



CHIEF CORONER

**HIS HONOUR JUDGE PETER THORNTON QC, CHIEF CORONER**

**THE CORONER SYSTEM IN THE 21<sup>ST</sup> CENTURY**

**HOWARD LEAGUE FOR PENAL REFORM - PARMOOR LECTURE**

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## **Introduction**

1. It is a real honour and a pleasure to be invited to speak today. The Howard League for Penal Reform is one of the great reforming charities of our time. As the oldest penal reform organization in the world, its work, since its inception in 1866 (as the Howard Association), has been outstanding, challenging government after government to make humanitarian changes. Some of its recent work, on children in prison, women in prison, suicide and self-harm and restraint, has been truly inspirational, thanks, no doubt, to the indefatigable and formidable talents of its director Frances Crook and her team.
2. John Howard (1726-1790), the penal reformer, was drawn into the world of prisons in his 50s in 1773 in his year of office as Sheriff of Bedford. He discovered that prisoners who had been acquitted at the Assize courts were taken back to prison and kept there, simply because they could not afford the fees of the gaoler and the tipstaff who had held them in custody in the first place. Howard requested that this injustice should be avoided by paying the gaoler a salary, but the counties resisted the extra expense. John Howard spent the next 17 years, as he said, 'looking into the prisons [where] I beheld scenes of calamity, which I grew daily more and more anxious to alleviate'. He survived the plague, gaol fever and much more on his prison visits, he claimed, because he was a vegetarian and a teetotaller.
3. I was proud to be a trustee of the Howard League until recently when the Board decided that I should go, so that they had the opportunity, if necessary, to challenge my work as Chief Coroner. I look forward to some robust criticism, to keep me on my toes. I still have the pleasure of chairing the Howard League Lawyers' Network Group.
4. I only met Lord Parmoor once, in a canteen in Holloway Prison, as one does. We were on a Howard League visit and we had a chat over a sandwich. He was delightful. I still have my Holloway Prison mug, made by prisoners through a charity. Sadly, Lord Parmoor has passed on his mug, and the tea towel no doubt too. But I am very much aware of his huge enthusiasm and generous support for the work of the League.

## **A local service**

5. You could say that prisoners and coroners have something in common. They are both locked away in their own little worlds, in their own particular corners of the administration of justice. Many coroners have said to me, that they feel isolated. Not unwanted and unloved exactly, but operating on their own under variable local conditions. And it is that localness which has produced a lack of consistency in their work, perhaps the greatest criticism levelled against coroners, one of which coroners are aware of and I believe are prepared to put right, with a little bit of help.
6. Although individual coroners are part of a national structure of coroners, part of a statutory framework of coroner services across England and Wales under the Coroners Act 1988, it is a service which operates very locally. Each coroner is appointed locally, by the local authority, paid locally and their service is funded locally.
7. Within that local structure coroners are required to operate independently, acting as judicial officers in their coroner work, making judicial decisions, investigating deaths, deciding whether a death is from natural causes or not, presiding over inquests in their court. They are best described as independent judicial office holders, although in the case of *Forrest* they were described as 'judges'.
8. This interface between the independent judge side of the coroner's work and hard-pressed local authorities who fund the service, provide accommodation, pay for the coroner and staff to support the coroner, pay the medical bills (such as post-mortem examinations and toxicology) is not without its difficulties. Not all local authorities fully understand this central element of judicial independence. After all, they say, we are paying the bill, it's our public money we're spending. Some want coroners to be brought more into the local authority fold, to be like Chief Officers. But coroners are not Chief Officers. They are not council employees. So being local is not always easy, particularly in hard financial times.

## **What is the purpose of a 21<sup>st</sup> century coroner system?**

9. The question I want to pose tonight and try and answer is this: What is the purpose of a coroner system in the 21<sup>st</sup> century? Whether local or national or a bit of both, what is the justification for a coroner system? Why do we have one?

## **The origins and history of coroners**

10. It may help to understand the role of the coroner today by looking briefly at the coroner of yesterday. The origins of the modern coroner system, despite being ancient, are surprisingly not obscure. Since coroners were originally keepers of records there are records which coroners kept. They tell us what coroners did. There have certainly been coroners for at least 800 years (although not a Chief Coroner until now). Nearly 130 years after the battle of Hastings and the arrival of William as the first Norman king, Article 20 of the Articles of Eyre, declared that coroners were (in September 1194 - that's pretty precise) the custodians of the Pleas of the Crown. Of course it was all about money. Nothing changes.
11. The English king at the time was Richard the Lionheart. He was not only a foreigner, a Norman who lived in France (although born in Oxford), he was a war-mongering foreigner. Modern tales of Robin Hood have a lot to answer for. Richard was not the benevolent, kindly king, much missed and longed-for by long

suffering serfs. On the contrary he disliked England, rarely visited, and bled the Saxon England dry of money to pay for his extravagant crusades. And when he holed up in a pub in Vienna on his way home to France, having been shipwrecked off Italy, he was recognized and held ransom for an enormous sum, which, of course, the English Saxons had to pay.

12. So money had to be collected and the office of coroner developed as something of a cross between a stipendiary magistrate and a collector of fines, also making sure the sheriffs did not cheat the king. The proper judges, known as the General Eyre, rather like the itinerant Assize judges much later, came round to levy justice and fines. But there were no Virgin trains then so they only got round every few years, sometimes only every seven years. In the meantime the coroner, who was at first a knight of the realm, would keep the records of all the local misdemeanours - the Pleas of the Crown - and hand them over when the judges rode into town: *Custos placitorum coronas*. Hence crowner or coroner.
13. Local rules got rather complicated, so if you broke a rule you had to pay a fine. No less than with dead bodies. A myriad of fines and penalties grew up: for violent deaths and suicide, for failing to prove that the body was Saxon and therefore not Norman (a *murdrum* fine); fines for an unclaimed body, for burial before the coroner arrived - anything to enrich the royal coffers. Dead bodies meant cash, for the Crown.
14. It was in this context that the medieval coroner inquired into deaths, holding inquests with local jurors who had to inspect the body. He also took confessions from criminals and kept the records. He supervised 'abjurations of the realm', a kind of voluntary deportation of murderers. They sought sanctuary, the coroner took their confession, then they were given a route for leaving the country to escape punishment (often execution) and a deadline. It did not always work out too well for the criminal. For example, malicious coroners in Yorkshire ordered criminals to leave the country, not by the quickest exit from Whitby or Harrogate, but by Dover. And of course most never made it; they were either killed on the way or starved to death.
15. So for a long time the ambit of the coroner's work was homicide, suicide, infanticide, all manner of unnatural deaths. For a while in the 13<sup>th</sup> and 14<sup>th</sup> centuries only homicide concerned the coroner. That did not stop some coroners from extracting bribes from bereaved families so that burial could be allowed to take place. The 1361 Justices of the Peace Act also took over some of the coroner's duties. By the 15<sup>th</sup> century the office of coroner was almost obsolete.
16. But not quite. The coroner became active again with the Coroners Act of 1509 in the first year of Henry VIII's reign. I am hoping that a doughty coroner will feature in the next instalment from Hilary Mantel (writer in residence at Hampton Court). A coroner had then to view the body of someone 'slain, drowned or otherwise dead by misadventure'. The coroner himself would be fined if he did not.
17. And so we leap with undue haste to the 18<sup>th</sup> century. By then, if not before, some coroners took bribes to avoid investigating suspicious deaths. So the Coroners Act of 1751 provided for 'the better Ordering of the Office of Coroner', including proper payment to coroners for inquests, if 'duly held' and if approved by judges at the local Quarter Sessions.

18. By 1829 the first edition of the standard text book for coroners, Jervis on Coroners, was far from positive in its assessment of coroners. The preface of John Jervis begins with these words: 'That the office of coroner is of great antiquity, and was originally of high dignity, all writers agree ...', and you feel a 'but' coming, '[but]... the office, whether in consequence of the rust and relaxation inseparable from ancient institutions, or of the inefficiency of its officers, has fallen from its pristine dignity into the hands of those, who are, in some instances, incompetent to the discharge of even their present limited authority.'
19. Never mind. Onward. In the 19th century the demand grew for sensible information from coroners about the causes of deaths. Recording a cause of death as resulting from 'long sickness' or even, in one case, 'mother', was no longer good enough. This led to the proper registration of deaths under the Births and Deaths Registration Act of 1836. Bureaucracy caught up. The fine for burying a body without the appropriate certificate was up to £10. The Coroners Act of the same year pushed the system towards medical authenticity by authorizing payment to medical witnesses for the first time, although the qualification for coroners was still only to be a freeholder. Dr Thomas Wakley, the founder of *The Lancet* in 1823, was the first coroner to be medically qualified when he took up his appointment in Middlesex in 1839. 174 years later, next year in 2013, new appointments of coroners will no longer include doctors who are not legally trained. There are very few doctor-only coroners left today.
20. By Victorian times the role of coroner as Crown money collector was long gone. The modern coroner system was taking shape, with the twin aims of the need to detect homicide and the provision of health data for the control of injury and disease, but only where the death was 'unnatural'. JJ Dempsey's call in 1859 for coroners to become 'chief officers of health' went unheeded. The Coroners Act of 1887 became the basis for modern coroner law, now framed in the Coroners Act 1988 and the Coroners Rules 1984. The Local Government Act of 1888 finally abolished the election of coroners; they were to be appointed by local authorities.
21. In more recent times the second half of the 20<sup>th</sup> century was not short on changes and proposals for reform. It was not until the 1970s, for example, that coroners no longer had to view the body, and juries were stopped from adding riders to their verdicts. No more could an inquest name and commit for trial a person believed to be guilty of murder or manslaughter. The last such person was Lord Lucan in November 1974, who was committed for trial in his absence at the inquest into the brutal death of his nanny, Sandra Rivett.
22. Since then there have been three major reports on death certification and coroners: the Brodrick Committee Report in 1971; the Luce Review in 2003; and Dame Janet Smith's Shipman Inquiry Reports, also in 2003.
23. But one recommended change, a fundamental change, has not been made. Luce and Smith (and to a lesser degree Brodrick) called for a national coroner service, not just a national framework as at present, but a national scheme, a coroner judge scheme paid for and run by the Ministry of Justice, like other judges. This has not happened; hence the continuing local nature of the coroner jurisdiction and the feeling that some coroners have of isolation.

### **The Coroners and Justice Act 2009**

24. Since those three reports there have also been Government papers on reforming the coroner and death certification service and much consultation. All of this led

to a draft Coroners Bill in 2006 and finally the Coroners and Justice Act 2009, passed broadly with all party support. It produced a Chief Coroner, the only coroner part (with one exception) of the Act which is in force. The rest is expected to be implemented in June next year.

25. It is not a radical Act of Parliament, perhaps because it was passed with broadly all-party support. It does not make sweeping changes. It does not create, as Luce recommended, a unified national coroner jurisdiction for the Chief Coroner to oversee. It does not create, as Smith recommended, a centrally governed national service led by a Chief Judicial Coroner, a Chief Medical Coroner and a Chief Coroner's Investigator.

### **A Chief Coroner**

26. But there are some good changes and the move is in the right direction. There will be greater flexibility within the coroner system, replacing, to some extent, the rigid jurisdictional concept of coroner territoriality. Some coroner areas will be amalgamated to produce consistency of coroner area size, each area with a full-time coroner. Appointments will be scrutinised by the Chief Coroner. Coroners will no longer be able to appoint (and discipline) their spouses or partners. There will be for the first time compulsory training (under the Judicial College), and not just for coroners but coroners officers too. The emphasis of the Act will be upon the whole investigation and not just the inquest. There will be a more co-ordinated complaints system (under the Office for Judicial Complaints).
27. In short the new Act will move steadily towards a more integrated system, more flexible, more alive to the needs of the bereaved, more open and transparent.
28. And there is a Chief Coroner to lead the coroner service. But there nearly was no Chief Coroner. After an open competition I was appointed Chief Coroner by the Lord Chief Justice after consultation with the Lord Chancellor (as the Act requires). I received my letter of appointment on 6 May 2010. It was the day of the last general election. That was not an auspicious day for appointments. The coalition Government was not keen on having a Chief Coroner; in difficult times it was considered to be too expensive.
29. The civil servants came to see me with gloomy faces and I was very politely told to keep up the day job at the Old Bailey. It is not often that you get an apology in person from the Lord Chief Justice and the Lord Chancellor two days running. They were really very nice about it.
30. So the Chief Coroner (and all his powers) was placed ignominiously into Schedule 1 of the Public Bodies Bill - commonly known as 'the bonfire of the quangos' - for abolition. The House of Lords, in their amending and revising role, led by the impressive Baroness Finlay, a doctor (Dr Finlay) and professor of palliative medicine, voted by a very large majority to keep the Chief Coroner off the funeral pyre. But the Government remained unimpressed. In December 2011 the Public Bodies Bill was due to become law.
31. Meanwhile I had been appointed to conduct the inquest into the death of Ian Tomlinson who died during the G20 protests in the City of London in 2009. It was my first experience of the loneliness of the long-distance coroner.

32. However, the final twists in the Chief Coroner's tale came last year. In June the Government announced that the Chief Coroner would be moved from Schedule 1 to Schedule 5 of the Public Bodies Bill so that some of the Chief Coroner's powers could be retained and distributed to the Lord Chief Justice and the Lord Chancellor. And finally in November of last year the post of Chief Coroner was re-created. I have not been told why that decision was made. There was certainly a lot of lobbying before it was made by the Royal British Legion and other groups. I do not propose to speculate.
33. There was, however, one major casualty. The Chief Coroner's appellate powers, to hear appeals from coroner and inquest decisions, would not be implemented; they were specifically repealed in the Public Bodies Act.
34. But nevertheless there is now a Chief Coroner, for England and Wales. I took up my appointment on 17 September. I am hoping that coroners will be more generous about me than Alun Michael MP (former Minister) was in the passage of the Coroners and Justice Bill when he said, considering the administrative side of the Chief Coroner's role: 'The Chief Coroner is a judge, so he is not necessarily competent to run anything.' I make no comment about that. I am a judge, a Senior Circuit Judge, sitting at the Old Bailey, and perhaps in my defence I could say that Norman Brodrick of the Brodrick Committee which reported in 1971 was also a judge of the Old Bailey.
35. It is my purpose as Chief Coroner to provide leadership for the coroner system, to oversee the implementation of the 2009 Act, to develop reform, to create a more coordinated and accountable system, all with a national consistency of standards and approach. No pressure then. Tom Luce in his *Review* of the coroner system in 2003 described coroners as the forgotten service. Not any more, I can assure you.
36. In my first speech, last month, to coroners at the Coroners' Society annual conference, I set out my 10-point plan. I will not repeat that tonight. As I turn over the page from the 10 points I find another 25 points ready and waiting. So there is much to do short term and long term. I welcome the challenge.
37. There are many excellent coroners out there. They work hard, they are dedicated and committed to the service, they perform their duties with sensitivity and understanding, and they have first class coroners officers. But they have also said to me, I do this my way, I may be right, I may be wrong, but if you tell me to do it differently I will. So I shall be happy to work with coroners in the development of a good consistent coroner service.

### **Posing the question**

38. So what then is the purpose of this 21<sup>st</sup> century coroner system?
39. The Brodrick Report expressed the opinion in 1971 that 'not many coroners appear to have a clear idea of their role in contemporary society'. 20 years later (1994) an article in *The Lancet* concluded that the coroner system was suffering from 'the absence of a clear purpose'. Tom Luce's Review team concluded in 2003 that there were 'no agreed objectives or priorities'. In the Third Shipman Report in 2003 (Harold Shipman, you will remember, was convicted on 31/1/00 of 15 murders, but it is thought that he killed over 200 people between 1975-1998) Dame Janet Smith expressed the view that neither the current Act nor the current Rules provided much in the way of establishing the purpose of an inquest. In 2006 the Coroners' Society complained of the lack of a clearly defined purpose for

the coroner service. Neither the present Coroners Act nor the next one states a purpose for the coroner system. So I must provide my own answer, a provisional answer because this is a Chief Coroner at the beginning of his tenure.

### **Some statistics**

40. Before I venture my answer I want to put the question into a modern day statistical context. In England and Wales (that is the limit of my remit) there are just under 500,000 deaths a year, quite a steady figure. For comparison there are about 700,000 births a year, quite a surprising difference. Over 60% of all deaths in the country are from circulatory diseases or cancer (about half and half). The next highest category is respiratory disease, at 14%.

41. Of the 500,000 deaths each year just under half, some 220,000 are reported to coroners. About half of those deaths, some 93,000 will undergo post-mortem examinations by pathologists. That figure is too high and I will try and reduce it. Only one third of those, some 30,000 deaths, will lead to inquests, 450 of them with juries.

### **Coroners and their duties**

42. So who deals with these 220,000 deaths reported to the coroner's office, locally, each year? There are just under 100 full time coroners, assisted by over 300 part-timers - all fully qualified to investigate deaths and conduct inquests in their local area. As I said they are independent judicial office holders, appointed and paid, but not employed, by the local authority.

43. In essence the coroner has a duty to hold an inquest where there is reasonable cause to suspect that the deceased has died a violent or unnatural death, a sudden death of unknown cause, or has died in prison or custody.

44. In each case the coroner must find the answers to four questions about the death: Who was the deceased, where, when and how did the deceased die? 'How' is interpreted, not as 'how' in a very broad sense which would involve general and far-reaching issues, but as 'by what means', and sometimes (particularly in death in custody cases) 'by what means and in what circumstances', slightly wider. So the emphasis for the coroner is upon the 'how': How did the deceased come by his or her death? This is the statutory context of the coroner's jurisdiction, as interpreted by the higher courts.

### **The purpose of a 21<sup>st</sup> century coroner system**

45. Bearing in mind the history of the coroner, the development of the coroner's role, the statistical context and the statutory framework I have just summarised, the question I posed was, What is the purpose of a 21<sup>st</sup> century coroner system?

(1) The need to know

46. In my view the purpose of the coroner system today is to provide justice to the public, in two ways. First, the public, especially the bereaved, family and friends, need to know what happened, how the deceased came by his death. That applies particularly to deaths in custody or at the hands of an agent of the state, where there is a wider duty to protect citizens from the wayward or mistaken actions of the state and to expose wrongdoing and bad practice. But it applies equally to all deaths where there is a real element of uncertainty. The public need to know.

They have a right to know. It is natural justice, public justice and justice to be done in public, openly and transparently, for all to see, particularly the family. The family has now become, quite rightly, the focus for this public process, to give them answers, where that is possible. They are at the heart of the process as the *Charter for Coroner Services* makes clear.

47. It is not a question of laying blame or apportioning guilt, either civil or criminal. That is expressly forbidden by law. The investigation and inquest process is inquisitorial, with a view to seeking out and recording as many facts concerning the death as the public interest requires. It is a fact-finding exercise and not a method of apportioning guilt. That is not to say that the process cannot find fault in someone or something. It can and must where something has gone wrong which led directly to the death or contributed to it as with hospital or care home neglect, but by way of findings of fact, not judgmental opinion.
48. As Lord Bingham said in the leading case of *Jamieson*, the coroner has a duty to conduct a full, fair and fearless investigation, and the coroner does so as an independent judicial officer, with powers to summon witnesses and jurors and hear evidence under oath. The verdict of the coroner or the jury can be in a short-form such as unlawful killing or suicide or accident, or it can be expressed in a brief, neutral, factual statement, expressing no judgment or opinion. This is called a narrative verdict. There may be a short-form verdict, a narrative verdict or both.
49. For example, in the Ian Tomlinson inquest, which I conducted as coroner, the short-form verdict was 'unlawful killing' but there was also a narrative of the facts as the jury found them, a single page, carefully considered, carefully written out, explaining the jury's essential findings of fact on key points: where the deceased was going, what he was doing, whether he was complying with police instructions, how he was pushed by a police officer, whether the force was excessive and unreasonable, what injuries he suffered and whether his injuries resulted from that use of force. Signed by all 11. The law requires a jury to be 7-11 in number (not the magic 12).
50. It is true that there is quite a list of investigating organisations, the Independent Police Complaints Commission, the Prisons and Probation Ombudsman, the Health and Safety Executive, the Local Safeguarding Children Board, to name but a few, all doing the job of independent investigation. But often their reports, their findings, are for one reason or another not made public. This is where the inquest provides the necessary public forum, in a public court, in open court, where the media can attend, with evidence under oath. Public justice, done publicly.

## (2) Preventing future deaths

51. The second way in which the system provides justice to the public is this. The coroner system exists to provide justice to the public not only in identifying causes of death but in preventing future deaths of a similar nature, something which families often feel passionately about. They say, and rightly say, our beloved should not have died in those circumstances, and what is more we do not want his death to be in vain; we do not want it to happen to anyone else in that same way.
52. Coroners are under a duty, and one which I shall emphasise, to report to Government and local government and agencies and institutions so that lessons can be learned for the future. For example, in identifying a defect in railway crossings, or a systemic failure in custody treatment in prisons or police stations,



or a lack of warning signs against a special danger for the public, or inadequate post-operative care in a hospital. These are just a few examples which can lead to changes for the better, to avoid future similar deaths.

53. There may be other answers to the question which I have posed, not least being the recent developing duty of coroners in Article 2 inquests. Article 2 of the European Convention on Human Rights provides that everyone's 'right to life shall be protected by law'. Where somebody dies at the hands of the state or somebody dies, particularly somebody vulnerable, in custody or detention or otherwise in the care of the state, the state is likely to have a duty to initiate an effective public and independent investigation. This procedural duty, as it is known, is usually carried out by full criminal proceedings or, if none, by a full coroner's inquest, known as a *Middleton* inquest. This is an important responsibility for coroners and, I would argue, an essential part of public justice.
54. On the other hand there are those who believe that coroner practice should be more medically focused. Catherine McGowan, in her excellent recent doctoral thesis on coroners, argues with some force that in the absence of a clearly stated statutory objective, the fundamental purpose of the coroner should be as facilitator of public health, with the coroner system taken in under the wing of the Department of Health. After all, she argues, some coroner systems inherited by common law countries have tended to move away from the legal coroner to the Medical Examiner system.
55. For example, much of the United States is served now by medical examiners. We exported the coroner system there, but only eight States operate a solely coroner system. Canada has a hybrid system, differing on a province by province basis. The website of the Office of the Chief Coroner of Ontario, where the coroner is required to be a physician, states that 'We speak for the dead to protect the living.'
56. Under our present law coroners are lawyers or doctors or both, although, as I said, there are not many doctor-only coroners left. The Coroners and Justice Act 2009 will require that all new coroners are lawyers and have the same legal judicial qualifications as all judges. I see that as a good thing. There is a good case for coroners being more judges than guardians of public health.
57. It is true that much of the coroner's work is out of court and even in court there are many straightforward, short inquests. Some coroners complete as many as six or eight in a day, without minimizing the importance to the bereaved family of the process of inquiry. I have seen that for myself. But there is also a growing number of complex inquests, taking days or weeks. Local authority payments to part-time coroners still refer to a long inquest as one lasting 'more than one day'. Unfortunately, not any more. These inquests may involve difficult issues, tough points of law, questions of admissibility of evidence, public interest immunity, careful directions to a jury, alternative verdicts and much more.
58. Inquests of that kind often involve lawyers representing interested persons. A lawyer coroner may be better equipped in that sort of forum. Expert medical opinion will provide the necessary medical expertise. Rule 43, the Rule empowering coroners to report and make recommendations, was amended in 2008 'to give greater prominence and importance to coroner reports to improve public health and safety' (guidance by the Ministry of Justice for coroners in 2009). So for me, at the beginning of my tenure, the balance between law and medicine is moving in the right direction.

59. So that is my assessment of the purpose of the modern inquest system.

### **The baby and the dingo**

60. But not all coroner cases go well. Finding justice is not always easy. You will all have heard of the controversial case in Australia about the baby and the dingo. It took 32 years and 4 inquests before the coroner of the Northern Territory in Australia came to the conclusion that the nine week old Azaria Chamberlain had been taken from her parents at Uluru (formerly known as Ayers Rock) by a dingo. Evidence had been collected that dingoes had attacked and killed before.

61. Meanwhile Lindy Chamberlain (now Chamberlain-Creighton) had served 6 years in prison for killing her own child. The case against her had been based upon the evidence that the body was never found and that traces of blood were discovered in her car. Those traces turned out years later, with the development of scientific techniques, not to be blood at all. The coroner at the fourth and final inquest (in June 2012) found that 'a dingo or dingoes were responsible for the death'. The death certificate was amended from 'unknown' to 'attacked and taken by a dingo'.

62. The father of Azaria, Michael Chamberlain, said this: 'I am here to tell you that you can get justice even when you think that all is lost. But truth must be on your side. I cannot stress strongly enough how important it is to pursue a just cause even when it seems to be a mission impossible'.

63. And that is what all families want: to get justice. Not just the parents of children, although they are almost always the most distressing of cases. But all families who lose a loved one. The four questions (who, when, where and how) will be answered in most cases. In a few cases the answers will remain incomplete - sometimes for a long time, even for ever. But it is always the duty of the coroner to do his or her best to obtain that justice for the family. That is what families want. That is what they are entitled to. Public justice for the public.

### **Finally - compassion and understanding**

64. Finally, I would like to end with a story about the Howard League.

65. My last case as a barrister when I was at Doughty Street Chambers before I became a judge at the Old Bailey was pro bono in the North Avon Magistrates' Court. I could not recommend the B & B where I stayed nearby, where the inmates all took turn to use the microwave for dinner with the freeze-packed curries which we had bought from Morrisons across the road.

66. My client was Pauline Campbell, a fellow trustee at the Howard League, who was charged with obstruction of the highway. Pauline's daughter, Sarah, had had a troubled life. Her father had left home when she was very young, she was raped as a teenager and she took to drugs. One day, she was begging in the street for money for drugs, and an elderly man refused. She pushed him away and he fell over and suffered a heart attack. He died and she was convicted of manslaughter and sent to prison, HMP Styal.

67. On her first night there Sarah took her own life. She was 18. The staff had declined her request to be put in a vulnerable prisoners unit. The jury at her inquest decided that the prison had failed in its duty of care to her. I would add in parenthesis that, unfortunately, the recommendation in the Corston Report in

2007 for the closure of women's prisons and their replacement with small local custodial centres has never been implemented.

68. Pauline, of course, never recovered from her terrible loss, the loss of her child. A friend of Pauline's said of her: 'I had a sense of a woman who would be wailing in pain if she was not able to keep herself busy.' Pauline kept herself busy by becoming an ardent campaigner for young women in prison. She turned her tragedy into positive action. Each time a young person committed suicide she went to the prison, outside, and protested. She stood in front of any prison van arriving with customers and asked the driver to take them to a safer place.
69. Pauline, an intelligent woman, a lecturer, made good with her protest, bringing the local media to film her and to give interviews, arguing her cause, giving publicity to her concerns. It was effective.
70. But she was arrested in different parts of the country: 14 times. She was charged three times but only one case was brought to court - in the North Avon Magistrates' Court. There we were. The television crew was outside, Pauline was smartly dressed, the rather ragged group of supporters came too and had to be shushed in court by the magistrate (I pretended to glare at them), and the prosecutor had certainly missed out on charm school.
71. But Pauline gave a good account of herself and there were a few technical arguments which might have helped. Arguably she was not on the highway at the key moment but on a private road. She was acquitted.
72. A few months later, shortly after another of Pauline's protests, at Styal, where her daughter Sarah had died, Pauline gave up the struggle. She was found dead in the cemetery where her daughter was buried. She took her own life with an overdose of anti-depressants. The coroner at her inquest described her as 'a significant campaigner in the cause of prison reform'. Like the Howard League itself.
73. This sad tale reminds us of the fragility of life, the need for compassion and understanding, and the provision of a system of fair justice for everybody, in life and in death. I hope that coroners will bring these qualities to their daily work. I shall do my best to make sure that they do.

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