Coronavirus (COVID-19)—impact on coroners' inquests and the investigation of deaths

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Corporate Crime analysis: Coronavirus (COVID-19) has impacted all parts of the justice system, but there are particular ramifications for a jurisdiction which has as its core purpose the investigation of deaths. Therefore, by means of the Coronavirus Act 2020 (CA 2020) and guidance issued by the Chief Coroner, various measures have been taken to ensure that coroners' courts are not overwhelmed. Matthew E Flinn, barrister at 1 Crown Office Row, discusses these measures.

What changes have been made to the operation of coroners' courts during the coronavirus pandemic and what effect do these have in practice?

Under the Health Protection (Notification) Regulations 2010 (HP(N) Regs 2010), SI 2010/659, reg 3, certain 'notifiable diseases' in dead persons must be reported to the relevant local authority, and in turn they are reported to Public Health England (PHE). Pursuant to HP(N) Regs 2010, SI 2010/659, Sch 1 (as amended by the Health Protection (Notification) (Amendment) Regulations 2020, SI 2020/237), coronavirus is now a notifiable disease, although that does not mean that a death linked to coronavirus needs to be reported to a coroner (see further below).

In normal circumstances, where a death has been reported to a coroner and an inquest is opened, section 7(1)(c) of the Coroners and Justice Act 2009 (CJA 2009) requires that the inquest is heard with a jury if the coroner has reason to suspect that the death was caused by a notifiable disease. However, CA 2020, s 30 provides that coronavirus is not a notifiable disease for the purposes of CJA 2009. Accordingly, inquests where the cause of death is suspected to be coronavirus will not require a jury unless another criterion under CJA 2009, s 7 applies (for example, cases involving detention or the actions/omissions of the police).

This increases the scope for the coroners' courts to carry out more of their business remotely, which they have been encouraged to do 'via whatever means' and wherever possible (Chief Coroner's Guidance No 34, para 10). Where attendance at court is essential, it has been made clear that social distancing must be maintained within the court building, in accordance with PHE guidelines (Chief Coroner's Guidance No 34, para 10).

What measures has the Chief Coroner implemented for inquests during this period?

The Chief Coroner has issued four guidance notes (Nos 34–37) to assist coroners in England and Wales in managing their workloads.

In that guidance, it has been emphasised that, in many cases, a death caused or contributed to by coronavirus will not require referral to a coroner at all. Although a coronavirus death is notifiable to PHE, reporting a death to the coroner is dictated by the Notification of Deaths Regulations 2019 (NDR 2019), SI 2019/1112, reg 3. NDR 2019, SI 2019/1112, reg 3(1)(b) requires that a death is reported where, inter alia, it is suspected by a registered medical

practitioner to be 'unnatural'. However, as Chief Coroner's Guidance No 34 confirms, coronavirus is a naturally occurring disease and therefore its cause or contribution to death will not in and of itself require notification to a coroner (Chief Coroner's Guidance, No 34, paras 17–19). Another factor requiring notification to the coroner under NDR 2019, SI 2019/1112, reg 3 must therefore be present (for example, the death is suspected to be unnatural due to some failure in medical care). Note that the notification requirements are also lessened by the effective disapplication of provisions requiring a report to the coroner where there are difficulties having an attending registered medical practitioner sign a Medical Certificate of Cause of Death (see: Chief Coroner's Guidance No 36).

Secondly, where a death has been reported to the relevant coroner, they need to carefully consider whether their duty to investigate is engaged. CJA 2009, s 1 provides that an investigation must take place as soon as practicable where there is reason to suspect that the death was violent or unnatural (CJA 2009, s 1(2)(a)), the cause of death is unknown (CJA 2009, s 1(2)(b)) or the death occurred in custody or otherwise in state detention (CJA 2009, s 1(2)(c)). That duty remains unchanged, however the Chief Coroner has emphasised that where a death is referred due to a cause of death being unknown, the coroner may request a post-mortem, which could establish the death as wholly natural (whether due to coronavirus or otherwise) and thus enable the coroner to decline jurisdiction. Further, CJA 2009, s 1(7) permits reasonable pre-investigation enquiries to determine if there is any basis for opening an investigation.

Other measures contemplated by the Chief Coroner's Guidance include the possibility of proceeding to an inquest without a post-mortem examination where one cannot take place within a reasonable period, the fast-tracked appointment of assistant coroners, the sharing of coronial courts and resources across coroner areas, and the use of 'Rule 23 type hearings' in which evidence is admitted in written form under the Coroners (Inquests) Rules 2013 (C(I)R 2013), SI 2013/1616, r 23. However, pursuant to C(I)R 2013, SI 2013/1616, r 11, the default position is that a hearing must be held in public, and the Chief Coroner has confirmed that, whereas other participants may attend remotely, this means the coroner must be physically present in court (Chief Coroner's Guidance No 35, paras 4–6).

How do these differ from the operational changes made to the criminal courts and why is a different approach being adopted?

CA 2020, ss 53–56 and Schs 23–24 have expanded the powers of the criminal courts to employ an electronic 'live link' to conduct hearings, including provisions for directions enabling any or all participants to participate remotely. Unlike the coronial jurisdiction, that includes judges. Importantly, however, that power does not apply to the jury, and from a practical point of view it would also seem impossible for jurors to participate remotely in an inquest hearing.

The fact that a more flexible approach regarding the attendance of judges has been provided for in the criminal courts reflects the inherent urgency of many such hearings, where liberty is frequently at stake.

For similar reasons, whereas socially-distanced jury trials in criminal cases have already re-started in some parts of the country, and the Lord Chief Justice has urged the government to increase funding or contemplate further temporary legislative changes to address a growing backlog in the criminal courts, the Chief Coroner's Guidance contemplates more scope for acceptable delay in the coroners' courts. For example, the Chief Coroner has emphasised that:

- inquests only have to be opened as soon as reasonably practicable after the coroner has made a judicial decision that the duty under CJA 2009, s 6 applies (C(I)R 2013, SI 2013/1616, r 5)
- coroners have a wide discretion in relation to many aspects of their investigations, including a discretion to suspend them where appropriate under CJA 2009, Sch

1, para 5, which they are expected to exercise pragmatically in light of the pandemic (Chief Coroner's Guidance Nos 34–35)

What measures should be taken in relation to deaths which involve possible exposure to coronavirus at the workplace?

Although many coronavirus deaths will not need to be reported to the coroner, there will inevitably be some cases where a death related to coronavirus requires both a report to the coroner and thereafter an investigation and inquest. Of particular note, aside from situations in which there is a factor additional to coronavirus requiring notification (for example, there is a suspicion of neglect) NDR 2019, SI 2019/1112, reg 3(1)(a)(ix) requires a death to be notified to the coroner where a registered medical practitioner suspects that the death was due to 'an injury or disease attributable to any employment held by the person during the person's lifetime'. This most obviously includes healthcare workers but could also extend to areas such as social care, deliveries and transport.

Where such deaths are reported, an investigation will be required where there is reason to suspect that the death is unnatural, including cases where some human error could have contributed. Such an error could arise in the way coronavirus was medically treated, or it might be possible that human error caused or contributed to the infection, for example through a failure to take precautions in the workplace. In that regard, however, coroners have been reminded that 'an inquest is not the right forum for addressing concerns about high-level government or public policy' (Chief Coroner's Guidance No 37, para 13). Accordingly, an inquest might examine a failure to provide a particular employee with adequate Personal Protective Equipment (PPE) or procedural failings in a workplace, but should not look at PPE procurement at a governmental or public policy level.

The Chief Coroner's Guidance No 37 suggests that where some investigation into policy or resourcing appears to be appropriate (perhaps relating to the adequacy of PPE provision for clinicians in a particular hospital department), the coroner may exercise their discretion to suspend the investigation until it becomes clear how such enquiries can best be pursued, bearing in mind their own ability to gather the necessary evidence and proceed to an inquest, and particularly in the context of healthcare workplaces, being sensitive to the additional demands placed upon hospitals and clinicians (Chief Coroner's Guidance, No 37, para 14).

What practical steps should practitioners take in relation to ongoing or new inquests during this time?

Many inquests have been and will be significantly delayed. Where hearings do proceed, written evidence may assume greater importance than previously, both when admitted under C(I)R 2013, SI 2013/1616, r 23 and when used to ease the process of giving oral evidence remotely. The Chief Coroner has also warned that 'we may all have to have to accept that the unprecedented situation we are in may mean it may not be possible to perform the sort of detailed death investigation process we are used to' (Chief Coroner's Guidance No 34, para 23(x)).

In those circumstances, the preparation of detailed written statements and the collation of other forms of documentary evidence could be of increasing importance. Practitioners should also anticipate that coroners are likely to direct the remote participation of legal representatives and witnesses, particularly in jury trials where the need for social distancing means that courtroom space will be at a premium. It is to be expected that every effort will be made to accommodate family members where they wish to attend in person.

Interviewed by Barbora Kozusnikova