CHIEF CORONER

CHIEF CORONER'S GUIDANCE No. 37

COVID-19 DEATHS AND POSSIBLE EXPOSURE IN THE WORKPLACE

1. This Guidance is supplemental to earlier Guidance notes from the Chief Coroner during the COVID-19 pandemic and should be read in conjunction with that Guidance (see Guidance No 34: Chief Coroner's Guidance for coroners on COVID-19, Guidance No. 35: Hearings during the pandemic and Guidance No: 36: Summary of the Coronavirus Act 2020, provisions relevant to coroners).[1] The pandemic and the aftermath is an evolving situation and this Guidance is being kept under review.

2. The Guidance is designed to assist coroners to continue to exercise their judicial decisions independently and in accordance with the law. Coroners make judicial decisions on a case by case basis and nothing in this Guidance should be taken as a statement of any policy or indication of the Chief Coroner's views on the way that coroners should exercise their duties. The Guidance is an expression of the law as it currently stands.

3. The Chief Coroner reminds coroners that although emergency legislation has modified some of the ways that death certification is carried out so that the system may cope during the pandemic, the legal decisions made by the coroner when a death is referred to them and thereafter remain the same as they do for every other case and coroners should consider these deaths in the same way as any other report of death to them. Coroners are reminded that they have a wide judicial discretion in relation to many aspects of their investigations and inquests (see Law Sheet No.5 – The Discretion of the Coroner).

4. The vast majority of deaths from COVID-19 are due to the natural progression of a naturally occurring disease and so will not be referred to the coroner. The Chief Coroner would like to remind coroners of the Ministry of Justice Guidance on the Notification of Deaths Regulations 2019 which provides:

> "24. A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course, where nothing else is implicated."[2]

[1] All Chief Coroner's Guidance and Law Sheets can be found here - https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/851972/ registered-medical-practitioners-notification-deaths-regulations-guidance.pdf

5. Death due to COVID-19 is designated as notifiable under the Health Protection (Notification) Regulations 2010, meaning that any death resulting from the disease must be notified to Public Health England. This has no bearing on whether such a death is reported to a coroner, still less on whether a death would be the subject of a coroner's investigation. The death may also sometimes be notifiable to the Health and Safety Executive ('HSE') under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 ('RIDDOR'). Regulation 6(2) of RIDDOR requires a report to be made where "any person dies as a result of occupational exposure to a biological agent". The expression "biological agent" includes the virus which causes the COVID-19 disease.[3] Consistent with the requirements of RIDDOR, the HSE has published guidance that death as a result of work-related exposure to the virus must be subject to the reporting procedure.

6. There may be concurrent investigations undertaken by regulators (such as the HSE, Care Quality Commission, Prison and Probation Ombudsman, the Department of Health and Social Care, etc). Coroners should establish single points of contact with those organisations as appropriate. There are Memoranda of Understanding which exist between the Chief Coroner and some of those organisations which may be helpful.[4]

7. Regulation 3(1)(a) of the Notification of Deaths Regulations 2019 provides that there must be a report to the coroner if the medical practitioner completing the Medical Certificate of Cause of Death "suspects that the person's death was due to… (ix) an injury or disease attributable to any employment held during the person's lifetime."

8. There are therefore some instances in which a COVID-19 death may be reported to the coroner, such as where the virus may have been contracted in the workplace setting. This may include frontline NHS staff as well as others (e.g. public transport employees, care home workers, emergency services personnel).

9. The coroner must first consider whether his or her s1(2) duty under the Coroners and Justice Act 2009 is engaged, which provides that the coroner must conduct an investigation if he or she has reason to suspect (a) that the deceased died a violent or unnatural death; (b) that the cause of death is unknown; or (c) that the deceased died while in state detention.

10. If the medical cause of death is COVID-19 and there is no reason to suspect that any culpable human failure contributed to the particular death, there will usually be no requirement for an investigation to be opened. The coroner may carry out reasonable pre-investigation enquiries under s1(7) to determine if there is any basis for opening an investigation

11. If the coroner determines that the duty is not engaged then as usual he or she would notify the Registrar by way of Form 100A (i.e. that he or she has made preliminary enquiries and has established that he or she is not under a duty to investigate the death under s1). If at any stage he or she wishes to revisit this decision, such as because further information about the death is provided, then he or she can properly

[3] See the HSE website https://www.hse.gov.uk/news/riddor-reporting-coronavirus.htm
[4] The MoUs can be found on the Chief Coroner's website and the website of the Coroners' Society of England and Wales.

do so without recourse to the Chief Coroner (see Chief Coroner's Guidance No.33 – Suspension, Adjournment and Resumption of Investigations and Inquests).

12. A death must be investigated and must usually be the subject of an inquest if the coroner has "reason to suspect that… the deceased died… [an] unnatural death". In this context, the words "reason to suspect" reflect a low threshold test; lower even than a prima facie case and requiring only grounds for surmise.[5] However, it is a matter for the coroner's judgement in each case whether the facts and evidence in the particular case provide "reason to suspect" that the death was unnatural. A death may be "unnatural" where it has resulted from the effects of a naturally occurring condition or disease process but where some human error contributed to death.[6]

13. Accordingly, a death which is believed to be due to COVID-19 may require a coroner's investigation and inquest in some circumstances. For instance, if there were reason to suspect that some human failure contributed to the person being infected with the virus, an investigation and inquest may be required. If the coroner decides to open an investigation, then he or she may need to consider whether any failures of precautions in a particular workplace caused the deceased to contract the virus and so contributed to death. Also, if there were reason to suspect that some failure of clinical care of the person in their final illness contributed to death, it may be necessary to have an inquest and consider the clinical care. If the person died in state detention (e.g. in prison or secure mental health ward), an inquest would have to take place.

14. If a coroner determines that an investigation and inquest must be held then the coroner is encouraged to hold a pre-inquest review hearing. See Guidance 22: Pre-Inquest Review Hearings which sets out, amongst other things that the coroner should list the issues to be raised, including whether Article 2 is engaged.

15. In the usual way, it is a matter of judgment for the individual coroner to decide on the scope of each investigation. Each coroner must consider the question of scope in the context of providing evidence to answer the four statutory questions,[7] notably how the particular deceased person came by his or her death. Coroners are reminded that an inquest is an investigation into how a particular person died, and that it is a question of judgment for the coroner how far to pursue enquiries into underlying causes and contributory factors. The inquiry must be full, fair and fearless, but it should also be focused upon the cause(s) and circumstances of the particular death.

16. There have been a number of indications in the judgments of the higher courts that a coroner's inquest is not usually the right forum for addressing concerns about high-level government or public policy, which may be causally remote from the particular death. See for example Scholes v SSHD [2006] HRLR 44 at [69]; R (Smith) v Oxfordshire Asst. Deputy Coroner [2011] 1 AC 1 at [81] (Lord Phillips) and [127] (Lord Rodger). In the latter case, Lord Phillips observed that an inquest could properly consider whether a soldier had died because a flak jacket had been pierced by a sniper's bullet, but would not "be a satisfactory tribunal for investigating whether more effective flak jackets could and should have been supplied by the Ministry of

[5] R (Fullick) v HM Senior Coroner for Inner North London [2015] EWHC 3522 (Admin) at [34]-[37].
[6] R (Touche) v Inner London North Coroner [2001] QB 1206.
[7] Coroner for the Birmingham Inquests (1974) v Julie Hambleton and others [2018] EWCA Civ 2081.

Defence." However, it is repeated that the scope of inquiry is a matter for the judgment of coroners, not for hard and fast rules.

17. When handling inquests in which questions such as the adequacy of personal protective equipment (PPE) for staff are raised, coroners are reminded that the focus of their investigation should be on the cause(s) and circumstance(s) of the death in question. Coroners are entitled to look into any underlying causes of death, including failures of systems or procedures at any level, but the investigation should remain an inquiry about the particular death.

18. If the coroner considers that a proper investigation into the death requires that evidence or material be obtained in relation to matters of policy and resourcing (e.g. the adequacy of provision of PPE for clinicians in a particular hospital or department), he or she may choose to suspend the investigation until it becomes clear how such enquiries can best be pursued. In making that decision, the coroner should consider his or her own ability (a) to pursue necessary enquiries to gather evidence and (b) to proceed to an inquest, having regard to the effects of the pandemic and the lockdown restrictions. As advised in previous Guidance, coroners pursuing enquiries with hospitals and clinicians should be sensitive to the additional demands upon them during this period. Coroners have a broad discretion under paragraph 5 of Schedule 1 to the Coroners and Justice Act to suspend an investigation. However, they should be mindful that it may be in the best interests of the bereaved family to proceed with the investigation and inquest in a prompt and timely way. Coroners will need to consider the facts and circumstances of each individual case when making their decisions on how to proceed. Coroners are reminded that, as set out in Guidance No. 36 (Summary of the Coronavirus Act 2020 Provisions Relevant to Coroners), where the coroner decides to open an inquest, section 30 of the Coronavirus Act 2020 removes the requirement for an inquest to be held with a jury if the coroner has reason to suspect death was caused by COVID-19.

HHJ MARK LUCRAFT QC

CHIEF CORONER

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