Judicial Communications Office

7 November 2016

PEARSE JORDAN INQUEST FINDINGS DELIVERED

Summary of Judgment

Mr Justice Horner, sitting as a Coroner, today delivered his findings at the inquest into the death of Patrick Pearse Jordan who was shot and fatally wounded by a member of the RUC on the Falls Road, Belfast on 25 November 1992. **He said it was impossible with the passage to time to say with any certainty what happened on that date**.

Mr Justice Horner's findings were:

> "The deceased was shot and fatally wounded on 25 November 1992 on the Falls Road. At the time of his death he was on a mission for PIRA. He was unarmed. The Ford Orion which he was driving had been used earlier that day to carry substances used in the making of improvised explosives, namely ammonium nitrate and sugar. At the time of the shooting the Orion car was not being used to ferry guns, explosives or other munitions.
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> "It is now impossible with the passage of time to say with any certainty what happened on that fateful afternoon. At the remove of a quarter of a century I am simply unable to reach a concluded view which is fair and just as to whether the use of lethal force was justified or not. I remain profoundly unsure as to what happened. Neither side, for the reasons I have set out, have been able to convince me that what they say did occur immediately prior to the deceased's death. On the balance of probabilities if the events did happen as the PSNI contend, and as I have said I have been unable to determine that issue on the balance of probabilities, I am satisfied that Sergeant A acted in self-defence and that there was no breach of Article 2. However, in so far as the onus lies on the PSNI to provide a satisfactory and convincing explanation to the inquest for the use of lethal force it has failed to do so. But how precisely the deceased met his death on that fateful afternoon has not been proved to the satisfaction of this inquest and remains unknown."

Background

The original inquest into the death of Patrick Pearse Jordan ("the deceased") commenced on 4 January 1995 but was adjourned part-heard. A further inquest held at the end of 2012 was set aside by the High Court and the Court of Appeal. The inquiry into the death of the deceased has been the subject of 24 judicial reviews, 14 appeals to the Court of Appeal, two

hearings in the House of Lords and one hearing before the European Court of Human Rights.

The scope of the inquest had previously been agreed between the parties and focussed on factual questions about the shooting, the debrief that followed the shooting and the planning and control of the operation. The Coroner, by agreement, sat without a jury.

The inquest heard that the Ford Orion car the deceased had been driving had been hijacked by the Provisional IRA ("PIRA") earlier on 25 November 1992. The RUC had suspicion that there was to be a movement of explosives/arms that day from Arizona Street in West Belfast. At 3.40 pm, military intelligence was received that a "DP2", was with an unknown person at the Whiterock Leisure Centre in a Ford Orion. DP2 was described as a well-known activist who had been a Quartermaster for PIRA and who had been involved in moving explosives on at least one other occasion.

Two cars containing HMSU[1] officers were deployed to go and stop the car. The stop was to be a "soft stop" ie an indication was to be given to the driver of the Orion to pull over on the basis of the car's defective rear lights and the car was then to be checked. The inquest was told the PIRA's usual practice was to give a car carrying munitions a "scout" car which would travel ahead. The fact that the Orion was not acting in conjunction with any other motor vehicle at the time of the proposed stop was a strong indicator that it was not being used to ferry munitions. The police's expectation, based on other successful counter terrorist operations, was that the driver would stop when requested to do so.

One of the HMSU cars flashed its headlights indicating to the Orion to stop. Instead it drove off at speed. This seemed to have confirmed to the police that the driver was on a terrorist mission and that there was good reason to suspect that the Orion was carrying munitions. The police gave chase and forced the Orion to stop by ramming it. The deceased ran from the car and was shot in the back by Sergeant A. First aid was attempted at the scene but the deceased died before he reached hospital. Other police officers immediately went to carry out a search of houses at Arizona Street and found evidence of homemade explosives and a timer unit. Mr Justice Horner said that "when all the information is considered, there is strong evidence of terrorist activity taking place at Arizona Street that day and that the Orion and its occupants were active participants in such activities".

PIRA subsequently claimed that the deceased was a volunteer although he had not come to the attention of the RUC or Army in connection with any terrorist or criminal activities. Mr Justice Horner said it was not contested that the deceased was acting on behalf of PIRA that day and that he was probably the unknown person seen with DP2 at Whiterock Leisure Centre. He said that while it is true that nothing was found on the deceased afterwards to indicate that he had been handling explosives or firearms that day, there were significant traces of substances in the boot of the car which are used in the manufacture of homemade explosives and that it is likely that the car had been used to move those substances that day and that the deceased had assisted in that operation:

[1] HMSU – Headquarters Mobile Support Unit

"PIRA's dirty work and the consequent risk of arrest or worse had been farmed out by its senior members to a young man scarcely out of his teens who in his naivety may not have appreciated the risks he was running. However, whatever his role, he was actively engaged in serious terrorist activities on that day in question and these could ultimately have resulted in widespread damage and mayhem, and caused perhaps causing injury or death, to civilians and security force members alike."

"However, in no way did membership of such an organisation or indeed lending assistance to such a terrorist group, mean that such a person had in some way forfeited the right to be protected by the law. Such a person was still entitled to the full protection of the law which includes the presumption of innocence, the right to a fair trial and the right to have legal representation. The rule of law demands no less. He does not become an outlaw who can be summarily executed whether by officers of the State or otherwise. It is only in carefully defined and circumscribed circumstances that an officer can open fire on a civilian. The central issue in this inquest is whether or not this was one such occasion."

The Coroner noted:

"It is impossible not to feel the pain and grief of Mr and Mrs Jordan, the Deceased's parents, sitting in court day after day with a quiet dignity listening intently as the events of that fatal day on 25 November 1992 were replayed time and time again. Grief was etched on their faces and their tragic loss after all these years was still painfully raw. They had needlessly lost a beloved son, taken from them in his prime. They were there looking for an answer. I respect their deep and proper desire for a fair, open-minded and diligent consideration of all relevant matters and facts relating to the death of their son.

"Looking across at the witness box they saw opposite them a number of policemen give evidence. These were men who have borne witness to the difficulties of operating in the terrible times which prevailed in Northern Ireland some 25 years ago. These men have had to live with the imminent threat to their lives as they did their best to contain a widespread terrorist threat across the whole of Northern Ireland. These too appeared to be decent men, placed in a world beyond most people's understanding, living their lives on a cliff edge, still at risk even today and too afraid for their own safety and that of their families to be called to give evidence by name.

> Many of them will bear deep mental scars, a product of their quest to protect the lives and properties of the ordinary, decent citizens of Northern Ireland."

Article 2 ECHR

Article 2 of the European Convention on Human Rights permits the State to use force in the prevention of crime or to affect a lawful arrest where it is absolutely necessary. Mr Justice Horner said the task for this inquest, conducting an Article 2 compliant inquest, must be to ask whether Sergeant A was acting in self-defence, that is "whether Sergeant A had an honest and genuine belief that it was necessary for him to open fire". He said he would have to examine Sergeant A's belief from a subjective position consistent with the circumstances in which he found himself and which would involve taking into account Sergeant A's training experience and his knowledge and awareness of the RUC Code of Conduct. He would then have to consider whether his decision to open fire was "absolutely necessary" ie whether in all the circumstances it was proportionate or reasonable having regard to what the person honestly and genuinely believed.

Article 2 also requires the State investigating a death that is a consequence of actions by State agents to do so with due expedition. The Coroner noted comments made by the High Court in quashing the 2012 inquest verdict 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". He further noted comments that the government also contributed to the delay by its dilatory behaviour in amending the Coroners Rules and failing to make legal aid available for inquests. The Coroner said the irony is that in delaying this inquest, the PSNI had made the task of satisfying the burden placed on them immeasurably more difficult:

> "The passing of time … makes the task of the fact finder more difficult. Consequently, the State, by delaying these investigations has placed itself at an inevitable disadvantage in trying to satisfy the Article 2 burden of proof."

Finally, Article 2 requires State authorities to plan the operation and put in place controls to minimise the need to resort to lethal force.

Representations made by the parties

The primary representation made on behalf of the deceased's next of kin was that he was shot in the back at close range by Sergeant A without cause or justification when he was fleeing the Orion and that he presented no threat to any policeman or anyone else at the scene. Their case is that Sergeant A believed that the driver of the car was DP2. The Coroner said there was strong empirical evidence to support this version of the events as the bullets which struck the deceased were fired from his rear. He said that if that is how the deceased met his death then his killing is without justification and contrary to Article 2.

The case made by the police, however, was that the deceased's decision to "do a runner" was compelling evidence that he was driving a car with either a bomb or munitions on board and it was likely that he was armed. He dashed from the stationary car with his hands low and unseen by Sergeant A. The deceased turned dynamically and Sergeant A, fearing he was armed and about to shoot either him or his colleagues, fired five bullets in automatic mode, three of which struck the deceased. Sergeant A was adamant that although the deceased was turning, he was facing him when he pulled the trigger. He also claimed that it was an error on his part when flicking the safety switch off which resulted in him firing five shots in quick succession in automatic mode instead of firing a single shot as he had intended.

Discussion and Findings

Mr Justice Horner found that the objective, empirical evidence proved beyond doubt that the deceased was shot in the back by Sergeant A who fired a burst of five rounds of automatic gunfire. But, he said, the circumstances in which those rounds were discharged are highly contentious and the difficult task of determining what actually occurred has been made nearly impossible by the delay of nearly 25 years which has undoubtedly dimmed memories and shaped the recollections of those who were involved.

The Coroner summarised his conclusions as follows:

<u>Evidence of Civilian Witnesses</u>

- The evidence given by the four civilian workmates had "undoubtedly been coloured by prejudice and animosity towards the security forces". The claims that the police administered a brutal kicking and punching to a dying man in full view of backed up traffic were scarcely believable. There is no physical evidence to support it. The Coroner considered their evidence unreliable with obvious inconsistencies running throughout. He remained unimpressed by their evidence but said that, in fairness, they face a near impossible task of trying to remember back all those years.
- The evidence of Lawrence Moylan was undermined by inconsistencies. The Coroner said his evidence could not be tested as he was unable to be contacted and therefore did not appear at the inquest.
- Patrick McAllister also could not be contacted and therefore did not give oral testimony. The Coroner said his statement and the transcript of his evidence to the 1995 aborted inquest seemed convincing. He clearly saw the deceased shot in the back and if there was a dynamic turn by the deceased, then he missed it, which the Coroner said would be surprising.
- The Coroner found the evidence of the civilian witnesses (for the most part) to be unreliable and having seen them give evidence he was not prepared to give weight to it whether for the next of kin or the RUC.

<u>The Expert Evidence</u>

- The Coroner was satisfied that it is scientifically possible in certain clearly defined circumstances that the deceased may have appeared to be facing Sergeant A when he decided to open fire but that the bullet that killed him would have entered him from the rear because of the turn he was making at the time.

The Police Officers

- The Coroner said the general impression he had of the HMSU officers in the two police cars which tried to stop the Orion was a "favourable one". He accepted the version of events they gave as scientifically possible, although objectively it is unlikely. He remained unconvinced, on the balance of probabilities, that what he was being told as to how the deceased met his death happened for a number of reasons including:
    - He concluded that some of the officers who gave convincing testimony were lying about their knowledge of how the operation was reported by the press in the immediate aftermath. The Coroner said he simply did not believe that none of them bothered to find out how this incident had been reported and consequently failed to learn that it had been described as a botched operation;
    - The way in which the debrief was conducted, by permitting Sergeant A to give his version first, had the ability to contaminate and taint the versions subsequently offered by his fellow officers;
    - The evidence of Patrick McAllister to the 1995 inquest, which appears to deserve to be given weight, contains no claim that the deceased turned around prior to the shooting;
    - The evidence of Sergeant A does not include any claim that he saw the deceased turn right around;
    - Sergeant A was prepared to tamper with a police log in 1982 to provide a false cover story.
- The Coroner said he had not been satisfied on the balance of probabilities that he had been told the truthful version by the police officers concerned as to how the deceased met his death. If the RUC version is correct, then there will have been no substantive breach of Article 2.

The Next of Kin

- The Coroner found that the version of events put forward by the next of kin also had its difficulties. He said that no satisfactory explanation had been offered why Sergeant A, with all his experience, training, and years of not using unnecessary force would "suddenly assume the mantle of a cold-hearted killer who believed that he was entitled to shoot on sight and in the back a young man simply because he was assisting PIRA".
- The Coroner was not persuaded by the representations made on behalf of the next of kin as to how the deceased's death occurred.

The Coroner concluded that he was not prepared to speculate on the circumstances in which the deceased met his death as they have not been proved to the requisite standard and it would be unjust and unfair of him to guess:

> "It is sufficient to record that no version has been put forward which commends itself to this inquest on the balance of probabilities. The reason why delay is the enemy of justice is clearly demonstrated by this inquest. Taking into account all the evidence which has been adduced it is not now possible at the remove of 25 years to reach a final conclusion which is fair and just to both sides, given the doubts which I continue to harbour about how the deceased met his death all those years ago. It follows therefore that in my opinion the State has failed to discharge the onus which lies upon it under Article 2 of the ECHR to prove on the balance of probabilities that the killing of the deceased was lawful. It remains a matter of some speculation whether, had the PSNI discharged its obligation of full disclosure at an earlier stage, and had an inquest been held with due expedition, whether the quality of the evidence available would have been sufficient to discharge the onus upon it."

Findings on Key Issues

In agreeing the scope of the inquest in 2014, Mr Justice Stephens set out a number of issues to be answered:

a) **Why Sergeant A had a round in the breech before he got out of his car?**
   Mr Justice Horner was of the view that when the Orion took off Sergeant A was justified in having a live round in the breech because of the real risk that such a reaction signified that the Orion was carrying munitions and that the driver might be armed and prepared to shoot his way out, if necessary, should the police attempt to stop his car.
b) **Whether Sergeant A shouted "Police, halt" or words to that effect before he fired:**
   The Coroner said the evidence on this was thin and there was no independent support for Sergeant A shouting these words or indeed shouting at all. He was satisfied that he shouted something at the deceased before he fired but could not be satisfied on the balance of probabilities that these were words to the effect of "Police, halt". He had no doubt that the deceased knew that police officers had exited their car and that they were almost certainly armed. The Coroner was unable to reach a definite and firm conclusion on this issue, however, he had no doubt that Sergeant A shouted and that the deceased was aware of his presence.
c) **Whether Sergeant A issued any warning that he was going to fire?**
   The Coroner was not satisfied on the balance of probabilities that Sergeant A issued any warning that he was going to fire and Sergeant A did not make that case.
d) **Whether the deceased did anything that as a matter of objective fact posed a threat to Sergeant A or to any other police officer?**

The Coroner was unable to reach a firm conclusion as to whether in fact the deceased turned as alleged by Sergeant A but said that if he did then Sergeant A would have a good reason to fear for his life and those of his colleagues. The Coroner said that 25 years later he remained unsure as to what happened on that night and is not prepared to speculate.

e) **Whether Sergeant A's view of the deceased's hands was obstructed?**
The Coroner was unable to reach a view on this as it depended on other evidence which caused him sufficient concern to leave him undecided as to how precisely the deceased met his death.

f) **Whether the deceased turned round to face Sergeant A?**
See (e) above.

g) **Whether the deceased was facing Sergeant A when Sergeant A fired at him?**
See (e) above.

h) **Whether Sergeant A honestly believed that the deceased did anything to pose a threat to him or at any other police officer?**
The Coroner said he remained unsure as to the circumstances in which the deceased was shot and was not prepared to guess.

i) **Whether Sergeant A selected automatic fire rather than a single shot deliberately or accidentally?**
The Coroner considered that Sergeant A did not intend to engage automatic mode but did so accidentally as he pushed the switch forward. He said there is evidently a problem with the gun's mechanism and that if the nature of the mechanism in general and the force required to move from safety to automatic is such that it is the same now as it was in 1992, then it should not be used by armed police officers. The Coroner strongly endorsed the recommendation to the PONI in the report prepared following the death of Neil McConville.

j) **Whether Sergeant A was justified in firing in breach of the RUC Code of Conduct governing the discharge of firearms?**
The Coroner said that on Sergeant A's version of events he was justified given that he reasonably feared for his life and/or that of his colleagues, but that whether the scenario painted by Sergeant A is accurate remains uncertain.

k) **Whether Sergeant A could have taken another course of action, such as using the protection of the armoured vehicle as an alternative to firing at the deceased?**
The Coroner said that if the deceased had turned as Sergeant A alleges, then Sergeant A could have taken the alternative action but the lives of his colleagues would still have been at risk as he assumed they would be getting out of the car. He said that in those circumstances, which were not proven on the balance of probabilities, Sergeant A did not have an alternative course of action open to him.

Mr Justice Horner also referred to two issues which arose in respect of **the debrief**:

- It was clearly not appropriate to conduct the debrief prior to the interviewing of witnesses by CID unless this was carefully supervised and there was no risk of Sergeant A's version of events being able to influence the evidence of the other police officers. The Coroner said that the failure of the Chief Constable(s) to ensure that this

practice was discontinued in this type of case was regrettable and that it was "deeply disappointing" that the lessons of the Stalker/Sampson inquiry had not been learnt;

- Whether the primary purpose of the debrief was to facilitate the exoneration of Sergeant A? The Coroner's view was that the primary purpose of the debrief was to establish the events which unfolded in a chronological fashion given CID's inability to attend. He concluded that an unintended consequence of the debrief was that Sergeant A's history of what he says happened was published in circumstances where it was capable of influencing the other police officers who were involved. He was, however, satisfied on the balance of probabilities that the debrief was not intended to facilitate a cover-up although it is possible that this may have been an unintended consequence.

Mr Justice Horner further referred to issues in respect of the **planning and control of the operation**:

- **Whether there was a clear line of command within the operations room?** The Coroner said it was clearly understood that Detective Superintendent AB was in overall control. Below him was Detective Inspector AA and then Officer M. He said that although there was a clear line of command, it would appear that Officer M did not provide the HMSU officers on the ground with all the necessary information they could reasonably expect to receive especially that DP2 might be driving the Orion.
- **Whether the TCG[2] exercised any adequate control and supervision over the conduct of officers on the ground?** The Coroner said the control exercised by TCG was adequate in the circumstances. The tactic of a casual stop of the Orion made good sense when it came out on its own without a scout car, meaning that it was most likely not carrying munitions. However, the reaction of the deceased in trying to escape provided evidence that it might be carrying munitions. It therefore made good sense that Sergeant A should make the decisions on the ground and react to events as they happened. His experience, which was unchallenged at the inquest, was that PIRA terrorists on an active mission would surrender to armed police when challenged in circumstances in which the odds were not in their favour. Sergeant A's reaction to give chase was a reasonable one and at all times TCG remained in radio contact with the HMSU officers. The Coroner concluded that in the circumstances TCG did exercise adequate control and supervision over the conduct of the officers and Sergeant A in particular.
- **Whether TCG officers or Officer M gave any advice, guidance or directions to the police officers on the group in relation to stopping the car and the importance or otherwise of stopping the driver?** No advice, guidance or directions were given by TCG officers or Officer M other than the advice that they should seek to effect a casual stop relying on the defective rear lights of the Orion. The Coroner said that Officer M should have advised Sergeant A of the potential involvement of DP2 as the driver of the Orion however even if he had been advised then it is likely that the same request would have been made to the driver to stop.

[2] TCG – Tasking and Co-Ordinating Group

- **Whether the decision to stop the vehicle by way of a casual stop, as opposed to a vehicle checkpoint, in the absence of any clear direction as to what should happen in the event that the driver ran away caused and contributed to the death of the deceased?** The Coroner said the decision to use a casual stop in the evidence before the inquest was reasonable. There was a strong indication that there were no munitions or primed bomb on board and the fact that the driver was on his own was another powerful indicator that he was likely to be compliant with requests by a police officer to pull over. The risks with setting up a VCP were not explored at the inquest in any detail. The Coroner said he was satisfied that it would have been physically possible to set up a VCP but this would have compromised the entire surveillance operation and a valuable intelligence opportunity to disrupt potential lethal bombing attacks or the movement of munitions could have been wasted. The Coroner said that conditions at the time were such that the HMSU acted reasonably by giving chase and bringing the Orion to a halt. The alternative of allowing it to escape with munitions on board was unacceptable at this time. The Coroner said he was satisfied on the balance of probabilities that the absence of any clear direction as to what would happen in the event the driver drove off at speed did not cause or contribute to the death of the deceased. If instructions had been given then those instructions would probably have been to give chase if the driver did not stop and to ensure that he did.
- **Whether, therefore, the planning and control of the police operation was such as to minimise recourse to lethal force?** The Coroner said the planning and control did minimise recourse to lethal force. There was no reason to conclude that the request to stop the car would be ignored and the police reaction in giving chase was a reasonable one in the circumstances – "Anyone can be wise after the event. The approach adopted by the RUC in attempting a casual stop with the Orion was reasonable and well planned. What happened afterwards could not have reasonably been foreseen."

Findings

Mr Justice Horner's findings were as follows:

> "The deceased was shot and fatally wounded on 25 November 1992 on the Falls Road. At the time of his death he was on a mission for PIRA. He was unarmed. The Ford Orion which he was driving had been used earlier that day to carry substances used in the making of improvised explosives, namely ammonium nitrate and sugar. At the time of the shooting the Orion car was not being used to ferry guns, explosives or other munitions.
>
> "It is now impossible with the passage to time to say with any certainty what happened on that fateful afternoon. At the remove of a quarter of a century I am simply unable to reach a concluded view which is fair and just as to whether the use of lethal force was

> justified or not. I remain profoundly unsure as to what happened. Neither side, for the reasons I have set out, have been able to convince me that what they say did occur immediately prior to the deceased's death. On the balance of probabilities if the events did happen as the PSNI contend, and as I have said I have been unable to determine that issue on the balance of probabilities, I am satisfied that Sergeant A acted in self-defence and that there was no breach of Article 2. However, in so far as the onus lies on the PSNI to provide a satisfactory and convincing explanation to the inquest for the use of lethal force it has failed to do so. But how precisely the deceased met his death on that fateful afternoon has not been proved to the satisfaction of this inquest and remains unknown."

Recommendations

The Coroner made the following recommendations, although noted that with the passage of time some may now be redundant:

- **Recommendation 1**: To endorse the recommendation in the Stalker/Sampson reports that there should be no debriefings of officers before interviews with CID unless on the instructions of a chief officer who would later accept responsibility;
- **Recommendation 2**: The weapons issued to PSNI officers must not have the facility to have an incorrect firing mode selected by mistake;
- **Recommendation 3**: A review should be held as to why the intelligence of 25 November 1992 at 3:40 pm was not disclosed in the initial disclosure of sensitive material relating to the death of the deceased and why it did not emerge until the last inquest was underway.
- **Recommendation 4**: It is vital that after the death of any civilian at the hands of the State's agents that the scene of the death is preserved until it has been adequately examined, tested, mapped and photographed by SOCO.
- **Recommendation 5**: The names and addresses of all possible witnesses at such scenes should be recorded contemporaneously to ensure that those who can give an insight as to what had happened are interviewed and given the opportunity to make a contribution to the investigation.
- **Recommendation 6**: An investigation should be instigated and completed with due expedition after the death of any civilian and especially when that death occurs at the hands of agents of the State.
- **Recommendation 7**: All log books kept in respect of any operation should be bound and the pages numbered sequentially. The TCG should always keep its own log book.

Mr Justice Horner finally commented that the gross and inordinate delay of nearly a quarter of a century in this case makes it almost impossible to reach any conclusion on the balance of probabilities as to what happened on 25 November 1992 and that this is a "most unsatisfactory outcome". He recognised that both sides will have reason to feel

disappointment and said that he cannot emphasise the importance for the future of the prompt investigation of any suspicious death, especially one in which there is suspected involvement of the security forces: "The sooner such inquests are held the better for all parties. The rule of law and justice demand no less".

The Coroner further commented that regardless of the outcome of this inquest, the clearer it has become that placing armed police in highly charged conditions will almost inevitably lead on occasions to the loss of innocent civilian life:

> "The police, no matter how well trained or how experienced, will be required to make instantaneous life or death decisions about whether to shoot. Sometimes they will make the wrong decisions with tragic consequences. But what should not be forgotten is that the presence of armed police such as the HMSU on the streets of West Belfast was a direct response to sustained terrorist activity, which was in large part due to the campaign of extreme violence waged by PIRA against the State, its security forces and its citizens."

NOTES TO EDITORS

1. This summary should be read together with the judgment and should not be read in isolation. Nothing said in this summary adds to or amends the judgment. The full judgment will be available on the Court Service website (www.courtsni.gov.uk).

ENDS

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