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IN THE HIGH COURT OF JUSTICE IN NORTHERN IRELAND

KING'S BENCH DIVISION
(JUDICIAL REVIEW)

IN THE MATTER OF AN APPLICATION BY SGM 15
FOR LEAVE TO APPLY FOR JUDICIAL REVIEW

AND IN THE MATTER OF THE FINDINGS AND VERDICT OF CORONER McGURGAN ON 6 SEPTEMBER 2022 ARISING FROM THE INQUEST INTO THE DEATH OF MASTER STEPHEN GEDDIS

Mr Joseph Aiken KC with Mr David Russell KC (instructed by Devonshire Solicitors) for the Applicant
Mr Frank O'Donoghue KC with Ms Laura McMahon KC (instructed by the Solicitor for the Coroner) for the Respondent
Ms Fiona Doherty KC with Mr Michael Mulvenna (instructed by Ó Muirigh Solicitors) for the Next of Kin of the deceased, Stephen Geddis
Mr Mark Robinson KC with Ms Leona Gillen and Mr John Rafferty (instructed by the Crown Solicitor's Office) for the Ministry of Defence and PSNI
Mr Ian Skelt KC with Mr Andrew McGuinness (instructed by McCartan Turkington Breen Solicitors) for SGM 3

<u>COLTON J</u>

Introduction

[1] The applicant seeks a judicial review of the findings and verdict of His Honour Judge McGurgan, sitting as coroner, delivered on 6 September 2022 ("the findings") in the matter of an inquest into the death of Master Stephen Geddis.

[2] On 28 August 1975, Stephen Geddis sustained a head injury in the Divis area of Belfast. In the course of that evening, the army was attacked with stones and bottles by a group of civilians. SGM 15 fired a baton round into a crowd. The crowd dispersed but Stephen Geddis was left lying on the ground. He was taken to the Royal Victoria Hospital where he died on 30 August 1975. There is no evidence that Master Geddis, aged 10, was involved in any unrest.

[3] The circumstances of Stephen Geddis' death were investigated by the police and military between August/September 1975. An inquest into his death was conducted on 8 January 1976. A verdict of misadventure was recorded.

[4] In 1995-1996 the police conducted a further investigation into the death, but no criminal or other proceedings followed. On 12 June 2014, the Attorney General for Northern Ireland directed that a fresh inquest be held pursuant to section 14(1) of the Coroners Act (Northern Ireland) 1959.

[5] The coroner carried out various case management hearings and in late 2020 directed an intended start date for the inquest in August 2021. A number of weeks before the intended commencement of the inquest, the Crown Solicitor informed the coroner that two soldiers that it represented, SGM 3 and SGM 15 required separate representation.

[6] The coroner received representations by those acting for SGM 15 that they would have difficulty in preparing fully for the inquest by the intended start date.

[7] Rather than adjourn the hearing, he decided to hear the inquest in two tranches by conducting an initial hearing to receive some scene setting evidence from Brian Murphy, the Consultant Engineer retained on his behalf and by receiving the evidence of all the civilian witnesses; subject to the Properly Interested Persons having the right to reserve their questioning of all witnesses, if required, to the reconvened section of the inquest which, in the event, occurred on 1 February 2022 over a further two weeks.

[8] The coroner heard evidence from 19 civilian witnesses, including five members of the Geddis family, between 23 August 2021 and 1 September 2021. Statements of a further nine civilian witnesses were admitted into evidence pursuant to Rule 17 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 ("the 1963 Rules").

[9] The coroner heard evidence from Mr Brian Murphy, Consulting Engineer, on 23 August 2021 and 1 February 2022. This was supplemented by evidence from Mr Robertson, the Architect who had designed the Divis Complex. The coroner received medical evidence in a statement from Mr David Mudd, dated 2 July 2021 admitted under Rule 17 of the 1963 Rules. Mr Mudd was a trainee neurosurgeon in 1975 working under the direction of Derek Gordon, Consultant, who performed surgery on Stephen Geddis. Further medical evidence was received in a statement from Dr Elaine Hicks under Rule 17 of the 1963 Rules.

[10] The coroner received statements from military witnesses which were admitted under Rule 17 from the following: John Patrick Ward, John Michael D'Arcy, SGM 24, SGM 16, Lieutenant Simon Peter Beaumont Badger, SGM 5 and SGM 14.

[11] The coroner heard oral evidence from SGM 1, SGM 3, SGM 6, SGM 9, SGM 10, SGM 11, SGM 12, SGM 15 and SGM 17.

[12] The following evidence was received from police witnesses: Alfred Entwistle – Rule 17 of the 1963 Rules; William Hawk –Rule 17 of the 1963 Rules; P2 – Rule 17 of the 1963 Rules; P3 – oral evidence; and John Brannigan – oral evidence.

[13] The coroner heard forensic evidence from Mr Alan Hepper, in relation to the production and use of baton rounds in Northern Ireland. He heard ballistic evidence from Ms Ann Kiernan, Forensic Scientist and from Mr Mark Mastaglio, Forensic Scientist.

[14] The coroner heard pathology evidence including written reports and agreed notes from Dr Derek Carson, Professor Jack Crane, Dr Richard Sheppard and Dr Laurence Rocke.

[15] He delivered his verdict which extended to 463 paragraphs on 6 September 2002.

[16] By these proceedings the applicant seeks leave to challenge the findings and verdict of the coroner.

Summary of challenge

[17] In summary, the grounds of challenge are founded on a submission that the learned coroner erred in law in deciding that Article 2 of the European Convention on Human Rights ("ECHR") was engaged both substantively and procedurally in relation to the inquest; that he misdirected himself in law as to the legal test to be applied to the use of force under consideration in the inquest; that he erred in law by undermining the applicant's fundamental privilege against self-incrimination and that he erred in law by holding that an inquest witness statement, other than one provided to the coroner's investigator, could (or did), attract less weight that one taken through an interview with an investigator of the coroner. The applicant further relies on procedural unfairness in respect of the way the coroner approached the applicant's evidence to the extent that he was guilty of apparent bias and relies on irrationality, arguing that the findings were perverse and not supported by the evidence.

[18] The applications on substantive judicial review were heard on the basis of a rolled-up hearing. This was with the consent of the parties. The court considered this an appropriate approach given that it had all the information available to it to deal with both the leave and the substantive hearing, in particular, detailed written findings and verdict from the coroner.

Factual background

[19] The factual background is extensively set out in the coroner's findings in paras [21]-[415]. In those written findings the coroner has set out all the material he considered, summarised and analysed the evidence he heard both orally and by way of statements received under Rule 17 of the Coroners Rules 1963. As is apparent from the summary set out above, this included evidence from civilian witnesses and expert witnesses.

[20] In summary, on the evening of 28 August 1975, a barricade had been erected across Albert Street near the Divis complex. An army vehicle was patrolling the area, and a group of civilians threw stones or other objects at the vehicle.

[21] The patrol, commanded by SGM 3, was ordered to dismantle the barricade shortly before 9pm and duly rammed it at least once before coming to a stop. The group continued to throw stones at the soldiers to the extent that SGM 3 shouted a warning that if they did not disperse a baton round or rounds would be fired. The group did not disperse. A baton round was fired, and the group then dispersed, some fleeing towards a courtyard area.

[22] SGM 3 then ordered three members of the patrol, including SGM 15 to go to the north side of St Jude's block. There was no evidence of a confrontation occurring before the three soldiers gained the strategic position of the gable end of the north side of St Jude's block. SGM 15 discharged one baton round into the courtyard area without any verbal warning. It is acknowledged that the applicable rules of engagement for the discharge of a baton round did not require a warning to be given. There was evidence that the discharge of the baton was an aimed one directed at Stephen Geddis.

[23] Stephen Geddis, aged 10 and a resident in the Divis complex, was struck by the baton round and died from his injuries two days later.

[24] There is no evidence that Stephen Geddis was involved in erecting the barricade or involved in the civil unrest on the evening of 28 August 1975.

The coroner's findings and verdict

[25] The coroner's detailed findings are an exemplar of a well-structured, fair and reasoned narrative account of an inquest. It is lengthy, running to 463 paragraphs. I do not, therefore, propose to rehearse its contents in full, although I will quote from it in this judgment. Many of the interested parties, including the next of kin of Stephen Geddis and some military and police witnesses may be disappointed with the coroner's findings. That said, the coroner has conducted a thorough public investigation of the evidence available to him relating to the death of Stephen Geddis. He has prepared a comprehensive ruling, publicly available, setting out the

evidence available to him, analysing that evidence and making findings in accordance with his statutory obligation.

[26] The findings themselves are well-marshalled and organised in a coherent structure.

[27] The written findings set out the background to the establishment of the inquest, the law relating to the holding of inquests, the effect of delay on evidence, a summary of the case management hearings prior to the inquest proper, the scope which was applied to the inquest, a description of the scene at the time of the matters under investigation, the relevant medical evidence relating to Stephen Geddis's death, evidence from the Geddis family, evidence from civilian witnesses who were present at the time of Stephen Geddis's death, evidence from military and police witnesses, an analysis of the use of baton rounds, an analysis of the ballistics and pathology evidence available to him relating to Stephen Geddis's death, a detailed consideration of the evidence, and a comprehensive setting out of his findings of fact which lead to his verdict.

[28] At this point it is useful to set out his verdict in full:

> "**Verdict**
>
> [463] To conclude I find as follows:
>
> (i) The deceased was Stephen Geddis of 5 St Comgall's Row, Divis, Belfast;
>
> (ii) He was born on 25 February 1965 at Belfast City Hospital;
>
> (iii) His father was William Geddis, unemployed Driver, and his mother is Teresa Geddis, a widow;
>
> (iv) He died on 30 August 1975 at 12.45pm at the Royal Victoria Hospital, Belfast;
>
> (v) The cause of death was:
>
> (a) Bruising and Odema of Brain, Extradural and Subdural Haemorrhage
>
> Associated with
>
> Comminuted, Depressed Fracture of Skull
>
> Due To:

(b) A Blow on the Right Side of The Head.

(vi) He was struck by a 25 grain PVC baton round to the right side of his head between 9.00pm – 9.15pm on 28 August 1975;

(vii) At the time he was struck he was located within the area known as the Courtyard, the Square or Old Trafford in the Divis Complex. This describes an area that lay between the Milford, Cullingtree and St Jude's Blocks within the Divis Complex;

(viii) The baton round was fired by SGM15;

(ix) The baton round was probably aimed at the ground;

(x) SGM15 was unjustified in discharging the baton round as the force used was more than absolutely necessary when it was discharged;

(xi) SGM15 did not "target" the deceased;

(xii) The matter was discussed by members of the patrol amongst themselves in the aftermath of the incident;

(xiii) The operation in which SGM15 was involved and the use of PVC baton rounds therein was not planned, controlled or regulated in order to minimise to the greatest extent possible the risk to life."

Grounds of challenge

[29] In his Order 53 Statement the applicant challenges the impugned findings and verdict as follows:

Illegality

(a) The coroner erred in applying the wrong legal framework to the inquest. Although not part of the Scope of the inquest, the coroner misdirected himself in law and applied ECHR article 2 to the inquest both procedurally and substantively. As a matter of law, ECHR article 2 was not engaged in relation to the inquest (paragraphs 6, 20 and 463(v) of the Findings).

(b) The coroner applied the wrong legal test when assessing and determining the force SGM 15 had used when the plastic baton round was fired. While not specifically stated, it is evident from the Findings that the coroner applied the ECHR article 2 test in respect of the use of lethal force. The coroner did not address nor analyse the proper legal test set out in the closing written submissions on behalf of the applicant dated 6 March 2022.

(c) The coroner misdirected himself in law as to the legal test of self-defence by approaching the circumstances that led to the death of Stephen Geddis as the deployment of lethal force. The circumstances of the death involved the deployment of non-lethal force, but which had an accidental and regrettable lethal outcome.

(d) The coroner erred in law by undermining the applicant's fundamental privilege against self-incrimination. The coroner rightly accepted the applicant's privilege against self-incrimination meant he did not have to answer any questions about the broad circumstances that led to the death of Stephen Geddis however, the coroner proceeded to make adverse findings against the applicant arising from his exercise of the privilege against self-incrimination (paragraphs 8, 300 and 417 to 421 of the Findings). Further, how the matter was dealt with was procedurally unfair in the circumstances.

(e) The coroner erred in law by holding that an inquest witness statement, other than one provided to the coroner's investigator, did (or may) attract less weight than one taken through an interview with an investigator of the coroner (paragraphs 18, 252, 289 and 420 of the Findings).

Immaterial considerations

(f) The coroner took into account irrelevant or immaterial considerations (or gave them manifestly excessive weight) in relation to the applicant's refusal to meet with the coroner's investigator and refusal to be interviewed by that investigator in order to provide a witness statement to the inquest. The applicant provided a witness statement in the manner envisaged by the statutory scheme.

Procedural unfairness

(g) The coroner acted procedurally improperly and/or in breach of his duty to act in a procedurally fair manner by:

    (i) The manner in which the coroner approached the applicant's witness statement to the inquest.

(ii) The manner in which the coroner approached the oral evidence of the applicant.

(iii) The manner in which the coroner approached the applicant's privilege against self-incrimination.

Sub-paragraphs (g)(i) to (iii) above show the coroner was unfortunately guilty of bias. Further, in the circumstances, a fair procedure was not followed by the coroner and the inquest has fallen short of proper standards to such an extent as to call into question the lawfulness of the findings and verdict.

Irrationality

(h) The findings and verdict of the coroner were perverse/*Wednesbury* unreasonable including in relation to the applicant's privilege against self-incrimination (see 12(d) above); by finding the applicant was not justified under ECHR article 2 in discharging the baton round (paragraph 463(v) of the Findings and 12(a) and (b) above); in an inconsistent determination of the facts (compare paragraphs 433 and 450 of the Findings, were there seconds or minutes between the discharge of separate baton rounds?); in the approach to the soldiers witness statements (paragraph 419 of the Findings); in making findings unsupported by the evidence.

The court's consideration of the arguments

[30] Whilst the Order 53 Statement is diverse, wide ranging, with significant overlapping grounds, it is clear from the submissions of Mr Aiken, that his starting point related to the alleged appearance of bias on behalf of the coroner which has, in turn, effected his findings and rulings. As a result, he says that the coroner has been unfair to the applicant, in making adverse findings against him and, in effect, undermining his privilege against self-incrimination. Thus, in his well-marshalled oral submissions, Mr Aiken opened with the issue of bias, leading on to the question of privilege against self-incrimination and the appropriate test to be used when assessing the use of force.

[31] Rather than go through the individual headings in the Order 53 Statement I, therefore, propose to consider the application based on those submissions. The court's findings on those matters deal with arguments in relation to material considerations, immaterial considerations and irrationality.

[32] Before doing so, however, I propose to deal with the issue relating to scope and whether the coroner erred in treating the inquest as one subject to the procedural obligations of Article 2 ECHR.

Article 2 ECHR

[33] The applicant submits the coroner applied article 2 ECHR to the inquest both procedurally and substantively when there was no proper legal basis for doing so.

[34] After the inquest was completed but before the hearing of this judicial review, the Supreme Court gave its judgment in *In the matter of an application by Rosaleen Dalton for Judicial Review (Northern Ireland)* [2023] UKSC 36.

[35] This case sought to definitively examine the circumstances in which Article 2 of the ECHR imposes both a substantive and a procedural duty on the State.

[36] *Dalton* was the latest in a series of cases which grappled with this issue, namely *Re McKerr* [2004] UKHL 12, *Silih v Slovenia* [2009] 49 EHRR 37, *Re McCaughey's Application* [2011] UKSC 20, *Janowiec v Russia* [2013] 58 EHRR 30, *R(Keyu) v Secretary of State for Foreign and Commonwealth Affairs* [2015] UKSC 69, *Re Finucane's Application* [2019] UKSC 7 and *R v McQuillan* [2021] UKSC 55.

[37] This inquest was another in the series which have arisen out of deaths which occurred during the Troubles, many years before the Human Rights Act came into force.

[38] The applicant argues that the effect of *Dalton* is such that the investigative obligation under article 2 ECHR did not apply to the inquest as a matter of domestic law.

[39] At the heart of this dispute is the extent to which the Human Rights Act has retrospective effect.

[40] Perhaps the issue is best summarised in the judgment of Lord Burrows and the Lady Chief Justice (Keegan) in the *Dalton* case at para [305] as follows:

> "305. It is well-established that Article 2 of the ECHR imposes both a substantive and a procedural duty on the State and that, although the HRA came into force on 2 October 2000 and is non-retrospective, the procedural duty to investigate deaths can apply to deaths prior to the coming into force of the HRA. This is so where, first, new information has come to light which satisfies the test for reviving an investigation laid down in *Brecknell v United Kingdom* (2007) 46 EHRR 42 ("*Brecknell*"); and, secondly, there is a 'genuine connection' between the triggering death and the 'critical date' of 2 October 2000. There is an exception to the need for a genuine connection if the death undermines the values of the Convention (as, for

> example, with genocide) so as to satisfy the 'Convention values' test."

[41] In order to satisfy the genuine connection test, the triggering death should normally be within 10 years of the critical date (*Janowiec*, *McQuillan*) but in exceptional circumstances the 10-year limit may be extended to a maximum of 12 years (*Finucane's Application*) and affirmed in *Dalton*.

[42] In this case the applicant submits that the genuine connection test is clearly not met as the triggering death occurred some 25 years before the "critical date." Therefore, it does not satisfy the temporal element of the genuine connection test.

[43] I do not consider, nor was it argued at the hearing, that this case met the "Convention Values" test.

[44] The applicant says, therefore, that it follows that the coroner was not obliged to carry out an inquest which complied with Article 2 ECHR and in doing so fell into legal error. Consequently, it is argued that the coroner applied the wrong legal framework to the inquest and the findings cannot stand.

[45] Ms Doherty, on behalf of the next of kin, supported by the coroner, argued that the proper approach was to be found in the *McCaughey* case.

[46] In *McCaughey* the Supreme Court ruled that, because the coroner intended to conduct an inquest into the death of Mr McCaughey and Mr Grew who were shot and killed by the SAS on 9 October 1990, that inquest should be conducted in compliance with Article 2 ECHR. Lord Phillips stated at para [50]:

> "The obligation to comply with the procedural requirements of article 2 is to apply where 'a significant proportion of the procedural steps' that article 2 requires (assuming that it applies) in fact take place after the Convention has come into force. This appears to be a free standing obligation. There is no temporal restriction on the obligation other than that the procedural steps take place after the Convention has come into force. Thus, if a state decides to carry out those procedural steps long after the date of the death, they must have the attributes that article 2 requires."

[47] In similar vein at para [61] Lord Phillips states:

> "… Insofar as article 2 imposes any obligation, this is a new, free standing obligation that arises by reason of current events. The relevant event in these appeals is the fact that the coroner is to hold an inquest into Martin

> McCaughey's and Dessie Grew's deaths. *Šilih* establishes that this event gives rise to a free standing obligation to ensure that the inquest satisfies the procedural requirements of article 2."

[48] this view was confirmed by the judgments of Lord Hope and Baroness Hale and are unequivocally endorsed in Lord Brown's short judgment at para [101] where he states:

> "101. … I too, in common with Lord Phillips (para 61) and Lord Hope (para 77), would hold that any inquests still outstanding, even, as in these cases, in respect of deaths occurring before 2 October 2000, must so far as remains possible comply with the relatives' article 2 Convention rights."

[49] Mr O'Donoghue and Ms Doherty both submit that *McCaughey* remains good law. The Supreme Court in *Dalton* did not take the opportunity to expressly overrule *McCaughey*.

The decision in Bradley and others [2024] NIKB 12

[50] This issue has arisen in several ongoing inquests and the legal implications of the *Dalton* judgment in this context were considered in the judgment of Humphreys J in the case of *Rosemary Bradley and others* [2024] NIKB 12.

[51] In that judgment Mr Justice Humphreys conducted a review of the relevant authorities and provided a definitive judgment on the effect of the cases to which I have referred on "legacy inquests." I cannot improve on this judgment or its reasoning which is of enormous value to coroners conducting "legacy" inquests (subject, of course, to the implications of the Northern Ireland Troubles (Legacy and Reconciliation) Act 2023).

[52] I, therefore, adopt the conclusions at para [99] of his judgment.

> "[99] The principle of legal certainty, espoused by all parties to this litigation, delivers the following outcomes:
>
> (i) No death which occurred before 2 October 1988 can engage the article 2 procedural obligation as a matter of domestic law, save where the Convention values test is met. This is the fixed and outer limit of the genuine connection test;

(ii) Where a death occurred between 2 October 1988 and 2 October 1990, the article 2 obligation may be engaged where:

(a) The original investigation was seriously deficient; and

(b) The bulk of the investigative effort was carried out after 2 October 1990.

(iii) Where a death has occurred between 2 October 1990 and 2 October 2000, the temporal aspect of the genuine connection test will be satisfied but the article 2 procedural obligation will only apply when much of the investigation took place, or ought to have taken place, after 2 October 2000;

(iv) For any death occurring after 2 October 2000, the article 2 procedural obligation will apply;

(v) If the Convention values test is satisfied, then the article 2 obligation will apply to a death occurring after 14 January 1966."

[53] Adopting this analysis, the coroner in this case was not under an obligation to carry out an Article 2 ECHR compliant investigation.

What are the implications of this analysis for the coroner's findings and verdict?

[54] There was an unfortunate dispute between the parties as to whether the scope of the inquest was actually agreed.

[55] When the inquest proceeded on 1 February 2022, it was the understanding of the coroner that the scope of the inquest had, in fact, been agreed.

[56] A draft scope document was circulated by counsel on behalf of the coroner to all representatives of all properly interested parties, including the applicant, in June 2021. He received submissions on scope from representatives of the next of kin and the MOD/PSNI prior to a review on 8 September 2021. Submissions from SGM 3 were received prior to 16 September 2021 at which stage senior counsel for the coroner circulated an amended draft scope document. At a case review hearing on 14 December 2021, it was indicated that counsel were discussing the draft scope document. On 18 January 2022, it was confirmed that an amended scope document had been circulated to all the parties. At no stage was it suggested to him that the scope was not agreed.

[57] In any event, it is for the coroner to determine the scope of an inquest. In his analysis in the *Bradley* case, Humphreys J went on to ask the question "**What difference does it make**?", in the context of whether an inquest is conducted on the basis that article 2 applies.

[58] Again, I adopt what he said in answer to that question:

> "**What difference does it make?**
>
> [100] It will be a matter for individual coroners charged with the conduct of a particular inquest to determine the scope, the relevant evidence and the nature and extent of the verdict and conclusions. Whether or not article 2 applies may have an impact on some or all of these questions. However, it may be observed that the difference might not be all that pronounced.
>
> [101] In *Middleton*, Lord Bingham said:
>
>> 'It must be for the coroner, in the exercise of his discretion, to decide how best, in the particular case, to elicit the jury's conclusion on the central issue or issues.'
>
> [102] In *R (Smith) v Oxfordshire Assistant Deputy Coroner* [2010] UKSC 29, Lord Phillips stated:
>
>> 'I question whether there is, in truth, any difference in practice between a *Jamieson* and a *Middleton* inquest, other than the verdict. If there is, counsel were not in a position to explain it.' (para [78])
>
> [103] Similarly, per Popplewell LJ at first instance in *R (Morahan) v HM Assistant Coroner for West London* [2021] EWHC 1603 (Admin):
>
>> 'In many instances, of which the current case is an example, there will be no practical difference in the scope of the inquiry conducted at a *Jamieson* inquest from that at a *Middleton* inquest.' (para [70])
>
> [104] Lord Brown commented in McCaughey:

> '…it may be doubted whether in reality there is all that much difference between an article 2 compliant inquest (a *Middleton* inquest: see *R (Middleton) v West Somerset Coroner* [2004] 2 AC 182) and one supposedly not (a Jamieson inquest: *R v Coroner for North Humberside and Scunthorpe, Ex p Jamieson* [1995] QB 1).'

[105] This observation around the difference in verdict has to be seen in the context of coronial law in England & Wales. Section 5 of the Coroners and Justice Act 2009 sets out that the purpose of a coroner's investigation is to ascertain who the deceased was and how, when and where he came by his death. By section 5(2), where article 2 applies, the 'how' question includes 'in what circumstances' he came by his death.

[106] Section 10 requires the coroner or jury to make a determination as to the section 5 questions without making any determination of civil liability or criminal liability on the part of a named person. The practice in that jurisdiction is to adopt one of a list of short form conclusions or, in certain cases, for a narrative determination to be given instead of or in addition to the short form conclusion.

[107] In this jurisdiction, verdicts (as they are still known) are not given in short form but, as a matter of course, extend to a set of narrative conclusions. Rule 16 of the Coroners (Practice and Procedure) Rules (Northern Ireland) 1963 prohibits a coroner or jury from expressing an opinion on any issue of civil or criminal liability. The latter is not restricted to a 'named person' as it is in England & Wales, and this explains the ability of coroners' courts in that jurisdiction to deliver a finding of unlawful killing.

[108] Having noted the restrictions, the coronial jurisprudence in recent times has recognised that the coroner is nonetheless under a duty "to ensure that the relevant facts are fully, fairly and fearlessly investigated" (per Sir Thomas Bingham MR in *Jamieson*). The same judge said in *Jordan v Lord Chancellor* [2007] UKHL 14 that whilst a verdict of unlawful killing is not open in Northern Ireland, an inquest may find facts which may point very strongly to the existence of criminal liability.

> [109] Given the potential scope for such findings, and the need for a full fact-finding exercise, it may be therefore in any given case that the application or otherwise of article 2 is a point of academic interest only, making little practical difference to the running or the outcome of the inquest."

[59] In this case, the coroner was obliged as a matter of law to answer the statutory questions as to who the deceased was and how, when and where he came by his death. In doing so, he was under a duty in the words of Sir Thomas Bingham quoted above "to ensure that the relevant facts are fully, fairly and fearlessly investigated."

[60] In the court's view, on any fair analysis this inquest was conducted in compliance with that obligation. The findings and verdict answered those questions and were entirely consistent with the coroner's obligation in relation to this investigation. In the context of this inquest, it must be remembered that a key issue in dispute was whether the plastic bullet which resulted in the death of Stephen Geddis was as a result of a baton discharged directly at him, in circumstances where he posed no threat to the soldier who discharged the baton. It will be seen later in this judgment that, in fact, the applicant criticises the coroner for the way in which he dealt with submissions on behalf of the applicant relating to the legal test for self-defence. Plainly, any proper investigation into the death of Stephen Geddis involved consideration of the circumstances in which the plastic baton round was fired. He had to grapple with the very issue that gave rise to the requirement for the inquest.

[61] He did not make a finding of unlawful killing, nor did he make a finding in relation to civil or criminal liability.

[62] Leaving aside the issue as to whether or not the scope was, in fact agreed, it is clear that at no stage was there any challenge to the scope of the inquest adopted by the coroner (it is to be noted that following the delivery of the Supreme Court's judgment in *McQuillan* no submission was made to the coroner that he had to revisit the issue of scope on the basis that Article 2 ECHR did not apply to the inquest). If this was a serious issue for the applicant, then it could and should have been raised with the coroner during the inquest hearing or prior to the delivery of his findings and verdict.

[63] In any event, as set out above, the obligation to ensure that the relevant facts leading to Stephen Geddis's death were "fully, fairly and fearlessly investigated" means that on the facts of this case it makes no difference to the outcome whether the coroner was under the procedural obligation contained in Article 2 ECHR.

[64] The court, therefore, concludes that there is no arguable case in relation to this argument and leave to apply for judicial review on this ground is refused.

Apparent bias

[65] I formed the impression that the issue of apparent bias lay at the heart of this application for judicial review.

[66] The test in respect of apparent bias is well-established in the seminal House of Lords case – *Porter v Magill* [2002] 2 AC 357. Lord Hope expressed the matter in this way:

> "[103] … The question is whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased.

[67] Mr Aiken also drew the court's attention to the authority quoted in para 5-84 of *Jervis on Coroners* (14th Edition) which referred to the case of *R (On the application of Carol Pounder (2) v HM Coroner for the North and South Districts of Durham and Darlington v Youth Justice Board, Serco Home Affairs Ltd, Lancashire County Council* [2010] EWHC 328 where Burnett J summarised the applicable principles in this way:

> "12. There was no disagreement between the parties as to the appropriate test to apply in cases such as this. Where an allegation of apparent bias is made, the test to be applied is 'whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the tribunal was biased.' That is the test approved by the House of Lords in *Porter v Magill* [2002] 2 AC 357, per Lord Hope of Craighead at [103] adopting the approach of Lord Phillips of Worth Matravers MR in *In re Medicaments and Related Classes of Goods* (2) [2001] WLR 700. The fair-minded and informed observer is neither unduly sensitive nor suspicious, yet he is not complacent. He is assumed to have taken the trouble to acquire knowledge of all relevant information before coming to a conclusion: see *Helow v Secretary of State for the Home Department* [2008] 1 WLR 2416, per Lord Hope of Craighead between paragraphs [1] and [3]. The fair-minded and informed observer is also expected to be aware of the law and the functions of those who play a part in its administration: see *Lawal v Northern Spirit* [2003] UKHL 35 at paragraphs [21] and [22]. When applying the test, any court will take account of an explanation given by the tribunal and

assume that the hypothetical observer is also aware of that explanation: see In *Re Medicaments* [67]. In *AWG Group v Morrison* [2006] EWCA (Civ) 6 [2006] 1 WLR 1163, the Court of Appeal summarised a number of the principles in play. In paragraph [8] of his judgment, Mummery LJ cited a passage from *Locabail (UK) Limited v Bayfield Properties Limited* [2000] QB 451 at 480, in which it had been observed that in most cases the answer regarding apparent bias would be obvious. However, the court on that occasion went on to indicate that if there were real ground for doubt, the doubt should be resolved in favour of recusal. …"

[68] In passing, I observe that whilst this case is useful in considering the factors that might be taken into account in assessing bias, it was a case which was considering recusal and not a case seeking to set aside the findings of a Tribunal based on a claim of apparent bias. Indeed, the text in Jervis at paragraph 5-87 notes that "an interested person who, with knowledge of the relevant facts giving rise to an appearance of bias, does not challenge a coroner's refusal to recuse himself before the inquest may be taken to have waived the objection." It will be noted that even though the coroner expressed views about SGM 15's failure to be interviewed by his investigator well before the commencement of the inquest, no application was made asking the coroner to recuse himself.

[69] The starting point in relation to apparent bias relates to the way the coroner dealt with the witness statement provided by SGM 15.

[70] The coroner addresses the issue of witness statements from SGM 15 in paras [15]-[18] of his findings. He says:

> "[15] In accordance with the presiding coroner for Northern Ireland's Witness Protocol, witnesses were interviewed by my investigator and statements recorded, reflecting the fact that witnesses in the inquest are witnesses of the coroner. Two witnesses, SGM 3 and SGM 15 who were also PIPs in this inquest, declined to be interviewed and advised me that they intended to submit statements prepared by them in consultation with their legal representatives.
>
> [16] I requested submissions setting out the reasons why both refused to be interviewed by my investigator and any submissions on their giving of evidence to the coroner via the approach adopted by Keegan J in *Re McElhone* [2021] NICoroner 1 (see paras [11]-[12]) often referred to as the '*McElhone* approach.' I also invited

> submissions from the PIPs legal representatives on this issue.
>
> [17] In considering this issue, the first matter to be determined was the admissibility of statements prepared by the witnesses, in conjunction with their legal representatives. Having considered the relevant legislative provisions, I determined such statements were admissible.
>
> [18] While the preferred process is as set out in the Witness Protocol, and cognisant there is no statutory power requiring a witness to provide a statement through an interview with the coroner's investigator, as with all matters of evidence it is for me to consider what weight could be attached to a pre-prepared statement submitted through the witness' solicitors. I took the view that <u>unless and until</u> the witness answered questions posed either by an investigator or my counsel, having due and proper regard to the witness' right to privilege against self-incrimination, it <u>may</u> not have been possible for me to place as much weight on the content of the statement as might have been the case if the answers were the product of direct questioning by my investigator."
> [my underlining]

[71] The coroner summarised the evidence of SGM 15 in paras [288]-[311] in his findings.

[72] At para [289] he says:

> "[289] SGM 15 was granted PIP status to this inquest given his apparent central role in this incident. He declined to be interviewed by my investigator and submitted a further statement, dated 16 December 2021, to the inquest through the offices of his solicitors, Devonshires. In permitting the witness to avoid being interviewed by my investigator and to submit his own statement through his solicitor, in this way I made it clear that adopting this strategy, while a matter for the witness, <u>may</u> affect the weight to be given to the statement."
> [my underlining]

[73] When analysing the evidence at paras [416]-[462] of his findings the coroner says at para [420]:

> "[420] Though SGM 15's historic statements and the transcript of his 1995 RUC interview were received into evidence by me, SGM 15 did not seek to adopt his statements as his evidence or to give oral evidence having refreshed his memory from those statements. Instead, his oral evidence was to the effect that he had little or no recall of relevant events and when his recall of events was tested in questioning, he asserted his privilege against self-incrimination. While he has a right of course, to do so, he was a potentially extremely important witness for it was after his discharge of a baton round a person was seen lying on the ground. Only two other soldiers (SGM 1 and SGM 12) were eyewitnesses to what was occurring in the courtyard immediately prior to the round being discharged. Only SGM 15 could have told me (or my investigator) why he decided to discharge the baton round, the manner in which he did so and his intention when doing so. By asserting his right against self-incrimination, I have been denied a significant evidential source."

[74] Highlighting these paragraphs and the coroner's findings on the verdict generally, it is argued that the coroner regarded the witness statement provided by SGM 15 as of less value, and less weight than one provided to a coroner through the coroner's investigator.

[75] Focusing on para [289] the applicant argus that the coroner regarded his conduct as some form of "strategy."

[76] Mr Aiken also draws the court's attention to a comment made by the coroner during an exchange between counsel in the context of the applicant asserting his right against self-incrimination. There was a debate about whether Mr O'Donoghue on behalf of the coroner was entitled to ask questions about his actual memory of the incident with reference to various statements made by him about the matter and, in particular, his responses to questions put by his solicitor in the statement submitted on his behalf. The coroner intervened at one point to say "he might have been better spoken to by an investigator, I think, is the outworking of this. Maybe that is something everyone should take on board moving forward."

[77] Against this background, Mr Aiken argues that taken together with other issues, a fair-minded observer would conclude there was a real possibility the Tribunal was biased against SGM 15 by reason of the coroner's views about the applicant's failure to agree to be interviewed by his investigator.

[78] The question of the applicant's witness statement and whether the coroner's approach to it demonstrated bias has two aspects. The first relates to his ruling on

the statement itself and the second relates to how he addressed this issue in the course of his findings.

[79] On the first aspect the coroner had to determine the issue of admissibility of the statement submitted through the applicant's solicitor.

[80] Mr O'Donoghue points out that this had to be seen in the context of the decision of Keegan J in *McElhone* [2021] NICoroner 1. A further context was that the coroner considered the matter shortly after a ruling by McAlinden J in an application by a soldier witness (M4) who sought to set aside a subpoena ad testificandum in the inquest into the death of Thomas Mills (deceased). M4 was believed to be the soldier responsible for discharging rounds that killed Mr Mills on 18 July 1972. However, the application to set aside the subpoena was grounded on an assertion that the applicant intended to invoke his privilege against self-incrimination. Accordingly, it was argued that calling the witness to give evidence would be futile and, therefore, the subpoena should be set aside.

[81] McAlinden J refused the application because if successful the application would have resulted in the coroner being unable to ask M4 any questions as to the circumstances of the death of the deceased in that inquest.

[82] As of 14 December 2021, the decision in M4 was under appeal.

[83] In the event, M4's appeal was unsuccessful. The Court of Appeal's judgment is reported at [2022] NICA 6. It bears reading in full but it is clear from paras [37]-[46] the court endorsed the coroner's approach that it was important to examine the witness given the relevant information he may have. The court was satisfied that the right to self-incrimination could not be evoked in a blanket sense. The court was satisfied that any witness relying on the privilege against self-incrimination would be safeguarded within the coronial process.

[84] On 14 December 2021, the coroner determined the issue of admissibility before the commencement of the second module on 1 February 2022. It is worth setting out what he said in full:

> "I note that it is the intention of some of the interested persons to submit statements prepared on their behalf rather than to answer questions of the coroner's investigator. While I welcome the fact that the interested persons are providing such statements and that they shall be considered by my team and me, this is a process which is not in accordance with the coroner's protocol which provides for the direct questioning of witnesses and properly interested persons by the coroner's investigator. The questioning of witnesses by the coroner's investigator is considered to be an important step in the coroner's

investigation in any inquest. The central purpose of any inquest is to allay suspicion and rumour where suspicion and rumour exits. Direct questioning by the coroner's investigator is a step intended to assist in achieving that aim. It is not the sole step, but it is nonetheless, in my consideration, an important step and the provision of a pre-prepared statement, while welcome, and in my consideration, properly falling as admissible to the inquest, bypasses completely the process of direct questioning that the investigator's role fulfils. I should also make it clear that the Protocol is there to reflect the fact that this is my investigation as coroner and that the investigator is my investigator to assist me in establishing the facts surrounding the death of Stephen Geddis. The provision of a pre-prepared statement risks compromising my ability to establish those facts as a witness has not submitted himself to what I consider is an important and integral part of the inquest process. Accordingly, while I cannot compel any witness to submit to interview by my investigator, when I come to examine the evidence before me at the conclusion of this inquest, the fact that a witness's evidence, while a matter of controversy, has not been tested by the investigator, may be a matter that I have to take into account in assessing the weight to be attached to the witness's version of events." [my underlining]

[85] Analysing this ruling it is difficult to see how any reasonable person could conclude apparent bias. It did not provoke a recusal application on behalf of SGM 15.

[86] Firstly, the coroner granted the application, despite strong opposition from the legal representatives of the next of kin. Secondly, he pointed out that the provision of a pre-prepared statement "risks" compromising his ability to establish facts. Thirdly, he points out that if a witness's evidence has not been tested by an investigator that "may" be a matter to be taken into account in assessing the weight.

[87] This was a ruling given before the witness had given evidence.

[88] It seems to the court that the coroner's comments could not be considered controversial. He identified a proper "risk" which "may" be a matter to be taken into account when "assessing the weight to be attached to the witness's version of events." There is no predetermined conclusion contained in the comments. The comments highlight the thinking and importance behind the Protocol which was adopted in respect of all but two of the witnesses at the inquest (SGM 15 and SGM 3).

[89] The second aspect is whether any apparent bias can be gleaned from the way in which the coroner, in fact, dealt with the applicant's witness statement.

[90] I turn now to the passages highlighted by the applicant in the coroner's findings. The first sequentially are his comments at para [18] which is set out above, together with the preceding paragraphs.

[91] Any reading of this paragraph confirms that the coroner simply states, correctly, that "unless and until" the witness answered questions posed by his investigator or counsel, it "may" not have been possible to give the statement as much weight. Making this comment, the coroner also recognises the importance to have "due and proper regard to the witness's right to privilege against self-incrimination." Thus, he was alive to the protection to which the applicant was entitled. It seems to the court that it is uncontroversial to say that a written statement which has not been the subject of challenge or questioning may not be given the same weight as evidence which has been either given in person or tested by questioning.

[92] In terms of the structure of the findings at this stage the coroner is simply dealing with pre-hearing issues and applications.

[93] At para [289] the coroner is at the commencement of his review and assessment of the applicant's evidence. He merely repeats what he said when he made his ruling on 14 December 2021. Again, he points out that the submitting of a written statement through his solicitor "may" affect the weight to be given to it.

[94] I do not consider that by using the words "avoid" and "strategy" the coroner was making some adverse comment or using the words in a loaded way. It seems to the court these are factual descriptions of what took place and what the coroner permitted. Thus, he acceded to the applicant's request to depart from the preferred practice set out in the witness protocol.

[95] Turning to para [420] of the findings, it is not correct to state that the coroner regarded giving a witness statement to his investigator to be the same as giving evidence to him.

[96] The paragraph concludes "only SMG 15 could have told me (or my investigator) why he decided to discharge the baton round, the manner in which he did so and his intention when doing so. By asserting his right against self-incrimination, I have been denied a significant evidential source."

[97] The coroner simply outlines the potential importance of SGM 15's evidence on the issue of the baton round that killed Stephen Geddis, and the fact that evidence on this issue from SGM 15 was not available to him. This is an uncontroversial statement of fact and is in no way evidence of any bias towards SGM 15, in my view.

[98] In analysing this (and also in relation to the subsequent consideration of the issue of self-incrimination) para [421] is important.

[99] The coroner says:

> "[421] Accordingly, in making my findings as to what occurred in this matter, I wish to make it clear that while I have taken into account the content of SGM 15's historic statements and his RUC interview, I have not had the benefit of hearing substantive oral testimony from this witness as to the full extent of his actual recollection. To the extent that any of my findings are expressly or impliedly critical of SGM 15, I wish to make it clear that I am not making any finding as a means of punishing the witness for asserting his privilege against self-incrimination. Nor am I drawing inference adverse to SGM 15 from the fact that he claimed to have little or no recollection of relevant events."

[100] In relation to the comment made during a hearing on 10 February 2022, the views expressed during this exchange were in the context of an issue that had arisen as to the construction of SGM 15's witness statement. The issue that was being debated at the time related to para [8] of the applicant's statement. Mr O'Donoghue was seeking to test whether the applicant had in truth, any memory about the incident that had occurred. In doing so, he wished to put to the applicant the questions that were posed to him in constructing the statement.

[101] In the course of the debate, the coroner made it clear that before being obliged to answer any question, the applicant would be reminded about his privilege against self-incrimination.

[102] It is during this debate that the coroner makes the comment about which the applicant complains. It should be remembered that this discussion took place in the absence of the witness because the live link had broken down. The context was that Mr Aiken had complained that counsel to the coroner had misunderstood the content of the statement. The simple point being made by the coroner was that this misunderstanding, if that is what it was, may not have arisen if the coroner's investigator had taken the statement in the first instance.

[103] I do not consider that there is anything in this exchange, or in the way in which the coroner dealt with the applicant's evidence through to his written findings of 6 September 2022 that would cause any fair-minded observer to conclude there was any or apparent bias or any possibility of bias against SGM 15.

[104] I am conscious that the applicant says that apparent bias can also be gleaned from the approach taken by the coroner in relation to other issues which I discuss below. He does not rely on the issue of the statement in isolation, rather it is the launching pad from which he seeks to establish apparent bias. I bear this in mind in this judgment. I will look at this issue based on individual issues raised and on their potential collective impact.

Privilege against self-incrimination

[105] Linked to the way in which the coroner dealt with the applicant's statement is the assertion that the coroner, in effect, undermined the applicant's privilege against self-incrimination.

[106] I have already referred to the way in which the coroner expressly dealt with this in para [421] of his ruling. I have considered the transcript of the evidence given by SGM 15 and the questioning by Mr O'Donoghue on behalf of the coroner. It is clear that throughout that questioning the applicant is reminded repeatedly of his entitlement not to answer questions and to exercise his privilege against self-incrimination. The questioning conducted by Mr O'Donoghue was directly related to the statement of evidence submitted on behalf of SGM 15 through his solicitors, which was based on a question-and-answer format.

[107] The coroner deals with SGM 15's evidence in paras [288]-[311].

[108] He sets out that the following statements and transcripts were received relating to SGM 15:

> "(i) RMP statement dated 29 August 1975.
>
> (ii) RUC statement dated 1 September 1975.
>
> (iii) Deposition of statement made to the coroner at the original inquest in 1976.
>
> (iv) Interview transcript arising from RUC investigation on 22 September 1995."

[109] He then refers to the further statement dated 16 December 2021 given through the offices of his solicitors.

[110] He points out at para [290]:

> "SGM 15 was provided with the appropriate warning regarding privilege against self-incrimination and this warning was repeated each time that a question was posed which justified the issue of such a caution."

[111] In analysing SGM 15's evidence, the following paragraphs are important:

> "[298] SGM15's formal position when he gave his oral evidence was that he had no recollection of the incident/allegation that he had fired a baton round into a crowd in which the deceased died. He did accept that he had no medical conditions affecting his memory, simply the ageing process. In response to a question from Mr O'Donoghue QC if he was prepared to tell the inquest if he had a memory of the incident, he asserted his privilege.
>
> [299] He accepted that if a baton round did strike an individual directly on 28 August 1975 then that would have been in contravention of the White Card Rules of Engagement.
>
> [300] SGM15, as he was entitled to do, asserted privilege against self-incrimination insofar as it related to answering questions relating to his earlier statements and interviews and the events of the 28 August 1975.
>
> [301] Notwithstanding the witness's assertion of privilege against self-incrimination, I have concluded that the statements attributed to SGM15 of 29 August 1975 and 1 September 1975, together with the deposition dated the 8 January 1976 were made by SGM15. I am satisfied that this is so as SGM15 was identified by other members of the patrol (in particular SGM1, SGM3 and SGM12) as being not merely another member of the patrol that evening but also the person responsible for discharging the baton gun immediately prior to a person falling to the ground (which I am satisfied was Stephen Geddis sustaining his fatal injury). It would stand to reason that he would thereafter account to the RMP and the RUC, along with his colleagues, as to the circumstances by which that discharge occurred. It would be usual that a person so involved would provide a deposition to an inquest. I am also cognisant that the witness has not denied making the statements or depositions.
>
> [302] Similarly, I have concluded that the transcript of the 1995 interview was of an interview with SGM15. As part of that RUC 1995-96 investigation all relevant personnel involved in the patrol were interviewed in light

> of the allegations made by John Patrick Ward. It stands to reason that SGM15 was interviewed as part of that investigation. I note that the witness has not denied being interviewed and has not denied that the transcript is indeed a transcript of his interview."

[112] I can find no fault with this assessment of the coroner.

[113] A fair reading of the coroner's findings leads to the conclusion that the failure on the part of SGM 15 to meet with the coroner's investigator played no part in the findings of fact or in the verdict of the coroner.

Illegality – the legal test when assessing the force used by SGM 15

[114] The applicant argues that the coroner applied the wrong legal test when assessing the force, he determined SGM 15 had used when the plastic baton round was fired.

[115] In this regard, the applicant argues that the appropriate test was the common law one which applies to self-defence - "A person may use such force as is reasonable in the circumstances as he honestly believes them to be in the defence of himself or another."

[116] The applicant complains that the findings and verdict of the coroner of 6 September 2022 do not identify the test he was applying in assessing the evidence before him. It is suggested that, to the extent that it can be discerned, the coroner appears to have considered the matter against the substantive obligation of ECHR Article 2 "the force used was more than absolutely necessary." (See para 463(v) of the findings and verdict of 6 September 2022.)

[117] This submission must be seen in the context of the facts actually found by the coroner.

[118] The relevant principal findings are as follows:

(a) On the evening of 28 August 1975, a barricade had been erected across Albert Street proximate to its junction with Cullingtree Road. **(Para 423)**

(b) A group of teenage and pre-teenage children had gathered in the area adjacent to the lift-shaft that lay between the St Jude's and Cullingtree blocks of the Divis complex. From that general area, they threw stones or other objects at the army vehicle commanded by SGM 3 as it passed while patrolling the area. The vehicle passed on a number of occasions prior to the events that led to the discharge of baton rounds. **(Para 424)**

(c) The patrol commanded by SGM 3 was ordered by Lieutenant Badger to dismantle the barricade shortly before 9:00pm on that evening. **(Para 425)**

(d) The patrol returned to Albert Street and rammed the barricade at least once before stopping in a position proximate to the barricade at the end of St Jude's block nearest to the lift-shaft, at which point its members debussed and began to dismantle the barricade by hand. **(Para 426)**

(e) The group continued to stone the soldiers to the extent that SGM 3, who was one of the two of the patrol armed with a baton gun (the other being SGM 15), warned the group verbally by shouting that if they did not disperse that a baton round or rounds would be discharged. **(Para 427)**

(f) The group did not disperse from the area of the lift-shaft until SGM 3 discharged one baton round in the general direction of the group, causing the group to flee back to the courtyard area via the lift-shaft area that lay between the St Jude's and Cullingtree blocks. **(Para 428)**

(g) Shortly thereafter, SGM 3 ordered three of the members of the patrol, SGM 1, SGM 12 and SGM 15, to go to the north side of St Jude's block. **(Para 429)** He considered that the most likely reason for instructing the soldiers as he did, was to ensure that the dispersed group did not get the opportunity to re-group at the northern end of St Jude's. **(Para 432)**

(h) The coroner was not satisfied that the patrol in Albert Street was under any form of sustained attack from the northern end of St Jude's block. **(Paras 430 and 431)**

(i) SGM 1, SGM 12 and SGM 15 took up their position at the northern end of St Jude's as instructed by SGM 3.

(j) SGM 15 then stepped forward so that he was visible as a single soldier for a very short period of time, in that time, he discharged one baton round without issuing any verbal warning of his intention to do so into the courtyard area before retreating immediately to a place of safety behind the gable end wall of the northern end of St Jude's block. **(Para 434)**

(k) At the time of discharge, the soldiers were not under any sustained attack from missiles thrown from the courtyard area. **(Para 435)**

(l) The baton round was fired without assessment of the risk to others being made by SGM 15. Nor was there sufficient evidence of any conduct in the courtyard that would have justified the discharge of a plastic baton round. **(Para 436)**

(m) Stephen Geddis was in the courtyard at the time of discharge with or in the presence of some of his friends and posed no threat to the soldiers. **(Para 442)**

(n) SMG 15 discharged the baton round into the ground from the position on the other side of the curved wall at a range of about 50 metres from where Stephen Geddis and others were standing or congregated. The baton round was probably discharged into the ground, and it bounced prior to striking Stephen Geddis. **(Para 443)**

(o) The coroner was not satisfied that SGM 15 discharged the weapon with the intention of causing death or serious injury to anyone, though he will have discharged the weapon appreciating that there was a risk of injury being suffered in the event that someone was hit by a ricocheting baton round. Nor did he find that SGM 15 deliberately aimed at Stephen Geddis or singled him out before firing. **(Para 445)**

(p) As to his actual intention, the coroner found that SGM 15 discharged the baton round probably with the intention of dispersing the remnants of the group that had been stoning the army on Albert Street and who had sought refuge within the courtyard area of the complex. **(Para 446)** He noted that SGM 15 was very young at the time of this incident, he was still a teenager. He had just run from an area on Albert Street where his patrol had come under a sustained attack that justified the discharge of a baton round. He said that SGM 15 may well have been "hyped up" by the events that had occurred in Albert Street. However, on the evidence available to him, he did not consider that SGM 1, SGM 12 or SGM 15 were under the same type of attack as they had been when in Albert Street by the time they gained their position at the northern end of the St Jude's block. Nor did he consider that SGM 15 honestly believed that he was under attack from that position.

(q) The coroner found that no warning was issued by the soldiers or ignored by civilians in the courtyard immediately prior to the discharge of the fatal baton round. **(Para 449)**

(r) At **para 451**, the coroner found that while SMG 15 must have been aware of the risk to others caused by discharging the baton round in the way that he did, he failed to assess or evaluate the risk or simply ignored it prior to firing. The coroner found as a fact that SGM 15 simply stepped out from his covert position (at the northern gable end of St Jude's block, moved forward and fired). The coroner found that it could not have been possible for SGM 15 to assess the risk of his actions in that time. In making this finding, the coroner noted that SGM 15 gave no evidence as to any assessment or evaluation of risk actually undertaken by him.

(s) The coroner found that the three soldiers were aware that they had hit a person and that he was injured. He found that they retreated hastily and their

knowledge that someone had been struck was material to their decision to do so. **(Para 454)**

(t) He found the fact that a person was struck was communicated to SGM 3 who communicated this fact by radio to his company's operation room. **(Para 455)**

(u) At **para 456**, the coroner stated that for all of the reasons that he set out in this section of his findings he did not accept that the discharge of the baton gun by SGM 15 was justified or justifiable on the evidence presented to this inquest. He stated that SGM 15 gave insufficient consideration to the risk caused by discharging the baton round in the way and in the location that he did. Had he given proper consideration to the risk he would have foreseen the risk of a child suffering injury. He was not satisfied that SGM 15 foresaw the risk of fatal injury occurring.

(v) At **para 547**, the coroner concluded that he found that the baton round which SGM 15 discharged struck Stephen Geddis, an innocent child, to the right side of the head and this use of force was neither necessary nor justified in the circumstances.

[119] I consider that there is simply no basis for challenging any of the findings of fact determined by the coroner. That is not the role of this court. It is clear that the coroner considered a vast amount of evidence and gave careful consideration to each of his findings of fact.

[120] It should also be remembered that the coroner made no findings in relation to civil or criminal liability.

[121] Based on his findings of fact, he was perfectly entitled to conclude that there was no justification for the firing of the plastic baton round that killed Stephen Geddis. This flows from a number of findings including (a) that soldiers SGM 1, SGM 12 and SGM 15 were not under attack at the point where they positioned themselves at the northern end of St Jude's block; (b) that SGM 15 did not sound a warning; (c) that he failed to make any assessment of the risks posed to those within the courtyard who were there.

[122] These findings contrast starkly with the facts in the case cited on behalf of SGM 15, namely *Stewart v Ministry of Defence, Stewart v UK Application* No.1044/82 relating to the right of authorities to take action to quell a riot. In *Stewart* the Commission found there was a "hostile and violent crowd of 150 persons who were attacking … [soldiers] with stones and other missiles." Lieutenant O'Brien ordered Corporal Smith to fire a baton round at a leader among the rioters. Corporal Smith was struck by several missiles at the moment of discharge which made him jerk as he fired. Brian Stewart, aged 13, was struck by the baton round and died from his injuries. The Commission found the "use of force was no more than absolutely necessary and lawful for the purpose of quelling a riot."

[123] Plainly, on the facts found by the coroner he could not have concluded as the Commission did in *Stewart*.

What conclusions does the court draw from the analysis in paras [65]-[123] above

[124] On an individual basis it is clear that I do not consider the judge's treatment of the applicant's witness statement, his treatment of the applicant's exercise of his privilege against self-incrimination or the legal test he applied when assessing the force used by SGM 15 constitute arguable grounds for leave to apply for judicial review.

[125] It is, however, important to consider these issues cumulatively.

[126] On the question of bias the most striking feature about the coroner's findings, in my view, is that on the key question he made favourable findings in respect of the applicant. Ms Doherty correctly drew the court's attention to the disappointment of the next of kin in respect of the coroner's findings as to whether the plastic baton round was fired as an "aimed" shot by the applicant.

[127] This belief on behalf of the next of kin was not mere conjecture.

[128] The evidence of a direct aimed shot came from a number of civilian witnesses who were present at the scene. This suggestion was also supported by the evidence from a military witness, John Patrick Ward. It found support from some of the expert evidence. In particular, Professor Crane, the well-known pathologist, provided an opinion that the deceased's injury was probably the product of a direct hit or direct impact. He maintained this position in oral evidence. The three pathologists instructed in the inquest in a minute of their meeting state:

> "We agree that we cannot exclude the possibility that the impact represented a re-bound strike (ie that the baton had bounced off an intermediary object or surface, including the ground, before impacting Stephen Geddis). However, Professor Crane is of the view that the severity of the skull fracture is more likely to have been the result of a direct impact."

[129] The pathologists Drs Swift and Sheppard are of the view that the scenario of either being fired directly or having "bounced" were equally probable. Dr Rocke who concluded the post-mortem report concluded that:

> "I believe that it is almost certain that the plastic bullet struck sideways-on, and this suggests it is probable that the missile was aimed so as to bounce off the ground or that it struck another surface before impacting on

> Stephen's head. There is a firm basis for accepting that such a missile fired from the range suggested was entirely capable of causing an injury of this nature and severity."

[130] It is significant, particularly in the light of this evidence, that the coroner accepted the applicant did not intend to cause death or serious injury to anyone. He accepted that the relevant guidelines in relation to the use of plastic bullets did not require a warning to be issued. Importantly, he found that the baton round was aimed at the ground and that SGM 15 did not target the deceased.

[131] In light of this it is difficult to conceive how one could conclude apparent bias against SGM 15 on behalf of the coroner.

[132] Accordingly, I conclude that the grounds relating to alleged bias, undermining of SGM 15's privilege against self-incrimination and illegality based on the wrong test for the use of force are unarguable.

[133] Leave is, therefore, refused on these grounds.

Other grounds pleaded in the Order 53 Statement

[134] I consider that allegations of illegality based on alleged taking into account immaterial considerations or irrational findings unsustainable. In this judgment I have set out the factual findings made by the coroner, and it seems to the court that there is no basis for interfering with those findings.

[135] In this regard, the court reiterates the general principles about the supervisory role of the court in assessing the conduct of inquests and the findings of a coroner. It is not for the court to rewrite the findings or to substitute its own views on the circumstances that led to Stephen Geddis's death.

[136] His findings of fact are clearly and carefully set out based on his assessment of the evidence. His conclusions in relation to the justification for the discharge of the baton round are entirely rational, lawful and, indeed, a natural consequence of his findings of fact. His findings on this issue are unimpeachable, in the court's view.

[137] As I heard the submissions on behalf of SGM 15 in this case, I formed the clear impression that his real grievance related to the fact that the coroner referred the matter to the DPP for consideration. He did so pursuant to section 35 of the Justice (Northern Ireland) Act 2002 which requires a coroner to report to the Public Prosecution Service if he considers that a criminal offence <u>may</u> have been committed. [My underlining] Given the low threshold for such a referral, he was perfectly entitled to do so. That decision, quite properly, has not been challenged. It seems to me, however, that it was this decision that has triggered a comprehensive attack on the conduct of the inquest, the coroner's findings and verdict.

Final conclusion

[138] I do not consider that this is an appropriate case in which to grant leave, and had I done so, the application would have been refused on the merits in any event.

[139] It is the court's view that on any fair reading, the coroner has complied with his procedural obligations. He has conducted a thorough examination of all the relevant and background information relating to the killing. That examination has been conducted in public and the evidence has been thoroughly tested. All relevant interested parties were legally represented and fully participated in the inquest.

[140] He has complied with his obligations under section 31 of the Coroner's Act (Northern Ireland) 1959, in that he has set forth "such particulars as have been proved to 'him', namely who the deceased person was and how, when and where he came to his death" in accordance with the relevant case law. In doing so, he has ensured that the relevant facts were fully, fairly and fearlessly investigated.

[141] The application for leave to apply for judicial review is, therefore, refused.