it is clear to me that the investigation into the McConville death focused on procedures, guidance, codes and arrangements that were not in place ten years earlier, further undermining its potential relevance to the present inquest.”(10/2/23/6)

The Coroner ruled that he was not permitting the next of kin to question Officer AA about matters arising from the report.

[206] This ruling had been given by the Coroner without disclosure to the next of kin of the documents received from the Ombudsman or having heard any further submissions. Objection was taken to this and the Coroner indicated that he would re-visit the matter with an open mind, (1/60/149).

[207] On 16 October 2012 there were further oral submissions (13/AH1/1-24). Ms Quinlivan on behalf of the next of kin referred to various parts of the report including for instance the part which asserted that stopping a vehicle from behind was a high risk tactic which should only have been used when other options had been excluded. She stated that Officer AA had rejected the notion that this was a high risk tactic but she asserted that he would know the outcome of the report and that the Ombudsman had formed the view that it was a high risk tactic (13/AH1/12). She contended that the view of the Ombudsman should be put to the

witness. That he could reply that he does not accept that view and justify that by reference to his experience “and there is no difficulty with that, but that we should not be prevented from putting to him that in fact the view that he presented as a general view is not in fact a view that is shared, at least not shared by Police Ombudsman of Northern Ireland” (13/AH1/22). Dr McGleenan submitted that this part of the report was an expression of opinion by the Ombudsman and should be excluded on the basis of the decision in *Siberry* (13/AH1/19).

[208] On 19 October 2012 the Coroner ruled that, neither the underlying documents, nor the report were *relevant or potentially relevant* to the issues in the inquest and consequently he was not ordering disclosure of the underlying documents. It followed that the materials could not be deployed in cross examination of Officer AA, (1/60/150).

### **Conclusion in relation to the Coroner’s decision not to disclose the statements**

[209] The test for disclosure by the police to the Coroner and by the Coroner to the next of kin is potential relevance. If a document contains matters of opinion then that is not a bar to disclosure. Disclosure is an aid to determining the scope of the inquest. Limiting the scope of the inquest should occur after disclosure of potentially relevant documents on the basis of submissions informed by those documents.

[210] Initially Mr Doran, on behalf of the Coroner, accepted that the report was potentially relevant as it demonstrated a lack of planning by Officers AA and M who performed broadly similar roles in relation to both incidents. He then withdrew that concession when faced with the proposition that if the report was potentially relevant then why were the statements, which were documents underlying the report, not also potentially relevant. I consider that Mr Dornan was in fact correct in conceding that the report was potentially relevant. Indeed not only was the report potentially relevant but it was held by the Coroner to be relevant and in part to be admissible in the cross-examination of Officer M. I consider that the statements of Officer AA which were documents underlying the report were also potentially relevant being documents relating to a similar incident. The incidents in *O’Brien* were 5 years before and 2½ years after the relevant death. The death of Neil McConville occurred a decade after the death of the deceased. If the events had happened within days of each other that does not make them relevant. Equally if they occurred after a gap of a number of years that does not make them irrelevant. The temporal gap is a matter appropriate to be considered at the control stage in relation to the admissibility of the material but it does not make matters which are relevant irrelevant. For instance a significant temporal gap might lead to an application that a number or a greater number of other similar facts ought to be admitted in order to balance the impact of the Neil McConville incident. Differences in procedures, guidance, codes and arrangements were not of such a nature to make

the evidence irrelevant but again were matters which could be considered at the control stage in relation to admissibility of the material. The statements were both relevant and potentially relevant. Accordingly the Coroner ought to have ordered disclosure of the statements. Any other decision was irrational.

[211] I issue an order of certiorari quashing the decision of the Coroner dated 19 October 2012 not to order disclosure of the statements to the applicant.

[212] The applicant also seeks an order quashing the verdict on this ground. If this was the only ground then in the exercise of discretion I would not quash the verdict but all these matters are cumulative and taking this matter into account together with the issues in relation to the Stalker/Sampson reports I conclude that the appropriate relief is also to quash the verdict.

[213] I decline to issue an order of mandamus directed to the Coroner in relation to the statements given that I am making such an order in relation to the application involving the PSNI.

#### **Conclusion in relation to the PSNI's decision not to disclose the statements**

[214] In previous judicial review proceedings which I heard and determined in 2008 the applicant sought an order of mandamus to compel the Chief Constable to disclose to the applicant all documents disclosed by the Chief Constable to the Coroner, whether relevant or irrelevant to the issues in the inquest, except for any document which is subject to legal professional privilege or to a valid public interest immunity claim. The applicant sought that relief on the basis of a contention that, irrespective of the position in other cases, he had a legitimate expectation that "all documents" (subject to privilege and immunity) should be disclosed to him irrespective of whether relevant or irrelevant to the issues expected to emerge on the hearing of the inquest. The contention that the applicant had such a legitimate expectation depended on an analysis of a considerable volume of documents dating back to 1999. In my judgment in *Jordan's Application* [2008] NIQB 148 I held that the applicant did have such a legitimate expectation, I quashed the decision of the Chief Constable and made an order of mandamus.

[215] In these judicial review proceedings the PSNI contends that the legitimate expectation could only relate to documents disclosed to the Coroner prior to the inquest commencing. That the role of the Coroner during the inquest is to keep the proceedings focussed and that requests for documents held by the Coroner to be irrelevant leads to the inquest procedure spiralling out of control with the potential for endless inquests being held within the inquest into the death of the deceased. In particular the PSNI contends that:

- (i) the issue of disclosure that arose during the course of the inquest was appropriately managed by the Coroner who had conduct of the case;
- (ii) the Applicant's reliance on earlier statements, affidavits and judicial dicta in respect of *pre-inquest* disclosure is not applicable in the context of discovery issues that arose during the course of an inquest and which were subject to case management by the Coroner;
- (iii) ...;
- (iv) In any event, the Chief Constable disputed (and continues to dispute) that his section 8 duty was engaged in respect of the McConville materials but nonetheless provided them to the Coroner who ruled they were not relevant to the scope of the inquest.

[216] The PSNI also contends that the applicant's reliance upon the undertaking given by Mr Mercier in 2000 is misplaced. It is submitted that when the undertaking was given in 2000 it related to documents *then in existence* touching upon the death of Mr Jordan in 1992. It was also submitted that it is absolutely clear that Mr Mercier could not have had within his contemplation materials relating to an investigation into a fatal shooting in 2003 that resulted in an Ombudsman's report in 2007 when he swore his affidavit in 2000.

[217] I consider that the representations that were made both by Mr Mercier and in the letter of 9 May 2008 were not limited to documents that were then in existence and were not limited to pre-inquest disclosure, see my judgment in *Jordan's Application* [2008] NIQB 148. I hold that in fulfilment of the applicant's legitimate expectation the statements ought to have been made available to him quite irrespective as to the subsequent ruling of the Coroner that the documents were irrelevant to the inquest into the death of the deceased.

[218] I issue an order of certiorari quashing the decision of the PSNI not to disclose the statements to the applicant.

[219] I also issue an order of mandamus compelling disclosure of the statements to the applicant within 14 days. I require the applicant to give an undertaking to the court that the disclosure of the statements is on a confidential basis solely for use in relation to the inquest. I give the Chief Constable liberty to apply in relation to any claim for privilege, public interest immunity or redaction given the convention rights of those who may be identified either expressly or by implication in the statements.

### **Conclusion as to deployment of the Ombudsman's report in cross examination of Officers AA and M**

[220] The decision of the Coroner was that the evidence was not relevant. The failures in relation to planning and control in relation to the events of 29 April 2003

throw light on and help to explain planning and control of the earlier events of 25 November 1992. If inadequate records are kept or alternatively options are not considered or if there is obstruction of an investigation those are relevant, ie logically probative, of what the same persons did on an earlier occasion. I consider that the decision of the Coroner that the report and the statements were irrelevant was Wednesbury irrational.

[221] The Coroner did not rule on the second stage, the control stage though submissions were made to him about issues relevant to that stage (see for instance 7/13/20-21). I do not consider that the outcome of that stage was inevitable in the sense that it was inevitable that the Coroner would have excluded the material. The control stage involves a difficult and finely balanced judgment in relation to each piece of evidence with analysis of factors both in favour and against admission of the evidence. It will also involve consideration as to whether evidence is opinion evidence and if so whether it should be excluded on that basis. It is for the Coroner to assess for instance the extent of admissible evidence as to credibility. If a witness's credibility has been undermined and demolished it may not be necessary for further evidence to be led to do further damage. That factor may have greater weight if the inquest is being conducted without a jury. The control stage is a matter for the Coroner to decide. He failed to do so, given the contention on behalf of the PSNI that the report and the statements were not relevant and therefore did not pass the first stage of the test.

[222] I quash the decision not to permit deployment of parts of the report and the statements. I also quash the verdict given the combination of this matter with the issue in relation to the Stalker/Sampson reports. It is a matter for the Coroner at the inquest which will now have to be held to rule on the control stage.



## Part Six: Jury

### **The challenge to the Coroner's decision to conduct the inquest with a jury**

[223] One of the issues that arose for decision by the Coroner before evidence was heard was whether to sit with a jury. I start this part of the judgment by setting out a sequence.

### **Sequence in relation to the Coroner's decision to conduct the inquest with a jury, precautions taken by the Coroner in relation to jury selection and admonitions to the jury.**

[224] By written submission dated 26 May 2012 it was contended on behalf of the applicant that there was no requirement for a jury to be summoned under Section 18(1)(e) of the Coroners Act (Northern Ireland) 1959. In support of that submission reliance was placed on *R v HM Coroner at Hammersmith ex parte Peach* and *R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461 (2/58-60). The applicant contended that no jury should be summoned referring to the obligation under Article 2 for there to be an objective and impartial investigation into the death. They contended that given a number of factors the objectivity and impartiality of a jury could not be guaranteed. Those factors were:-

- (i) The controversial nature of the inquest involving a fatal shooting of an alleged IRA member by a member of the RUC.
- (ii) The widely recognised and continuing problem of perverse verdicts related to sectarian loyalties in a divided society.
- (iii) The requirement for unanimous verdicts.
- (v) The statutory anonymity of jurors (with the attendant difficulty of challenging for cause).
- (vi) The absence of effective safeguards against a perverse verdict (2/61/16).

The applicant adverted to the Justice and Security Act (Northern Ireland) 2007 which permitted, what he submitted were analogous criminal trials to be tried by a judge alone. He also referred to the safeguard in a criminal trial of a majority verdict which was not available in an inquest in Northern Ireland. It was contended that the requirement for unanimity gave rise to a real risk that one member of the jury would, for perverse religious or political reasons, refuse to subscribe to a verdict which entailed a finding that during a planned anti-terrorist operation a member of the RUC unjustifiably killed an alleged member of the IRA (2/65/29).

[225] At a preliminary hearing on 28 May 2012 it was agreed by all the parties that there was no requirement that a jury should be summoned (1/6/32/70).

[226] On 6 June 2012 the Coroner heard submissions as to whether to exercise discretion under Section 18(2) to summon a jury. The Chief Constable adopted a neutral position. The next of kin contended that the Coroner should not summon a jury.

[227] On 6 June 2012 the Coroner ruled that it was desirable to and that he would summon a jury (2/67-71). The Coroner accepted that this was a clear case in which a jury was not legally required under Section 18(1) of the Coroners Act (Northern Ireland) 1959. That Section 18(2) conferred discretion to summon a jury if it appeared to the Coroner that it is desirable to do so. He recognised his obligation to conduct an objective and impartial investigation into the death. He summarised the submissions on the part of the next of kin. He considered that any judicial Officer coming to this case would not be able to come to it without having read or heard his or her fair share of conjecture and speculation rumour. He recognised that he had the ability to put that to one side but considered that a jury brings a very clear advantage of an entirely fresh open set of ears listening to this difficult evidence. He recognised the risk of perverse verdicts (2/69/25-27). He considered that he could take proactive steps to guard against that risk. He then set out those steps as:-

- (a) the methods of jury selection;
- (b) the instructions to the jury to hear the case without prejudice; and
- (c) the greatest protection being the protracted and detailed nature of the verdict itself.

He considered that a jury could cope with the inquest in that it was not too unwieldy or complicated or lengthy. He considered that there was a fundamental jurisprudential reason to convene a jury being the desirability of members of the public being involved in the process. He adverted to the fact that in England and Wales and in the Republic of Ireland there would be no discretion in a case such as this where a member of the police had shot an individual. In those jurisdictions a jury is a requirement.

[228] On 12 June 2012 submissions were made to the Coroner on behalf of the applicant as to the questions that should be addressed to potential jurors during the selection process (1/6/39/75 and 2/72). The applicant contended that the Coroner should excuse anyone who:-

- (i) has ever been a member of the police or armed forces or has ever had a close connection with the police or armed forces personally or through close friends or family;
- (ii) has ever been convicted of an offence of a terrorist or sectarian nature, including public order offences;
- (iii) has ever been a member of any sectarian organisation (including the Loyal Orders); or
- (iv) would have any reservations about finding (if the evidence warranted it) that the actions of a member of the RUC in shooting a member of the IRA who was believed to be involved in IRA activity were unreasonable and unjustified.

[229] By letter dated 17 August 2012 the Coroner set out how best to safeguard the impartiality of the jury. He intended to summon a jury panel of 100 people randomly selected in accordance with the process set out in an affidavit sworn by Jim Coffey in another judicial review application. That affidavit also relates how potential jurors receive an information pack (2/80/15) which amongst other matters emphasises the need for jurors to be fair, impartial, willing to listen and to keep an open mind (2/80/17). The Coroner also stated that the jury panel would be told some basic facts about the case. The potential jurors will be asked to consider whether they have any connection to Mr Jordan or the Jordan family. They will be asked whether they have any close connection to the RUC and/or PSNI or the Army, particularly whether they themselves or a parent, spouse, sibling or any other close relative or friend has been in either organisation. The panel will also be read the witness list and asked if any witness is known. Finally they will be instructed as follows

“It is necessary for you to commit to dealing with this matter solely on the evidence in an entirely dispassionate and unbiased manner. If you feel because of your life experiences, connections or beliefs that you cannot deal with this matter in an unbiased, open-minded, dispassionate manner, solely on the evidence, then you should let me know.”

[230] On 24 September 2012 that process was followed. Eleven jurors were sworn (1/39-41). One juror was discharged on 2 October 2012 (1/42/82).

[231] A number of clear directions were given by the Coroner to the jury during the course of the inquest as to their duties, for instance as to the obligation to keep an open mind, to decide the case on the evidence, and to inform him as to any concerns

that any one of them may have as to the conduct of the other jurors. This court does not have a complete transcript of the entire inquest and accordingly it is not possible to identify each and every direction and admonition. However such directions and admonitions can be found in those parts of the transcript which are available at 6/2/67, 6/5/84, 7/12/34, 7/14/2-3, 7/14/75 and 7/14/100. There is no suggestion on behalf of the applicant that these directions were not robust and clear. It was also not suggested on behalf of the applicant that such directions would not have been repeated on other occasions, for instance at the very start of the inquest.

### **The approach to the exercise of discretion**

[232] The decision of the Coroner is an exercise of discretion. He can either conduct the inquest himself or he can conduct it with a jury. Accordingly the balance includes assessing the respective merits of either course of action. The balance includes matters such as the complexity of the case, the number of documents, the number of witnesses, the length of the inquest, the need to involve the community in the legal process and impartiality.

[233] The Coroner after conducting that balancing exercise has to decide positively that "it is desirable to summon" a jury (Section 18(2)). The balance has to shift to one in favour of a jury being summoned.

[234] In conducting that balance impartiality will be decisive. There cannot be an effective investigation where there is a real risk of a perverse verdict or bias. In circumstance where unanimity is required if there is a real risk of a perverse conclusion or of bias on behalf of a single juror then there can be no other outcome to the balancing exercise but that the inquest should be conducted without a jury. In such certain circumstances all the many advantages of a jury trial have to give way. Accordingly if all legacy inquests fall within the category of cases where there is a real possibility of a perverse jury verdict then discretion should be exercised in all of them for them to be conducted without a jury.

[235] The Coroner in considering prospectively the appearance of bias or the real risk of a perverse verdict should apply the two stage test in *Porter v Magill*. First the Coroner should ascertain all the circumstances which have a bearing on the suggestion that the jury or a juror will arrive at a perverse conclusion or be biased. The second is to determine whether the fair-minded and informed observer having considered those circumstances would conclude that there was a real possibility that the jury or a juror will arrive at a perverse conclusion or be biased.

[236] In this judicial review those questions are then for this court to consider. The function of this court is not merely to review the reasonableness of the decision-makers judgment of what fairness requires see *Osborne v Parole Board* at paragraph [65].

[237] What are the circumstances which have a bearing on the suggestion that the jury or a juror will be biased? They include:

- (a) The nature of the matters to be considered in this inquest. These can be summarised as follows. The shooting of an alleged member of the IRA, a terrorist organisation, by a member of the security forces during an IRA bombing campaign which campaign led to the destruction of property, damage to the economy, grievous and on occasion fatal injuries with in either case horrific consequences for individuals and communities.
- (b) The evidence as to perverse verdicts in certain criminal trials in Northern Ireland. I set out below the risks and the type of criminal trials in which they occur.
- (c) The safeguards that can be put in place to secure an impartial jury and the effectiveness of those safeguards. There are many safeguards which can be put in place and which the Coroner did put in place. However in certain cases there is a real risk of a perverse verdict regardless as to safeguards.

### **The risk of perverse verdicts in criminal trials**

[238] A consultation process was conducted by the Northern Ireland Office in August 2006 on the “Replacement arrangements for the Diplock Court system”. This consultation was in advance of what became the Justice and Security (Northern Ireland) Act 2007. The consultation paper set out the background to jury reform. It referred to perverse acquittals because of, for instance, partisan jurors (12/B/4/2.1), to the close-knit communities in which people live in Northern Ireland (12/B/5/2.8) and to the perception that the polarised nature of society within Northern Ireland is such that the jurors may be unduly influenced by their political and religious backgrounds in reaching a verdict (12/B/7/3.13). Lord Carlile of Berriew QC, the Government’s independent reviewer of terrorism legislation, assessed that the risk of perverse jury verdicts still existed in Northern Ireland and was enhanced in Northern Ireland as compared to other parts of the United Kingdom (12/B/21/14).

[239] The view of the Northern Ireland Office and of Lord Carlile in 2006 that there was an enhanced risk of perverse jury verdicts in Northern Ireland was reflected in the Attorney General’s Guidelines on Jury Checks on the use of the prosecution of standby issued on 1 August 2007. It stated that in certain cases it was in the interests of both justice and the public that there should be further safeguards against the possibility of bias and in such cases checks which go beyond the investigation of

criminal records may be necessary. It identified typical aspects of a case which may make it desirable to seek extra precautions as including that:

“(b) *in both security and terrorist cases* the danger that a juror’s political beliefs are so biased as to go beyond normally reflecting the broad spectrum of views and interests in the community to reflect the extreme views of sectarian interest or pressure group to a degree which might interfere with his fair assessment of the facts of the case or lead him to exert improper pressure on his fellow jurors” (8/6/23/5) (emphasis added).

[240] The view of the Northern Ireland Office and of Lord Carlile in 2006 was endorsed by the Divisional Court when it gave judgment on 9 January 2008 in the case of *McParland* (8/6). Kerr LCJ stated at paragraph [37] that:

“The existence of the risks identified by the jury’s subgroup ... of partisan juries and of perverse jury verdicts has not been seriously disputed by most commentators, although there has been acute disagreement about the measures needed to deal with those risks.”

[241] So whatever may be the position in other jurisdictions it is recognised that in some cases in Northern Ireland, that is in security and terrorist cases, there is a real possibility of perverse jury verdicts. Accordingly the fact that in England and Wales and in the Republic of Ireland a jury must be summoned in inquests where a death is caused by a police officer only illustrates the differences between those jurisdictions and Northern Ireland.

[242] The real possibility of perverse verdicts that has been identified is of perverse verdicts either for or against the security services or for or against those involved in terrorist activities. Furthermore it has also been identified that the community divisions in our society are such that the exact nature of the perverse verdict is influenced by the geographical location of an inquest.

[243] The question becomes whether this case falls within the category of cases where there is a real possibility of a perverse jury verdict.

## **Conclusion in relation to the decision to conduct the inquest with a jury**

[244] This inquest involved both security and terrorist issues. It was controversial. In relation to analogous criminal trials it has been recognised that there remains a real risk of perverse verdicts in security and terrorist cases. In criminal trials the real risk exists regardless of the method of jury selection and instructions and admonitions to the jury during the course of the trial. It was submitted that the contrast between verdicts in inquests and in a criminal trial was significant and was of such a degree as to enable the use of a jury in inquests in situations where a jury would be inappropriate in a criminal trial. In criminal trials the verdict is either guilty or not guilty. The nature of the verdict in an Article 2 compliant inquest can, as the Coroner stated, be protracted and detailed. However that is to over simplify the complexity of the directions as to the law that are given to jurors in criminal trials. Detailed directions can be given to jurors in the form of routes to verdicts. These can also be both protracted and detailed. In certain types of criminal trials the real risk of a perverse verdict exists despite the ability of a judge to set out in written instructions the exact questions that a jury should address in arriving at an overall verdict. Detailed routes to verdicts are insufficient to guard against the real risk of perverse verdicts in certain criminal trials. I consider that the detailed verdict in an inquest is insufficient to safeguard against the real risk of a perverse verdict in controversial security and terrorist cases.

[245] The essential purpose of an investigation is “to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility”. That cannot be achieved if there is a real risk of a perverse verdict. For this legacy inquest to be Article 2 compliant it should not allow of that real risk of a perverse verdict. I emphasise that this is a prospective decision. The applicants do not have to establish that the jurors who were eventually selected and who heard the inquest were perverse in their verdict. Rather prospectively at the start of the inquest what had to be established by the applicant was a real risk of a perverse verdict. I consider that such a risk was clearly established.

[246] In relation to the decision of the Coroner dated 6 June 2012 to conduct this inquest with a jury I grant a declaration that it ought not to have been conducted with a jury.

## **Delay in bringing this judicial review challenge**

[247] On 11 July 2012 the applicant commenced judicial review proceedings in relation to the decision of the Coroner to grant anonymity and to allow screening of witnesses (8/14/2/2). The application was dismissed by Deeny J on 17 September

2012 and the applicant appealed to the Court of Appeal. The appeal was dismissed with reasons being given under citation [2012] NICA 47. At the time that the applicant launched judicial review proceedings on 11 July 2012 it had already been decided by the Coroner on 6 June 2012 to summon a jury. The applicant could have challenged that decision by the Coroner to summon a jury in the judicial review proceedings which were launched on 11 July 2012 but chose not to do so. That application would have fallen within the exception to the rule against satellite litigation.

[248] I consider that there was a failure to challenge the decision of the Coroner at an earlier and therefore more appropriate stage. That is a factor to be taken into account in the exercise of discretion as to whether to quash the verdict. Ordinarily in such circumstances I would exercise discretion declining to quash the verdict. However there is, not only, the interests of the applicant to be considered but also the wider public interest including the interest in confirming or allaying public suspicion and the public interest in securing “the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility.” Those public interests cannot be discharged where there is a real risk of a perverse verdict. The authority of such a verdict would be undermined by that risk. In such circumstances and despite the delay on the part of the applicant I consider that it is also appropriate to and I do quash the verdict on this ground.

### **The issue as to compatibility of the statutory scheme with Article 2 of the Convention**

[249] Section 31 of the Coroners Act (Northern Ireland) 1959 (“the 1959 Act”) requires that the jurors are unanimous. The applicant contends that Section 6 of the Human Rights Act 1998 required the Coroner not to apply Section 31 but rather to accept a majority verdict. The applicant also seeks a declaration that Section 31(1) of the Coroner’s Act (Northern Ireland) 1959 and Article 26 of the Juries (Northern Ireland) Order 1996 (as amended by Section 10 of the Justice and Security (Northern Ireland) Act 2007) are incompatible with the applicant’s Article 2 rights.

[250] No application was made to the Coroner on behalf of the next of kin that Section 31 should be not be applied. The possibility of accepting a majority verdict was never canvassed at the inquest. If section 31(1) could in principle not be applied as subordinate legislation if incompatible with the Convention then the question would have arisen as to with what it should be replaced. For instance what numerical majority would be acceptable? I take into account the public interest as well as the interests of the applicant. I make it clear that in view of the fact that this matter was not raised during the course of the inquest I would in the exercise of discretion not grant any relief in relation to it. However the matter has been argued and I will set out my conclusions.



[251] The power to hold an inquest, with or without a jury, is contained in Section 13 of the 1959 Act. There is a requirement upon the Coroner to sit with a jury only in the cases set out in Section 18(1). In any other case the Coroner conducts the inquest without a jury unless it appears to him “that it is desirable to summon a jury”. Section 21 of the 1959 Act allows flexibility in the number of persons comprising a Coroner’s jury which shall consist of not less than seven and not more than eleven persons. Section 31 of the 1959 Act provides for verdicts. The requirement is for unanimity but if unanimity or timeous unanimity cannot be achieved then the Coroner has discretion to discharge the jury and to summon another jury. The requirement of unanimity is in contrast to the position in England and Wales. In that jurisdiction section 9(2) of the Coroners and Justice Act 2009 allows for a majority verdict if only one or two of the jury do not agree.

[252] The Juries (NI) Order 1996 (except Articles 12-22) (“the 1996 Order”) applies to Coroners’ Juries. Under Schedule 1 those disqualified include:

- (a) any person who has at any time been convicted in the United Kingdom to imprisonment for life or a term of five years or more;
- (b) any person who at any time in the last ten years has in the United Kingdom served any part of a sentence of imprisonment or detention, had passed on him a suspended sentence or had made in respect of him a community service order;
- (c) any person who at any time in the last five years has in the United Kingdom been placed on probation.

Accordingly an individual who has been convicted in Northern Ireland of a terrorist related offence and who had been sentenced for instance to imprisonment would not be automatically disqualified if the sentence was for less than five years and no part of the sentence was served in the last ten years.

[253] Schedule 2 of the 1996 Order provides that those ineligible for jury service include police officers and prison officers (and those who have fallen within those descriptions within the past ten years); and persons serving on full pay as members of any of the naval, military or air forces of the Crown or any member of the Royal Irish Regiment.

[254] One of the essential points raised by the applicant is that the requirement for unanimity is not Convention compliant. However if unanimity is not possible there are a number of options available to the Coroner in cases such as this which do not fall within Section 18(1) of the 1959 Act. The Coroner may discharge the jury and decide to continue the inquest without a jury. He may discharge the jury and hold

another inquest either with or without a jury. He may discharge a particular juror if he is satisfied that there is actual or apparent bias. He may consider that it was not possible on the evidence for the jury to arrive at a conclusion but that there has been a full examination in public of the relevant evidence including involvement by legally represented next of kin.

[255] I consider that inquests can be conducted in a Convention compliant manner. The obligation on the State is to provide a system which is capable in principle of giving rise to clear findings. It is an obligation of means not an obligation of results. The Coroner has discretion as to what action he will take if the jury cannot agree.

[256] Another essential point raised by the applicant relates to the decision of the Coroner to conduct the inquest with a jury. That however was the Coroner's decision. It was not imposed by the legislative scheme. While the use of a jury might be in contravention of Article 2 that breach would be occasioned by the decision of the Coroner to sit with a jury and not by the statutory provisions. Those statutory provisions provide discretion to him. If a jury cannot comply with the requirements of Article 2 the response is to dispense with the jury. The legislative scheme is compatible with Article 2 of the Convention.

## **Part Seven: Juror J**

### **The Coroner's decision not to discharge Juror J**

[257] On 4 October 2012 the applicant applied for an order discharging Juror J (6/4/30/21). The Coroner refused that application (6/4/39-43). The applicant's Order 53 statement did not assert that there was actual bias on the part of Juror J (1/2/13/xvi). An allegation of actual bias was not contained within the applicant's skeleton argument and was specifically excluded during oral submissions. I make it clear that the actual integrity of Juror J is not in issue. The issue is as to whether there was apparent bias. This involves a two stage process. It is for this court to determine the circumstances and then it is for this court to determine whether the fair minded and informed observer having considered those circumstances would conclude that there was a real possibility that Juror J was biased.

### **The circumstances**

[258] On 4 October 2012 Officer M commenced giving evidence at 10.34 am (2/4/2). He was examined by the Coroner and then Mr Macdonald commenced cross-examining the witness on behalf of the next of kin (2/4/12). The witness was asked for his opinion about Officer A firing on automatic (2/4/25/7). There then followed an exchange between counsel and the Coroner in the presence of the jury. It was submitted on behalf of the Chief Constable to the Coroner that the question was "unfair" as the witness did not have the knowledge to answer it. The Coroner indicated that it was appropriate to obtain "the thoughts of the Officer and other Officers in the HMSU with regard to it" and that the direction of the question was a "fair" enough direction. The question was put again to Officer M in the following terms:-

"Well in this case the Officer fired five shots on automatic, two of which actually missed completely apparently, one nearly missed. We have no idea where those rounds ended up. Does that not suggest to you a fairly reckless disregard for human life in the vicinity of this operation?"

Officer M replied

"Sir, I wasn't physically on the ground. I did not know the number of people in the area. I did not know the number of vehicles in the area. I cannot make a judgment in relation to what Officer A did."

[259] Shortly after these questions were asked the Coroner received a note from Juror J. That note read:

“Is an opinion necessary for the jury. I feel this inquest is very unfair” (6/4/31/22).

[260] The initial response of the Coroner was that the note was unlike any other that he had received from a juror in any jury inquest, or indeed, ever seen in any kind of proceedings, (30/4/30/15). He observed that

“the juxtaposition of the fact that these questions are being asked and then the note coming forward, obviously gives rise to (Mr Macdonald’s) conclusion that the unfairness and the hostility is with regard to (Mr Macdonald’s approach to the witness).”

[261] Mr Macdonald submitted that the note was capable of only one interpretation being that Juror J considered the inquest very unfair in particular to the police. Mr Montague QC submitted to the Coroner that whilst it was open to the interpretation that the inquest was unfair that might be because the event about which the inquest was concerned occurred 20 years ago. Mr Doran submitted to the Coroner that the juror perceived there to be procedural unfairness in the sense that matters of opinion were being put to the witness. Mr Simpson QC in these proceedings submitted that the unfairness related to the fact that the witness was being asked for his opinion about the selection of automatic when he was not there and he did not know the precise circumstances. The Coroner did not ask Juror J any questions as to what was meant by the note. For instance he did not ask Juror J “What did you mean by that part of your note which states that you “feel this inquest is very unfair”?” Such a question may have elicited either a simple short answer identifying one particular aspect of the inquest which was considered by the juror to be unfair. It may have elicited a long and complex answer indicating concerns about the fairness of many aspects of the inquest.

[262] Mr Macdonald referred to the gender of the juror who had written the note (6/4/30/27) and was able to identify the particular juror (6/4/38/7). He accepted that there had been no perceived hostility from the juror prior to the note (6/4/38/16).

[263] Having heard all the submissions the Coroner ruled (6/4/39) that Juror J’s thoughts about the fairness of the inquest may relate to any number of possible concerns but that the juxtaposition of the two sentences persuaded him that the juror’s concern was procedural in nature. He did not consider that the note indicated that Juror J had made up his or her mind but that he or she had anxieties about the procedures. He considered that the anxieties could be remedied by six

directions which he proposed to give to the jury (6/4/40-41). He identified the juror by his or her number (6/4/39/28). He then gave those six directions in clear terms to the jury (6/4/41-43).

[264] I consider that the correct construction of the note is that Juror J was complaining about the cross-examination by counsel for the next of kin of a police witness and that the view of Juror J was that this inquest, that is the entire inquest, was very unfair. That is unfair to the members of the security services. That the juror was not prepared to keep an open mind when listening to the evidence and this was despite the directions and admonitions of the Coroner. If I am wrong in that decision then I find as a circumstance that the note is ambiguous but includes that construction.

[265] There were no further notes from Juror J during the inquest which lasted a further 22 days. No further untoward incident occurred in relation to Juror J or in relation to any other juror. No other juror reported to the Coroner any concerns as to Juror J or any other juror despite admonitions from the Coroner that they should make such a report if they had any concerns.

[266] The applicant relies as relevant circumstances not only on what occurred during the inquest but also on subsequent events. In an article published in the "Detail" on 28 October 2012 and written by Barry McCaffrey (2/82-85) (1/6/43/86) there was reference to Juror J's note to the Coroner. The account in that article of the content of the note is inaccurate in that it asserts that the note also contained the sentence "Do we really need to hear all this?" The same inaccurate description of the content of the note is contained in the affidavit of the applicant's solicitor, see 1/3/43/84. I do not consider that the content of the article is reliable.

[267] The applicant also relies as a relevant circumstance upon an allegation that subsequent to the conclusion of the inquest the applicant's solicitor was given further information about a complaint made by Juror J to Mr Jim Allister MLA, the leader of the Traditional Unionist Voice political party ("TUV"). The information as to this circumstance was hearsay evidence. The applicant's solicitor relates what he had been told by a person whom he did not name and that person in turn was relating what he had been told by another person, namely Sammy Morrison, the TUV's press Officer, (1/3/81/22). Mr Morrison was then relating what he had been told by Mr Allister who in turn was relating what he had been told by Juror J. I treat this evidence with considerable caution. The nature of the allegation is that subsequent to the conclusion of the inquest the applicant's solicitor was told that Sammy Morrison, the TUV's press Officer, was in contact with at least one media organisation and advised that organisation that Juror J had complained to Mr Allister about the Coroner. The applicant's solicitor goes on to state that the specifics of Juror J's complaint, *as he understood matters*, were that Juror J claimed that the Coroner had endangered his or her life by identifying his or her jury number in

open court while in the course of the inquest. That Juror J had submitted a note to the Coroner complaining about the cross-examination by counsel for the next of kin of a police witness. The applicant's solicitor also states that Mr Morrison advised the media organisation that Mr Allister had sent a letter of complaint on Juror J's behalf to the Lord Chief Justice and the Department of Justice. In fact a letter had not been sent to the Office of the Lord Chief Justice (1/11/1450 and 1451). It transpires that a letter had been sent to the Minister of Justice but the Department of Justice considered that the letter was exempt from disclosure under Section 41 of the Freedom of Information Act 2000 (1/11/1454) (1/11/1435-1537) and accordingly it is not possible to determine what was contained in the letter.

[268] It is submitted by Mr Macdonald, on behalf of the next of kin, that the TUV is "one extreme of the Unionist spectrum". He seeks to rely on an inference that Juror J is a supporter of the TUV and also holds extreme Unionist views. Despite the hearsay nature of the evidence and the inaccuracies to which I have referred I am prepared to find as a primary fact that subsequent to the conclusion of the inquest Juror J contacted Mr Allister. I am also prepared to find as a fact that this was to complain about the Coroner identifying the juror by his or her number. I am not prepared to find that the nature of the complaint was that Juror J was complaining to Mr Allister about the cross-examination by counsel for the next of kin of a police witness. The primary fact that Juror J contacted Mr Allister does not establish on the balance of probabilities the inference that Juror J supports the views or policies of the TUV, a legitimate democratic party or that Juror J holds extreme Unionist views. I do not consider that the contact between Juror J and Mr Allister is a circumstance which bears on the question as to the apparent bias of Juror J.

### **Conclusion in relation to the challenge to the Coroner's decision not to discharge Juror J.**

[269] The test is whether the fair-minded and informed observer having considered the circumstances would conclude that there was a real possibility that Juror J was biased. On the basis of what I consider to be the correct construction of the note and taking into account all the circumstances I consider that the fair-minded and informed observer would conclude that there was a real possibility of bias. On the alternative construction that there was ambiguity as to the meaning of the note but that one of the meanings is what I have held is the correct meaning, and given the lack of any enquiry of Juror J as to what he or she meant, then I also consider that the fair-minded and informed observer having considered all the circumstances would conclude that there was a real possibility that Juror J was biased.

[270] I consider that the Coroner ought to have discharged Juror J. I quash the decision of 4 October 2012 not to discharge Juror J. I also quash the verdict of the jury.

## Part Eight: Jury questions, directions and verdict

### The issues as to the questions left to the jury, the Coroner's directions to the jury and the jury verdict

[271] On 16 October 2012 the Coroner produced draft questions for consideration by the parties (2/414-416). On 17 October 2012 the applicant's solicitor provided proposed draft questions to the Coroner (2/431A-431E). The questions as drafted by the applicant invited yes or no answers to some questions with the potential for the answer "don't know". On 19 October 2012 the Coroner received submissions and was reminded of a number of examples of jury inquisitions from Article 2 inquests conducted in England and Wales (1/3/61/154 and 2/417-431). On 23 October 2012 the Coroner produced a final draft of the questions (2/432-433). These closely followed his original draft.

[272] The applicant contends that the questions posed by the Coroner:-

- (i) Compromised the jury's ability to effectively scrutinise the planning and control of the operation and the actions of Sergeant A in having recourse to lethal force.
- (ii) Tended to steer the jury towards the conclusion that the force used was lawful.
- (iii) Failed entirely to direct the jury to the issues and contentions so as to ensure that the jury reached a meaningful verdict capable of determining whether the force used was justified and whether the operation was planned and controlled in such a way as to minimise recourse to lethal force.

[273] The Coroner posed six questions for the jury (2/2-4). The questions were as follows:-

1. Summarise the scenario in which the death occurred, so that if I were a newcomer to the case with no knowledge of it, I could understand the broad background and circumstances.
2. What role, if any, did the Royal Ulster Constabulary have in the death of Mr Jordan? In particular:
  - (a) What was the nature and purpose of the operation in which the RUC was involved on 25 November 1992?

- (b) If you find that the death occurred as a result of a shot or shots fired by a police officer, describe as precisely as possible how the shooting took place. Consider in particular any actions, if there were any, by Mr Jordan before and at the time the shot or shots were fired, his position and orientation, and the actions and position of the officer who fired the fatal shot or shots.
- (c) If you find that the death occurred as a result of a shot or shots fired by a police officer, then when the officer fired, what was the officer's state of belief concerning the actions of Mr Jordan?
- (d) If you conclude that Mr Jordan died as a result of a shot or shots fired by a police officer then, having regard to your answer above regarding the officer's state of belief, was the force used by the officer reasonable in the circumstances?
- (e) Having regard to your answers above, particularly in relation to the officer's state of belief, was there another reasonable course of action (or other reasonable courses of action) open to the officer as an alternative to firing?
- (f) Having regard to the above, was the operation conducted by the officers at the scene in such a way to minimise to the greatest extent possible any recourse to lethal force?
- (g) Was there any aspect of the training of, or planning by, any RUC officer at the scene that could account for the death?

3. Please specify the wound or wounds sustained by Mr Jordan. Please specify, if you consider it possible to do so, what wound or wounds caused Mr Jordan's death? Is it possible to say in what order any wounds sustained by Mr Jordan occurred? If so, in what order was the fatal wound, or were the fatal wounds sustained?

4. Was the operation planned, controlled and supervised in such a way by the RUC as to minimise to the greatest extent possible any recourse to lethal force? Consider in particular:

- (a) The purpose of the operation;
- (b) The roles and responsibility of the various personnel involved;



- (c) Whether there were other reasonable steps that might have been taken in the course of the planning and control/supervision of the operation.

5. What part, if any, did Mr Jordan have in his death?

6. Beyond any findings you have made on consideration of the above questions, is there any other factor that you would wish to record as having in some (more than minimal) way caused or contributed to the death of Mr Jordan?

[274] At 4.00 pm on 26 October 2012 the jury returned and the foreperson stated that they had completed questions 1 and 2 a). That they had attempted question 2 b) and thereafter moved on to 2 c) and they were at a stalemate. The Coroner then sent the jury back to consider whether any further direction he could give would make a difference (1/3/64/163). The jury returned at 4.44 pm (7/15/11/12). The foreperson stated that in relation to question 2:-

“I mean, at this point in time there is a mind-set there that we’re not going to get by it.”

[275] The Coroner then asked about the other questions and was told:-

“... We have looked at a couple of them and we’re not going to come to an agreement on them either.”

[276] The Coroner then took questions 4, 5 and 6 away from the jury’s deliberation. He invited them to answer question 3. In relation to questions 2(b) - (g) he directed them that if they could not come to a unanimous verdict in relation to those questions then they were to record that, (7/15/12). After the jury had returned Mr Macdonald submitted to the Coroner that the answers could be no more than the most general description and that it would be wrong to allow it to masquerade as a verdict.

[277] The jury only answered questions 1, 2 a) and 3. In relation to questions 2 b)-g) they recorded “Findings not unanimous.” The answers to questions 1, 2 a) and 3 were as follows:

1. On 25/11/1992 based on intelligence (surveillance) of a Ford Orion being present at a site of a possible munitions movement, the RUC were to stop this car. After a forcible/controlled stop of the red Orion on the Falls Road, the driver exited the car, and was shot by an RUC officer

resulting in the death of the driver, Mr Jordan who died at 5.25 pm in RVH. A post mortem examination confirmed Mr Jordan died of a bullet wound of chest.

2. a) The nature and purpose of the RUC in the death of Mr Jordan was based on on-going military surveillance of 2-4 Arizona Street, and intelligence on 25/11/1992 of a possible movement of munitions in West Belfast by PIRA. T.C.G. directed HMSU to deploy personnel to the area to monitor movements of vehicles observed in the Arizona Street area.
3. Mr Jordan sustained three wounds, a bullet wound to the back of his left arm, a wound to the left shoulder and the fatal wound to the chest. It is not possible to determine the order in which the wounds were sustained.

[278] The Coroner accepted the verdict of the jury.

### **Conclusion in relation to this part**

[279] In *R (Middleton) v West Somerset Coroner and Another* [2004] 2 AC 182 Lord Bingham stated that the choice of questions must be that of the Coroner and his decision should not be disturbed by the courts unless strong grounds are shown. In *Re Gribben* [2012] NIQB 81 Weatherup J refused leave to apply for judicial review in relation to the questions left for the jury in the inquests into the deaths of Mr McCaughey and Mr Grew. In that case the jury returned an extensive narrative verdict. The questions in this case were broadly similar and left it open to the jury to arrive at a conclusion in relation to all the factors in dispute.

[280] I do not consider that the questions pointed the jury to a particular result. Question 2(b) invited the jury to consider the actions and position of the officer who fired the fatal shot or shots. Question 6 enabled the jury to make any finding that it wished to make. So also did question 2(b). Questions 2(c) and (d) put the issue of self-defence to the jury. Question 2(e) put to the jury whether the officer could have adopted an alternative. Question 2(f) again puts the issue fairly to the jury. I adopt in relation to these questions what Weatherup J stated about the questions in *Re Gribben* at paragraph [28] of his judgment.

[281] The applicant contends that the Coroner's directions did not comply with the test of absolute necessity set out by the European Court of Human Rights in *Bennett*.

It was submitted that a trained officer ought to be less likely to over-react and use lethal force and yet the Coroner directed the jury that the officer's training and experience led him to act in the way that he did. It was also submitted that an officer who fires in breach of codes of practice would be acting unreasonably and yet the Coroner directed the jury that it was open to them to conclude that even if Sergeant A acted in breach of the codes of practice it does not necessarily follow that he was not justified in law in resorting to lethal force. Those submissions have to be seen in the context of the clear direction given by the Coroner to the jury as to the correct test to be applied in relation to self-defence (7/15/7-9). That direction specifically referred to training and experience in the codes of conduct. It is also to be seen in the context of the element of discretion available to the Coroner in relation to his directions.

[282] In relation to the test of absolute necessity it is not necessary for it to be put to the jury in those terms as opposed to in domestic law terms. The direction in relation to self-defence and domestic law terms was a full and accurate statement of the law governing the use of force in this jurisdiction.

[283] I reject the challenge to the form of the questions and in relation to the Coroner's directions.

[284] In relation to the Coroner's decision to accept the verdict of the jury the obligation under Article 2 is not an obligation of result but of means. A jury could unanimously agree that it was not possible to answer the questions on the evidence available. That was not the jury's decision in this case. Rather the jury stated that they could not agree. In circumstances where, as here, the jury verdict did not arrive at a result as to how the deceased died and it was possible for an inquest to arrive at such a result, I consider that it was irrational to accept the verdict. In that context a result would include finding facts that tended to point to the killing being lawful or unlawful or alternatively that it was not possible to make a finding on the evidence in relation to some or all of the issues. On that basis I quash the decision of the Coroner to accept the jury verdict and I quash the verdict.

[285] I also consider that in exercise of discretion it was irrational to accept the jury verdict where, as here, the initial decision to conduct the inquest with a jury was inappropriate as also was the decision not to discharge Juror J. There was a reference by the jury foreperson to mind-set and stalemate giving added emphasis to these factors. Also on that basis I quash the decision of the Coroner to accept the jury verdict and I quash the verdict.

## Part Nine: Anonymity and screening

### The Coroner's decision on the anonymity of and on the screening of witnesses

[286] The sequence in relation to the decisions of the Coroner in relation to anonymity and screening were illustrated to me in relation to Officer B. That Officer submitted a statement of his personal circumstances which was made available to the applicant in redacted form (3/465). The police then made available a document entitled "Additional Information" (3/468). It recorded previous threat assessments. All threat assessments are carried out by the Security Services and not by the police. It stated:

"There is no specific intelligence held to indicate a specific threat to the subject at this time. However, there is a possibility that his personal security may be undermined should he be called to give evidence at the inquest in question. This may very much be influenced by the nature of the evidence he is giving, how this will be examined by the Coroner and whether or not it is considered "controversial" in nature." (3/469)

[287] It can be seen that the police assessment was that the undermining of his personal security may be very much influenced by the nature of the evidence he is giving ... and whether or not it is considered "controversial". The Coroner was also provided with a threat assessment carried out by the Security Services (3/470). Officer B was assessed at "a moderate threat from Northern Ireland related terrorism (NIRT) in Northern Ireland, which reflects our assessment of the threat to him from dissident republicans (DRs). The definition of moderate is "an attack is possible, but not likely."

[288] The threat assessment then went on to state that:

"An appearance at the Patrick Pearse Jordan inquest may serve to increase ... profile and potentially bring him to the attention of DR groups, *particularly if he is named and appears unscreened*. Should ... be identified in such a manner as a result of his appearance at the inquest, we assess that the NIRT threat to him has the potential to rise into the substantial threat band and possibly beyond. The definition of substantial is "an attack is a strong possibility"." (3/470) (emphasis added)

[289] The Coroner issued a *provisional* decision in June 2012 granting Officer B both anonymity and screening (3/471). There were then extensive submissions on behalf of Officer B (3/474-482) and on behalf of the applicant (3/483-492). On 29 June 2012 the Coroner decided to grant anonymity and screening to Officer B but declined to hold that a moderate risk engaged Article 2 and declined anonymity and screening to a number of other officers.

[290] Those officers who had not been granted anonymity and screening, commenced judicial review proceedings. The applicant commenced judicial review proceedings in relation to those officers who were granted anonymity and screening. These judicial reviews were heard by Deeny J. In his judgment delivered on 17 and 18 September 2012 he directed the Coroner to grant anonymity and screening to a number of officers who had previously not been granted anonymity and screening and he referred the position in relation to two other officers back to the Coroner.

[291] The inquest commenced on 24 September 2012. The applicant appealed the decision of Deeny J to the Court of Appeal and judgment was given on 17 October 2012. By that stage all the witnesses except Officer A had already given evidence anonymously and screened from members of the public and the next of kin though being seen by the Coroner, the jury and legal representatives. Officer A had commenced his evidence on 15 October 2012 and completed his evidence on 17 October 2012. In real terms all the anonymous and screened evidence had been completed prior to the judgment of the Court of Appeal. The Court of Appeal dismissed the applicant's judicial review proceedings on the basis that it was satellite litigation. The issues raised by the applicant should be addressed at the conclusion of the inquest. The Court of Appeal clarified the law in relation to a real and immediate risk and accordingly the engagement of Article 2. The court held that Article 2 was engaged in relation to the officers who had been refused anonymity and screening. They quashed the Coroner's orders refusing anonymity and screening and remitted the matter to the Coroner for reconsideration. The court stated:

“While it seems likely that the Coroner, following through the logic of his decisions in respect of those officers who were granted anonymity and screening will accord the witnesses the same arrangements it is a matter for the Coroner to determine in the light of the ruling of this court. In the meantime the anonymity of the witnesses should be preserved.”

[292] No application was made by the applicant to the Coroner to reconsider his decision in relation to those officers to whom he had not granted anonymity and screening. The Coroner drafted a decision but did not give it (10/3/25). In relation to those officers whom the Coroner had initially not granted anonymity and

screening the question arises as to what is the impugned decision. The Coroner was not invited to make a decision.

### **The applicant's contentions**

[293] The applicant contends that the effectiveness of the inquest was adversely affected by the orders granting anonymity in a number of ways:

- (a) The inability of the applicant and his legal representatives to carry out their own independent out of court inquiries into whether any of the police officers had been involved in other instances where lethal force was deployed or had been involved in instances which reflected adversely on their credibility. That this feature arises because the applicant does not know the names of the police officers and it is to be seen in the context that officers may have had a number of different cyphers attributed to them in different legal proceedings there being no central police record of all the different cyphers. For instance the personnel files of each individual officer do not have a record as to whether an officer has had a cypher attributed to him in an inquiry or in legal proceedings.
- (b) An inappropriate and heightened sense of confidence given to an anonymous witness when giving evidence in that the witness knows of the difficulties being faced by the cross-examiner in checking any of the witnesses assertions.
- (c) The difficulty in the jury following the evidence and the scope for confusion between different individuals given that the distinguishing terminology is a cypher. This difficulty and this scope for confusion is to be seen in context that different officers may have played similar roles.
- (d) Press reports and therefore the extent of public scrutiny being adversely affected in that press reporting is affected if the articles are about cyphers as opposed to identified named individuals.
- (e) The fact that anonymity and screening were granted in circumstances where it was anticipated that the evidence of the witnesses would not be controversial.

[294] The applicant also contends that screening was not a proportionate response.

### **The lack of names**

[295] The applicant asserts that the effectiveness of the inquest was adversely affected in that the applicant did not have the names of the police officers and accordingly he and his legal representatives could not carry out enquiries as to similar fact or credibility issues, see paragraphs [7], [8], [9](a) and (c) of *R v Davis* [2008] UK HL 36, paragraphs [63] and [64] of *Re Guardian News and Media Limited* [2010] 2 AC 697 at 723-724 and paragraph 26 of *R (on the application of E v Chairman of the Inquiry into the death of Azelle Rodney Inquiry* [2012] EWHC 563. I agree that anonymity has the consequence that independent enquiries cannot be made against the names of the witnesses but that is not to say that the inquiries necessarily would have revealed issues as to credibility or similar facts. Nor does it mean that such evidence would have been admissible in the inquest under the control stage even if they were relevant. The applicant asserts that the last injustice is not knowing what injustice has occurred. Again I agree that there is a risk that independent enquiries may have revealed some further information which is unknown to this court and that on analysis the further information could have been admitted in evidence. However, even if the names were known there is no guarantee that independent enquiries would have revealed such evidence.

[296] I also note that there were counter-measures that were taken to guard against this adverse consequence. Access was given to the Coroner to the personnel files of all the police officers. The Coroner made available documents from those files to the applicant. Each officer was asked whether he had been involved in any other incident involving lethal force and whether his credibility had been impugned in any way in the past. As a consequence, for instance, Officer M revealed his involvement in the events leading to the death of Neil McConville. The step of making those inquiries proved to be effective though there is no guarantee of complete effectiveness. In addition I consider that there were additional steps which it was open to the applicant to have sought. An application could have been made to the Coroner that every witness was asked on oath in the absence of the jury as to whether there was any credibility or similar fact issue. I do not consider that in the event the effectiveness of the inquest was undermined either at all or disproportionately to the need to protect life by the fact that the witness's names were not revealed.

### **An inappropriate sense of confidence**

[297] I am not satisfied that it has been established that there was any such impact at the inquest. In any event it is a matter to be assessed by the Coroner at the inquest and is within his discretion once Article 2 is engaged.

## **Difficulty in following the evidence**

[298] Thirteen cyphers were used for police officers in the inquest. H did not give evidence. There were three military witnesses who were surveillance officers. Each was anonymised with a cypher. Two of them were in the area of Arizona Street and one witnessed a part of the incident involving the death of the deceased.

[299] In the course of cross-examination other cyphers were used in relation to the death of Neil McConville and those involved in the 1982 deaths may have been referred to by way of ciphers. However Ms Quinlivan accepted that this part of the evidence was clear. In essence the complaint as to the difficulty following the evidence and the potential for confusion relates to the 13 police officers. There was in fact no confusion as to the lead or significant witnesses. Throughout the whole inquest the only confusion to which the applicant refers occurred during a small part of the Coroner's charge to the jury (see 7/14/28, 7/14/101 and 7/15/2/26). The upshot of that confusion was a ruling by the Coroner that he considered that he had got it right, that in any event it was corrected in court in front of the jury and even if it was not entirely clear he took "the view that not a tremendous amount hangs on it and the jury will, of course, have the bigger points that had been raised concerning this". The Coroner was not requisitioned in relation to that ruling.

[300] I do not consider that any significant confusion occurred at the hearing of the inquests and accordingly the balance that was struck prospectively was in fact vindicated retrospectively. I come to the conclusion that there was in fact no significant confusion for a number reasons including:

- (a) The lack of any requisition to the Coroner when he ruled that not a tremendous amount hangs on the confusion that arose during his charge. The lack of a requisition is not decisive but it is a factor that can be taken into account in assessing the significance of the matter being raised.
- (b) The lack of any protest during the inquest by counsel on behalf of the applicant.
- (c) The fact that it never occurred to the applicant's legal representatives or to anyone else that there was a need for a concise list of all the cyphers with against each cypher a short description of the role played by each individual.
- (d) The limited number of cyphers and the clear distinctions between those on the ground, those in the control room and any surveillance witnesses.



## **Press reports**

[301] I am not satisfied that it has been established that there was any adverse effect on press reporting by virtue of the fact that cyphers were used as opposed to identified named individuals. In any event it is a matter to be assessed by the Coroner at the inquest and is a matter for his discretion once Article 2 is engaged.

## **Controversial nature of the evidence**

[302] The applicant also asserts that anonymity was granted to some of the witnesses in circumstances where it was anticipated that the evidence of the witnesses would not be controversial. The applicant contends that the risk assessments linked the controversial nature of the evidence with the extent of the risk. It is correct that the police document entitled "Further Information" adverted to the influence of the nature of the evidence that is given and whether that evidence was considered controversial in nature (3/469). However, that connection was not contained in the Security Service's threat assessment which connected the increase in threat to *an appearance at the inquest* (3/470). The Security Services did not impose any limitation as to the nature of the evidence to be given by the police officer. The most reliable assessment is that of the Security Services and accordingly if the Coroner did not consider the nature of the evidence to be given, or which was given by individual officers, then that was in accordance with the threat assessment of the Security Services.

[303] In any event what is and what is not controversial in the context of this inquest is subjective influenced by the perspective of individuals forming a view. The controversial nature of the evidence is to be assessed from a number of subjective perspectives including those who would inflict a murderous assault. In relation to those police officers on the ground whose evidence was to the effect that they did not see or witness particular events immediately prior to the death of the deceased and from the perspective of the Coroner it might be suggested that this evidence was not controversial. However, the Coroner could anticipate that it would be suggested to those officers that they were lying to protect a colleague. Evidence that was uncontroversial in that the witnesses did not support Officer A could easily be anticipated would become controversial. Indeed, that is what occurred. It is more difficult to anticipate every twist and turn of cross-examination of other witnesses and it is even harder to anticipate what may be controversial from the perspective of those who would commit a murderous assault. It might be anticipated from the Coroner's perspective that the evidence of an officer who is a Log Keeper would be uncontroversial but against that the Coroner could anticipate that events might unfold in a way that called the log into question. The uncontroversial nature of the evidence could not be assumed even from the perspective of the Coroner. If in fact the witness having been granted anonymity and screening gives uncontroversial evidence either in the sense of not being

challenged or alternatively in the sense of some improper motive or conduct not being attributed to him, then in the event the nature of his evidence will not be of significance in the overall conduct of the inquest. Also in the event no application was made to the Coroner after evidence was given to withdraw anonymity from any of the Officers.

**Conclusion in relation to the challenge to the Coroner's decision on the anonymity of and on the screening of witnesses**

[304] A pre-requisite to a judicial review challenge is a decision. The Coroner was not invited to make a decision after the judgment was delivered by the Court of Appeal. Accordingly on that basis I dismiss the judicial review application in relation to those Officers to whom the Coroner had not initially granted anonymity and screening. Alternatively in the exercise of discretion I decline to grant any relief to the applicant in relation to those Officers.

[305] If I am incorrect in that conclusion I consider that the outcome of the balancing exercise, given the analysis of Deeny J and all the submissions which have been made to the Coroner was inevitable. If that was not so then an application would have been made to the Coroner.

[306] I dismiss that part of the judicial review challenge that relates to those officers to whom the Coroner had not initially granted anonymity and screening.

[307] The impugned decision in relation to officers who had been granted anonymity and screening is the decision of the Coroner dated 29 June 2012. The reasons given by Deeny J for refusing judicial review of the decision to screen the witnesses (see paragraphs 83-108) were prospective in advance of the inquest. I consider that all of those factors were in play. I note that the Security Services linked the risk to life with both a witness being named and appearing unscreened. I do not consider that the effectiveness of the inquest was undermined by the decisions to grant anonymity and to screen the witnesses.

[308] I dismiss that part of the judicial review challenge that relates to those Officers to whom the Coroner had initially granted anonymity and screening.

## **Part Ten: RUC Special Branch**

### **The involvement of former RUC Special Branch Officers in the disclosure process**

[309] Section 8 of the Coroners Act (Northern Ireland) 1959 imposes an obligation on the Chief Constable to provide the Coroner with such information ... in writing as he is able to obtain concerning the finding of the body or concerning the death. That obligation should not be compromised by (a) the appearance of bias, (b) actual bias or (c) lack of independence. The applicant contends that the involvement in the disclosure process of former RUC Special Branch Officers, the very unit under investigation in the inquest, compromised the independence of that process and the independence of the inquest. The applicant also contends that the manner in which these officers exercised their functions appears prima facie to have amounted to actual bias or the appearance of bias in that documents that would have been relevant to credibility and similar fact evidence were not disclosed by the officers to their superiors.

### **Sequence**

[310] The evolution of the various bodies responsible for the examination of legacy materials is as follows:-

- (a) In 2005 the PSNI set up the Public Inquiry Unit to assist in preparation for the public inquiries into the deaths of Hamill, Nelson and Wright.
- (b) In 2007 the Public Inquiry Unit became a part of crime support and was renamed "Public Inquiry and Legacy Unit".
- (c) In the summer of 2009 the Legacy Support Unit subsumed the Public Inquiry and Legacy Unit. (1/11/1362).

[311] The inquest which had been before Mr Sherrard concluded on 26 October 2012. The Senior Coroner in relation to what has been termed the Stalker/Sampson inquests had written on 23 October 2012 to the Crown Solicitor representing the PSNI raising a range of questions relating to the background of the support staff at Seapark which is the facility at which documents relating to the Stalker/Sampson inquests and this inquest are stored.

[312] By letter dated 29 October 2012 the Crown Solicitor responded. The solicitor for the applicant is involved in the Stalker/Sampson inquest and accordingly they were aware of this correspondence.

[313] The applicant's solicitor's first affidavit stated that it was subsequent to the conclusion of the inquest and in the course of his representation of the next of kin in

the Stalker/Sampson inquests in respect of Gervaise McKerr, Eugene Toman and Sean Burns that he was advised that former RUC Special Branch Officers and a former RUC Intelligence officer were responsible for the Chief Constable's compliance with the Section 8 obligation in the Jordan inquest (1/3/71/187-190). It was asserted that this emerged from a letter dated 29 October 2012.

[314] The letter of 29 October 2012 reveals that the issue had been evolving since 9 March 2012. For instance on 20 April 2012 the next of kin in the Stalker/Sampson inquests had enquired as to whether staff involved in the disclosure in those inquests, were former RUC or PSNI Officers. The matter was raised directly at a preliminary meeting in relation to the Stalker/Sampson inquests on 30 May 2012. The Crown Solicitor wrote on 20 June 2012 (13/44) confirming "that all five of the support staff had been RUC Officers that none of the officers had been involved in any of the index incidents and all had been appropriately security cleared for this type of work". Furthermore that the personnel in question were acting under the direction of the Legal Services Branch of the PSNI.

[315] It also emerges from the letter of 29 October 2012 that subsequently on 21 June 2012 counsel for the next of kin in the Stalker/Sampson inquests raised a further query as to whether the support staff were members of RUC Special Branch. This issue was raised in a letter dated 4 July 2012 and a reply was sent on 4 September 2012 (13/46). In that letter it was confirmed that four of the five officers engaged in the disclosure work had been Special Branch Officers and one had been engaged in intelligence work in the RUC. It was stated that the staff were overseen by a solicitor from the PSNI Legal Services Branch. That they were not involved in any investigative capacity but were solely involved in collating and preparing materials for appropriate PII certification and onward disclosure to the next of kin. The letter of 29 October 2012 goes on to state that "The same support staff assisted your office in the ... Jordan inquest ..." (3/673).

[316] After receiving the letter of 29 October 2012 the applicant's solicitor wrote to the Crown Solicitor on behalf of the PSNI and to the Coroner. The Coroner responded that "The employment of personnel to undertake the work required to fulfil the disclosure obligation is a matter for the Chief Constable" (3/679).

[317] By letter dated 15 February 2013 the Crown Solicitor responded on behalf of the PSNI (1/11/1362). The earlier letter of 29 October 2012, on behalf of the PSNI, had asserted that the same support staff had assisted the Coroner's Office in the Jordan inquest. The letter of 15 February 2013 makes it clear that the same individuals were not involved. The letter stated that the vast bulk of discovery in the Jordan inquest was provided on or before June 2008.

## **The RUC and Special Branch Officers involved in this inquest and the function that they performed**

[318] By letter dated 28 May 2013 (9/7/29) in relation to the Stalker/Sampson inquests the Crown Solicitor on behalf of the PSNI set out the involvement of six Legacy Support Unit ("LSU") Officers involved in the disclosure process in those inquests. Those Officers were not named but rather were referred to by the ciphers LSU1-LSU6. Insofar as this letter is relied upon by the PSNI I take into account that the sources of information have not been identified. The letter addresses the duties of the LSU Officers and the question as to whether they had heard of or served with any of the Stalker/Sampson witnesses. The Crown Solicitor has stated that "heard of" means "knew of the existence of" and "served with" means "involved in police operations" (9/7/230). I consider that those definitions are imprecise. There can for instance be many different ways in which one knows of the existence of an individual. The letter does not attempt to identify which of these LSU Officers were involved in the Jordan inquest. There was a degree of confusion at the hearing of this part of the judicial review application as to which officers had been involved in the disclosure process in this inquest as opposed to in the Stalker/Sampson inquests. I granted leave to the PSNI to file the further affidavit of Colin Stafford, Senior Legal Advisor with the Legal Services Branch of the PSNI (13/6). This clarified the position.

[319] The LSU staff involved in the Jordan disclosure process were LSU1, the supervisor, LSU6, a consultant and one other researcher who was also involved in a minor capacity in collating Jordan materials.

[320] The other researcher has since died but he was a Special Branch Officer and also served in HMSU. He had service overlap with one or more of the witnesses in the Jordan inquest (1/11/1364). He is stated to have had a minor role but no definition has been brought to that role. I will infer that it was the same as any other LSU researcher. No enquiries appear to have been made of the Jordan witnesses as to whether they knew or served with this individual.

[321] The duties of LSU1, the supervisor, who had not served in Special Branch but had been in the CID, was to allocate work to other team members, the application of electronic redactions to materials and preparation of disclosure bundles together with operation Nickel database searches. He had "heard of" Officers V, M and A.

[322] The duties of LSU6, consultant, who had served in Special Branch from 1989 to 2002 was to lead on consideration of sensitive materials provided by LSU1 for proposed PII redactions. He had heard of Officers V, M and A.

[323] Assistant Chief Constable Harris stated in his affidavit that:-

“... the disclosure process operated by PSNI in relation to legacy inquests and inquiries is subject to close internal and external scrutiny. Where former RUC personnel are engaged to examine archived material they do so under the supervision of the Legal Services Department of PSNI. Those employed as researchers do not make any executive decisions in relation to the disclosure or non-disclosure of materials. Their role is confined to the preparation of the original sourced materials for any necessary PII process or for redactions on common law or Convention grounds. Where there is a PII process the materials are examined by independent counsel and are then scrutinised by the Chief Constable and the Minister of State or Secretary of State prior to any certification. It is also important to note that these processes are completed under the supervision of the Coroner who will ultimately have access to all disclosure materials in redacted and unredacted form. This process was followed in the disclosure exercise in the Jordan inquest. All the materials that were subject to PII redactions were examined by the Coroner in unredacted form.” (13/4/15)

### **Other relevant factual conclusions**

[324] A substantial volume of documents had been disclosed on or before June 2008 but no sensitive material was disclosed prior to that date. Specifically none of the information relating to the overlap in personalities between the death of the deceased and those involved in the Stalker/Sampson investigation (1/3/78/9).

[325] The Coroner and the Coroner’s counsel had unredacted access to all the Stalker/Sampson material and to all the documents in what is termed the Nickel database, that is all the documents involved in the Stevens Inquiry. They attended at Seapark and availed of that access. For instance in relation to the Nickel database 20 lever arch files of documents were searched and nothing came out of that search. All the material held by the police was available to be seen by the Coroner and by counsel on behalf of the Coroner in unredacted form. The Coroner and counsel on behalf of the Coroner could have instructed that any document was relevant and should be disclosed.

[326] There was oversight of the disclosure process by:-

- (a) PSNI solicitors.

- (b) Counsel on behalf of the PSNI.
- (c) The Coroner.
- (d) Counsel for the Coroner.

[327] The LSU staff was not engaged in the investigation of linkages or overlaps between various inquests. They did not have an investigative remit (13/7/9). This accords with the information contained in the letter of 28 May 2013 that the PSNI are now establishing a system of cross-checking involvement of former HMSU witnesses in other controversial shootings. It also accords with the contents of a letter dated 5 July 2013 (9/7/231/10).

[328] The work of the LSU researchers, though under the control of the PSNI, was under the completely independent supervision of the Coroner and the Coroner's counsel. Furthermore it was under the supervision and control of solicitors in the PSNI Legal Department which solicitors as officers of the court owed duties to the court as well as to their employers. The PII process has elaborate legal safeguards. Any PII claim has to be considered by the Minister or the Secretary of State. At that stage there would have been consideration by counsel on behalf of the PSNI. The PII certificate is then subject to the court's final determination. All these stages involve consideration of the justification of any PII claim, see *Conway v Rimmer* [1968] AC 910 and *Wiley* [1995] 1 AC 274. In relation to Article 2 and Article 8 redactions the Coroner and his counsel are given access to the unredacted materials and the Coroner makes a determination on whether the proposed redactions are appropriate.

[329] The issue as to the involvement of Special Branch Officers was not raised with the Coroner in the Jordan inquest. In view of the contents of the letter dated 4 September 2012 the representatives of the next of kin could have raised this issue in this inquest before it commenced on 24 September 2012.

[330] The PSNI are presently dealing with approximately 40 legacy inquests (13/7/6). The resulting documentation is vast including documents generated by the initial police investigations, the Stevens Inquiry, the Stalker/Sampson Inquiry, prosecution files and personnel files. The risks of jigsaw identification and the consequences for individuals are not to be underestimated. Andrew Harris, Assistant Chief Constable, has stated:-

“Because of the sensitive nature of the intelligence materials involved, it has been necessary to engage individuals who had a working knowledge of RUC intelligence systems.”

In effect it is the evidence of the PSNI that the engagement of the particular individuals was a pragmatic response to a difficult situation.

### **Submissions on behalf of the Coroner and the PSNI**

[331] The Coroner submits that this matter was never raised with him and that he has no responsibility for and no control over those whom the Chief Constable engages.

[332] The PSNI submits that:

- a) factually the former Special Branch Officers and the former RUC intelligence Officer have not been delegated the responsibility of complying with Section 8 of the Coroner's Act (Northern Ireland) 1959. That the Chief Constable has, at all times, retained that responsibility.
- b) the role of the Officers was limited.
- c) disclosure in the Jordan inquest took place over a period of two decades and that the vast bulk of disclosure was made prior to 2008. That since 2008 and since the involvement of the former Special Branch Officers and the involvement of the former RUC Intelligence Officer the additional materials which have been provided have been limited to:
  - a. A small number of Ministry of Defence statements;
  - b. Some pages from the Investigating Officer's report;
  - c. Statements made by Officers A, M and V in relation to the Stalker/Sampson Inquiry;
  - d. There was no actual bias and that there were sufficient safeguards in place to deal with any appearance of bias;
  - e. The role of the PSNI in the inquest is administrative to assist the Coroner. That is for the Coroner to investigate and obtain the evidence and that the staff, in the Legacy Support Unit are there to ensure that the PSNI's Article 2 duties by way of redaction and PII obligations are properly performed.

### **Conclusions in relation to this part**

[333] For an investigation into alleged unlawful killing by State agents to be effective, it may generally be regarded as necessary for the persons responsible for



and carrying out the investigation to be independent from those implicated in the events. This means not only a lack of hierarchical or institutional connection but also a practical independence. In addition there must not be actual bias or the appearance of bias. All State Authorities involved have an obligation to maintain the independence of those involved on their behalf and it is the responsibility of the Coroner to deal with any allegation that there is a lack of independence if the matter is raised with him or comes to his attention. I reject the submission that legally the Coroner has no responsibility for and no control over those whom the Chief Constable engages. It is the Coroner's investigation and he can direct the PSNI. However this issue was not raised with the Coroner nor is there any evidence that it was brought to or came to his attention. On that basis I dismiss this part of the challenge to the role played by the Coroner.

[334] I consider that there was some justification for using Special Branch Officers given the potential for compromising the right to life of, for instance informers, the limited role of the LSU researchers and the safeguards inherent in the system. I am not satisfied that it was a necessity and so much is evident from the alternative arrangements that are now being considered or have already been put in place. The question remains as to whether the safeguards ensured the independence of the process.

[335] The independence of the PSNI's investigatory process and therefore the independence of the Coroner's investigation is not in question because factually the LSU Officers were not investigators. Their role related to PII and Article 2 redactions. The LSU Officers had no investigatory role by virtue of the limitations on their duties. The independence of the investigatory role has not been compromised.

[336] I reject the suggestion that the LSU staff, knowing of the involvement of the Jordan witnesses in events surrounding the Stalker/Sampson deaths failed in their duty to bring this to the attention of the PSNI Legal Services Department or of the Coroner. They had been given no such duty. They were specifically told that they were not investigators. The PSNI had proceeded on the basis that the investigator is the Coroner and all that the PSNI is required to do is to provide administrative assistance to the Coroner. Accordingly, that the PSNI had no obligation to obtain similar fact or credibility evidence. That was a misconception which led to the roles of the researchers being restricted. As is apparent from this judgment the police have an obligation to bring similar fact or credibility issues to the attention of the Coroner and they have an investigative role in that respect.

[337] The role of the LSU Officers in relation to PII and Article 2 redactions was all the same an important and significant role. It also should be independent. If there were no safeguards in place then I consider that there would be a breach of the Article 2 requirement of independence and that there would be the appearance of

bias. However I consider that the safeguards that were in place were sufficient to ensure independence. For instance there was nothing secret. All the documents were available to the Coroner and his counsel. They could have called for a justification of any action by any of the researchers.

[338] I reject the proposition advanced on behalf of the PSNI that the role of the police is purely administrative rather than investigatory. The obligation on the PSNI is "to obtain" as well "to give" documents. That includes obtaining documents potentially relevant to similar fact or credibility issues.

[339] I reject the proposition that the PII and Article 2 redactions were not independent given the safeguards in place. I decline to grant any relief to the applicant in relation to this part of the judgment.

[340] If I am incorrect in my conclusions I would still in the exercise of discretion decline to make any order given that the matter was not raised with the Coroner by the applicant at an earlier and more appropriate stage.

## Part Eleven: Delay

[341] There has been delay. The Article 2 requirement of promptness and reasonable expedition has not been met. The question is whether one or other or both of the notice parties is responsible.

[342] Delay in this case has been judicially analysed on a previous occasion by Hart J. The circumstances in which he did so arose in a somewhat different context. An application was made to the Senior Coroner that he should recuse himself from hearing the inquest on the grounds of both apparent and substantive bias. Alleged delay on the part of the Senior Coroner was one of the circumstances upon which it was suggested that a fair-minded and informed observer would conclude that there was a real possibility that the Senior Coroner was biased. The Senior Coroner decided not to recuse himself and the applicant brought judicial review proceedings in relation to that decision. It was those proceedings which were heard and determined by Hart J. The Coroner was a respondent to the application and the PSNI was a notice party. Hart J delivered judgment on 17 July 2009 under citation [2009] NIQB 76. He dismissed the application for judicial review. The applicant appealed and on appeal the question was raised as to whether, quite apart from the allegations of apparent bias which were strongly refuted and had been rejected by the trial judge, it would be in the best interests of the inquest for a differently constituted Coroner to hear the inquest. The question was raised not as an indication that the Court of Appeal had formed any adverse view of the Senior Coroner's conduct, for they had not, but rather to see how best the inquest should be brought to conclusion, see [2009] NICA 64. The Senior Coroner stood down and thereafter Mr Sherrard had conduct of the inquest.

[343] Hart J in his lengthy and detailed judgment, which the Court of Appeal described as compelling, had carefully analysed all the periods of delay. In relation to the period from 1995 to 2007 he stated:-

“In general terms it can be stated that virtually all of the delay which occurred during that period was occasioned by:-

- (i) Deficiencies in the Coroner's Rules;
- (ii) Inaction on the part of the Government in making changes in the rules;
- (iii) The non-availability at the early stages of legal aid for inquests;

- (iv) The steadfast resistance of the Chief Constable to making available to the applicant various categories of documents which the applicant sought;
- (v) Frequent, complex and protracted litigation over many issues arising out of (i) to (iv).

None of the matters at (i) to (iv) can properly be considered to be the responsibility of the Senior Coroner, ...”

He also held that:-

“I am satisfied that there was no unjustifiable delay on the part of the Senior Coroner in convening a preliminary hearing after the House of Lords gave its judgment, and that there is no substance in the assertion that the Senior Coroner was at fault in this respect.”

Further it was held by Hart J:-

“Having considered the chronology of events during that period, the transcripts of the preliminary hearings and the voluminous correspondence between the parties which interspersed these hearings, I am satisfied that it is apparent that the repeated delays in commencing the inquest during that period were entirely due to the continuing efforts of the PSNI to avoid providing to the next of kin documents that they sought, (a) in respect of the withheld portions of the investigating officer’s report, and (b) the ‘irrelevant documents (as they will be later described) promised by the Chief Constable to the next of kin as far back as 2000, together with claims for PII brought by the Chief Constable and the judicial review generated. Throughout the entire period not only was the Senior Coroner making every effort to fix dates, but he had to deal with voluminous and detailed correspondence from the parties in relation to this matter. He rapidly responded to the matters raised therein and, where necessary, as I have

already pointed out, fixed deadlines for the productions of documents.”

[344] In effect Hart J exonerated the Senior Coroner in respect of any delay prior to June 2009 and he attributed the delay to amongst other matters, deficiencies in the Coroners Rules and to the PSNI.

[345] Deficiencies in coronial law have been recognised on a number of occasions. The Court of Appeal on 6 October 2009 stated:-

“The current state of coronial law is extremely unsatisfactory. It is developing by means of piecemeal incremental case law. It is marked by an absence of clearly drafted and easily enforceable procedural rules. Its complexity, confusion and inadequacies make the function of a coroner extremely difficult and is called on to apply case law which does not always speak with one voice or consistently. One must sympathise with any coroner called on to deal with a contentious inquest of this nature which has become by its nature and background extremely adversarial. The problems are compounded by the fact that the Police Service which would normally be expected to assist a coroner in non-contentious cases is itself a party which stands accused of wrong-doing. It is not apparent that entirely satisfactory arrangements exist to enable the PSNI to dispassionately perform its functions of assisting the coroner when it has its own interests to further and protect. If nothing else, it is clear from this matter that Northern Ireland coronial law and practice requires a focused and clear review to ensure the avoidance of the procedural difficulties that have arisen in this inquest. What is also clear is that the proliferation of satellite litigation is extremely unsatisfactory and diverts attention from the main issues to be decided and contributes to delay.”

[346] *In the matter of an application by Officers C, D, H & R* [2012] NICA 47 Girvan LJ stated:

“... the law of inquests and coroners has developed in an unstructured and piecemeal way, particularly following the incorporation of the European Convention of Human Rights

and the need to ensure that inquests comply with the state's Article 2 obligation to ensure proper investigation into deaths involving state agencies. The underlying statutory provisions and rules governing inquests are outdated and were clearly not drafted with the Convention in mind and they have not been properly updated to be made fit for purpose in the new Convention world. The state authorities have effectively allowed costly litigation to take the place of sensible, rational and structured reform of coronial law."

[347] Hart J held in respect of the Senior Coroner that so far as lies within his power he had made every effort to ensure that the inquest was heard. This finding reflected evidence in the affidavit of the Senior Coroner (11B/B/1/27/38) in which it was stated:-

"It is not my role as Coroner to ensure full compliance with the process of disclosure as between the police and other interested persons. ... However, if a particular class of document is sought (or it is apparent to me that the police either have it or should have it) I will of course write to the police to request production of such documents. Beyond that, however, I have no power."

This passage reflects again the need for clearly drafted and easily enforceable procedural rules. The Senior Coroner cannot be faulted in the present state of coronial law for making those assertions. I have held that the Senior Coroner is not restricted to requesting documents but rather does have power to require compliance with directions. Again the law is being clarified by means of piecemeal incremental case law. The obstacles and difficulties that impact on the Senior Coroner and the Coroner is the state of coronial law. The Senior Coroner and the Coroner are not responsible for coronial law. I dismiss this judicial review challenge in respect of them.

[348] The PSNI were a notice party to the proceedings before Hart J. In a skeleton argument in this application it was contended on their behalf that "the doctrine of res judicata should apply" with the consequence that there was no culpable delay prior to the date of Hart J's judgment and that this challenge should be confined to the period following that judgment. However Hart J did not find that there had been no culpable delay but rather that there was no such delay on the part of the Senior Coroner. He found culpable delay on the part of the PSNI. The principle of res judicata, if it applies, would lead to a finding against the PSNI.

[349] The applicant relied on a number of periods of delay on the part of the PSNI. I do not propose to analyse all of them. As will become apparent I am content that the PSNI have both created obstacles and difficulties which have prevented progress in the inquest and have also not reacted appropriately to other obstacles and difficulties.

### **Over redacted documents**

[350] On 28 March 2007 the House of Lords delivered judgment in *McCaughey v Chief Constable* [2007] UKHL 14. Lord Bingham stated that the duty under Section 8 of the 1959 Act was a continuing duty. The PSNI purported to discharge that duty in late December 2007 by providing four lever arch files of documents to the Coroner and to the applicant. The applicant states that the documents had been so heavily redacted that they were unintelligible. In January 2008 the PSNI undertook to look again at the redactions and in May 2008 provided six lever arch files of documents that had been redacted in an appropriate manner. Accordingly the law having been clarified in March 2007 a period of one year and two months elapsed before the documents were made available by the PSNI.

[351] Dr McGleenan accepted that the December 2007 documents had been overly redacted. That the redactions had been done imperfectly. I consider that the redactions undertaken to the 2007 documents created obstacles and difficulties. This was not the PSNI justifying delay by reference to obstacles and difficulties but was rather the PSNI, albeit in good faith, creating obstacles and difficulties.

[352] In addition to that finding I have considered whether any part of the period March 2007 to May 2008 has been justified by the PSNI by reference to obstacles and difficulties. There is no evidence that the PSNI undertook any steps in relation to disclosure until they were directed to do so by the Coroner in September 2007. Thereafter it took some three months before the four lever arch files were delivered in December 2007. I consider that given the complexities and difficulties of the case a three month period may well have been appropriate but not a period of one year and two months.

[353] The delay in relation to disclosure was a factor which impacted on the hearing date of the inquest. The hearing was due to commence on 1 February 2008. Given the failure to disclose the documents the Coroner on 4 December 2007 adjourned the hearing until 7 April 2008 (11A/3/12/32).

### **The threat assessments for the purposes of Article 2**

[354] On 5 September 2007 at a preliminary hearing the PSNI advised the Coroner that anonymity applications would take three months (11A/10/5/10). The inquest was listed for February 2008. Some three months later on 4 December 2007 the

Coroner directed that anonymity applications should be in a position to proceed in the first week of January 2008.

[355] The inquest was adjourned to 7 April 2008. On 7 January 2008 the PSNI advised that the process of carrying out threat assessments had been placed within the remit of MI5 and that a memorandum of understanding had to be reached between the PSNI and MI5.

[356] In effect the process of risk assessment, which is an essential component part of any anonymity application, had not commenced, or if it had commenced would have to commence again but only after a memorandum of understanding had been reached .

[357] I consider that this was an obstacle or difficulty created by the PSNI which prevented progress of the inquest.

#### **Conclusion in relation to this part**

[358] I dismiss the third judicial review application in respect of the Coroner.

[359] I grant a declaration in respect of the PSNI. I will hear further submissions in relation to the question of damages and the form of the declaration.



## **Part Twelve: Overall conclusion**

[360] The overall conclusion is that I issue an order of certiorari quashing the verdict at the inquest. I give liberty to apply in relation to the exact form of the various orders and will hear further submissions in relation to damages, if any.