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Explanatory Regulations, Virus Inquests and COVID-19 Disease

Paola Charalampous*
Department of Medical Ethics and Law at King's College, London, UK

Abstract

With more than 4,375,000 cases and over 127,000 deaths [1] since coronavirus' first appearance and following outbreak on November 2019, the UK comes first in death roll in Europe and fifth in the world, after US, Brazil, Mexico and India [2]. As a result, the question of whether the excessive death rates should fall under the coroners' jurisdiction came on the frontline. At the very beginning of the pandemic, the cases and deaths due to COVID-19 were not that common and thus many of them were appointed to coroners, albeit a naturally occurring disease like the flu and pneumonia are not usually referred to an expert.

Keywords: Corona virus; Pandemic; Clinical negligence; Medical cause; Planning of numerous inquests

Introduction

Is it possible then, under certain occasions, a death caused or contributed to by COVID-19 to be subject to an inquest? In order to answer to this question, I will examine circumstances, such as those of unnatural death, caused or contributed to by clinical negligence or human error, death in custody and at work, where it is essential to address the case to the coroner to request an inquest so that any unanswered questions could be scrutinising examined. I will also critically approach the prerequisites of an inquest under this realm and the connection between coronavirus and article 2, according to which a state may be held into account, if it had failed in its duty to protect life.

Do we need coronavirus inquests?

Coronavirus in not of course neither the first disease nor the first pandemic that hit the humankind. A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course. For the purposes of completing the Medical Certificate of Cause of Death, COVID-19 is an eligible direct or underlying cause of death of course, there may be other circumstances surrounding the death that necessitate a report to the coroner, as for example, whether the cause of death is unknown or there are other related factors. The coroner is then faced with two choices. If it is possible to conduct a brief inquest shortly after the death certificate, which considers the facts and comes to a verdict of a medical cause of death, either having COVID-19 as the cause or, where there is any doubt, reaching a verdict of an unexplained cause. It is possible then for the coroner to ask the pathologist to check whether there is an undetermined natural cause on the balance of probability [3].

COVID-19 has also been listed as a notifiable death under the Health Protection Regulations 2010, which means it was notifiable to Public Health England. While COVID-19 was a notifiable disease under this Regulation, this does not imply that a notice of death to a coroner is expected (the notification is to Public Health England), and there will often be no need for deaths caused by this disease to be referred to a coroner, unless suspected COVID-19 deaths have occurred in the community, where an MCCD is not produced [4]. The Royal College of Pathologists suggested that "in general, if a death is believed to be due to confirmed COVID-19 infection, there is unlikely to be any need for a post mortem to be conducted and the Medical Certificate of Cause of Death should be issued [5]." Where a post-mortem examination is clearly needed but not feasible, whether due to infection risk or a lack of capacity, coroners are asked to examine all related medical history and other facts that might allow a decision to be drawn.

According to the aforementioned statistical clues, coronavirus became a lethal disease for thousands in the UK and approximately 3 million globally [6]. Due to the number of victims and the difficulties that the planning of numerous inquests with jury would cause, it is not considered a notifiable disease and the requirement to hold inquest with jury was suspended in England and Wales, by section 30 of the Coronavirus Act 2020 (c. 7). The same conclusion is reached through numbers 66 to 69 of the Explanatory Notes related to the Coronavirus Act 2020 (c. 7), which stated that: "Under existing legislation, the status of COVID-19 as a notifiable disease in England meant that any inquest into a death where the coroner has reason to suspect that the death was caused by COVID-19 must take place with a jury (66). This could have very significant resource implications for coroner workload and Local Authority coroner services, resulting in a possible 25,000 additional jury inquests even at the lower end of COVID-19 mortality modelling in England and Wales (67). Although the inquests could be adjourned until the pandemic has passed, this would deprive bereaved families of swift closure and would, in any event, simply delay resource pressure for the future (68). The Act modifies the existing legislation to disapply the requirement that coroners must conduct any inquest with a jury where they have reason to suspect the death was caused by COVID-19. For Northern Ireland, the Act makes corresponding provision, including in relation to inquests into a death in prison from natural illness (69)".

Thus, the nature of each investigation is left up to the discretion of the individual coroner. Each coroner must consider the issue of scope in the sense of presenting evidence to address the four statutory questions, namely who, when, where and particularly how the deceased person came by his or her death [7]. It is up to the coroner to decide how much to seek inquiries into underlying causes and contributory factors. The investigation must be thorough, honest, and fearless, but it must also be narrowed down to the causes and circumstances of the specific death. Moreover, a coroner's inquest is not necessarily the best venue for raising questions about high-level administration or public policies, which might be causally distant from the actual death. A COVID-19 death does not necessitate an inquest by the Coroner and can be handled

***Corresponding author:** Paola Charalampous, Department of Medical Ethics and Law at King's College, London, UK, Tel: +447549190020; E-mail: paolacharalampous3@gmail.com

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by the MCCD procedure, unless there is any other variable at stake to be assessed like the three possibilities below.

Deaths in custody

A death, even a COVID-19 one, can fall into a category that necessitates a more thorough description, such as a prison death. In this case, namely when the person died in state detention, either in prison or secure mental health ward, an inquest would have to take place. The coroner would have no alternative but to open an investigation, collect all pertinent information for the file, release the body for burial or cremation and then schedule the inquest for a later date. Section 1 of the Coroners Justice Act 2009 allows coroners to hold an inquest even when a natural death occurs in jail or another state correctional facility. When a death occurs as a result of natural causes, an inquest with a jury is not needed. There may be deaths that are not the result of natural causes and they should be given as much consideration and resources as investigators during the pandemic have. Even if the death was caused by natural causes, a post-mortem examination will also be required if there were any problems with treatment, as should happen when a death due to COVID-19 could have been avoided with the adequate care. However, the existence of the COVID-19 emergency can preclude a post-mortem inspection, but the Chief Coroner believes that it is important to do as many investigations as possible into prison deaths [8].

Of course, the detention conditions in combination with the high transmission of the virus are resulting to multiple prisoners' deaths. Questions that need to be answered like whether the prisoner could have been transferred from a prison to a hospital, if the adequate care has been provided to him and the management of the prison had applied all the governmental guidelines appropriately, are mandatory, albeit, in coronavirus times, might hamper the investigation progress even more.

Deaths from possible exposure in the workplace

Regulation 6(2) of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 mandates a report to be filed if "any person dies as a result of occupational exposure to a biological agent." The virus that causes COVID-19 disease is included in this term. According to the regulation 3(1)(a) of the Notification of Deaths Regulations 2019, a report to the coroner is required, if the medical practitioner completing the Medical Certificate of Cause of Death believes that the person's death was caused by an accident or disorder related to any work kept during the person's lifetime, namely where it is suspected that it was due to a disease, attributable to the deceased person's employment. As a result, there are certain circumstances in which a COVID-19 death can be recorded to the coroner, such as when the infection was contracted at work. This may include front-line NHS staff as well as others, such as public transport and groceries stores employees, care home workers and emergency services personnel. If the coroner wishes to open an inquest, he will have to determine whether any shortcomings in safeguards, in a certain workplace, induced the deceased to catch the virus and thereby contributed to his death [9]. While an inquest may investigate a failure to provide a specific employee with adequate personal protective equipment (PPE) or procedural flaws in the workplace, it should not be expanded on PPE procurement at the governmental or public policy level.

Taking into consideration that many clinicians, nurses and care workers, by overexposing themselves to the virus, as this is the very own nature of their work, have lost their lives, many families will seek to find justice through inquests and courts. In contrast to England and Wales, it is ordered in Scotland, which does not have coroners, that all COVID-19 or presumed COVID-19 deaths should be identified to the procurator fiscal, regardless of whether the deceased contracted the virus in the course of their employment or was a patient of a care home [10]. The difficulty coroner's face in carrying out this role is the absence of real standard by which to judge the actions or the system in any given workplace. Given the current state of understanding about COVID-19, this will inevitably come later, when we will have more clues to reach a safer conclusion.

Some writers suggest that coronavirus could be included in the category of 'industrial disease', as many other infections, such as hepatitis and tuberculosis when they are transmitted through hospitals and care homes. When a clinician or medical staff member develop infections following contact with COVID-19 positive patients or residents, a coroner may well have reason to suspect that such a death was due to that exposure and arose from the employment environment [11]. However, it is very early to be able to judge whether coronavirus will be co-categorised with industrial related diseases as mesothelioma, as COVID-19 is not confined solely in hospitals, residential care homes, groceries stores and public transport but it can be contracted everywhere.

Deaths contributed to by human error

Where the medical cause of death is COVID-19 and there is no evidence to believe that any culpable human fault led to the individual death, an investigation is normally not required. Under section 1(7) of the CJA 2009 , the coroner can conduct reasonable pre-investigation inquiries to decide if there is a cause for opening an investigation [12]. 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 the death and there is public interest to do so. If there is evidence to believe that a lack in health treatment during the person's illness led to death, an inquest will be required, to shed light to the clinical care provided [13]. As a consequence, it seems that an investigation may be opened into a COVID-19 death that was caused by insufficient PPE coverage for physicians in a specific hospital or department, but not into a COVID-19 death that was caused by national NHS guidelines or protocol on the provision and use of personal protective equipment more broadly.

It was stated that in order for us to better understand the nature of the virus, the problems that led to its widespread, especially in care homes, the impact that chronic diseases had to the death of elderly people and hence to implement more efficient prevention measures, more post-mortem investigations and inquests should be made [14].

The problem is that elderly and vulnerable individuals have been disproportionately ignored during the pandemic, with insufficient testing and those who care for them not having the PPE they need to protect themselves and those they care for [15].

Stillbirths

According to s 41 of the Births and Deaths Registration Act 1953, the term 'still-born infant' refers to a child born after the 24th week of pregnancy that did not breathe or exhibit any other signs of life after being totally removed from its mother and the term 'still-birth' is to be interpreted accordingly. Under normal circumstances, in a pro-pandemic period, the coroners did not have a duty of death investigation, except to decide if a stillbirth did happen, by making preliminary inquiries and pre-inquest decisions. However, in the coronavirus era, during the first lockdown period in England, from April to June 2020

[16], as data suggest, the rate of stillbirths has been slightly decreased, creating reassurance for pregnant women that hesitate to access health care treatment, fearing that they might get infected. Although there is still uncertainty about how many pregnancies has coronavirus affected, it is, once again, very early to reach conclusions. If the data change eventually, this might mean that there was indeed a causal connection between the precautionary measures for the prevention of the virus' spreading and the stillbirths and, by extension, the state may have breached its operational duty of protecting life. Thus, we cannot eliminate the possibility that an inquest might be ordered if a breach of article 2 is proved in due time.

Policy & PFD reports

If a coroner decides that an investigation and inquest are needed, he is encouraged to hold a pre-inquest summary hearing according to guidance No 22, which states that the coroner should list the questions to be raised, and whether or not Article 2 is engaged [17]. Coroners have the authority to investigate the underlying causes of death, including device or process defects at any stage, but the report should be focused on the specific death and the obtaining of necessary evidence and information to answer the four questions of inquest and reach a verdict. With the consequences of the pandemic and the lockdown constraints in mind, the coroner should consider his own ability to conduct required investigations to collect evidence and proceed to an inquest.

In relation to legislation, resources and policy, among his other duties, he should write a report to further state his research findings and any deficiencies found, to share valuable learned lessons and prevent future deaths (paragraph 7 of Schedule 5 CJA 2009). It is in the coroner's discretion, though, whether to make a PFD report about changes that should be considered by relevant recipients. He may also be asked to extend extensions to NHS Trusts, other hospital organisations and agencies, such as hospitals, that are expected to respond to PFDs and the same rules may adhere to those decisions. Nonetheless, it is not mandatory to submit a report if appropriate steps have been taken to address the risk of future fatalities. If the evidence suggests that the risk of future fatalities may arise nationally and the coroner believes that national action should be taken, a report to a relevant national organisation to raise awareness of the issues may still be appropriate. When it comes to coronavirus, although it is a very dangerous and contagious disease and as the pandemic continues, we keep on learning from mishandlings and inexpediencies, both in terms of politics and policy, continuous reports from coroners to prevent future deaths would be, after a certain point, to no use, as almost every national entity is taking action to impede the virus' spread.

Coronavirus handling under article 2 ECHR

Article 2 of the European Convention on Human Rights safeguards the right to life and imposes a procedural duty on the state to investigate deaths for which it may be held liable. Article 2 can be invoked only in two cases. First, in a case in which a patient's health is deliberately jeopardised by lack of lifesaving emergency care, as happens in situations during which the patient receives inadequate, incorrect, or delayed treatment. Secondly, when a patient is denied access to lifesaving care due to a systematic or procedural failure in hospital services and the authorities were aware of the possibility or should have been aware of it but refused to take the adequate precautions to keep it from materialising, putting the patient's life in jeopardy [18].

The crucial question is whether, according to evidence, the UK may have failed in its duty to protect life and should be held to account for any systemic failure or dysfunction that resulted to thousands of deaths caused or contributed to by COVID-19. If there has been a breach of either the substantive or the operational duty, according to which the authorities should have known that there was a real and immediate risk for the person in question and failed to provide adequate care [19], there is a need to ascertain in what circumstances the deceased came by his or her death [20].

Consequently, it is a matter of proving state's deficiency relating to the handling of the pandemic and the inability to save lives in order for the coroners to open inquests for the thousands of deaths around the UK and especially concerning the compounding factors of the diseased in custody, the ones overexposed to the virus in the workplace or those who came by their death by a human error. The threshold in an Article 2 inquest is low, in contrast to a non-article 2 inquest, because the coroner has a power to find circumstances which are possible but not probable causes of death, namely that they may have caused or contributed to it, but we cannot be absolutely sure [21]. It can be argued that a causal connection can be set between the state's actions and the result, in light of more effective measures had been taken by the state, the number of deaths could have been smaller, as in other European countries.

The guidelines underline that coroners should be reached only when is absolutely necessary during the pandemic. In certain cases, as the ones aforementioned, the contribution of the coroners will be crucial for the operational qualification of the health and legal system in terms of prevention, safety and justice. Despite the fact that resources are exceedingly limited, it is perhaps more important than ever to ensure that human deaths are not seen as 'the new normal'. The UK's recorded highest COVID-19 death toll in Europe points to hundreds of thousands of additional avoidable deaths as a result of public authorities' actions or omissions. In such a case, article's 2 of ECHR procedural duties to ensure timely successful inquests into certain deaths, irrespective of those responsible, should be invoked [22].

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