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*(subject to editorial corrections)**

IN THE COURT OF APPEAL IN NORTHERN IRELAND

IN THE MATTER OF AN APPLICATION BY THERESA JORDAN FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

Before: STEPHENS LJ, DEENY LJ and COLTON J

STEPHENS LJ (delivering the judgment of the court)

Introduction

[1] On 25 November 1992, shortly after 5.00pm, Patrick Pearse Jordan, then aged 22, ("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, a member of the RUC's Headquarters Mobile Support Unit ("HMSU"). This is an appeal against the refusal by Keegan J to grant leave to the applicant, Theresa Jordan, the mother of the deceased to apply for judicial review in respect of the verdict of the Coroner, Horner J ("the Coroner"), which verdict was delivered on 7 November 2016 following an inquest into the death of the deceased. Previous judicial review proceedings have been brought by Hugh Jordan, the father of the deceased, but due to an unfortunate deterioration in his health he has been unable to bring this application. The Coroner is the proposed respondent and the Chief Constable of the PSNI ("the Chief Constable") is a proposed notice party.

[2] Prior to the hearing before Keegan J and in accordance with Practice Note 1/2008 revised on 10 October 2013, notice of the leave hearing was given to the Coroner and to the Chief Constable. The applicant, the Coroner, and the Chief Constable all submitted detailed skeleton arguments and appeared by counsel to make oral submissions before Keegan J.

[3] The appeal initially came before us as an appeal against the refusal by Keegan J to give leave to apply for judicial review. The test for leave to apply for judicial review is "the demonstration of an arguable case with a reasonable prospect of success," see paragraphs [5] and [43] of *Omagh District Council v The Minister with*

responsibility for Health Social Services and Public Safety [2004] NICA 10 and paragraph [9] of the *Chief Constable PSNI's application* [2008] NIQB 100. There may be an enhanced arguability threshold in some circumstances, see the observations of Gillen J in *Colin Armstrong's Application for leave to bring Judicial Review* [2007] NIQB 20, the decision of the Court of Appeal in England and Wales in *Mass Energy Limited v Birmingham City Council* [1994] ENV LR 298 and the observations of Keene J in *R v Cotswold District Council ex parte Barrington* [1998] 75 P and Cr 515. However, absent an enhanced arguability threshold and *if* the applicant demonstrated an arguable case with a reasonable prospect of success the situation would arise of allowing the appeal with a further hearing at first instance to be followed by the prospect of a further appeal back to this court. Each of the parties has confirmed that all the material on which they wish to rely for a substantive hearing was before this court. In circumstances where this court has to consider all the material in order to determine whether there is an arguable case with a reasonable prospect of success which in itself involves a considerable degree of analysis and a consideration of the relevant authorities we considered that if we were of the view that there was such an arguable case then we should proceed to hear and determine the substantive application under Order 53 Rule 5(8) of the Rules of the Court of Judicature (Northern Ireland) 1980, see *Re Rice's Application* [1998] NI 265 at 268 and *Re SOS's Application* [2003] NIJB 252 at 254 paragraph [5]. Therefore in the event the hearing before us was a rolled up hearing of both the appeal against the refusal of leave and if then appropriate a determination of the substantive application.

[4] The appearances in this Court are the same as before Keegan J. Mr McDonald QC SC and Ms Quinlivan QC appeared on behalf of the applicant. Mr Doran QC and Mr Skelt appeared on behalf of the Coroner in accordance with the guidance of this court in *Jordan's (Hugh) Applications* [2014] NICA 36 as to the role of the Coroner where his decision is the subject of judicial review proceedings. Mr McGleenan QC and Mr Colmer appeared on behalf of the Chief Constable.

[5] We have had the benefit of a 54 page skeleton argument on behalf of the applicant dated 27 February 2018, a 19 page skeleton argument on behalf of the Coroner dated 6 March 2018 and an 18 page skeleton argument on behalf of the Chief Constable dated 7 March 2018. We have also been provided with and have considered 3 small and 6 large lever arch files of documents and 2 lever arch files of authorities. We have had the benefit of oral submissions on behalf of the applicant, the Coroner and the Chief Constable. We are grateful for the assistance which has been provided to us.

The first two inquests

[6] The first inquest into the death of the deceased commenced on 4 January 1995 but was adjourned, part heard, without a verdict.

[7] The second inquest into the death of the deceased was heard before the Coroner, Mr Sherrard, with a jury between 24 September 2012 and 26 October 2012.

On 31 January 2014, sitting in the High Court, I quashed the verdict in relation to that inquest, see *Jordan's Applications* [2014] NIQB 11. The order which I made was affirmed on appeal under citation [2014] NICA 76.

The third inquest

[8] The third inquest into the death of the deceased, which is the subject of this application for judicial review, was heard by Horner J, an independent High Court judicial officer sitting as a Coroner without a jury. There is discretion under Section 18(2) of the Coroners Act (Northern Ireland) 1959 not to summons a jury. At paragraph [4] of his verdict the Coroner set out the position that there was no request by any of the parties for a jury. At paragraphs [64] he set out an observation as to two different and distinct narratives arising on the facts as being:

> "On the one hand, a young man, unarmed, running away following a car chase is shot in the back three times by an armed police officer. On the other there is a terrorist escaping from a car which is suspected of carrying munitions and which has had to be stopped forcibly by the police, and who is suspected of being armed. He is shot in the back when he acts in a way that the police officer considers places him and his colleagues in mortal danger."

The Coroner considered that in this inquest a "jury in Northern Ireland is likely to display the divisions which disfigure this society." He exercised his discretion not to summons a jury.

[9] The hearing took place in public and occupied a total of 16 days over the period 22 February 2016 to 21 April 2016. In addition there were also other hearing days devoted to the issues of public interest immunity, anonymity and screening.

[10] The next of kin were represented throughout the inquest by two highly experienced and capable senior counsel instructed by an extremely competent firm of solicitors. All the legal representatives had through their prior involvement in relation to this death and also by virtue of their involvement in other legacy cases a vast repository of knowledge. In short throughout the inquest the next of kin were able to contribute to the proceedings and actively participate in them with the benefit of highly experienced and capable legal representatives.

[11] The Coroner listed at paragraph [12] of his verdict the 17 main police and military witnesses who made statements and/or gave evidence at the inquest. Those witnesses who gave evidence included Sergeant A. The legal representatives of the next of kin were able to cross-examine every witness including the key witnesses.

[12] Many of the civilian witnesses who saw the events of 25 November 1992 unfold gave evidence at the inquest though some of the evidence was by reference to their statements or to evidence in the first inquest. The civilian witnesses were Mr Hugh Malone, Mr Gary Brown, Mr Ciaran McNally, Mr Lawrence Moylan, Mr Emmanuel Cullen, Mr James McAllister and Mr Patrick McKeown.

[13] The Coroner had available expert ballistic evidence together with evidence of the post mortem and from pathologists.

[14] Photographs and plans were provided to the Coroner at the inquest.

[15] The Coroner's understanding of the scene was not solely dependent on the photographs and plans as he visited the scene of the fatal shooting during the course of the inquest. He recounts in his verdict that he found "(this) visit provided a more reliable way of assessing distance" and that it "helped (him) to understand the various sketch maps and photographs produced in evidence …" He added that "(it) is clear that the final events leading to the deceased's death were played out within narrow confines and a short time frame."

[16] The Coroner was shown in court an unloaded gun of similar but not identical construction to the Heckler and Koch MP5 used by Sergeant A. The Coroner personally assessed the pressure necessary to switch the gun between the three firing modes, safe, single shot and automatic, which confirmed for him the assessment that the pressure necessary to switch the gun between the different modes was light and equivalent to activating a light switch.

[17] The Coroner actively sought and obtained further documents from the PSNI, see paragraphs [151] – [152] and [157] of the verdict.

[18] Following the conclusion of the evidence the Coroner was provided with an undated but detailed and comprehensive closing written submission on behalf of the next of kin extending to 173 pages. He also received a 118 page written submission on behalf of the Chief Constable dated 6 May 2016. There was also a supplementary 19 page submission on behalf of the next of kin dated 17 May 2016. All these submissions were settled by highly experienced counsel. Those written submissions were considered by the Coroner in advance of a hearing on 20 May 2016 at which he received oral submissions on behalf of the next of kin and on behalf of the Chief Constable.

[19] Following the hearing the Coroner read and re-read over 5,000 pages of evidence which included transcripts of previous inquests into the death of the deceased together with hundreds of pages of legal authorities. In short there was an exhaustive consideration of all relevant documents.

[20] The Coroner produced a comprehensive 130 page verdict dated 7 November 2016 divided into 337 paragraphs. The verdict was delivered in public. It was

published on the internet and remains available to be read on the Judiciary NI website. The Office of the Lord Chief produced a press summary summarising the verdict.

The obligation on the Coroner and the issues at the third inquest

[21] The obligation on the Coroner in accordance with Section 31 of the Coroners Act (Northern Ireland) 1959 was to:

> "give, in the form prescribed by rules under section thirty-six, (his) verdict setting forth, *so far as such particulars have been proved to (him)*, who the deceased person was and how, when and where he came to his death" (emphasis added).

Rule 15 of the Coroners (Practice and Procedure) Rules (NI) 1963 also provides that:

> "(the) proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely:- (a) *who the deceased was*; (b) *how, when and where the deceased came by his death*; (c) the particulars for the time being required by the Births and Deaths Registration (Northern Ireland) Order 1976 to be registered concerning the death" (emphasis added).

In order to comply with the Article 2 ECHR procedural obligation to carry out an effective official investigation into the circumstances of the death of the deceased "how" the deceased came by his death meant not only that the Coroner had the obligation to investigate "by what means" but also had the obligation to investigate "in what broad circumstances" the deceased came to his death: see *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182. The nature of the Article 2 ECHR procedural obligation was considered by the ECtHR in *Jordan v UK* (2003) 37 EHRR 2 and in *Nachova & others v Bulgaria* (2006) 42 EHRR 43. We do not intend to set out all the matters which can be taken from those judgments though we emphasise that 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" and that 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. Furthermore, that 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.

[22] In paragraph [7] of his verdict the Coroner recorded that the scope of the inquest had been agreed between the parties in the terms I set out in paragraph

[46]-[48] of the judgment in *Jordan's Applications* [2014] NIQB 11 and as incorporated in the judgment of this court under citation [2014] NICA 76 at paragraphs [3] and [14]–[16] with "some minor modifications." At paragraphs [44] and [45] under citation [2014] NIQB 11 I stated that "(the) *central* issue was whether his killing was justified" doing so on the basis of the judgment of the House of Lords in *Middleton* and of the ECtHR in *McKerr v United Kingdom* which at paragraph [113] stated that "the investigation must also 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" (emphasis added). Such an effective investigation is achieved by a statement of the inquest's conclusion on the main facts leading to the death. In *Middleton* the House of Lords held that "to meet the procedural requirement of Article 2 an inquest ought ordinarily to culminate in an expression, however brief, of the jury's conclusion on the disputed factual issues at the heart of the case." The disputed factual issues at the heart of this inquest were agreed between the parties before me during the judicial review proceedings leading to my judgment under citation [2014] NIQB 11. Those factual issues were then set out at paragraphs [46]–[48] of that judgment which were the paragraphs to which the Coroner referred in his verdict and which were also incorporated in the judgment of this court under citation [2014] NICA 76 at paragraphs [3] and [14]–[16] with "some minor modifications." Paragraphs [14]-[16] were in the following terms

> "[14] 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.

[15] 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.

[16] 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."

[23] The Coroner in his verdict at paragraphs [330] – [333] expressly addressed each of these issues.

A summary of the verdict

[24] It is necessary for us to summarise parts of the verdict but in doing so we emphasise that any summary will not be sufficient. A full and proper appreciation

of the verdict can only be gained by reading and re-reading it in its entirety as all the members of this court have done. We would observe that it is not appropriate to extract a number of words or a number of sentences out of the verdict but rather to consider those words or sentences in the context of the verdict as a whole. Furthermore we would also observe that the Coroner had a vast array of evidence, documents and submissions to consider and it is entirely unrealistic to expect him to deal with every argument or every piece of evidence in his verdict. This is the point that he expressly made at paragraph [8] of his verdict. In that paragraph he expressed his gratitude to the legal representatives who acted for the next of kin, the PSNI and the Coroners Service, recognising the prodigious amount of work which had been undertaken and stating that it was simply not possible for him to deal with each of the arguments on an individual basis otherwise his judgment, which was already far too long, would assume wholly unreasonable proportions. The Coroner assured the parties that each argument had been considered with care, even though in the interests of brevity not every argument had been specifically referenced in his judgment.

[25] We set out under various headings different aspects of the Coroner's verdict.

(a) Delay

[26] The Coroner was hearing evidence in 2016 in relation to events which had occurred some 24 years before in November 1992. At paragraph [3] of his verdict he described delay as the enemy of justice. At paragraph [66] he stated that "as a general rule the longer the delay, the staler the evidence is likely to be" and that "this can rarely be to the advantage of the State which bears the burden of adducing evidence to provide a convincing explanation for the killing under Article 2." At paragraphs [76] – [79] under the heading "delay and memory" the Coroner having reviewed a number of authorities as to the adverse impact of delay stated that the passage of time was bound to have affected the recollections of those who witnessed and participated in the events of 25 November 1992. The Coroner concluded that it was "not possible to over-estimate the difficulty in relying on sworn testimony in a search for the truth at a remove of (some) 25 years from the event to which it relates."

(b) The general and particular context of terrorist activity in Northern Ireland and in England

[27] Under the heading "Prevailing conditions in Northern Ireland 1992 and 1993" the Coroner set out the general context to the events of 25 November 1992 which he described as "truly terrible times." In this section he recorded examples of the Provisional IRA's ("PIRA") "limitless appetite for wanton violence" and of their "intention to destroy, demolish, maim and kill." He stated that the general context was one of "savage violence, indiscriminate murder, widespread destruction of property and fear and threats to lives and property." He recorded that this appetite for wanton violence and intention to destroy, demolish, maim and kill was not just

confined to Northern Ireland. In relation to the PIRA's campaign in England he recorded that on "7 October 1992 5 civilians were injured when a bomb exploded in Piccadilly. Another exploded in Flitcroft Street. There were other bombings – one in October in Downing Street, the very heart of government. These attacks continued when two children were murdered and 56 injured in Warrington when a bomb planted by PIRA went off on 20 March 1993. The bombing of Bishopsgate in London resulted in one civilian being murdered, 30 being wounded and £350m worth of damage being caused." In relation to the campaign in Northern Ireland he recorded that on 23 September 1992 the PIRA detonated a 3,700lb bomb at the Northern Ireland Forensic Science Laboratory in South Belfast, destroying it, damaging 100's of houses in the immediate neighbourhood and injuring 20 people. He also recorded that on 21 October 1992 a 200lb bomb planted by PIRA exploded on Main Street, Bangor, causing widespread destruction. On 13 November 1992 PIRA detonated a van bomb in the centre of Coleraine laying it waste. On 1 December 1992 two bombs planted by PIRA exploded in Upper Queen Street, Belfast, injuring 27 people. In October 1992 there were 43 terrorist incidents in Northern Ireland. In November 1992 there were 47 terrorist incidents. In December 1992 there were 33 terrorist incidents.

[28] The Coroner found that there was not only a general but also a particular context to the events of 25 November 1992. At paragraph [74] the Coroner stated that in "the autumn of 1992 there was convincing intelligence that PIRA intended to carry out a bombing campaign in Belfast in the run up to Christmas to try and bring the city to its knees. There was reliable intelligence that Arizona Street was a base for the distribution of munitions and explosives." The Coroner stated that it was not clear whether the munitions were being moved to another hide or whether the intention was to detonate a bomb in the city centre. The Coroner went on to find that this intelligence was confirmed by the presence of "dickers" (PIRA observers) in the immediate area prior to the shooting, the finding of a Mark 15 Timer and Power Unit ("TPU") which can be used in under car 'booby trap' devices during a search of the premises in Arizona Street after the shooting and traces of substances used to make homemade explosives in the Orion and in the "wheelie bin" at Arizona Street."

[29] At paragraph [68] the Coroner considered the impact of this context on the police officers stating that they "were men who have borne witness to the difficulties of operating in the terrible times which prevailed in Northern Ireland some 25 years ago" and that they "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", "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." He also stated at paragraph [137] that each member of the HMSU "will have appreciated his life could depend on the split second reaction of a colleague."

(c) The effect of the general and particular context on the minds of the police officers

[30] The Coroner stated that the context which we have summarised under the heading of the general and particular context was "essential in any attempt to try and understand what happened on 25 November 1992 and what was in the mind of those police officers in Call Signs 8 and 12 as they went about the execution of their duties."

(d) Particular intelligence as to terrorist activity around Arizona Street, Belfast on 25 November 1992

[31] The Coroner found that "on the morning of 25 November 1992 the RUC suspected on the basis of what it considered to have been reliable intelligence that there was to be a movement of explosives and/or arms ("munitions") later that day from West Belfast by (the Provisional IRA ("PIRA")). It was thought that this movement of munitions would involve the area around Arizona Street, West Belfast. Arizona Street was known to the RUC and the Army as a place where PIRA would engage in terrorist related activity involving the preparation and movement of munitions."

(e) The deceased

[32] In relation to the deceased the Coroner found that the deceased lived with his parents at 7 New Barnsley Drive, Belfast and was 22 years of age on 25 November 1992. He also found that prior to that date he had not attracted the attention of the security forces as a consequence of any suspected involvement in terrorist or criminal activity. The Coroner went on to find that the deceased "was actively engaged in serious terrorist activities on (25 November 1992) and these could ultimately have resulted in widespread damage and mayhem, perhaps causing injury or death to civilians and security force members alike." The Coroner also found that "(after) the Deceased's death PIRA claimed that he was a volunteer." In relation to exactly what the deceased was doing the Coroner stated that it was not possible to say with any degree of certainty what the Deceased was doing on the afternoon of 25 November 1992, save to say that he is likely to have been at Whiterock Leisure Centre in the company of DP2 (believed to be a hardened terrorist, see paragraphs [146] and [152]) and involved in the movement of homemade explosives whether by driving the Orion or by providing logistical support on the ground. The Coroner went on to state that "there can be no doubt that after 5.00 pm (the deceased) was driving a car for PIRA along the Falls Road and that this car had been used that afternoon to transport improvised explosives or substances to be used for the manufacture of homemade explosives." Further, the Coroner found "that what cannot be in any doubt is that anyone assisting PIRA in 1992 would have known that in doing so they would be complicit in the bombings and shootings being carried out by PIRA at that time and that such assistance would inevitably contribute to the potential loss of life, both of civilians and members of the

security forces, huge damage to property and the violent disfigurement of Northern Ireland."

(f) The topography of the Falls Road, the weather conditions and street lighting

[33] The Coroner found that the Falls Road is and was at that time a major arterial traffic route into and out of Belfast and that at 5.00 pm on 25 November 1992 there was a lot of traffic heading in both directions on the road. The Coroner referred to the 2 sides of the road as 'countrywards' (i.e. the carriageway heading generally south west and away from the city) and 'citywards' (i.e. the carriageway heading generally north east and towards the centre of the city). He stated that the road has 3 lanes, 2 heading in the citywards direction and one heading countrywards and that the 2 citywards lanes are divided by a white dotted line. He also stated that there is a further white broken line dividing the citywards and countrywards carriageways and that there are pavements on each side of the carriageway, raised up from the carriageway and edged by continuous kerbstones.

[34] The Coroner stated that the road conditions were wet although it did not appear to have been raining at the time of the incident and that by about 5.00 pm it was substantially dark and the street lights on the Falls Road were illuminated.

(g) The HMSU

[35] The Coroner found that in the early 1990s the HMSU comprised three sections which provided uniformed support to Army and police services. He stated that they were an elite squad of some 60 officers, highly trained and operating under the most exacting of circumstances and that day and daily they were engaged in operations in which they placed their lives on the line in order to try and maintain some sort of semblance of public order in Northern Ireland.

[36] The Coroner found that "in the past members of HMSU have equivocated and lied for a variety of reasons about the circumstances leading up to the killing of civilians" and "that this investigation has not been given the complete picture of what happened …."

[37] The Coroner set out the control structure of the HMSU including the role of the Tasking and Co-Ordinating Group ("TCG").

(h) The command room

[38] The Coroner found that the RUC command of the operation was conducted from the command room at the Belfast Regional Headquarters at Castlereagh and that Detective Inspector AA was effectively in charge of the RUC officers in the HMSU who were deployed in the operation. The Coroner also found that there was

liaison with the army and that there was a request for military surveillance to be performed in the Arizona Street area.

(i) Surveillance operation and the deployment of call signs 8 and 12

[39] The Coroner found that on 25 November 1992 as a result of intelligence a surveillance operation was commenced and Sergeant R "deployed a number of call signs (that is a particular vehicle containing police officers deployed on operations) and in particular Call Signs 8 and 12, from police HQ to west Belfast to assist in" that operation.

[40] In relation to call sign 8 the Coroner's findings were that Sergeant A and Officers B and C were deployed as a group in a red Ford Sierra Registration Mark WXI 3711 and that this was collectively known as "Call Sign 8." The Coroner went on to state that "Officer C was the driver of Call Sign 8. Sergeant A was the front seat passenger and Officer B sat in the rear of the car behind Sergeant A."

[41] In relation to call sign 12 the Coroner's findings were that "Officers D, E and F were deployed in a dark blue Ford Sierra Registration Mark XXI 8693 known as "Call Sign 12." The Coroner went on to state that Officer E was the driver, Officer D was the front seat passenger and Officer F was the rear seat passenger. He sat behind the driver."

[42] The Coroner found that "Sergeant A was the most senior officer in the two Call Sign cars and was, as a result, in overall charge as between the two vehicles. The Coroner also found that Sergeant A had a wealth of experience gained over the years dealing with many terrorist incidents.

[43] The Coroner found that Officers A to F were all HMSU officers and were dressed in police uniform and that all were armed with a revolver and also a Heckler and Koch MP5 gun.

(j) The Heckler and Koch MP5 and timing in relation to 5 rounds in automatic mode

[44] The Coroner found that the Heckler and Koch MP5 had three firing modes: safe, single shot and automatic. He found that the modes are selected by the position of a switch on the right hand side of the gun, placed for easy access by the right thumb of the user. He accepted the evidence of the expert witness, Mr Boyce that the pressure necessary to switch the gun between the different modes was light and equivalent to activating a light switch. The Coroner recounted that he was told by Sergeant A that the mechanism of the actual gun was worn by use and would have required less force to change the mode of operation than the one given to him. The Coroner stated that there was no expert evidence to support this claim and made no specific finding in relation to it. He found that Sergeant A did not intend to

engage automatic mode but rather he did this accidentally as he pushed the switch forward.

[45] The Coroner found that in single shot mode only one round is fired per activation of the trigger and that to fire more than one round in that mode requires repeated and separate activations of the trigger.

[46] In relation to automatic mode the Coroner found that the weapon will fire repeatedly with one continued activation of the trigger.

[47] The Coroner found that it took .375 of a second to fire 5 rounds in automatic mode.

(k) The Orion, the driver of the Orion, the press reports after the shooting and the evidence of the police officers as to those reports

[48] The Coroner found that a red Ford Orion Registration Mark BDZ 7721 ("the Orion") had been hijacked by PIRA earlier on 25 November 1992.

[49] The Coroner also found that at about 3.40 pm there was a report from military surveillance that two men and a red Orion were seen in the area of the Whiterock Leisure Centre who were thought to be engaged in paramilitary activity. The Coroner stated that military intelligence identified one of the persons "using" the Orion as DP2 who was a person with a relevant history of suspected involvement in terrorist activity it being thought that he had been a Quarter Master in PIRA.

[50] The Coroner did not believe Officer M when he said that he did not know who DP2 was or that he was unaware of DP2's participation in the events at the Whiterock Leisure Centre. The Coroner held that Officers M and Q decided to hide the fact that DP2's identity was known to them earlier in the afternoon and that this was recorded in the HMSU log. The Coroner also held that part of the log was destroyed by one or other or both of them.

[51] The Coroner accepted the evidence of Officers A, B, C, D, E and F that they had not been told that DP2 was using the Orion car and that for some reason Officers M and Q did not pass on the intelligence that DP2 might be driving the Orion. The Coroner stated that as Officer M was under pressure and required to work excessively long hours he may simply have made a mistake and forgot to convey this important piece of evidence to the Call Sign crews.

[52] The Coroner found that following the shooting there were press reports which claimed that there had been a mistake and that the police had shot the wrong man. The Coroner referred by way of example to articles in the Daily Mirror and the News Letter. The Coroner recorded that none of the officers involved in the shooting when questioned at the inquest knew anything about any mix up being reported in the press, which he found strange, given the roles that they played in the

deceased's death. An explanation proffered to the Coroner was that this confusion about the identity of the driver had arisen because the "Blues", local police officers working in West Belfast, who had arrived on the scene after the incident but before Chief Inspector Lowry arrived, had concluded that DP2, a well-known PIRA activist, had been shot and had passed that information to Chief Inspector Lowry when he arrived. The Coroner concluded that:

> "(a) Officers M and Q were untruthful in their testimonies when they claimed that they had no idea that there was a real possibility the driver of the Orion was DP2, a hardened member of PIRA with a history of involvement in explosives and firearms.
>
> (b) Officers M and Q did not pass the information about the identity of DP2 to any of the Call Signs and to Calls Signs 8 and 12 in particular.
>
> (c) TCG and HMSU did believe that initially DP2 had been shot.
>
> (d) While Chief Inspector Lowry may have told (an individual) in confidence that the Deceased was DP2, this was not the entire reason for the press reporting that there had been a "botch up" or DP2 being identified as the person who was shot. The "Blues" may also have wrongly identified the Deceased as DP2."

[53] In relation to the evidence of the police officers involved in the shooting that they knew nothing about any mix up being reported in the press the Coroner concluded that while it was possible that some of them did not learn how it was reported in the press, other officers did know though the Coroner was not in a position to identify those officers who did and those who did not. On this basis the Coroner concluded that some officers, though he was not sure who, misled the inquest on this issue.

[54] The Coroner found that at about 5.00 pm on 25 November 1992 the deceased "had been driving, and was the sole occupant of the Orion."

[55] The Coroner found that "(there) can be no real doubt that the Orion had been used that day to transport improvised explosives and that such explosives were being stored or manufactured at the rear of 2-6 Arizona Street. The presence of a TPU indicated the intention of the terrorist was to make some sort of bomb which would be used to inflict damage, suffering and misery on Belfast and its citizens."

(l) Logs, press reports and disclosure

[56] Under the heading of "Logs, press reports and disclosure" the Coroner set out his findings as to the contemporaneous official documents recording the events of 25 November 1992 as they unfolded. He stated that it was surprising that there was no TCG log and that he was unclear as to whether there was a separate TCG log or any military surveillance log. The HMSU log only commenced at 5.03 pm and concluded at 6.26 pm. The Coroner found that the HMSU log was unsatisfactory in many respects which he set out at paragraph [143] (ii). The Coroner concluded that either Officer M or Officer Q or both of them edited the original log by removing and destroying all entries made before 5.03 pm and that there was a much fuller HMSU log than the one produced by those officers for the inquest.

(m) The immediate circumstances in relation to the death of the deceased

[57] In summary the Coroner found that shortly "after 5.00pm on 25 November 1992, (the Orion) being driven by the deceased was forced off the road by a police car. The deceased ran from (the Orion) and was then shot by Sergeant A, a member of the RUC. The deceased was gravely injured and collapsed and died very shortly after being shot."

[58] The Coroner found that call signs 8 and 12 amongst others were deployed to stop the Orion but that the initial order was rescinded so that the police officers had to wait outside Andersonstown Police Station which served to heighten the tension and anxiety which they felt. The Coroner stated that the rescission of the order was because sight of the Orion had been lost but that that at approximately 4.30 pm the Orion was again seen by surveillance in Arizona Street and this sighting coincided with what was thought to be intense PIRA activity in that street. The Coroner stated that the Orion left Arizona Street returning at about 5.00 pm before being observed to leave at about 5.08 pm. The Coroner found that Detective Superintendent AB requested HMSU to perform a stop on the Orion it having been identified that the rear lights were not working which stop was to be a "soft stop" namely an indication to the driver to pull over. The Coroner stated that the expectation was that the driver would stop when requested to do so but that it was at the discretion of Sergeant A to decide how to react in the unlikely event that a soft stop could not be effected. The Coroner stated that this "seemed a reasonable way to proceed."

[59] The Coroner found that call signs 8 and 12 which had been waiting outside Andersonstown Police Station then travelled citywards along the Falls Road. The Coroner also found that the Orion was being driven citywards in the nearside lane on the Falls Road. The Coroner stated that call sign 8 was directly behind the Orion and call sign 12 was directly behind call sign 8. The Coroner found that call sign 8 flashed its headlights indicating to the Orion to stop but the Orion did not stop so call sign 8 was driven into the off-side lane and drew alongside the Orion. The Coroner stated that eye contact was made between Sergeant A in the front passenger seat of call sign 8 and the deceased. The Coroner went on to recount that following

this eye contact the deceased slowed the Orion and then drove off at speed pursued by both call signs. The Coroner stated that the refusal of the deceased to stop and his determination to escape seems to have confirmed to the police officers that he was on a terrorist mission and that there was good reason to suspect that the Orion was carrying munitions. The Coroner went on to state that call sign 8 accelerated up alongside the fleeing Orion and forced it to stop by ramming it but that call sign 12 was some distance behind and it followed up in the outside lane stopping adjacent to and overlapping with call sign 8.

[60] The Coroner found that the deceased ran from the Orion and was shot by Sergeant A. The Coroner identified two "representations" made to him being in summary:

(a) "on behalf of the next of kin that the Deceased was shot in the back at close range by Sergeant A without cause or justification. Their case is that Sergeant A believed that the driver of the car was DP2, a well-known PIRA activist who was suspected of involvement in previous gun and bomb attacks on the police. Sergeant A had a round in the breech prior to exiting the vehicle indicating a readiness to fire and he deliberately selected automatic mode. His actions, putting a round in the breech prior to leaving the vehicle, the speed at which he exited the vehicle, the decision to select automatic mode, all point to an intention to deploy lethal force. Sergeant A exited from the vehicle rapidly and shot the Deceased as soon as he was in a position to do so. He did not panic or make an error of judgment. His experience and training would have equipped him so as not to do so. The Deceased was fleeing the Orion following its forced stop and in running across the road at most made a modest deviation in direction. He presented no threat to any policeman or anyone else at the scene."

(b) "on behalf of the police that given the context they were under enormous pressure and that "the Deceased's decision to "do a runner" was compelling evidence that he was driving a car with either a primed bomb or munitions on board and it was likely that he was armed. He was running with his hands low and unseen by Sergeant A who had emerged from the front seat of Call Sign 8 and run to its rear. Sergeant A shouted "police halt" or "halt police" with his sub-machine gun at the ready. 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 is adamant that although the Deceased was turning, he was facing him when he pulled the trigger. He also claimed it was an error on his part in flicking the safety switch off which meant that instead of firing a single shot as he had intended, he fired five shots in quick succession in automatic mode."

From these representations it can be seen that one of the central issues to be decided by the Coroner was whether the deceased did or did not turn dynamically towards Sergeant A.

[61] The Coroner found that the deceased did not move from the point he collapsed on the ground and that he ended up lying very close to or partially on the pavement on the countrywards carriageway, with his head facing in the countrywards direction of the Falls Road. The Coroner stated that some of the police officers attempted to give medical assistance to the deceased which included applying bandages to his wounds but that the nature of the deceased's injuries were such that these efforts were to prove fruitless.

[62] The Coroner found that the shooting was reported to the command room at 5.18 pm and that this tended to time the shooting at very shortly before 5.18 pm.

[63] The Coroner stated that there was a bus travelling in the countrywards carriageway of the Falls Road which had stopped very close to the scene so that many of the occupants of the bus had been able to view the deceased lying on the ground fatally injured. The Coroner went on to state that a decision was made to allow the bus to pass which was ill-judged as the names and addresses of those on the bus should have been taken at the very first opportunity. The Coroner also stated that while efforts were made subsequently to trace such passengers, and the bus driver, those failed to produce any tangible results.

[64] The Coroner found that Call Sign 12 was reversed back to permit Officer D to let the bus pass on the orders of Officer H who had just arrived at the scene. The Coroner stated that this again was most unsatisfactory especially as the position of Call Sign 12 was not marked on any sketch map at the time and that there have been disputes and disagreements about the precise location of Call Sign 12 and where it stopped immediately prior to the shooting. The Coroner also found that Call Sign 12 remained at the scene for several minutes before it was driven away on the instructions of Officer H taking Officers D and F to Arizona Street. The Coroner stated that the vehicle should not have been moved until SOCO had arrived and it had been properly mapped.

[65] The Coroner found that an ambulance attended at the scene, the deceased was removed to hospital and at 5.30pm his life was declared extinct. The Coroner also found that in the light of the deceased's injuries it was likely that he had died very soon after being shot.

[66] The Coroner found that Sergeant A and Officers B, C and E remained at the scene whilst other officers were deployed to carry out a search of premises at Arizona Street.

[67] The Coroner found that several of the civilian witnesses believed that it was Officer F who had fired the fatal shots. However the Coroner found that it was

Sergeant A who fired the bullets that killed the deceased and that the casings found on the pavement on the citywards side of the Falls Road adjacent to the rear of the car known as Call Sign 8 were deposited close to where Sergeant A opened fire.

(n) The injuries sustained by the deceased

[68] The Coroner found that the deceased had been struck by three of the five bullets which had been fired by Sergeant A and that it was probable that the bullet which killed the deceased was the one which struck him on the left side of the back. The Coroner stated that the injuries sustained by the deceased in the shooting were:

(a) An entrance gunshot wound to the back of the left shoulder centred 5cm below and 22cm to the left of the 7th cervical spine and 54 inches above the soles of the deceased's feet. The bullet had passed forward and to the right at an angle of about 45 degrees and slightly downwards. The bullet exited from the front of the left upper chest.

(b) An entrance gunshot wound on the left side of the back, centred 25cm below and 12.5cm to the left of the 7th cervical spine and 46 inches above the deceased's feet. This bullet had passed forwards and to the right at an angle of about 45 degrees and upwards at an angle of about 15 degrees. In its course the bullet grazed the 9th left rib, lacerated the lower part of the left lung, the aorta (the main artery leaving the heart), the heart, the heart sac and the right lung before fracturing the right rib. The bullet made its exit on the right side of the front of the chest.

(c) An entrance gunshot wound on the back of the left arm, centred about 4cm above the point of the elbow and a corresponding exit wound on the front of the forearm centred 3cm below the elbow.

(o) The search of premises in Arizona Street

[69] The Coroner found that after the shooting Officer AB had directed certain HMSU officers to attend immediately at 2-4 Arizona Street in order to conduct searches. Officers D and F left the scene in Call Sign 12 and drove to Arizona Street.

[70] The Coroner was satisfied that the order for the officers to leave the scene in Call Sign 12 to go to Arizona Street was done as a result of the genuine wish to search Arizona Street and he did not consider that there was any substance in the claim that their leaving the scene was part of some cover up or to spirit the shooter away. However, the vehicle should not have been moved until SOCO had arrived and it had been properly mapped.

[71] The Coroner found that it was significant that in the course of these searches at Arizona Street a Mark 15 Timer and Power Unit ("TPU") which can be used in under car 'booby trap' devices was found. The Coroner stated 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 from the time of its hijacking were active participants in such activities.

(p) The debrief

[72] The Coroner found that after the incident Officers B, C and D were driven back to Lisnasharragh Police Station and that Sergeant A was also driven back to Lisnasharragh with Officers E and F, but separately from Officers B, C and D. The Coroner went on to state that at Lisnasharragh, Sergeant A was examined by Dr Crowther and that whilst Sergeant A did not report any anxiety he was seen by the doctor to be shaking and exhibiting signs of tension. The Coroner found that Sergeant A did suffer some sort of a nervous reaction to what happened on the Falls Road that night.

[73] The Coroner found that all the officers were debriefed after the incident at about 6.45 pm and before they were interviewed by CID officers. The Coroner stated that the debrief was conducted by Officer M under the supervision of Officer V who was the head of HMSU, who had come in from leave for the purpose and during the debrief Sergeant A gave his account in the presence of the other officers. The Coroner found that present at the debrief were Officers V, R, T, S, J, N, I, E, K, P, O, L, D, A, C, B, F, Q, M, and J.

[74] The Coroner stated that a debrief was standard practice at that time and it did have advantages in that it establishes a clear chronology at an early stage when events are still fresh in the minds of those who participated. However, the Coroner stated that there is no doubt that such a debrief has at least the potential to allow all the officers taking part in it to get "their story straight" and he referred to the Stalker Sampson Reports into earlier incidents which had occurred in 1982 at (a) Tullygally Road East, Craigavon (b) Ballynerry Road North, Lurgan and at (c) Mullacreevie Park, Armagh. The Coroner found that in the earlier Stalker/Sampson Reports it had been recommended that the practice be stopped. The Coroner went on to find that there was an egregious failure to learn from the findings in the Stalker/Sampson Reports and a failure or refusal on the part of the Chief Constable(s) to implement the recommendations by ensuring that any future CID investigations into the deaths of civilians who had been killed by the police or Army were unsullied by actions taken immediately after any shooting.

(q) The Coroner's finding that if the deceased did turn then Sergeant A could have feared for his life and that of his colleagues

[75] In the context which I have summarised under the heading of the general and particular context the Coroner found at paragraphs [205] (h) and [330] (d) of his verdict that if the deceased did turn as described by Sergeant A, then Sergeant A could in those particular circumstances have feared for his life and those of his colleagues, and in particular Officer C.

(r) The Coroner's assessment of the evidence

[76] The Coroner at paragraphs [198]–[227] analysed in detail the police evidence. He set out the RUC code of conduct finding that Sergeant A did not comply with it. He set out Sergeant A's evidence recounting that in Sergeant A's opinion "the deceased's refusal to halt, his aggressive turn towards the police who he must have known were armed with his arms down so that his hands could not be seen, convinced A that his life and those of his colleagues was in mortal danger." The Coroner dismissed the submission that it was simply inconceivable that Sergeant A honestly believed he was under threat in circumstances where there was no objective threat whatsoever. The Coroner held that if the circumstances were as described by Sergeant A then it was certainly credible given the catenation of circumstances that Sergeant A should believe that his life and that of his colleagues, and in particular Officer C, were under mortal threat. The Coroner stated that the lack of any objective threat on the facts of this case could only be determined afterwards, when the deceased was found not to be armed. The Coroner considered Sergeant A's previous record as a police officer holding that "(on) the evidence presented to this inquest, Sergeant A appeared to have behaved with great caution prior to 25 November 1992 and certainly did not use any of the many opportunities presented by other counter-terrorism operations in which he had taken part to "take out" those whom he perceived to be terrorists." However the Coroner also recognised that while Sergeant A was someone of good character with no convictions and an unblemished record of service to the RUC, he was someone who was capable of lying when he considered the occasion demanded it. The Coroner found Sergeant A to be taciturn, to appear to be a credible witness stating that he was quietly impressive and did not embellish. The Coroner set out his understanding of Sergeant A's evidence as being that he "saw the Deceased turning his head over his right shoulder. He then shouted a warning. The Deceased then spun round with Sergeant A unable to see his hands because his arms were down by his side. He then opened fire." The Coroner went on to state that:

> "On the basis of his testimony, Sergeant A had an instant to react to a sudden manoeuvre of the Deceased which he concluded was the immediate prelude to the Deceased opening fire on him and his colleagues. He had no time to weigh up the pros and cons, he had to react instantaneously and instinctively *relying on his training and experience* to save, he claims, his life and that of his colleagues. He had to react immediately and he did so. There was no possibility of him playing it by the book if he was not to place his life and those of his colleagues at a very serious risk." (emphasis added).

[77] In relation to Officer C the Coroner stated that he "did not appear to be lying, he made a convincing witness and he did seem to try to give an accurate recollection

of what had happened nearly 25 years ago." In relation to Officer B the Coroner stated that he "seemed to give honest testimony" and that he "offered what appeared to be reliable and convincing testimony." The Coroner found Officer D to be a credible witness. The Coroner found Officer E to have given "convincing evidence" and that he clearly feared for his life which fear was instilled by the actions of the deceased. The Coroner found Officer F to be "a credible witness" who described the deceased as "burling" round with his hands low. The Coroner stated that this witness was plausible and that he attested to the "real and imminent threat" posed by the deceased.

[78] The Coroner then considered the submission that "all the police officers had got together and made up a version of events designed to exculpate Sergeant A." The Coroner rejected this on the basis that "there were too many loose ends; too many easy answers not given. The differences and similarities in the testimonies of the police officers had the ring of truth."

[79] Overall the Coroner stated that he was impressed with the testimonies of the police officers finding their evidence in respect of what happened that evening to be persuasive in the face of testing cross-examination. However, the Coroner then went on to consider the denial by all the police witnesses that they knew anything about the killing being reported subsequently in the press as a mix up. The Coroner remained unconvinced that all of the officers were unaware at the time as to how this killing was being reported in the media. He stated that he did not know how many or which of the officers were trying to mislead him.

[80] The Coroner at paragraphs [228] – [243] analysed in detail the civilian evidence. He considered the evidence of Hugh Malone not to be reliable. He also found the testimony of Ciaran McNally not to be reliable. The Coroner was also unconvinced by the evidence of Gary Brown and found difficulties with the evidence of Patrick McKeown. He concluded that the testimony of these four witnesses provided little assistance to him in trying to resolve what happened at teatime on the Falls Road on 25 November 1992.

[81] The Coroner then considered the statement of evidence of Lawrence Moylan. He found the statement to be unreliable.

[82] The Coroner also considered the witness statement of James Patrick McAllister who had given evidence at the first inquest in 1995 but not at the second or third inquests. The Coroner stated that this witness certainly did not see any dynamic turn immediately before the burst of automatic gunfire rang out. However, the Coroner also observed that he not had a chance to see him give oral testimony and be cross questioned so that his evidence was not tested. However, the Coroner also stated that his evidence deserved to be given proper and due consideration and at paragraph [317] stated that he found the testimony of Mr McAllister to the first inquest to be persuasive.

(s) The expert evidence

[83] The Coroner considered the expert evidence at paragraphs [244] – [303]. The issue was whether the evidence that the deceased turned towards Sergeant A was consistent with the deceased being shot in the back given factors *such as* perception time, reaction time, the time it took to fire 5 shots in automatic mode, the velocity of the bullets, whether the gun moved on firing and if so in what direction, the distance between Sergeant A and the deceased and the posture and movement of both of them at the critical moments. Professor Pounder in his evidence stated:

> "All I can say is that the scenario presented by Sergeant A and the police officers is feasible, that's to say it is possible. Whether it is probable or not depends upon the assessment of the other evidence and its credibility and reliability and that is a matter entirely for the Court."

[84] The Coroner highlighted the difficulties that he faced at paragraph [297] in the following terms:

> "Throughout the evidence there has been debate about the angles of the bullets' paths, the distance Sergeant A was away from the Deceased when he fired, the view Sergeant A would have had and the conclusions which should be drawn from those facts. The fatal shots were fired from a sub-machine gun which was not anchored but held by Sergeant A. It will have moved on firing. So too might the Deceased and Sergeant A. Any movements in such a tight space will have significant effects. The difficulty is that there were no fixed points. It is not possible to say precisely where Sergeant A was when he fired the fatal shots. This is not something that can be worked out with precision or accuracy. For example, it is impossible to say the precise angle the Deceased took when he opened his driver's door to flee the scene. It is impossible to say what angle the Deceased took after he, and I stress that I use the word neutrally, changed direction. It is not clear whether he bent forward at any time. I found there to be limited assistance on these matters dependent as they were on variables which made definite and final conclusions difficult, if not impossible, to reach, especially given the time that has passed since the incident in question. For example, I do not accept that Sergeant A 25 years later would know exactly where he stood on the pavement in relation to Call Sign 8 when he pulled the trigger. His memory is bound to be dimmed by the passage of time."

[85] The Coroner did not find that the expert evidence was conclusive either for or against the proposition that the deceased turned just before he was shot. Rather the Coroner found on the basis of the expert evidence that it was possible that when Sergeant A made the split second decision to fire the deceased appeared to be facing towards him so that the police version of how the deceased came to be shot in the back provides a possible explanation for what happened. The Coroner went on to state that this possibility, in the sense that it could happen, had to be weighed in the balance with all the other evidence before being able to reach a definite conclusion.

(t) The Stalker/Sampson reports and the Ombudsman report

[86] The Coroner considered the impact of the Stalker/Sampson Reports and the Police Ombudsman's report on the killing of Neil McConville at paragraphs [304]-[317]. The Coroner concluded that in the light of those reports it was appropriate that he should look hard at the evidence of the police officers, subject that evidence to anxious scrutiny and weigh it in the balance against the empirical, objective evidence. The Coroner stated that he intended to treat the evidence of Officer M with very considerable caution and that he bore in mind that Sergeant A and Officer V were prepared to dissemble on receipt of orders to do so from above approximately ten years before this incident.

(u) Discussion by the Coroner and his findings

[87] The Coroner concluded that if the deceased did turn as stated by Sergeant A then Sergeant A could in those particular circumstances have feared for his life and those of his colleagues, and in particular Officer C and that there would have been no substantive breach of Article 2 ECHR. On that basis the crucial issue was whether the deceased did turn. In order to arrive at a conclusion in relation to that issue the Coroner considered that the civilian evidence apart from the evidence of Mr McAllister was unreliable. The Coroner went on to state that he had no opportunity to assess the bona fides of Mr McAllister though his evidence to the 1995 aborted inquest hearing seemed convincing. The Coroner repeated that he was satisfied that it was 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 ipsi lateral turn he was making at the time. The Coroner then stated that his general impression of the police evidence was favourable and that the evidence was credible and cogent though he remained unconvinced by it for a number of reasons. Ultimately the Coroner concluded that no version had been put forward which commended itself to him on the balance of probabilities remaining unsure and uncertain. At paragraph [334] the Coroner expressed his degree of uncertainty as being "*profoundly unsure* as to what happened" (emphasis added). On that basis as the onus rested on the PSNI to provide a satisfactory and convincing explanation to the inquest for the use of lethal force it had failed to do so. On that basis the Coroner found at paragraph [329] that "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."

[88] We have emphasised the words "*profoundly unsure*" as this is not a case where the evidence almost led the Coroner to one or other conclusion on the balance of probabilities or where he stated that the evidence was evenly balanced so that he was almost persuaded. Rather the Coroner remained *profoundly unsure* as to whether the deceased did or did not turn as stated by Sergeant A. He was not going to find that the deceased did turn nor was he going to reject this evidence but rather he was *profoundly unsure* on the evidence so that he could make no finding on the balance of probabilities. We emphasise that being profoundly unsure does not betoken a fine balance or a 50/50 case where the evidence could be tilted one way or the other.

[89] The impact of the Coroner being profoundly unsure in relation to the crucial issue as to whether the deceased did turn can then be discerned in the way that the Coroner addressed the specific issues set out in paragraph [22] of this judgment. In relation to those specific issues:

(a) The Coroner found 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) The Coroner was satisfied that Sergeant A shouted something at the deceased before Sergeant A opened fire. However the Coroner was not satisfied on the balance of probabilities that these were words to the effect of "Police, halt" but he found that the deceased knew that police officers had exited Call Sign 8, that these officers were armed and that the deceased was aware of Sergeant A's presence.

(c) The Coroner found that to the extent that Sergeant A shouted, this would have the effect of warning the deceased of his presence but the Coroner was not satisfied that Sergeant A issued any warning that he was going to fire.

(d) The Coroner found that the deceased who was unarmed objectively was no threat to Sergeant A or any of his colleagues. However the Coroner held that if the deceased did turn in the manner described by Sergeant A, and for which there was support from other police officers, then Sergeant A could have feared for his life and those of his colleagues, and in particular Officer C. However the Coroner repeated that he was unable to reach a firm conclusion as to whether in fact the deceased did turn in the manner alleged by Sergeant A.

(e) The Coroner found that while the deceased's hands may have been obstructed from Sergeant A's vision he was unable to reach a final view on this issue on the balance of probabilities.

(f) The Coroner repeated that he was unable to decide whether the deceased turned round to face towards Sergeant A.

(g) The Coroner held that he was unable to decide whether the deceased was facing Sergeant A when Sergeant A fired at him.

(h) The Coroner found that he was unable to decide whether Sergeant A honestly believed that the deceased did anything to pose a threat to him or at any other police officer.

(i) The Coroner held that Sergeant A selected automatic fire rather than a single shot accidentally.

(j) The Coroner held that on Sergeant A's version of events he was justified in firing in breach of the RUC Code of Conduct governing the discharge of firearms given that he reasonably feared for his life and/or that of his colleagues. However the Coroner stated that whether the scenario painted by Sergeant A was accurate remained uncertain.

(k) The Coroner found that if the deceased turned as Sergeant A alleges then whilst an alternative course of action to opening fire would have been available to Sergeant A such as using the protection of the armoured vehicle, this would not have protected the lives of his colleagues, and in particular the driver, Officer C. The Coroner stated that in those circumstances Sergeant A did not have an alternative course of action open to him. However the Coroner repeated that those circumstances had not been proven on the balance of probabilities.

The applicant's grounds for judicial review

[90] At paragraphs [205] (h) and [330] (d) the Coroner found that if the deceased did turn as described by Sergeant A, then Sergeant A could in those particular circumstances have feared for his life and those of his colleagues, and in particular Officer C. In these judicial review proceedings there was not nor was it possible for there to be any sensible direct challenge to this finding given the Coroner's conclusions as to the context of "these truly terrible times" and all the other "catenation of circumstances" and the impact of that context on what was in the mind of the police officers as they went about the execution of their duties facing a threat from a terrorist organisation which had an appetite for wanton violence and an intention to destroy, demolish, maim and kill.

[91] In summary terms the appellant contended that the verdict should be quashed on the following six grounds:

(i) Failure to decide central issues

[92] It was submitted that the Coroner abdicated his responsibility to arrive at a verdict in relation to the central issues to be determined in the inquest, concluding that "It is now impossible with the passage of time to say with any certainty what happened on that fateful afternoon." It was also contended that the Coroner was obliged as a matter of law to make every effort to arrive at a conclusion and it was only in the most exceptional circumstances that it was proper for a Coroner to fail to reach a verdict on the evidence. It was also contended given that the evidence was so *finely balanced* that the Coroner was unable to be satisfied on the balance of probabilities that the shooting of Pearse Jordan was not justified it must follow that any failure to take into account, or give appropriate weight to, evidence, which pointed towards the conclusion that the shooting of Pearse Jordan was not justified, would have been sufficient to tip the balance in favour of that conclusion. It was contended that given the finely balanced nature of the Coroner's decision, the other grounds of appeal are sufficient to justify quashing the inquest because on the evidence the Coroner ought to have concluded that the shooting of Pearse Jordan by Sergeant A was not justified.

(ii) Burden and standard of proof

[93] It was submitted that the Coroner fell into error in relation to both the burden and the standard of proof in that he effectively imposed a burden on the next of kin to prove their case and that he adopted an approach and expressed himself in terms that indicated that he was in fact applying a higher, stricter standard in his assessment of the allegations against Sergeant A.

(iii) Failure to take into account ballistics evidence

[94] It was submitted that the Coroner failed to take into account (and therefore essentially rejected without evaluation or explanation) the agreed evidence of the forensic scientists who gave evidence about ballistics to the inquest, including in particular evidence of the speed of the bullets fired and the characteristics of the weapon used. It was also submitted that the rejection of this evidence was crucial to his acceptance of the evidence of Professor Pounder which he in turn relied upon to conclude that the evidence of Sergeant A that the deceased was facing him at the time he was shot was possible. The appellant states that had the Coroner taken the ballistics evidence into account he would necessarily have rejected Professor Pounder's evidence and concluded that the account given by Sergeant A was not even possible. In those circumstances he could not but have concluded that the shooting of Sergeant A was unjustified.

(iv) Code of Conduct

[95] It was submitted that the Coroner failed to appreciate the importance and significance of the Code of Conduct and failed to give any or adequate weight to Sergeant A's admitted breaches of it. It was also submitted that the Coroner also disregarded the Code and, in the process, also disregarded the higher level of training, experience and skills possessed by Sergeant A and that the effect was to assess both Sergeant A's honesty and the reasonableness of his actions on a mistaken basis.

(v) Selective reliance on Police Evidence (Call Sign 12)

[96] It was submitted that the Coroner relied upon the evidence of Officers D, E and F in support of Officer A but rejected, without explanation, a strand of their evidence that rendered the account given by Sergeant A inherently implausible. It was suggested that those officers gave an account of the shooting that (objectively) involved Sergeant A firing not only in the direction of the deceased but in their direction as well and that the Coroner selectively relied upon the evidence of these officers insofar as it exonerated Sergeant A but rejected it insofar as it undermined him.

(vi) Officer V

[97] It was submitted that the Coroner failed to reach a determination on the question of whether Officer V had perjured himself in the inquest conducted in 2012 and again in 2016. It was submitted that Officer V was central to the debrief conducted by HMSU officers after the shooting of Pearse Jordan and that the purpose of this debrief (consistent with the purpose of debriefs conducted in the Stalker/Sampson series of shootings) was to secure the exoneration of Sergeant A. It was also submitted that the High Court and Court of Appeal had identified this as one of the issues to be determined in the inquest and that the failure to evaluate the evidence against Officer V and to arrive at a conclusion on this issue undermined the Coroner's conclusions in relation to both the debrief and the credibility of HMSU witnesses to the shooting.

The judgment of Keegan J

[98] In relation to ground (i) that the Coroner had abdicated his responsibility to decide central issues Keegan J held that the particular issue which the Coroner identified and about which he did not arrive at a conclusion was the nature of the movement of the deceased which occurred in a matter of seconds prior to the fatal shots being fired. She stated that the Coroner had to assess that issue at a historical reach with conflicting accounts from witnesses and experts. She went on to state that this was clearly a difficult task which the Coroner undertook in painstaking detail and that having conducted the exercise the Coroner could not decide where the truth lay so that the particulars were not proven to him. In her view it was not

arguable that this decision was outside the range of decisions that can be reached in this type of case and accordingly she refused leave to apply for judicial review on this ground.

[99] In relation to ground (ii) that the Coroner fell into error in relation to both the burden and the standard of proof Keegan J having considered the entirety of the Coroner's verdict was unconvinced that the Coroner fell into legal error or that there was a procedural error in this case regarding the burden and standard of proof. She did not consider that there was an arguable case that the Coroner had made a legal error as claimed on this ground.

[100] In relation to ground (iii) that the Coroner failed to take into account the ballistics evidence Keegan J held that the ballistics evidence was contained in an agreed note dated 24 October 2012 which was produced by Mr Boyce and Mr Greer at the inquest in 2012 and which was read at this inquest by agreement. She held that this evidence was then interpreted by the experts who gave evidence at the hearing that is principally by Professor Pounder and Dr Cary. She also held that the Coroner did not specifically reference the agreed note however that did not mean he disregarded it. She considered that the evaluation of the evidence was a matter of judgment and that the Coroner had provided an overall analysis of this part of the evidence at paragraph [297] of his verdict. She did not consider that an arguable case had been made out that the Coroner disregarded the ballistics evidence.

[101] In relation to ground (iv) that the Coroner failed to appreciate the importance and significance of the Code of Conduct Keegan J held that the Coroner had set out the terms of the Code, had found that Sergeant A was in breach of the Code and that the breach of the Code had been taken into account. She did not consider that it was arguable that this was a ground for judicial review.

[102] In relation to ground (v) that the Coroner selectively relied upon the evidence of Officers D, E and F in support of Officer A but rejected, without explanation, a strand of their evidence that rendered the account given by Sergeant A inherently implausible Keegan J held that this was a matter of judgment and within the discretion of the fact finder. She did not consider that an arguable case had been made out on this ground.

[103] In relation to ground (vi) that that the Coroner failed to reach a determination on the question of whether Officer V had perjured himself in the inquest conducted in 2012 and again in 2016 Keegan J held that this was a matter of judgment and within the discretion of the fact finder. She did not consider that an arguable case had been made out on this ground.

[104] In the event Keegan J dismissed the application for leave to apply for judicial review on the basis that none of the grounds gave rise to an arguable case.

Discussion

[105] We will consider the 6 grounds of challenge in turn.

(i) Failure to decide central issues

[106] The Coroner being profoundly unsure did not decide whether the deceased did or did not turn towards Sergeant A. Furthermore the Coroner's profound uncertainty on this issue also impacted on and influenced his failure to decide a number of other issues such as whether Sergeant A honestly believed that the deceased did anything to pose a threat to him or to any other police officer. At paragraph [327] of his verdict the Coroner held that the decisions in relation to these issues were not binary decisions consisting of a decision between two possible factual outcomes but rather that there was a third possible factual outcome which was that he was unpersuaded on the balance of probabilities in relation to either of the two possible outcomes. On that basis the possible outcomes in relation to factual issues were (i) a positive finding one way on the balance of probabilities, (ii) a positive finding the other way on the balance of probabilities and (iii) a decision that he could not make any finding one way or the other on the balance of probabilities.

[107] The Coroner resorted to the burden of proof which lay on the police and the State to provide a satisfactory and convincing explanation to the inquest for the use of lethal force in order to hold that the police had failed to do so. We consider that resort to the burden of proof was not to decide facts but was rather to establish a consequence and that in the context of an inquest the determination of a consequence does not establish on the balance of probabilities a whole series of facts.

[108] The appellants contend that the Coroner was obliged as a matter to law to make every effort to arrive at a conclusion in relation to these issues and it is only in the most exceptional circumstances that it is proper for a Coroner to fail to reach a verdict on the evidence. The appellant also contends that the reasons given by the Coroner for his failure to reach a conclusion are neither exceptional nor sufficient to justify his findings.

[109] We were referred to *Stephens & Ano'r v Cannon & Ano'r* [2005] EWCA Civ 222 in which Wilson J giving the judgment of the Court of Appeal reviewed seven relevant authorities about the circumstances in which a court is entitled to despatch a disputed issue of fact by resort to the burden of proof. It is important to appreciate that *Stephens* was a commercial action between the sellers and buyers of land and buildings in which the Master on an assessment of damages had resorted to the burden of proof to resolve an expert valuation issue in favour of the defendant buyers. Wilson J stated that from the authorities the following propositions could be derived:

(a) "The situation in which the court finds itself before it can despatch a disputed issue by resort to the burden of proof has to be exceptional.

(b) Nevertheless the issue does not have to be of any particular type. A legitimate state of agnosticism can logically arise following enquiry into any type of disputed issue. It may be more likely to arise following an enquiry into, for example, the identity of the aggressor in an unwitnessed fight; but it can arise even after an enquiry, aided by good experts, into, for example, the cause of the sinking of a ship.

(c) The exceptional situation which entitles the court to resort to the burden of proof is that, notwithstanding that it has striven to do so, it cannot reasonably make a finding in relation to a disputed issue.

(d) A court which resorts to the burden of proof must ensure that others can discern that it has striven to make a finding in relation to a disputed issue and can understand the reasons why it has concluded that it cannot do so. The parties must be able to discern the court's endeavour and to understand its reasons in order to be able to perceive why they have won and lost. An appellate court must also be able to do so because otherwise it will not be able to accept that the court below was in the exceptional situation of being entitled to resort to the burden of proof.

(e) In a few cases the fact of the endeavour and the reasons for the conclusion will readily be inferred from the circumstances and so there will be no need for the court to demonstrate the endeavour and to explain the reasons in any detail in its judgment. In most cases, however, a more detailed demonstration and explanation in judgment will be necessary."

[110] We consider that those are the propositions that apply to civil actions and that some of those propositions can be read across to an inquest, including for instance that a Coroner should strive to make a finding and if he cannot do so that he should explain why he cannot. However, as Deeny LJ has insightfully observed the impact of the differences between inquests on the one hand and civil and criminal litigation on the other have to be recognised. The differences have recently been set out by Lord Burnett of Maldon CJ, Lady Justice Hallett and Lord Justice McCombe in *Coroner for the Birmingham Inquests v Julie Hambleton and Others* [2018] EWCA Civ

2081 at paragraph [46]. The differences there stated as adapted by reference to the legislation applicable in Northern Ireland were that "There are no parties to an inquest. The rules allow various people to participate as interested persons. There are no pleadings in cases whose facts might engage civil liability; and no indictment in cases where criminal responsibility is suspected or clear. The inquest is not an adversarial proceeding. A coroner is a judicial officer working within a statutory framework. His responsibility is to discharge the statutory duty imposed upon him, with a jury in appropriate cases, by conducting an investigation and inquest in accordance with the (Coroners Act (NI) 1959). The purpose of the inquest is set out in section (31)." We would also observe that another distinction is that in certain civil cases there is presumed undue influence until the contrary is proved whereas in an inquest there is no scope for presumptions. So we consider that there are relevant and material distinctions between civil actions and criminal proceedings on the one hand and inquests on the other.

[111] In an inquest, as in this inquest the Coroner may resort to the burden of proof which lay on the police and the State to provide a satisfactory and convincing explanation to the inquest for the use of lethal force in order to establish a *consequence* that the police had failed to do so. That resort to the burden of proof was not to decide facts but was rather to establish a *consequence*. In the context of an inquest the determination of a *consequence* does not establish on the balance of probabilities a whole series of facts such as in this case that the deceased did not turn, that his hands were visible and that Sergeant A was intent on shooting the deceased in the back.

[112] The obligation on a Coroner in an inquest under Section 31 of the Coroners Act (Northern Ireland) 1959 is confined to "setting forth" in his verdict particulars "so far as such particulars have been proved to (him)." The statutory obligation on the Coroner is to consider whether a particular has or has not been proved on the balance of probabilities. This must also involve consideration as to whether the Coroner is undecided as to whether the particular did or did not occur. In this way the decision is not as between one of two possible outcomes that is the particular did occur or the particular did not occur, but includes a third possible outcome in which the Coroner states that he is undecided or as in this case profoundly unsure as to whether it did or did not occur. We agree with the Coroner that it was not and could not be said to be a binary decision and we consider that the Coroner was positively obliged to consider the third possible outcome as to whether he was undecided provided that he gave his reasons for being undecided. We conclude that insofar as any particular was not proved to him his verdict represented the proper discharge, rather than the abrogation, of section 31 of the Coroners Act (NI) 1959.

[113] We would also observe that the potential result of being undecided is consistent with the submissions made to me at first instance in *Jordan's Applications* [2014] NIQB 11 as recorded at paragraph [271] of my judgment. In that case it was suggested to me on behalf of Hugh Jordan, the father of the deceased, that the

questions to be left to the jury should have included the potential for the answer "don't know."

[114] The Coroner stated that he was agnostic in relation to a number of issues in the inquest. One of the reasons relied upon by him was the delay of some 25 years between the events and the hearing of the inquest. It was submitted that the Coroner's reliance on delay as a reason for not coming to a concluded view was inappropriate given that he heard from a significant number of witnesses and none of them *professed* to be unable to remember salient facts. We reject that criticism as what the witnesses *profess* was relevant but not determinative, it being for the Coroner to *assess* the impact of delay on their evidence. It was also suggested that "if delay, without more, could justify a failure to arrive at a verdict, the reality is that in no legacy inquest would Coroners be able to arrive at verdicts." We also reject that criticism as the question as to whether delay does or does not contribute to agnosticism in relation to an issue will depend on the particular facts of each case. Furthermore, the reasons for the Coroner being unable to decide the issues included delay but was not confined to the issue of delay. He explained that he was presented with what seemed credible evidence by the police but for the reasons that he expressed he was not prepared to accept all of it. He was also presented with evidence on behalf of various civilians which he rejected apart from the evidence of Mr McAllister but his evidence had not been tested before him. He considered that the expert evidence was not conclusive and in addition given the impact of delay he was undecided in relation to various issues.

[115] We are satisfied that the Coroner demonstrated that he had striven hard to make a finding about the various issues and that he had explained the basis for his conclusion that it was not possible for him to do so. We consider that there is no arguable case that he abdicated his duty in the conduct of this inquest. We dismiss the appeal in relation to this ground on the basis that Keegan J was correct not to grant leave and in the alternative we dismiss this aspect of the application for judicial review on the merits.

(ii) Burden and standard of proof

[116] In section D of his verdict and between paragraphs [52]–[62] the Coroner addressed the question of the "onus and standard of proof at inquests of this nature." He concluded that the inquest is an inquisitorial process which involves the Coroner making an inquiry into the circumstances of the death of the deceased in accordance with his statutory obligations. In that respect the only burden of proof identified by the Coroner relying on paragraph [103] of the decision of the ECtHR in *Hugh Jordan v UK* Appl No 24746/94, was a burden on the "State in general and the police in particular" to provide a satisfactory and convincing explanation on the balance of probabilities to justify the death of the deceased. The Coroner repeated at paragraph [66] of his verdict that the State "bears the burden of adducing evidence to provide a convincing explanation for the killing under Article 2." He also stated at paragraph [54] that "insofar as Sergeant A relies on the defence of self-defence, the

onus will lie on Sergeant A to prove this on the balance of probabilities." In relation to the standard of proof the Coroner stated at paragraph [36] of his verdict that "findings must be grounded on reliable evidence and not on speculation or guess work and must be proved to the requisite standard, the balance of probabilities." At paragraph [57] the Coroner stated that "(it) is important to note that in any inquest any fact has to be proved to the civil standard, (which) is the balance of probabilities." He referred to that standard of proof at paragraphs [325], [327], [329], [330] (b) (c) (e) (i) and (k), [332], [333] (d), [334] and [336].

[117] No criticism was made in relation to that summary of the legal position as to the onus and standard of proof. Rather it was submitted that the Coroner having concluded that the version of events which the police officers gave him was objectively "unlikely" and having given additional reasons why their account should not be accepted at face value, he ought to have rejected their account "on the balance of probabilities" leading to a conclusion for instance that the deceased did not turn as alleged. It was also suggested that the Coroner proceeded as if it was open to him to be "undecided" if the next of kin could not advance an alternative version of events that he found likely and by this means it was suggested that he effectively imposed a burden on the next of kin to prove their case, failing to appreciate that, because this was a police shooting, the next of kin had no case to make being simply obliged to test and challenge the police case. The appellant submits that this approach therefore reflects both a misapprehension of the burden of proof and a failure to apply the correct standard of proof. In addition it was submitted that the language used by the Coroner in arriving at his conclusions suggest that the standard actually applied by him was more akin to the criminal standard rather than the balance of probabilities.

[118] The Coroner did use the word "unlikely" in relation to the police evidence on a number of occasions in his verdict. For instance at paragraph [325] when he stated that "the version of events which they gave is scientifically possible, although objectively it is unlikely." However, the Coroner went on in that paragraph to state that he remained "unconvinced on the balance of probabilities that what I was being told as to how the Deceased met his death did happen for a number of reasons" which he then set out. A fair reading of the entire verdict and indeed of that paragraph leads us to the conclusion that the Coroner was not rejecting the evidence of the police officers that the deceased did turn prior to Sergeant A opening fire but rather that he was unconvinced and *profoundly unsure* as to whether the deceased did or did not turn. We repeat that that it is not appropriate to extract a word or a sentence out of the verdict but rather to consider that word or that sentence in the context of the verdict as a whole. The Coroner was not deciding that the police version of events did not occur but rather he was deciding that he was profoundly unsure as to whether it did or did not occur.

[119] It was also submitted that the language used by the Coroner indicated that he was applying the wrong approach to the standard of proof. For instance in paragraph [329] he stated:

> "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." (Emphasis added)

Another instance relied on by the appellant is at paragraph [330](e) where the Coroner stated:

> "However, if he turned in the manner described by Sergeant A, and for which there is support from other police officers, then Sergeant A for the reasons which I have set out could in those particular circumstances have feared for his life and those of his colleagues, and in particular Officer C. However, on this issue I am unable to *reach a firm conclusion* as to whether in fact the Deceased did turn in the manner as is alleged by Sergeant A. Twenty five years later I remain *unsure* as to what happened on that early evening and I am not prepared to speculate." (emphasis added)

It was submitted that applying the correct standard of proof the Coroner could have *doubts* about how the Deceased met his death or be *unsure* but nonetheless could arrive at a conclusion on the balance of probabilities and did not need to reach a *firm conclusion*. It was argued the language employed was more consistent with the criminal standard of beyond all reasonable doubt.

[120] We consider that reading the verdict as a whole reaching a firm conclusion could only be a firm conclusion on the balance of probabilities. Furthermore that the doubts that the Coroner was referring to was his being profoundly unsure as to what had occurred so as to prevent him from coming to a conclusion rather than the sort of doubts which are necessarily involved in any decision on the balance of probabilities.

[121] It was also submitted that the Coroner imposed a burden on the next of kin to prove their case. This submission is based on the Coroner setting out at paragraph [326] "the version of events put forward by the next of kin" and his conclusion at paragraph [329] that "no version has been put forward which commends itself to this inquest on the balance of probabilities." We do not consider that there is any significance to be attached to the categorisation by the Coroner as a version of events being the next of kin's version. A reading of the entire verdict establishes that the Coroner was considering whether facts had been established to the civil standard of proof during the course of the inquisitorial procedure. The Coroner was evaluating all of the evidence presented to him and we do not consider that he placed any onus on the next of kin.

[122] The dangers of taking out of the context of the entire verdict words or sentences can be illustrated by the Coroner's reference in paragraph [326] to the principle from philosophy known as Occam's razor which is the problem-solving principle that, when presented with two explanations for an occurrence, the simpler explanation is usually the better. Another way of expressing the principle is that the more assumptions one has to make, then the more unlikely is the explanation. The basis of this principle is that one should select the answer that makes the fewest assumptions or is the simplest. The reference to the principle is interesting but on one interpretation it could have been suggested that importing the principle of Occam's razor into the decision making process was to import a different standard of proof than the balance of probabilities as the principle creates a presumption in favour of the simplest explanation or the explanation with the fewest assumptions. We are content that throughout the Coroner applied the correct standard of proof but we refer to his reference to Occam's razor to illustrate that it is inappropriate to over analyse language in a verdict rather than considering the verdict as a whole.

[123] We dismiss the appeal in relation to this ground on the basis that Keegan J was correct not to grant leave and in the alternative we dismiss this aspect of the application for judicial review on the merits.

(iii) Failure to take into account ballistics evidence

[124] The appellant contends that in order to understand the significance of the ballistic evidence to the eventual verdict it is important to understand the essential dispute between the interested parties. The pathology evidence confirmed that the deceased was shot twice in the back and once in the back of the left arm. Sergeant A's case was that the deceased turned in a clockwise direction towards Sergeant A and it was this action that led Sergeant A to believe that his life was in danger and led to his firing the fatal shots. Sergeant A also gave evidence that the deceased was facing him when he fired 5 rounds on automatic (hitting the deceased with 3 of those rounds). The appellant submits that the ballistic evidence and the pathology evidence was crucial in assisting in the determination of the issue as to whether the deceased did turn and if so whether it was in a clockwise direction. The appellant submits that the exact sequence of shots would enable an analysis as to whether the deceased was turning in a clockwise direction on the basis that if he had been then the later wound would be to the right of the earlier wound. It was also submitted that if the later wound was the wound to the upper arm then it was to the left of the earlier wounds and this would undermine the proposition that the deceased was turning in a clockwise direction. In this inquest the pathologists could not assist in determining the sequence of shots. However in the second inquest in 2012 the relevant ballistics experts Mr Boyce and Mr Greer produced a note in response to questions framed by the interested parties and the Coroner. Point 5 of that note sets out two questions in the following terms:-

> "The court has been told that 5 bullets were fired and 3 struck Mr. Jordan. Is it possible to comment on the order in which these three wounds were sustained? Is it possible to say whether any one of the wounds was the first wound or the last wound to be sustained?"

The answer was as follows:

> "Given that the MP5 *tends to rise* when being fired in automatic mode, it is our *opinion* that of the three bullets that struck Mr Jordan, either of the two lower wounds could have been the initial one as they were at similar heights, the wound to his shoulder would have succeeded these. It is not possible to tell the position or the order of the two remaining bullets in the pattern. This is *assuming that Mr Jordan was upright and the MP5 was rising*." (emphasis added).

It can be seen that this evidence goes some way to supporting the proposition that the deceased was not turning in a clockwise direction as the later wound was to the left of the earlier wounds. However the opinion is qualified in the way which we have emphasised and we also note that the wound to his shoulder had a downward trajectory which could be inconsistent with the MP5 rising but might be explained by the posture of the deceased.

[125] The appellant also submits that Inspector Brown's evidence was that the MP5 also tends to move left to right which would again suggest that the last wound should be to the right of the earlier wounds. So if the last wound was the wound to the left arm this would also go some way to supporting the proposition that the deceased was not turning in a clockwise direction as the later wound was to left of the earlier wounds. We would observe at this stage that if the deceased was just running away from Sergeant A whilst he was shooting him in the back then on the basis of Inspector Brown's evidence the last wound should have been to the right of the earlier wounds whereas it was to the left if the ballistics evidence was correct as to which wound was the last wound.

[126] The appellant submits that the Coroner in his verdict simply ignores the agreed ballistics evidence and essentially disregards that evidence in its totality without explanation or justification. That submission is made despite the appellant only making one single reference to that document in extensive closing submissions.

[127] We do not accept that the Coroner simply ignored all the ballistics evidence. The Coroner considered different aspect of the ballistic evidence at the following paragraphs of his verdict, namely [22] [256] [268] [269] [274] [277] [281] [284] [286] and [297]. We consider that the Coroner took into account the ballistics evidence but for the reasons he sets out at paragraph [297] that there were just too many

variables to arrive at a conclusion. The Coroner stated that "(throughout) the evidence there has been debate about the angles of the bullets' paths, the distance Sergeant A was away from the Deceased when he fired, the view Sergeant A would have had and the conclusions which should be drawn from those facts. The fatal shots were fired from a sub-machine gun which was not anchored but held by Sergeant A. It will have moved on firing. So too might the Deceased and Sergeant A. Any movements in such a tight space will have significant effects. The difficulty is that there were no fixed points. It is not possible to say precisely where Sergeant A was when he fired the fatal shots. This is not something that can be worked out with precision or accuracy. For example, it is impossible to say the precise angle the Deceased took when he opened his driver's door to flee the scene. It is impossible to say what angle the Deceased took after he, and I stress that I use the word neutrally, changed direction. It is not clear whether he bent forward at any time. I found there to be limited assistance on these matters dependent as they were on variables which made definite and final conclusions difficult, if not impossible, to reach, especially given the time that has passed since the incident in question." In short the Coroner was not prepared to come a factual decision based on the expert evidence which necessarily included the ballistics evidence. The Coroner was entitled to form that view and we consider that there is nothing irrational or Wednesbury unreasonable about it.

[128] We consider that Keegan J properly identified that the essence of this ground related to the interpretation of the evidence, that it was obvious that the Coroner had difficulty in reaching a firm conclusion on the expert evidence and that the evaluation of that evidence was a matter of judgment for the Coroner.

[129] We dismiss the appeal in relation to this ground on the basis that Keegan J was correct not to grant leave and in the alternative we dismiss this aspect of the application for judicial review on the merits.

(iv) Code of Conduct

[130] The Coroner at paragraphs [173] – [192] analysed the authorities in relation to self-defence. At paragraph [187] he stated that:

> "The task for this inquest when conducting an Article 2 compliant inquest must be to ask whether Sergeant A had an honest and genuine belief that it was necessary for him to open fire. Whether that belief was subjectively reasonable, having regard to the circumstances pertaining at the time, is relevant to the question of whether it was honestly held. I should not examine A's belief from the position of a detached observer but from a subjective position consistent with the circumstances in which he found himself and which will necessarily also involve taking into account his training, experience and

> his knowledge and awareness of the RUC Code of Conduct. I have to consider whether his decision to open fire was "absolutely necessary". To put it another way, whether in all the circumstances it was proportionate, that is, "reasonable, having regard to what the person honestly and genuinely believed"." (emphasis added)

Then at paragraph [202] the Coroner considered the relationship between the Code of Conduct and self-defence stating that if the Code is:

> "followed to the letter then it provides an assurance to the Officer that he will not be in breach of Article 2. "The Code in effect requires that the use of lethal force is unavoidably necessary." (See para [66] of Court of Appeal in *In the Matter of Three applications by Hugh Jordan for Judicial Review)*. However, the Code does not represent the law on self-defence. It does not deal with the situation where a police officer might have to make an instantaneous decision when he believes his life or that of his colleagues is at grave risk. The unfortunate truth is that in such circumstances a police officer can only make an immediate assessment because regardless of how experienced or well-trained he is, if he wants to make sure and weigh up the pros and cons either he or his fellow officers may well be dead. It is not an enviable position. Under such stress, police officers in trying to make such an assessment can make a mistake: eg see *Curtis (aka Jason) Davis v Commissioner of Police of the Metropolis* [2016] EWHC 38) where the police officer, who was held to have acted lawfully, opened fire having mistaken a jump lead in the hand of the injured party for the barrel of a gun. The *de Menezes* case provides another clear example.

[131] As we have indicated the Coroner held at paragraphs [205] (h) and [330] (d) that if the deceased did turn as described by Sergeant A, then Sergeant A could in those particular circumstances have feared for his life and those of his colleagues, and in particular Officer C. He also held that there would be no alternative course of action available to Sergeant A except to open fire. There is no direct challenge to those findings but rather in relation to this ground of appeal there is an indirect challenge it being asserted that there was a breach of the Code and "it is difficult to see how conduct that fails to comply with the Code could be regarded as anything other than unjustifiable." We consider that the Coroner was correct to state that "the Code does not represent the law on self-defence" and was also correct to state that "it does not deal with the situation where a police officer might have to make an instantaneous decision when he believes his life or that of his colleagues is at grave

risk." The impact of the Code was clearly identified in paragraph [66] of the judgment of the Court of Appeal *In the Matter of Three applications by Hugh Jordan for Judicial Review* under citation [2014] NICA 76 which was the very paragraph to which the Coroner referred. Morgan LCJ delivering the judgment of the court stated that:

> "The true issue was whether, in light of the higher standard of care demanded of a trained and experienced police officer and in light of the requirements demanded by the Code before a decision to use lethal force was made, Officer A was acting properly in self-defence when he shot dead the deceased. The Code in effect requires that the use of lethal force is unavoidably necessary."

The Lord Chief Justice did not state that if the requirements of the Code were not followed that Sergeant A could not have been acting in self-defence rather that the training of the police officer and the requirements of the Code are factors which weigh against the use of lethal force being unavoidably necessary. A trained officer and an officer following the Code should be less likely to resort to lethal force. However this does not necessarily preclude a split second decision in breach of the Code from being lawful.

[132] We consider that the Coroner applied the proper legal standard governing the use of lethal force, both in domestic and ECHR terms, that he did take into account the breach of the code by Sergeant A as part of his evidential determination in the manner set out by this court at paragraph [66] of its judgment under citation [2014] NICA 76. We also consider that Keegan J was correct in rejecting this ground of challenge relating to the code with reference to the Coroner's exposition of the relevant law and his overall assessment of the Sergeant A's evidence.

[133] We dismiss the appeal in relation to this ground on the basis that Keegan J was correct not to grant leave and in the alternative we dismiss this aspect of the application for judicial review on the merits.

(v) Selective reliance on Police Evidence (Call Sign 12)

[134] This ground of challenge arises out of the proposition that Sergeant A's evidence should have been rejected on the basis that on the account given by the police officers in Call Sign 12 the shots that he discharged would have been fired in their direction. It is submitted that the Coroner selectively relied upon the evidence of officers D, E and F in a manner which tended to exonerate Sergeant A while disregarding a key strand of their evidence which placed them in the line of fire and which it is submitted rendered the account given by Sergeant A inherently implausible on the basis that he would not have fired at the deceased if Call Sign 12 had been immediately behind the deceased, particularly in circumstances where the

car lights were on and the vehicle would thus have been clearly visible to Sergeant A.

[135] In support of this submission we were referred to the evidence of the police officers in Call Sign 12 and to the evidence of Sergeant A. Officer D thought the deceased collided with Call Sign 12 which caused the "spin." Officer E thought the spin was possibly the result of the impact with the car. Officer F said the deceased ran straight into the car. When asked whether it was this impact that caused the "burling around clockwise" or just a "voluntary pirouetting," F said "it probably could have been either." Officer F also described the deceased continuing to run across the road after the short burst of gunfire. Sergeant A suggested that the deceased did not reach the car and made no connection between the arrival of Call Sign 12 and the deceased's movements.

[136] The essential basis of this ground of challenge is that the Coroner must have rejected this part of the evidence of officers D, E and F whilst relying on other parts of their evidence. We would observe that the evidence of witnesses is divisible so that it is permissible for an adjudicator of fact to accept part of the evidence of a witness and not accept another part. However we do not consider that the Coroner rejected this part of the evidence of officers D, E and F but rather he referred to the sketch maps "which are not properly scaled" stating that it was a mistake to rely on them. The Coroner concluded that officers D, E and F each placed "the deceased in different position adjacent to the front of Call Sign 12" and that while the shots were in the general direction of the car (which … Sergeant A did not know to be Call Sign 12) they are likely, … to have been fired at an angle across the road."

[137] The legislature has entrusted fact finding to the Coroner. This court is concerned with the legality of the decision making processes and outcomes not with their merits. This court does not exercise an appellate jurisdiction and even if it did it would be constrained by authorities such as *DB v Chief Constable of Police Service of Northern Ireland* [2017] UKSC 7 at paragraphs 78 – 80 as to the approach to be taken by an appellate court to its review of findings made by a judge at first instance. In that case Lord Kerr quoted Lord Hope of Craighead in *Thomson v Kvaerner Govan Ltd [2003] UKHL 45; 2004 SC (HL) 1*, para 17 where he stated that: "It can, of course, only be on the rarest occasions, and in circumstances where the appellate court is convinced by the plainest of considerations, that it would be justified in finding that the trial judge had formed a wrong opinion." The exact position of Call Sign 12 and of the deceased in relation to the police officers in that call sign some 25 years ago was obviously a matter of close analysis at the inquest. We are not persuaded that even if this was an appeal this was one of those rare occasions where the plainest of considerations would justify us in concluding the Coroner had formed a wrong opinion. We do not consider that this aspect of the fact finding process was *Wednesbury* unreasonable.

[138] We dismiss the appeal in relation to this ground on the basis that Keegan J was correct not to grant leave and in the alternative we dismiss this aspect of the application for judicial review on the merits.

(vi) Officer V

[139] An issue at the inquest was whether the primary purpose of the debrief was to facilitate the exoneration of Sergeant A. Officer V was the senior HMSU officer in Belfast who was off duty when the deceased was shot but he attended on the evening of the shooting at the debrief which was conducted by Officer M prior to the police officers being spoken to by CID officers. The credibility of Officer V and his role in previous debriefs which were subject to the Stalker/Sampson reports into deaths occurring in 1982 was relevant to the issue as to the primary purpose of the debrief on 25 November 1992. Officer V had accepted that in relation to the deaths in 1982 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 see paragraph [160] of *Jordan's Applications* [2014] NIQB 11. In the 2012 inquest into the death of the deceased Officer V 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."

The proposition on behalf of the appellant was that all statements prepared by Officer V in relation to each of the investigations and all subsequent investigations in relation to the Stalker/Sampson shootings had been made available to them and that no such secret statement existed. On that basis it was part of "the appellant's case" before the Coroner that "the evidence unequivocally demonstrated that in contending that (Officer V) had produced a secret statement for the DPP which corrected his earlier false statements, Officer V perjured himself in the Pearse Jordan Inquest in 2012 and again in 2016."

[140] At paragraph [306] of his verdict the Coroner having observed that the Stalker/Sampson inquests were still to be heard stated in relation to the "serious allegations of perjury (which had) been made against … Officer V" that "there (was) much force in the PSNI's submission that in the instant case the next of kin are asking the Coroner "to make the findings of fact in support of allegations of the utmost gravity having been presented with only fragments of the evidential material." The Coroner went on to recount at paragraph [309] that Officer V said that there was a secret file created which set out exactly what had happened. The Coroner found that there was no doubt that a secret file did go to the DPP containing statements which to some extent contradicted the original statements given immediately after the December (1982) killings, for example. The Coroner went on to state that Officer V says that he gave further comprehensive statements disclosing exactly what had happened to a senior officer about all three incidents which led to

the officer being identified and being called to give evidence at the inquest. The Coroner stated that this officer had no recollection after 30+ years of receiving such a statement or statements but he said, he had no reason to doubt the claims of Officer V. The Coroner concluded that it was simply impossible for him at this inquest to investigate what might be described as peripheral information. The Coroner also stated that to conclude that Officer V committed perjury before this inquest, when he *may* not have all the information, would be unfair not just to Officer V but to everyone concerned. The Coroner also observed that no doubt this will be the subject of an in-depth inquiry and determination at the Stalker/Sampson inquests." (emphasis added).

[141] On that basis the Coroner did not make a finding that Officer V had committed perjury but the Coroner went on to state that there were a number of lessons to be learned from the Stalker/Sampson incidents. Firstly, that the inquest must be alert to at least the possibility that one or more police officers may conspire together when it suits their purposes or those of their superiors to provide a misleading cover story to explain their actions or inactions. Secondly the Coroner considered that the judgment of Kelly LJ cast considerable doubts on the credibility of Officer M and raises the question of whether he would lie under oath when it served his purposes. Thirdly, the officers, including Officer V, clearly made up a story about Grew and Carroll crashing through a police vehicle checkpoint and injuring Constable Brannigan who was not even on duty at the time.

[142] At paragraph [332] the Coroner gave his conclusions in relation to issue as to whether the primary purpose of the debrief was to facilitate the exoneration of Sergeant A. The Coroner stated

> "[332] …. It is my view that the primary purpose of the debrief having listened to the evidence was to establish the events which unfolded that afternoon in a chronological fashion, given CID's inability to attend. No evidence was adduced before the inquest to demonstrate that CID's delay in attending was due to pressure of other work. Such an explanation has not been tested in cross-examination. However, I conclude that an unintended consequence of the debrief, and the way in which it was managed was that Sergeant A's history of what he says happened was relayed in circumstances where it was capable of influencing the other police officers who were involved. This is a matter which has weighed with me in trying to reach a conclusion as to what happened. *Having scrutinised Officer V giving his evidence under significant pressure*, I am 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 unintentional consequence." (emphasis added).

[143] The issue was the primary purpose of the debrief. Evidence as to its primary purpose was given not only by Officer V but also by other officers who attended the debrief including Sergeant A and for instance officers D, E and F. All of those witnesses were or were available to be cross examined in public by experienced counsel on behalf of the appellant. The Coroner had the opportunity to see all of those witnesses as they gave their evidence and to assess their demeanour. There were also notes of the debrief (see paragraph [142] of the verdict). The Coroner's task in deciding the primary purpose of the debrief was not restricted to deciding the truth or honesty of Officer V though his credibility was in issue and he was the senior officer though not the officer conducting the debrief. The Coroner saw Officer V give his evidence and had to weigh his credibility in circumstances where Officer V accepted that he had made statements to the CID in relation to the Stalker/Sampson incidents which he knew were inaccurate and that he was aware that those statements were to go to the DPP for a decision. In assessing the primary purpose of the debrief the Coroner far from exonerating Officer V stated that "he clearly made up a story about Grew and Carroll crashing through a police checkpoint and injuring Constable Brannigan who was not even on duty at the time." Also in assessing the primary purpose of the debrief the Coroner had stated in relation to the officer conducting the debrief, Officer M, that there were considerable doubts as to his credibility raising the question of whether he would lie under oath when it served his purposes. The Coroner had also held that Officer M had been untruthful when he claimed that he had no idea that there was a real possibility the driver of the Orion was DP2 and that either he or Officer Q or both of them had destroyed part of the HMSU log. There was a lot of material to be assessed and evaluated by the Coroner and in that assessment it is correct that he did not make a finding that one of the witnesses relevant to this issue, Officer V, had committed perjury and it is also correct that the Coroner formed the view that there was much force in the submission that he was being asked to make findings of fact having been presented with only fragments of the evidential material. There was evidence in support of that proposition that the evidential material was not complete. Officer V said that there were further statements. The senior officer who was called to give evidence said that he had no reason to doubt the claims of Sergeant A that there were further statements. It was the case on behalf of the Chief Constable that "it (was) entirely possible that he did make a single further statement that was provided to his senior officers and could have been used, for example, to inform their meeting with the DPP on 31st May 1983. The fact that the statement he refers to (in 2012 and 2016) has not been located in the police archives does not conclusively mean that the statement was never made." Given the volume of documents held by the Chief Constable, the experience of the judiciary in this jurisdiction as to documents in legacy cases and the amount of time that has passed since the events of 1982 such a proposition could well carry weight with the Coroner, though the weight was a matter for the Coroner.

[144] The appellant's skeleton argument for this appeal at paragraph 120 (ii) referred to my decision in *Jordan's Applications* [2014] NIQB 11 at paragraph [210] where in relation to the question of *admissibility* of similar fact evidence in accordance with *O'Brien v Chief Constable of South Wales Police* [2005] 2 AC 534 I stated that the length of the temporal gap does not make earlier or later similar fact evidence irrelevant but rather was a matter to be considered at the control stage. In the event in this inquest the Stalker/Sampson incidents were *admitted* in evidence being considered relevant and presumably having passed the control stage. However, the temporal gap is still relevant in the *assessment* of the weight if any to be attached to similar fact evidence. People or organisations can change. The degree of external scrutiny and control can change. The Coroner was entitled to and did consider at paragraph [310] of his verdict that "the relevance of the Stalker/Sampson incidents and the McConville killing is considerably weakened and undermined by the passage of time that separates them from the killing under present investigation."

[145] We consider that the evaluation of all the evidence in relation to the issue as to the primary purpose of the debrief was a matter for the Coroner and that even if this was an appeal as opposed to judicial review proceedings this court should only come to the conclusion that the judge had formed a wrong opinion on the rarest occasions, and in circumstances where the appellate court is convinced by the plainest of considerations. These are judicial review proceedings and in such circumstances the appellant has to establish an arguable case that the decision of the Coroner was *Wednesbury* unreasonable or left out of account a relevant consideration. For the reasons which we have given we do not consider that this aspect of the fact finding process was *Wednesbury* unreasonable.

[146] We dismiss the appeal in relation to this ground on the basis that Keegan J was correct not to grant leave and in the alternative we dismiss this aspect of the application for judicial review on the merits.

[147] In any event the remedies in judicial review are discretionary. The appellant submits that given the Coroner's conclusion as to how finely balanced the issue was as to whether Sergeant A acted unlawfully in shooting the deceased that the failure to determine the question of whether Officer V perjured himself was a significant one. On this basis of a fine balance it was contended that the inquest should be quashed in relation to this ground alone. As we have explained at paragraph [88] the Coroner did not find that the issues such as whether the deceased did or did not turn were finely balanced. The Coroner did not express himself in the terms such as 50/50 in relation to that issue or any other issue. Indeed the Coroner did not put any percentage figure on the evidence that had been presented to him. Rather he stated that he was "profoundly unsure." It can be seen that we do not accept the premise that the issue as to whether Sergeant A acted unlawfully was finely balanced but rather we consider that the Coroner having heard all the evidence was profoundly unsure. We also consider that the evidence in relation to Officer V was not the only evidence to be assessed in relation to the primary purpose of the

debrief. Even if the Coroner ought to have held one way or the other as to whether Officer V perjured himself during his evidence in 2012 or 2016 we would not in any event in the exercise of discretion have quashed the verdict or granted any relief.

Conclusion

[148] For all these reasons we dismiss the appeal.

[149] I should not leave this judgment without expressing my gratitude for the assistance provided by my colleagues and without expressing on behalf of all the members of this court our appreciation of the most conscientious examination of the issues by the Coroner.