CHIEF CORONER

GUIDANCE No.34

COVID-19

INTRODUCTION

1. This document is the main guidance for all coroners in England and Wales from the Chief Coroner about the COVID-19 pandemic[1]. The Chief Coroner has also issued separate guidance on recovery (see Guidance Note 39). Both guidance notes will be kept under review.

2. The pandemic has had a significant impact on the functioning of the coronial service, and on the organisations with which our service interacts. At the start of the pandemic, the stringent restrictions placed on society meant many of our working practices had to be changed, or even halted. We then entered a period of recovery, and have been operating more normally since July 2021. However, there are still public health issues to consider, the situation with the virus may evolve, and there are backlogs that we need to address.

3. The Coronavirus Act 2020 (CA 2020), which was passed at the start of the pandemic, introduced temporary easements that affected the coroner system. Most of that Act's provisions expired at midnight on 24 March 2022, although some provisions were extended and are now due to expire on 24 September 2022. The expired provisions have either been replaced by provisions in other legislation, or the processes they governed have reverted to pre-pandemic practice.

4. This note aims to provide guidance on Covid-19-related issues, including highlighting some of the measures that remain in place for managing the pandemic, and the changes that occurred following the expiry of some CA 2020 provisions.

REPORTS TO THE CORONER

Covid-19 as a notifiable disease

5. COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010. That does not mean, however, that a report to a coroner is always required. COVID-19 is a naturally occurring disease and may be a natural

[1] This Guidance Note replaces Guidance Notes 34-38 that were issued in 2020, and is an updated amalgamation of the information in those previous notes.

cause of death. Whether a report is needed will depend on the circumstances of the case.

Medical Certificates of Cause of Death (MCCDs)

6. The CA 2020 allowed any registered medical practitioner to sign an MCCD, even if the deceased was not attended during his or her last illness and not seen after death, provided that the medical practitioner could state the cause of death to the best of their knowledge and belief. This easement has expired, and attendance requirements have reverted to those in force prior to the pandemic. However, the time-period within which the attending doctor must have seen the deceased has been permanently altered from 14 to 28 days.

7. If the attendance requirements are not met, or the attending doctor cannot state the cause of death, the death must be referred to the coroner. Where a report is made to the coroner in a suspected COVID-19 death, the coroner should consider the following:

    - The aim of the system should be that every death from COVID-19 that is a natural death should be dealt with via the MCCD process.

    - If the attending doctor declines to sign an MCCD, it would be legitimate for the coroner to make the doctor aware of any facts the coroner may hold that may be relevant to that decision.

    - If an MCCD is signed and the coroner is satisfied on the information available that the duty to investigate under section 1 Coroners and Justice Act 2009 (CJA 2009) is not engaged, Form 100A should usually be issued.

    - If the coroner is not sure that the duty to investigate under section 1 is engaged, they can usually request a post-mortem examination. That examination need not be invasive, if consideration of the medical records, an external examination of the body and a test for COVID-19 are considered to be sufficient. If the post-mortem examination produces a natural cause of death, the coroner can issue Form 100B.

    - If the post-mortem examination does not ascertain the cause of death, one approach may be for the coroner to ask the pathologist to confirm if on the balance of probabilities, it is an unascertained natural cause. If so, that could lead the coroner to issue Form 100B.

    - If the duty to investigate under section 1 is engaged, but the coroner is subsequently satisfied (whether or not there has been a post-mortem) that the cause of death was a natural one, the coroner can discontinue the investigation and issue Form 100A.

    - If the cause of death remains unascertained and there is no evidence to suggest an unnatural death, the coroner could consider admitting written evidence under rule 23[2] or, if appropriate, holding an inquest in writing[3].

[2] The Coroners (Inquests) Rules (2013).
[3] Section 9C(1)(b) CJA 2009.

SPECIAL CASES

COVID-19 deaths in state detention

8. Section 1 CJA 2009 requires coroners to open an inquest in the event of a natural death in prison/state detention. However, it is not compulsory to have a jury inquest if the death is from natural causes.

9. All coroners will make decisions carefully on the facts and merits of each case. It is obviously important that deaths in state detention are scrutinised carefully, and unnatural deaths are given as much attention and resource as they need. A post-mortem examination may still be a necessity even if the death was from natural causes, for example where there were issues with care.

10. Coroners rely on others to gather information and to provide evidence in a death in prison, including Her Majesty's Prison and Probation Service, the healthcare provider within the prison, the police and the Prisons and Probation Ombudsman. The pandemic put pressure on the normal multiagency process after death. Each senior coroner should ensure they are in dialogue with institutions in their jurisdiction and that their Local Resilience Forum (LRF) (see below) is aware of any ongoing issues and is actively managing them.

Possible exposure in the workplace

11. Regulation 6(2) of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 requires a report to be made to the Health and Safety Executive (HSE) 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. The HSE therefore published guidance that death due to work-related exposure to COVID-19 must be subject to the reporting procedure.

12. 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 maintain single points of contact with those organisations, as appropriate.

13. Regulation 3(1)(a) of the Notification of Deaths Regulations 2019 provides that there must be a report to a coroner if a medical practitioner completing an 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." A COVID-19 death may therefore be reported to the coroner if there is a suspicion that the virus was contracted in the deceased's workplace.

14. When a COVID-19 death is reported, the coroner must consider whether his or her duty to investigate the death is engaged. If the medical cause of death is COVID-19 and there is no reason to suspect that any culpable human failure contributed to the death, there will usually be no requirement for an investigation to be conducted. The coroner may carry out reasonable pre-investigation enquiries under s1(7) CJA 2009 to determine whether there is any basis for conducting an investigation.

15. If the coroner determines that the duty is not engaged, then he or she would notify the Registrar by way of Form 100A.

16. The coroner may, however, consider that there is reason to suspect the deceased died an unnatural death. For example, if some human failure (e.g. lack of safeguards in the workplace) contributed to the person being infected with the virus, or they received inadequate clinical care. The words "reason to suspect" reflect a low threshold test; lower even than a prima facie case and requiring only grounds for surmise. It is a matter for the coroner's judgment in each case whether the facts and evidence in the case provide "reason to suspect" that the death was unnatural.

17. If a coroner determines that an investigation and inquest must be held, the coroner is encouraged to hold a pre-inquest review hearing, unless any issues that need to be aired prior to the inquest can easily be dealt with by email.

18. It is a matter of judgment for the individual coroner to decide on the scope of each investigation. One area in which scope issues have arisen during the pandemic is in relation to the adequacy of personal protective equipment (PPE). 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.

19. There have been 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. In *Smith*[4], 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." Coroners will be aware that there is going to be a public inquiry into the government's response to the COVID-19 pandemic (UK Covid-19 Public Inquiry (public-inquiry.uk)). The scope of a coroner's inquiry, however, is a matter for the judgment of the coroner, not for hard and fast rules. It is important to remember that 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.

20. Where the coroner decides to open an inquest, section 7 Coroners and Justice Act 2009[5] removes the requirement for an inquest to be held with a jury if the coroner has reason to suspect the death was caused by COVID-19. This temporary provision will expire on 27 June 2024, unless it is extended for up to two years by the Secretary of State.

21. There has been some debate over whether a jury is required when COVID-19 is suspected to have been contracted at work. It is the Chief Coroner's view that a jury is currently not mandatory. However, an inquest may be held with a jury under the discretionary power in s7(3) CJA 2009 if the coroner considers that to be appropriate in a particular case.

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[4] *R (Smith) v Oxfordshire Asst. Deputy Coroner [2011] 1 AC 1,* see [81] (Lord Phillips) and [127] (Lord Rodger).

[5] As amended by s 42 Judicial Review and Courts Act 2022 to replace s30 CA 2022 from 28 June 2022.

HEARINGS

22. Coroners should consider what measures are needed to ensure the safety of those who attend hearings. Coroners should bear in mind any relevant national guidance, as well as any local guidance issued in respect of their court accommodation.

23. If public health considerations from time to time limit the number of people it is possible to have in the public gallery and in court generally, that will not prevent a hearing from being 'in public'. There has always been a limit on how many people can physically be accommodated within the precincts of a court. If a court does not have enough space to accommodate everyone wanting to observe a hearing, it is permissible to livestream hearings either to specific individuals, or to premises designated by the Lord Chancellor[6].

24. When dealing with medical professionals (including pathologists), coroners should recognise their primary clinical commitments, especially at times of high pressure on health services. This may mean avoiding or deferring requests for lengthy reports/statements, accommodating clinical commitments if calling clinicians as witnesses, considering admitting written evidence under rule 23 of The Coroners (Inquests) Rules 2013, and granting extensions where appropriate.

25. As a result of the need to postpone hearings for public health reasons at the beginning of the pandemic, professional witnesses may have been experiencing a surge in calls for them to attend rescheduled hearings. Coroners should be aware of the impact this may have on service delivery, and may wish to consider ways to alleviate any pressure (for example, by considering permitting remote attendance[7], or admitting written evidence under rule 23, if appropriate).

PRACTICAL MATTERS

Managing the deceased

26. Planning for excess deaths during the pandemic will have been undertaken by each area's LRF, which brings together all the relevant local organisations and bodies, including the police, ambulance service, GPs, hospitals and local authorities. Senior coroners should ensure they remain familiar with LRF plans and discussions locally, and continue to support a collective approach.

27. For community deaths, a collective multi-agency response involving the senior coroner should be in place to ensure that there is a consistent process that complies with national guidance. That process should include arrangements for the use of PPE, where appropriate.

28. The Health and Safety Executive has issued guidance on handling the deceased with suspected or confirmed COVID-19 (link: https://www.hse.gov.uk/biosafety/handling-the-deceased.htm).

[6] section 85A(2) and (3) Courts Act 2003
[7] See the Chief Coroner's Guidance Note 42 on Remote Hearings.

Cremation

29. The expiry of CA 2020 provisions on 24 March 2022 did not mean a return to the use of confirmatory medical certificates before cremation; only one medical certificate is still required.[8]

30. An attending doctor who saw the deceased within 28 days before death, or viewed the body in person after death, will be able to complete the form Cremation 4.

HH JUDGE THOMAS TEAGUE QC
CHIEF CORONER

16 December 2021
Last updated 5 July 2022

[8] Changes were made to the Cremation (England and Wales) Regulations 2008 by the Cremation (England and Wales) (Amendment) Regulations 2022, making the removal of the confirmatory Cremation 5 Form permanent.