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<i>Judgment: approved by the court for handing down (subject to editorial corrections)*</i>	Delivered: 27/10/2022

**BEFORE THE CORONER FOR NORTHERN IRELAND
MR JOSEPH McCRISKEN**

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

Decision in relation to the whether a jury should be summoned pursuant to section 18 of the Coroners' Act (Northern Ireland) 1959 ('the 1959 Act')

Introduction

[1] This decision is in respect of an application made by Ms Fiona Donohoe, the Next of Kin (NoK) of Noah Donohoe, that I should summon a jury at the inquest inquiring into his death, which is scheduled to commence on 28 November 2022. The NoK say, primarily, that in all the circumstances of the death it is mandatory for me to hear the inquest with a jury and, even if I am not satisfied that it is mandatory to sit with a jury, it is, in the alternative, desirable that a jury be summoned.

[2] The issue as to whether the inquest should be held with a jury ('the jury issue') was raised by the NoK during a pre-inquest review held on 26 April 2022. Following this hearing, on 15 May 2022 and 23 September 2022, the NoK provided written submissions in support of an application that a jury should be summoned. The Department for Infrastructure ('DfI') has indicated that it intends to remain neutral on this issue and in July 2022 the Police Service of Northern Ireland ('PSNI') indicated that it was remaining neutral. On 6 October 2022, I convened an oral hearing to allow arguments to be ventilated.

[3] The NoK was represented by Ms Campbell KC and Mr Magowan BL instructed by KRW Law, Solicitors. The DfI was represented by Mr Aldworth KC and Mr Philip McAteer BL instructed by the Crown Solicitor's Office and the PSNI was represented by Mr Lunny KC and Ms Laura Curran BL. I was represented by Mr Sean Doran KC and Mr Declan Quinn BL, who provided me with copies of relevant commentary and authorities but made no submissions in relation to the jury issue.

Background

[4] Although it would not be appropriate for me to outline all of the evidence contained within the inquest papers it is, I believe, necessary to identify certain features of the evidence which are relevant to this application. Any summary provided below is, of course, subject to the important caveat that this evidence remains to be examined and tested properly at inquest.

[5] At 21:44 hrs on 21 June 2020 police received a telephone call from Fiona Donohoe reporting that her son, Noah Donohoe, had left their flat earlier that day having informed her that he was going to Cavehill with two friends. Ms Donohoe told police that she was now concerned as Noah had not returned home and she had not been able to contact him since he left. Ms Donohoe told police that she was worried about Noah's present state of mind and had been worried about his mental health for some time.

[6] Closed Circuit Television Footage (CCTV) was obtained from a number of sources which showed Noah leaving his home in Fitzroy Avenue at around 17:40 hrs riding his black Apollo bicycle and wearing a helmet, jacket, shorts, hoody, trainers and carrying a rucksack. Noah is then seen riding his bicycle through Belfast City Centre. At various points on his journey, Noah appears to discard some of his possessions including his rucksack and mobile telephone. At approximately 17:59 hrs Noah is seen (on CCTV and by eyewitnesses) falling from his bicycle. He then travels along York Road before turning left into Skegoniell Avenue and then into Northwood Crescent and finally Northwood Road. His helmet was later recovered from an address on Northwood Road and it is possible that some of his other clothing was left at a different address on Northwood Road. His black Apollo bicycle was left outside 89 Northwood Road.

[7] Police became aware that Noah had been in the area around Northwood Road on the evening of Monday 22 June 2020 following an appeal by police and the NoK using, among other sources, social media. A resident of 89 Northwood Road contacted police as she had found a black Apollo bicycle matching the description given. CCTV from an address in Northwood Road showed Noah riding his bicycle naked before discarding his bicycle and making his way down the side of 89 Northwood Road. At the rear of 89 Northwood Road is a small stream leading to a culvert inlet. Access to the land around the stream and culvert inlet is the property of DfI and, in June 2020, was controlled by a locked gate. The culvert inlet itself was secured by way of a metal cover and grille. It was not secured by a padlock. Only residents of certain properties had access to the land around the storm drain, it was not a public park.

[8] Following a large-scale search operation, the body of Noah Donohoe was recovered from within the drain system downstream of the inlet culvert on 27 June 2020. The location of his body was approximately 600 meters from the entrance to the culvert inlet. There is evidence from an expert to suggest that Noah Donohoe must have made his own way along this distance underground before he reached a section of pipe network located close the M2 motorway.

[9] A forensic post-mortem examination found that the cause of death was drowning. Although the forensic pathologist could not provide an exact time of death she found there to be nothing inconsistent with a finding that Noah Donohoe died in the hours after his last known sighting, which was at around 19:00 hrs on 21 June 2020.

Relevant Law and submissions.

[10] Section 18 of the 1959 Act provides (insofar as it is relevant to this application):

“18-(1) If it appears to the coroner, either before he proceeds to hold an inquest or in the course of an inquest begun without a jury, that there is reason to suspect that-

...

(e) the death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health and safety of the public or any section of the public;

He shall instruct the [Juries Officer to summon a sufficient number of persons in accordance with the Juries (Northern Ireland) Order 1996] to attend and be sworn as jurors upon such inquest at the time and place specified by the coroner.”

(2) If in any case other than those referred to in sub-section (1) it appears to the coroner, either before or in the course of an inquest begun without a jury, that it is desirable to summon a jury, he may proceed to cause a jury to be summoned in accordance with the said sub-section.” [My Emphasis]

[11] Section 18 of the 1959 Act thus provides two *potential* avenues by which a Coroner may conduct an inquest in this case with the assistance of a jury. The first is provided by section 18(1)(e). This provision makes it mandatory (use of the word shall in bold above) for a Coroner to hold an inquest with a jury as long as the Coroner is satisfied that there is a *“reason to suspect that the*

death occurred in circumstances the continuance or possible recurrence of which is prejudicial to the health and safety of the public or any section of the public."

[12] The second avenue is contained within section 18(2), which gives a Coroner a discretion to sit with a jury if he considers it "desirable."

Reason to suspect test

[13] The NoK assert that the "reason to suspect" test within section 18(1) carries a low threshold. In support of this argument, they rely upon *R(Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin). In that case, the Senior Coroner had decided to hold an inquest without a jury, against the wishes of the next of kin, pursuant to section 7 of the *Coroners and Justice Act 2009* (the 2009 Act) (which does not apply in Northern Ireland). Section 7(2) of the 2009 Act contains the same "reason to suspect" test as section 18(1) of the 1959 Act. The court considered the case of *R v Inner London Coroner ex parte Linnane* [1989] 1 WLR 395 and *R (Davey) v HM for Leicester City and South Leicestershire* [2014] EWHC 3982, before adopting the approach of Hickinbottom J in *R (Davey)*:

"Reason to suspect' is a low threshold for the triggering of the obligation to empanel a jury, 'suspicion' for these purposes being a state of conjecture or surmise arising at the start of an investigation in which obtaining a prima facie proof is the end."

Mandatory requirement to sit with a jury

[14] The NoK say that the death of Noah Donohoe occurred "in circumstances the continuance or possible recurrence of which is prejudicial to the health or safety of the public or any section of the public", so that the holding of the forthcoming inquest with a jury is mandatory, in accordance with section 18(1)(e) of the 1959 Act. In support of this assertion, the NoK rely initially upon a decision of the *English Court of Appeal in R v HM Coroner at Hammersmith, ex parte Peach* [1980] 2 All ER 7. This case involved a death as a result of a blow to head from a police officer while the deceased was watching a political demonstration. There was some evidence that the police truncheon was heavier than normal and could have been a lead weighted rubber cosh or hosepipe filled with lead shot. A number of unauthorised weapons were later found in the lockers of police officers who had also been present at the demonstration. The Coroner refused an application made by the family of the deceased that he should hear the inquest with a jury. This decision was quashed by the Court of Appeal which found (1) that the term "circumstances" applies to "circumstances of such a kind that their continuance or recurrence may reasonably and ought properly to be avoided by the taking of appropriate steps which it is in the power of some responsible body to take", and (2) the reference to "continuance or possible

recurrence” indicates an intention to apply only to circumstances the continuance or recurrence of which was preventable or to some extent controllable.

[15] The NoK then rely upon the authority of *In Re Neal* [1996] COD 190 which concerned a death in a holiday apartment in Spain as a result of a defective gas water heater. The inquest was held without a jury and this was overturned on judicial review, Staughton LJ observing that “*this was a case which cried out for an inquiry into the possibility of repetition.*”

[16] Finally, the NoK rely upon a number of decisions of the English Divisional Court, chiefly, *R(Paul) v Deputy Coroner for the Queen’s Household* [2008] QB 172. In this case, which involved the inquests into the deaths of Princess Diana and Dodi al Fayed, the English Divisional Court observed certain features of the test to be applied (under section 18(1)(e)) which include:

- (i) For the provision to apply, the circumstances need not “cause the death.”
- (ii) The prospect of recurrence required for the section to be applicable is low, it is the possibility of recurrence and not any higher chance.
- (iii) For the provision to apply, the risk does not have to relate to a “substantial section” of the public, rather only a section of the public needs to be at risk from recurrence.
- (iv) That section of the public could encompass categories as broad as “any celebrity” and “even bystanders” to a road traffic collision.
- (v) The Court considered the test was met where the safety of such celebrities or members of the public generally were potentially put at risk.
- (vi) Applying the test in the context of a road accident, factors supporting a conclusion that the test was met included that “the circumstances leading up to this collision were very unusual and had additional features to those found in a more usual type of road accident.”

[17] The NoK say that the test must reasonably be regarded as being satisfied in this inquest for “numerous reasons” although only five are relied upon:

- (1) The risk relating to the failure of the DfI to properly secure the entrance to the storm drain.

- (2) The lack of clarity about (a) what in fact caused the apparent change in Noah's behaviour and (b) what led to his death, prevent a conclusion that there is no risk of reoccurrence.
- (3) The risk relating to the possibility of third party interventions.
- (4) The risk relating to the inadequate police response.
- (5) The possibility that a road or bicycle accident was a feature of the death.

[18] Although the NoK written argument addresses each reason, Ms Campbell KC only sought to expand upon reason (1) in her oral submission. In relation to that reason, failure to properly secure the culvert inlet, the NoK say that there is evidence to suggest it was "relatively easy" to access the culvert inlet and that this was a risk "the Department were or should have been aware of." To support this assertion, the NoK rely upon an investigation by the PSNI and referral to the Public Prosecution Service into actions of the DfI in terms of securing the culvert inlet. The NoK assert that there is "plainly a possibility of this occurring or reoccurring in relation not only to this entrance but to other entrances to the storm drain network." In her oral submission, Ms Campbell KC reinforced the NoK belief that the "risk" in terms of section 18(1)(e) test must be taken as an ongoing risk to members of the public from unsecured culvert inlet entrances.

[19] In the case of *R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461 the English Court Appeal considered an application by the wife of Mr Pavlos Takoushis. He was a long-term schizophrenic who had been treated periodically in psychiatric hospitals, both voluntarily and involuntarily. On 9 January 2003 he was admitted to a hospital as a voluntary patient. On 13 January, at approximately 11:15 hrs, Mr Takoushis obtained permission to leave the hospital. He did not return. He was next seen at about midday apparently preparing to jump off Tower Bridge in London. A member of the public was concerned by Mr Takoushis' behaviour and decided to follow him. After Mr Takoushis had made several more approaches towards the river edge, the emergency services were called. When he was spoken to by police officers, Mr Takoushis agreed to go to a local hospital. He did not mention that he was currently an in-patient at a psychiatric hospital. Mr Takoushis was then taken by ambulance to St Thomas' Hospital Accident and Emergency Department, arriving at approximately 13:00 hrs. The ambulance staff explained to a staff nurse who was the triage nurse on duty at that time, that Mr Takoushis had been found trying to jump off Tower Bridge.

[20] The Trust had a system in place for assessing the needs of psychiatric patients who present themselves at the A & E Department. This was based on

a document termed the Manchester Triage Mental Health Flowchart. It involved the clinical prioritisation of patients including those with mental health problems.

[21] A nurse triaged Mr Takoushis as being category 2 (to be seen by a doctor within 10 minutes). He was also recorded as being at "high risk of self-harm." Mr Takoushis was then left alone in a cubicle before he absconded from the hospital. Just before 15:00 hrs, an office worker at St Katherine's Way saw a man jump into the Thames at St Katherine's Dock. Mr Takoushis was recovered some five weeks later, on the 14 February, from the River Thames.

[22] At inquest the NoK asked that the Coroner hold an inquest with a jury either under section 8(3)(d) of the Coroners Act 1988 (which reads the same as our section 18(1)(e)) or in the alternative under section 8(4) (the same as our section 18(2)). The NoK submitted that Mr Takoushis' experiences on 13 January 2003 were not unique and that further deaths might occur in similar circumstances. The Coroner refused and this decision was challenged by way of judicial review.

[23] In a wide ranging decision, which examined other elements of a coronial inquiry not relevant to the instant case, the Court of Appeal provided some guidance in terms of how section 8(3)(d) (our section 18(1)(e)) should be interpreted. Sir Anthony Clarke MR, giving the judgment of the Court said at paragraphs 64-66:

"In our opinion section 8(3)(d) is looking to the future as at the time of the inquest. The coroner has a duty to summon a jury under the subsection if it appears to him that the death occurred in circumstances the continuation or possible recurrence of which is prejudicial to the health or safety of the public (our emphasis). Quite apart from the precise language, the purpose of the provision seems to us to be to stop similar risks to the health and safety of the public in the future. If the coroner is satisfied that because of steps taken since the relevant events there is no such risk, we can see no reason why the coroner should summon a jury under section 8(3)(d). He of course retains a broad discretion to summon a jury under section 8(4).

That approach seems to us to be consistent with the approach of this court in R v Her Majesty's Coroner at Hammersmith ex p Peach [1980] QB 211. So, for example, Lord Denning said at page 226 that a jury must be summoned:

"when the circumstances are such that similar fatalities may possibly recur in the future, and it is reasonable to expect that some action should be taken to prevent their recurrence."

Bridge LJ said at page 227:

"The key to the nature of that limitation is to be found, I think, in the paragraph's concern with the continuance or possible recurrence of the circumstances in question."

...

In these circumstances, the coroner will wish to consider all the circumstances of the case in deciding whether to summon a jury when a new inquest is held."

[24] On 14 October 2022 my legal officer wrote to the DfI requesting information as to whether the culvert inlet at Northwood Road was now secure and, if so, by what means it had been secured. On 20 October 2022 the DfI responded as follows:

"A Public Safety Risk Assessment (PSRA) for the Premier Drive Stream screen was undertaken in January 2021 followed by a Screen Need and Type Assessment in March 2021. The Screen Need and Type Assessment indicated that the debris screen which was installed at the inlet to the culvert was the appropriate type of screen at this location and that a change of screen to a security screen was not required.

As outlined in our correspondence of 6 October 2021, an operational need was identified in 2020 which necessitated the installation of "tideflex" valves at the Premier Drive Stream outfall to Belfast Lough at Duncrue Road. The works related to the need, for flood risk management purposes, to control and mitigate against silt deposits in the lower tidal regions of the culverted system. "Tideflex" valves are essentially non-return valves which prevent water and silt re-entering the culvert as a result of tidal flow.

As a consequence of the installation of these valves, it was necessary to change the Premier Drive Stream culvert inlet screen from a debris screen to a security screen, in order to comply with current national guidelines relating to culverts and screens. It is important to make clear that the requirement to change the screen arose directly from the installation of the non-

return valves which resulted in the closure of the previous open culvert outlets. Accordingly, work was undertaken to change the culvert inlet screen on the Premier Drive Stream designated watercourse and this work was completed on 16 December 2021.

It may also assist the Coroner to confirm that the Department decided, following Noah's death, that although not required by current guidance, all access hatches should be routinely locked irrespective of the type of screen on a culvert inlet structure. This was, and is, managed as a matter of routine during weekly inspections and includes the access hatch at the Premier Drive inlet."

[25] In light of this response and the comments of the court in *Takoushis*, by an e-mail dated 20 October 2022, I asked the PIPs if they had any further views specifically on the response by DfI relating to the present risk posed by the culvert inlet. The NoK responded on 24 October 2022 indicating that their submissions remained unaffected by the DfI response. The NoK submitted, further, that notwithstanding the work that they appear to accept has been carried out on the culvert inlet since Noah Donohoe's death it ought to be of little reassurance to me that:

- (a) That the hatch is now locked - for, the NoK say, it seems that Noah Donohoe would not have needed to open the hatch.
- (b) That the 'general public' cannot access the area - for indeed they can from two sides.
- (c) That the grille to this culvert has been replaced - for that provides little reassurance in relation to the (presumably hundreds) of other grilles on the underground culvert network to which members of the public may have access.

[26] The NoK submission of 24 October 2022 says, finally, that it is not possible for me to be satisfied, on the basis of the material currently before me, that '*because of steps taken since the relevant events there is no [risk possible recurrence of which is prejudicial to the health or safety of the public or any section of the public]*' *Takoushis* para 83. They say that to be so satisfied would be to adopt too narrow an interpretation of section 18(1)(e) and one which would allow for state or other agencies to mask systemic risk by focusing on discrete changes to individual aspects of a wider problem.

Discretion to sit with a jury

[27] At paragraph 39 of their written argument the NoK set out a number of relevant factors that, they say, support the exercise of discretion to hear this inquest with a jury pursuant to section 18(2):

- (i) The strongly expressed views of the NoK. (see *R(Paul)* at paragraph 44),
- (ii) Where the facts of the instant case bear any resemblance to the types of situations covered by the mandatory provisions (*Paul* [45], *Shafi* [69], *Fullick* [42]),
- (iii) To ensure public confidence in the outcome of the inquest a jury should be summoned in cases where the State, by its agents, may have had some responsibility for the death.
- (iv) The circumstances of the death are uncertain.
- (v) The expert evidence is uncertain.

[28] The NoK say that, in the present case, all of these requirements are satisfied. They also say that Fiona Donohoe considers that this inquest ought to be heard before a jury. Further, the NoK say that article 2 of the European Convention on Human Rights (ECHR) requires public confidence in an investigation to satisfy the requirement for an effective investigation.

[29] I was referred to the judgment of Stephens J (now Lord Stephens) in the case of *Jordan's Application* [2014] NIQB 11. That was a case in which the NoK of Pearse Jordan, who was shot dead by members of a police patrol, requested that the Coroner not sit with a jury. The Coroner refused and his decision was challenged.

[30] The NoK of Pearse Jordan, relying upon *R v HM Coroner at Hammersmith ex parte Peach* and *R (Takoushis) v Inner North London Coroner* [2006] 1 WLR 461 contended that there was no requirement for a jury to be summoned under section 18(1)(e) of the 1959 Act. Indeed, in contrast to the NoK of Noah Donohoe, the NoK of Pearse Jordan argued that no jury should be summoned with reference to the obligation under article 2 ECHR for there to be an objective and impartial investigation into the death. They said that, given a number of factors, the objectivity and impartiality of a jury could not be guaranteed. Those factors, as they related to the circumstances of the death of Pearse Jordan, were said to be:

- (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.

[31] The NoK referred to the safeguard in a criminal trial of a majority verdict which is 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.

[32] Stephens J discussed the exercise of discretion by a coroner when asked to make a decision on whether or not to sit with a jury. He said that the balance includes assessing the respective merits of either course of action which will include 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. After conducting that exercise, a coroner 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. According to Stephens J, in conducting that balance, impartiality will be decisive. He said there cannot be an effective investigation where there is a real risk of a perverse verdict or bias. In circumstances 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 have to give way.

[33] At paragraph 235 Stephens J said that a 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* [2002] 2 AC 357. First a 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.

[34] So, what are the circumstances which have a bearing on the suggestion that the jury or a juror will be biased? According to the Court in Jordan's Applications they include:

- (a) The nature of the matters to be considered in this inquest.
- (b) The evidence as to perverse verdicts in certain criminal trials in Northern Ireland. Stephens J referred to a consultation process which was conducted by the Northern Ireland Office in August 2006 on the "Replacement arrangements for the Diplock Court system." The consultation paper referred to perverse acquittals because of, for instance, partisan jurors, to the close-knit communities in which people live in Northern Ireland 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.
- (c) The safeguards that can be put in place to secure an impartial jury and the effectiveness of those safeguards. In *Jordan's Application*, Stephens J recognised that there were many safeguards which can be put in place and which the Coroner did, in fact, put in place. However, he said, in certain cases there is a real risk of a perverse verdict regardless as to safeguards.

Omnibus conclusions

Conclusion regarding section 18(1)(e)

[35] I am cognisant that the evidence in this inquest still has to be properly tested. In arriving at my decision on the jury issue I have examined material that is presently available which includes, written statements, expert reports, photographs, CCTV footage, maps, plans and diagrams. I have also had the benefit of having visited the location of the culvert inlet, the location of where the body of Noah Donohoe was recovered and the location which marks the outlet of the stream which runs past Northwood Road and through the culvert inlet.

[36] The evidence at present suggests that Noah Donohoe, for reasons as yet not fully understood, rode his bicycle along the Shore Road, Belfast before travelling up Skegoniell Avenue, Northwood Crescent and finally Northwood Road. Once at the top of Northwood Road (a cul-de-sac) he alighted from his bicycle, without any clothing, and proceeded to enter an area of ground within which there was a small stream and a culvert inlet to a drain. There is no CCTV footage and no eyewitness evidence as to what occurred next. On 27 June 2020 the body of Noah Donohoe was located some 600 meters within the drain.

[37] The NoK submit that section 18(1)(e) of the 1959 Act makes it mandatory for me in these circumstances to hold this inquest with a jury. No other PIPs have made substantive submissions opposing this application. The core of the NoK submission (reason 1 at paragraph 17 above) seems to be that there still exists a risk to the public, more specifically children like Noah Donohoe, from access to this specific culvert inlet and also from the other “presumably hundreds” of other such culvert inlets to which members of the public may have access. I have considered reasons 2-5 (at paragraph 17 above) and it seems to me that Ms Campbell KC was correct not to expand upon them in her oral argument since they are not persuasive.

[38] I am satisfied from a consideration of the authorities, in particular *Takoushis*, that section 18(1)(e) requires me to look to the future as at the time of the inquest. I consider that I should summon a jury only if I am satisfied that there is reason to suspect that the death occurred in circumstances the continuation or possible recurrence of which *is* prejudicial to the health and safety of the public. That is, that the risk exists presently at the time of writing.

[39] I have no evidence before me to support the NoK assertion that, as per *ex parte Peach*, there are “hundreds” of other risky or dangerous culvert inlets to which members of the public have access and which ought properly to be avoided by the taking of appropriate steps which it is in the power of some responsible body to take. In such circumstances, in the absence of evidence, it seems to me I ought not to proceed on the basis of speculation or assumption that such risks may exist.

[40] What then of the risk posed by the culvert inlet at Northwood Road? It would, appear from the DfI response (above) that members of the public cannot now access the culvert inlet in a similar way to Noah Donohoe. The grille, that he may have climbed through, has been replaced by a security grille, and the metal cover is now padlocked. On that basis, taking into account the guidance provided by the English Court of Appeal in *Takoushis* and the response from the DfI, I am satisfied that steps have indeed been taken to prevent such a risk from occurring in the future. For this reason, I do not consider that there is a mandatory requirement to hold this inquest with a jury and I dismiss this part of the application.

Conclusion regarding section 18(2)

[41] In terms of the second limb of the NoK argument in favour of holding this inquest with a jury, that it is desirable to do so, I have taken great assistance from the decision of Stephens J in *Jordan’s Application*.

[42] It seems to me that there are a number of factors in this inquest which may – at least potentially – have a tendency to adversely affect the ability of the jury to be objective and impartial. They are:

- (1) The controversial nature of the inquest involving the death of a young Catholic boy, last seen in an area known to be predominantly Protestant/Loyalist.
- (2) The requirement for unanimous verdicts.
- (3) The statutory anonymity of jurors (with the attendant difficulty of challenging for cause).
- (4) The absence of effective safeguards against a perverse verdict.
- (5) The persistent commentary relating to the death of Noah Donohoe, particularly, on social media.
- (6) The persistent high profile campaign for “Justice” and “A new, proper investigation” with flags, posters, protests and media interviews which imply that the present PSNI investigation is deficient.
- (7) The lack of any “Fade Factor” as described by authorities in relation to prejudice under the Contempt of Court Act 1980, if the inquest goes ahead as planned on 28 November 2022.

[43] According to Stephens J, in order to exercise my discretion properly, I should conduct a balancing exercise and ask myself if “it is desirable to summon” a jury. Those factors, suggested by Stephens J, that I should consider include:

- (a) Complexity of the case – this inquest could be described a particularly complex with voluminous amounts of material, CCTV footage and expert reports.
- (b) The number of documents – see above.
- (c) The number of witnesses – there are at least 60 witness statements and/ or reports, although it can reasonably be expected that a number of statements can be received under Rule 17.
- (d) The length of the inquest – the NoK submit that this inquest will likely take 6 weeks, although that will depend on the number of witnesses who will need to be called to give oral evidence.

- (e) The need to involve the community in the legal process – there is a longstanding acceptance of the utility of community involvement in the administration of justice.
- (f) Impartiality- see my concerns at [42] above.

[44] I do have some concerns regarding the potential for a perverse verdict in this inquest and all the outworking's of such an occurrence in terms of public confidence and resources. During the oral hearing on 11 October 2022, I specifically asked Ms Campbell KC if Ms Fiona Donohoe was fully aware of those factors highlighted by Stephens J in *Jordan's Application* which, even in a general sense regarding inquests in Northern Ireland, might affect the ability of a jury to act impartially. Ms Campbell confirmed that Ms Fiona Donohoe was fully aware and still wanted this inquest to proceed with a jury.

[45] In reaching my conclusion on this issue, I have taken into account - (1) the very strongly held view of the next of kin that a jury should be summoned, (2) the widespread public concern about the circumstances in which the death occurred, (3) the uncertainty surrounding the circumstances of the death, (4) the precautions that can be taken to ensure that the jury comes to the case without bias or preconception and (5) the assistance that can be given to the jury to follow the evidence. Having regard to these matters, notwithstanding my reservations and concerns I do not conclude that there is a "real risk" of a perverse conclusion or bias as per Stephens J in *Jordan's Application*. Therefore, on balance, I conclude that it is "desirable" to have a jury sworn in this inquest and I will exercise my discretion pursuant to section 18(2) of the 1959 Act.

[46] It goes without saying, that it is imperative that nothing should be reported or said about this inquest in a public forum, which includes social media, that may impinge on the ability of potential jurors to hear the case impartially and objectively.