NEW GUIDANCE FOR CORONERS ON COVID-19 DEATHS AND WORKPLACE EXPOSURE

By Toby Riley-Smith QC

Concerns have been raised, not least by the bereaved families of key-workers in the frontline, about the possible link between workplace exposure to coronavirus and COVID-19 deaths. The Chief Coroner has now published his Guidance Note No 37 on whether, and how, coronial investigations into such deaths should be opened. This development highlights the likelihood that Coroners' Courts will be the first fora in which issues over the adequacy and quality of the protection available to workers (whether by PPE or workplace procedures) will be investigated publicly. Given the significance of such issues, it is essential that organisations are prepared for such investigations and inquests.

Background

1. COVID-19 is a naturally occurring disease. As a cause of death, it does not of itself require referral to a coroner.[1] The Chief Coroner and the National Medical Examiner have therefore indicated that every death from COVID-19 (which does not, for other reasons, require

[1] Guidance No 34: Chief Coroner's Guidance for coroners on COVID-19, §18

referral to the coroner) should be dealt with via the Medical Certificate of Cause of Death (MCCD) process.[2]

2. The vast majority of such deaths will not be referred to a coroner. The Chief Coroner recognised from the outset, however, that other factors could trigger such a reference in accordance with the *Notification of Death Regulations 2019*. Such a report must be made, for example, 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.*"[3]

3. In recent weeks, concerns have been raised by the bereaved relatives of front-line staff – including NHS staff, care home workers, emergency services personnel, public transport employees and supermarket workers – that PPE and/or workplace procedures may not have provided adequate protection to their deceased relations and may have caused their subsequent death from COVID-19. It is likely that, as society prepares for our emergence from lockdown and many more people return to work, such issues will be raised in an increasing number of cases.

4. It is therefore timely that the Chief Coroner has provided guidance to Coroners on the approach to be taken to the investigation of deaths which may have been caused (or contributed to) by possible exposure in the workplace. It is published as: *Chief Coroner's Guidance No. 37: COVID-19 deaths and possible exposure in the workplace.*[4]

When does a coroner have a duty to investigate?

5. A coroner's starting point should be to consider whether their duty under the *Coroners and Justice Act 2009* is engaged. Section 1(2) provides that the coroner must conduct an investigation if they have reason to suspect (a) that the deceased died a violent or unnatural

[2] Guidance No 34: Chief Coroner's Guidance for coroners on COVID-19, §20
[3] Regulation 3(1)(a)
[4] https://www.judiciary.uk/wp-content/uploads/2020/04/Chief-Coroners-Guidance-No-37-28.04.20.pdf

death; (b) that the cause of death is unknown; or (c) that the deceased died while in state detention. The coroner may carry out reasonable pre-investigation enquiries under s1(7) to determine if there is any basis for opening an investigation.

6. 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. If the coroner concludes that the duty is not engaged, then (as usual) he or she would notify the Registrar by way of Form 100A.

7. On the other hand, 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*".[5] A death may be "*unnatural*" if it resulted from the effects of a naturally occurring condition or disease process but where some human error contributed to death.

8. It follows that an investigation may be required if there is reason to suspect that some human failure contributed to the person being infected with the virus. This is a low evidential threshold - lower even than a prima facie case and requiring only grounds for surmise.

How should a coroner conduct an investigation?

9. In each case, it is a matter for the individual coroner how they approach such an investigation. But the Chief Coroner has now given coroners a helpful steer in his *Guidance Note No. 37*. Certain passages from this important Guidance deserve to be quoted verbatim (with my emphasis supplied).

10. Paragraph 12 addresses the issues that may need to be considered:

> *12. ….. 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.

11. In the next paragraph, he warns against the temptation to allow the inquest to be turned into a public inquiry on government policy:

> *13. In the usual way, it is a matter of judgment for the individual coroner to decide on the scope of each investigation. The coroner must consider the question of scope in the context of providing evidence to answer the four statutory questions. Coroners are reminded that an inquest is not the right forum for addressing concerns about high level government or public policy. The higher courts have repeatedly commented that a coroner's inquest is not usually the right forum for such issues of general policy to be resolved: see Scholes v SSHD [2006] HRLR 44 at [69]; R (Smith) v Oxfordshire Asst. Deputy Coroner [2011] 1 AC 1 at [81]. 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 Defence." By the same reasoning, 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.*

12. Finally, he provides practical advice on the management of such an investigation at a time when clinicians are facing huge demands in any event:

> *14. 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.*

Practical points

13. Coroners have already received, and will continue to receive, reports of deaths of workers who may have been infected with COVID-19 in the course of their work. Some of them have already attracted considerable media attention. And it is likely that coronial investigations will be opened in any cases in which there is a reason to suspect that the virus was contracted at work.

14. In such cases, it is understandable and expected that bereaved families will ask the coroner to investigate the adequacy and quality of their protection at workplace (whether by PPE or workplace procedures). They may also ask him or her to look into medical equipment used in the treatment of COVID-patients in hospitals (such as ventilators etc) and the care generally provided by clinicians and care staff. The Chief Coroner's recent *Guidance Note No 37* anticipates, and may even encourage, such requests.

15. It is therefore likely that coroners will soon be gathering evidence from individuals and organisations who may be connected to any such a death – whether employers, healthcare providers or product suppliers. And that many of these – whether NHS Trusts, care homes, emergency services organisations, public transport organisations, local councils, supermarkets, and suppliers of PPE and other medical equipment – will eventually be afforded status as Interested Persons at inquests.

16. In many of these tragic cases, the Coroner's Court will be the first forum in which these issues, which may have huge significance for organisations and individuals alike, will be investigated in public. It is likely that these inquests will attract significant media attention and will be watched carefully by those contemplating criminal prosecutions or civil claims.

17. It is therefore essential for organisations to be aware of this process and to prepare to assist any coronial investigations in which they may become involved. In particular, they should be aware that coroners will be gathering evidence. In normal times, the initial letters / emails from coroners are rarely sent to named individuals in organisation and often take time to

reach the appropriate department. When so many are working at home, there is an increased risk that such important correspondence is missed.

18. It is important for such organisations to keep a weather-eye open for any correspondence from coroners or their officers. And to have systems in place to ensure that they are able to respond effectively to any coronial investigation.

TOBY RILEY-SMITH QC

10 May 2020