Coroners and COVID-19 – the guidance and the process

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The Chief Coroner has recently published a series of guidance notes to advise coroners on dealing with COVID-19 related deaths. Carin Hunt summarises the advice and the process to be followed by medical practitioners where a death has been caused by this coronavirus

Introduction

On 26 March 2020, the Chief Coroner published guidance (no 34) for all coroners in England and Wales on the approach to be taken to COVID-19. This was followed on 27 March 2020 by guidance (no 35) which deals specifically with hearings during COVID-19.

In guidance (no 36), published on 30 March 2020, the Chief Coroner summarised the provisions of the Coronavirus Act 2020 which are relevant to coroners, including those which modify statutory provisions relating to the registration of deaths and the cremation of bodies.

More recently, on 28 April 2020, the Chief Coroner published guidance (no 37) on the topic of 'COVID-19 deaths and possible exposure in the workplace'.

Carin Hunt of our Private Client team summarises the available guidance for coroners and also sets out the process to be followed by medical practitioners where a death has been caused by COVID-19.

This article is not intended as, and it is not, legal advice appropriate to the individual situation of any particular person. We suggest that any person requiring support or assistance in this ares should seek advice from a specialist lawyer.

Hearings

The Chief Coroner has given the following guidance on conducting hearings:

- **No physical hearing should take place unless it is urgent and essential business** and it is safe for those involved, including that suitable arrangements can be made to ensure social distancing (which, in many jurisdictions, may be difficult).
- **All hearings that can possibly take place remotely should do so**. No particular technology is prescribed.
- **Inquest and pre-inquest review hearings must take place in public.**[1] It is noted in guidance (no 34) that "taking place in public" may mean that only a member of the immediate family is present and a representative of the press is able to be present, though this is ultimately a question for the individual coroner.
- **Coroners should conduct hearings from a court**, not their homes or offices.[2] A coroner's attendance by Skype or by telephone will **not** qualify them as being present for a hearing.

The Chief Coroner expects that "*coroners will still need to hold some inquests – perhaps a limited number of short Rule 23 type hearings – over the coming months*". ***[3]***

Adjournments

The Chief Coroner's COVID-19 note #3 deals with adjourning inquests. He advises:

- Any jury inquests of any significant length which are due to start between 31 March and 28 August should be adjourned.
- Long or complex inquests not involving a jury due to start between 31 March and 28 August, including those which require large numbers of witnesses to give evidence in person, should be reviewed and may have to be adjourned.
- There may be other factors which mean cases which otherwise might proceed should be adjourned. This may include the vulnerability of family members and other Interested Persons in relation to COVID-19 risk factors.
- The coroner should seek views on adjournments from Interested Persons where possible, though of course such views are not decisive.
- The decision to adjourn should be communicated to the bereaved family with sensitivity.

The Chief Coroner observes that coroners may find themselves under significant pressure over the coming months and "*may have no choice but to prioritise investigation and decision making on reports of death over inquests and this may well lead to adjournments*". It is anticipated that this will result in an increased number of coronial investigations lasting over 12 months. Any investigation lasting over 12 months (beginning on the day that the coroner was made aware that the deceased's body was within her area) must be reported to the Lord Chancellor in the Coroner's Annual Report.[4]

MCCDs and referring deaths to the Coroner

A coroner has a duty to investigate a death if they have reason to suspect that it was unnatural.[5] In guidance (no 34), the Chief Coroner states that COVID-19 is a naturally occurring disease and is therefore capable of being a natural cause of death. Therefore, **a COVID-19 death does not *prima facie* require investigation by the Coroner and should be dealt with via the Medical Certificate Cause of Death ("MCCD") process**, unless there is some additional factor at play (discussed below). In guidance (no 37), the Chief Coroner observes that ***"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 requirements for medical practitioners to refer deaths to coroners are set out in the Notification of Deaths Regulations 2019. These Regulations are modified by the Coronavirus Act 2020 and the Ministry of Justice has published interim guidance to the modified regulations which states, inter alia, that:

"Whilst Covid-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010, ***a death caused by Covid-19 virus is not reason of its own to notify the death to the coroner****."* (my emphasis)

Further, the MOJ's interim guidance and guidance (no 34) state that **Covid-19 is an acceptable direct or underlying cause of death for the purposes of completing the MCCD.**

Where a patient has died of COVID-19 in hospital, following the MCCD process will be relatively straightforward because the deceased will have been diagnosed and treated there, and the attending doctor will be available to sign the certificate. However, for COVID-19 deaths occurring in the community, there may be insufficient capacity within the health service to diagnose COVID-19 as an illness in life and to produce an MCCD after death. This issue will be alleviated by section 4(2) of Schedule 13 of the Coronavirus Act 2020 which enables a doctor who was not the attending doctor to sign the MCCD if a) the

attending doctor is unable to sign the MCCD or it is impractical for them to do so, and b) the signing doctor is able to state the cause of death to the best of their knowledge and belief.[6] Further, pursuant to section 4(3), if the deceased was not attended at all during their last illness, any medical practitioner can sign the MCCD provided they are able to state the cause of death to the best of their knowledge and belief. The government has published guidance F66 for doctors to explain the process for MCCDs during the COVID-19 emergency period in detail. The BMA has also published guidance for doctors on completion of MCCDs .

If an MCCD is completed in circumstances where there was no attendance on the deceased within 28 days before or after death, then the Registrar charged with registering the death must refer this to the coroner. This window has been extended from 14 days to 28 days by Section 6(3)(b) of the Coronavirus Act 2020. Upon referral, the coroner can then issue a Form 100A, which sanctions the completion of the death registration process, if they consider it appropriate to do so.

There are likely to be cases of suspected COVID-19 deaths in the community where an MCCD is not produced and the death must be reported to the coroner for that reason. It will then be for the coroner to investigate the reason for the death in order to decide whether an inquest needs to be held. Guidance (no 34) advises a coroner in such a situation to open a dialogue with the doctor reporting the death and any other doctor involved in the care of the deceased. The Chief Coroner notes that a doctor's unwillingness to sign the MCCD may not be for valid reasons and "*it is legitimate for the coroner or coroner's officer to make the doctor aware of facts which may be relevant to the decision to sign an MCCD*".

Section 7(2)(c) of the Coroners and Justice Act 2009 sets out a requirement for an inquest to be held with a jury if a senior coroner has reason to suspect the death was caused by notifiable disease. As discussed above, COVID-19 has been designated a notifiable disease under the Health Protection (Notification) Regulations 2010. However, section 30 of the Coronavirus Act 2020 provides that for the purposes of section 7(2)(c), COVID-19 is not a notifiable disease and thus **if an inquest is opened into a death involving COVID-19, it will not require a jury to sit.**

Deaths following possible exposure to COVID-19 in the workplace

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 MCCD "*suspects that the person's death was due to… (ix) an injury or disease attributable to any employment held during the person's lifetime*." Therefore, the Chief Coroner writes in guidance (no 37) that;

***"…there are 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)."*

When such a case is referred to a coroner, the Chief Coroner advises that they must first consider where their duty under s1(2) of the Coroners and Justice Act 2009 is engaged. As discussed above, this duty requires a coroner to investigate a death where they have reason to suspect that it was unnatural.[7] A death may be unnatural where it has resulted from the effects of a naturally occurring condition or disease (such as COVID-19) but where some human error contributed to death.[8] Therefore, **if there were reason for a coroner to suspect that some human failure contributed to the deceased being infected with or dying from COVID-19, an investigation and inquest may be required.**

The Chief Coroner gives an example of a failure to take precautions "*in a particular workplace*" as such a human failure.[9] However, the Chief Coroner warns that an inquest is not the right forum for addressing concerns about high-level government or public policy.[10] Therefore:

"an inquest would not be a satisfactory means of deciding whether adequate general policies and arrangements were in place for provision of personal protective equipment (PPE) to healthcare workers in the country or a part of it."

As such, it would appear to be the case that an inquest might properly be opened into a COVID-19 death which may have been contributed to by inadequate provision of PPE for clinicians in a *particular* hospital or department, but not into a COVID-19 death which might have been a result of national NHS guidance or protocol on the provision and/or use of PPE more generally.[11] In respect of the former situation, the Chief Coroner advises that if a coroner considers that a proper investigation requires that evidence or material be obtained in relation to matters of policy and resourcing at the particular hospital in question, they may choose to suspend the investigation until it becomes clear how best to do so. The Chief Coroner advises that in making the decision to suspend, the coroner should consider their 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"*. Coroners are reminded that they have a broad discretion to suspend an investigation under paragraph 5 of Schedule 1 to the Coroners and Justice Act 2009.

Separate to the coronial process, it should be noted that a COVID-19 death may be notifiable to the Health and Safety Executive ("HSE") under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, as Regulation 6(2) requires a report to be made where "*any person dies as a result of occupational exposure to a biological agent*".[12] HSE guidance confirms that this applies to a COVID-19 death.

Death in state detention

A coroner's duty pursuant to s2(1) of Coroners and Justice Act 2009 requires them to conduct an investigation if they have reason to suspect that the deceased died while in state detention. Therefore, **where a person dies of COVID-19 while an inmate in prison or as a patient in a secure mental health ward, an inquest will have to take place.** This is noted in guidance (no 37).[13]

Registering deaths

Schedule 13 of the Coronavirus Act 2020 extends the list of people who can give the necessary information to register a death under sections 16 and 17 of the Births and Deaths Registrations Act 1953, to include, where authorised by the deceased's family, a funeral director. Additionally, the requirement for a person to attend the Registrar's office and sign the register in relation to a death in the presence of the Registrar is removed and this can now be done over the phone.

Cremation

The Cremation (England and Wales) Regulations 2008 set out the conditions that must be met before the body of a deceased person may be cremated. Pursuant to section 19 of the Coronavirus Act 2020, the requirement for a confirmatory certificate[14] (Cremation Form 5) is suspended. There is only a requirement for one medical certificate (Cremation Form 4). The removal of the need for additional medical practitioner oversight in this context is intended to reduce the burden on healthcare professionals and prevent delays for families seeking cremations for loved ones.

Any medical practitioner can complete Cremation Form 4. They do not have to have seen the deceased. However, a medical practitioner (not necessarily the medical practitioner who signs the Cremation Form 4) should have attended (in person or by video) the deceased within 28 days before death, or viewed the body (in person) after death. However, the crematorium medical referee may accept a Cremation Form 4 where the deceased has not been seen within 28 days before death or after death but where the death has been registered with an MCCD supported by a Form 100A.

Dealing with medical professionals

Coroners are reminded by the Chief Coroner to recognise the primary clinical commitments of any medical professional they have cause to work with, including pathologists. Further, it is noted that;

"Coroners may be asked to grant extensions for NHS Trusts, other healthcare organisations and other institutions like prisons who are required to respond to Prevention of Future Death Reports and the same principles should apply to those decisions. Coroners may wish to proactively review outstanding PFD responses and write to some recipients, as they see appropriate, inviting an extension."

This advice is caveated by the suggestion that there should be no blanket policy of granting extensions for all Prevention of Future Death reports, as not all charged with producing them will be affected by health sector's COVID-19 response.

Coroners are also advised that the availability or lack of availability of post-mortem examination facilities and pathologists will be a factor to consider in deciding whether to order an examination (or a particular type of examination) in each case that is before them. Where a post-mortem examination is simply not possible, either due to risk of infection or a lack of capacity, coroners are invited to consider other relevant medical and other evidence that may enable a conclusion to be reached.

Responding to the increased demand on coronial services

The Chief Coroner is "*urgently pursuing a number of avenues to try to widen the pool of assistant coroners who may be available*". He and the Lord Chancellor are prepared, "*in principle, to consent to the appointment of assistant coroners to local authorities without open competition*" and will aim to fast track the statutory consent process. Further;

"The Chief Coroner is prepared to consider the appointment of assistant coroners who have no previous coroner experience, including where they are already appointed as a judge in other jurisdictions in England and Wales or have inquest experience at the bar or as a solicitor. The Chief Coroner is actively pursuing online induction training modules to cater for such appointments."

Additionally, retired assistant coroners may be willing to be re-appointed.

Conclusion

Throughout his guidance, the Chief Coroner emphasises that many of the issues raised by COVID-19 are to be determined by individual coroners using their discretion and responding to the individual circumstances of the cases before them. For example, in guidance (no 37), the Chief Coroner reminds coroners that "*they have a wide discretion in relation to many aspects of their investigations and inquests*", and refers them to Law Sheet No.5 – The Discretion of the Coroner. However, the message that no physical hearing should

take place unless it is urgent and essential business is unequivocal. So too is the guidance that "*absent a coroner a court is not a court*".

It is clear that COVID-19 has significantly increased demand on coronial services and requires a response that minimises burdens to the health sector while safeguarding the protections in place for the reporting and investigation of deaths in England and Wales. The priority for coroners at this time has necessarily shifted to death reporting and it follows that inquests are likely to be adjourned and investigations suspended while resources are focused there.

Find out more

Carin Hunt is a member of our Private Client Team and specialises in private client law, public law, personal injury and clinical negligence amongst other areas. Carin is also a member of The Court of Protection Bar Association.

If you would like to discuss any of the issues covered in this article please contact Carin Hunt directly or via her Practice Director, Paul Barton on +44(0)20 74274907 for a confidential discussion.

Endnotes

[1] These hearings must take place in public pursuant to Rule 11(3) of the Coroners (Inquests) Rules 2013.
[2] In the civil jurisdiction and under the Civil Procedure Rules, it is possible for hearings to take place without the need for a judge to physically present in court. The Chief Coroner has emphasised that the situation is not the same for coroners.
[3] A Rule 23 Inquest is one where the inquest is held and concluded by admitting relevant documents into evidence.
[4] Pursuant to section 18 of the Coroners and Justice Act 2009.
[5] Pursuant to section 1(1) of the Coroners and Justice Act 2009.
[6] This modifies section 22 of the Births and Deaths Registrations Act 1953, which requires the medical practitioner who personally attended the deceased during their last illness to sign the MCCD.
[7] The words "*reason to suspect*" in s1(2) reflect a low threshold test; lower even than a *prima facie* case and requiring only grounds for surmise. See *R (Fullick) v HM Senior Coroner for Inner North London* [2015] EWHC 3522 (Admin) at [34]-[37].
[8] *Coroner for the Birmingham Inquests (1974) v Julie Hambleton and others* [2018] EWCA Civ 2081.
[9] Another example given by the Chief Coroner is where there is reason to suspect that there was some failure of the clinical care of a person who died of COVID-19.
[10] See *Scholes v SSHD* [2006] HRLR 44 at [69]; *R (Smith) v Oxfordshire Asst. Deputy Coroner* [2011] 1 AC 1 at [81].
[11] The NHS guidance is currently the subject of a legal challenge brought by two NHS doctors who argue that it *inter alia* fails to address the higher risk posed to BAME workers in the COVID-19 context, is unclear, and results in inconsistent practice across trusts. See https://www.bindmans.com/news/legal-challenge-against-the-uk-governments-guidance-about-personal-protective-equipment-in-hospitals
[12] http://www.legislation.gov.uk/uksi/2013/1471/regulation/6/made
[13] See this article by Gideon Barth of 1 Crown Office Row for a discussion of the issues that may arise in an inquest into a COVID-19 death in prison: https://ukhumanrightsblog.com/2020/04/06/inquests-into-deaths-in-custody-during-the-covid-19-pandemic/.
[14] This requirement is set out in Regulation 16 of the Cremation (England and Wales) Regulations 2008.