CHIEF CORONER

CHIEF CORONER GUIDANCE – COVID-19

1. This document is intended to be the main piece of Guidance for all coroners from the Chief Coroner about the approach to COVID-19, although it will be particularly relevant for senior coroners and area coroners.

2. The Guidance applies to reports of death and coroner investigations in England and Wales only (the extent of the Chief Coroner's remit). It does not apply to coroners in Northern Ireland and it does not apply in Scotland (which does not have coroners).

3. This Guidance is designed to help coroners continue to exercise their judicial decisions independently and in accordance with the law, but in the context of the extraordinary pressures which are present.

4. As independent judicial office holders, coroners remain responsible for their own judicial decisions and the Chief Coroner cannot direct them to make a particular kind of decision in an individual case or a group of cases, neither can he intervene in any other way in individual cases. Nothing in this Guidance changes that.

5. Coroners are reminded of their obligations under the Guide to Judicial Conduct. The Chief Coroner cannot envisage a situation in the current pandemic where a coroner should be engaging in interviews with the media or making any public statements to the press. All coroners should be focussing on their vitally important judicial role.

Who is planning locally for excess deaths and how should coroners be involved?

6. Planning for significant numbers of excess deaths will fall to your local resilience forum (LRF) which brings together all the relevant local organisations and statutory bodies including the police, ambulance service, GPs, hospitals, local authorities and so on. These organisations should already have done work on excess death scenarios (usually in relation to 'pan flu' scenarios). Although coroners and the coroner service locally are an integral component of the LRF, planning for these situations clearly goes much wider than simply addressing coroner matters; it will also involve the practicalities of dealing with all those deaths which are not required in law to be reported to the coroner. In the case of COVID-19, that could be the majority of such deaths.

7. Senior coroners should ensure they are familiar with LRF plans and current discussions locally as required. This will no doubt include issues around body storage capacity, post-mortem examination capacity and other resilience factors.

8. All coroners should maintain a collective approach in response to the emergency, both within the LRF context and with other coroners.

9. The COVID-19 emergency presents a number of challenges for coroners.

Practical matters

10. Potential practical steps to be considered, built into resilience planning and implemented by coroners and local authorities could include the following:

- The current position in the mainstream judiciary, as expressed by the Lord Chief Justice and which the Chief Coroner adopts is that no physical hearing should take place unless it is urgent and essential business and that it is safe for those involved for the hearing to take place. A particular concern is to ensure social distancing in court and in the court building.

- All hearings that can possibly take place remotely (via whatever means) should do so, and other hearings should continue only if suitable arrangements can be made to ensure distancing although the Chief Coroner accepts that in many jurisdictions this may be difficult. Hearings which must continue should be those considered essential business.

- Coroners are reminded that such hearings must in law take place in public and therefore coroners should conduct telephone hearings from a court, not their homes or their office. In the light of the statement of the Prime Minster on March 23, 2020 as to gatherings and travel only where absolutely necessary, hearings taking place in public may mean they take place where only a member of the immediate family is present and with a representative of the press being able to be present.

- Social distancing in accordance with PHE guidelines must be in place at all times and at all places within the court building.

- Ultimately whether a hearing can continue or not, and in what form, is a matter for the senior coroner in terms of the jurisdiction as a whole, and the coroner dealing with the case, for that case.

- The Chief Coroner is actively reviewing the position for the medium-term, in expectation that coroners will still need to hold some inquests – perhaps a limited number of short Rule 23 type hearings – over the coming months.

- Therefore, coroners should make an assessment about adjourning inquests – see also see the Chief Coroner's COVID-19 note #3. It is inevitable that

adjournment will cause the number of cases over 12 months old to increase. It will be the role of the Chief Coroner in due course to explain to Parliament and the public the reasons for that.

- Consider prioritising your judicial and staff resources towards decision-making on reports of deaths. This may militate in favour of adjourning some inquests, especially those likely to occupy significant time and judicial / staff effort.

- Take steps with your local authority and the police to ensure that you have a resilient, functioning office. Clearly government guidance on practising social distancing, including working from home where possible, should be followed. However, coroners and staff while responsible for the management of the deceased are regarded as performing key public services (and are key workers) for the purpose of government guidance. The details of staff working arrangements must be worked out locally but clearly some staff may be needed in the office for essential work and to facilitate hearings as necessary. Absence because of illness or for other reasons amongst staff and issues connected with caring responsibilities will have an impact and senior coroners should have a plan in place with their local authority and the police where necessary to manage this.

- Senior coroners, in discussion with their local authorities and the police, should consider requesting, where possible, the deployment of additional resources into the coroner office from elsewhere in their local authority / police force area. They should also consider the sharing of coroner's officers, other staff resources, facilities and accommodation with neighbouring coroner areas in need. Where the accommodation housing the coroner's court is closed the senior coroner may wish to discuss other locations with his local authority and indeed with HMCTS in relation to any other court facility.

- When dealing with medical professionals in their work generally (including matters of evidence in inquests generally), coroners should recognise their primary clinical commitments, especially at times of high pressure on health services. This also applies to pathologists who will be under significant pressure as well. This may mean avoiding or deferring requests for lengthy reports / statements and accommodating clinical commitments if calling clinicians as witnesses. 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. However, there should be no blanket policy of extension for all PFD reports – many recipient organisations, individuals or businesses have nothing to do with the COVID-19 response and are continuing to work in as normal a way as possible.

Appointing additional assistant coroners

11. The Chief Coroner and the Lord Chancellor are prepared, in principle, to consent to the appointment of assistant coroners by local authorities **without open competition** to deal with urgent workload pressures caused (this may include cross-appointments for neighbouring areas). The Chief Coroner and the Lord Chancellor will aim to 'fast-track' the statutory consent process. Clearly there is a finite group of trained assistant coroners in the country but recently retired assistants in your area may be prepared to be re-appointed, so they are ready for work on a 'stand-by' basis. 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.

12. Any proposed applications for appointments will still need to be made by your local authority, on terms arranged or approved by the authority, and will still be subject to the statutory age limit of 70.

13. However, please remember that in law these appointments will be permanent appointments to the age of 70. Those appointed may in some cases be invited to resign their posts once the period of emergency has passed.

14. The Chief Coroner is urgently pursuing a number of avenues to try to widen the pool of assistant coroners who may be available. He will update senior coroners and local authorities on that matter separately.

15. Senior coroners in Wales should take advantage of the fact that any coroner appointed to one Wales area is able to make judicial decisions in all Wales areas.

Welfare

16. Welfare of all coroners, coroners' officers and those working in the coronial system is vitally important. Please do ensure that you monitor your workload and that of those around you.

COVID-19 as a natural cause death

17. The Chief Coroner would like to remind coroners of the Ministry of Justice Guidance on the Notification of Deaths Regulations 2019[1] which provides:

"24. A death is typically considered to be unnatural if it has not resulted entirely from a naturally occurring disease process running its natural course, where nothing else is implicated."

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/851972/registered-medical-practitioners-notification-deaths-regulations-guidance.pdf

18. Although every case is different and the normal test as to duty to investigate under section 1 of the Coroners and Justice Act 2009 (CJA 2009) should apply to deaths reported to the coroner, the Chief Coroner supports the position, communicated recently by NHS England and the Chief Medical Officer as advice to medical practitioners in England, that:

    - COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death (MCCD);
    - COVID-19 as cause of death (or contributory cause) is not a reason on its own to refer a death to a coroner under the CJA 2009;
    - That COVID-19 is now a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status (the notification is to Public Health England), and there will often be no reason for deaths caused by this disease to be referred to a coroner;
    - For registration: where next of kin/informant are following self-isolation procedures, the arrangement for relatives (etc) should be for an alternative informant who has not been in contact with the patient to collect the MCCD and deliver to the registrar for registration purposes. The provisions in the Coronavirus Act will enable this to be done electronically as directed by the Registrar General.

19. To restate: COVID-19 is a naturally occurring disease and therefore is capable of being a natural cause of death. There may of course be additional factors around the death which mean a report of death to the coroner is necessary – for example where the cause is not clear, or where there are other relevant factors. This is set out in the Notification of Death Regulations 2019. There may also be cases where an otherwise natural causes death could be considered unnatural.

20. The aim of the system should be that every death from COVID-19 which does not in law require referral to the coroner should be dealt with via the MCCD process. On this matter the Chief Coroner and the National Medical Examiner are in full agreement.

21. In a hospital death scenario, establishing COVID-19 as cause of death and following the MCCD process is a relatively straightforward matter because of diagnosis and treatment in life. In community deaths it may become more complex. Because of the pandemic pressures, 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 without any report to the coroner.

22. The Coronavirus Act of Parliament gained Royal Assent on 25 March 2020, meaning it is now law. Once the clauses relating to death certification and cremation are commenced the legislation will expand the MCCD 'window' from 14 to 28 days and allows a doctor who was not the attending doctor to sign the MCCD; this will reduce the risk of the scenario above happening. However, there may remain a proportion of suspected COVID-19 (to a greater or lesser degree of confidence) deaths where report of death is likely to be made to the coroner because a doctor is unable to sign a MCCD.

23. In those circumstances the coroner should consider the following options when a death is reported to them:

    i. Where possible there should be a dialogue with the doctor who reported the death, or any other doctor involved in the care. There may be a degree of reluctance to sign an MCCD and this may not be for valid reasons. 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 (based on knowledge of the patient's prior history, communications from the family, any report to the coroner, etc.).

    ii. Where a doctor cannot sign an MCCD, the coroner will be unable to issue a Form 100A (since that requires a MCCD to be issued).

    iii. Where an MCCD is signed, if the coroner is satisfied on the information available that the duty to investigate under section 1 of the CJA 2009 is not engaged, a Form 100A should usually be issued.

    iv. If the coroner is not sure that the duty to investigate under section 1 of the CJA 2009 is engaged, normally they can request a post-mortem examination. If the post-mortem examination produces a natural cause of death, the coroner can decline jurisdiction and enable the death to be registered via the Form 100B route. It should be noted that the Form 100B procedure may be used where the pathologist confirms a natural cause of death even if the exact cause is not ascertained.

    v. However, a post-mortem examination may not be possible, either on infection risk grounds or because of capacity problems in the system, including problems with the availability of a pathologist (also see paragraphs 24 to 29 and 30 to 37 below).

    vi. In this scenario, the Chief Coroner invites coroners to take a pragmatic approach. It is obviously not in the interests of justice for deaths to be unregistered. If the coroner considers that an investigation may be necessary but that a post-mortem examination is not practicable within a reasonable time, the Chief Coroner's view is that coroners should open an investigation into a death if at all possible and proceed to inquest. Coroners are reminded that they cannot discontinue an investigation when there has been no section 14 post-mortem examination. Coroners are further reminded that the 'reason to suspect' test in section 1 of the Coroners and Justice Act 2009 is a low threshold and that although the death may be suspected COVID-19, there are likely to be enough grounds in law to consider the cause of death unknown at this stage. Accordingly, a coroner who is notified of a death due to suspected COVID-19 but cannot establish the position satisfactorily and/or cannot arrange a post-mortem examination in a reasonable time may need to proceed to inquest.

    vii. The coroner should assemble all the relevant medical and other evidence, including witness statements etc; this includes accurate information from the scene in a community death. If there is no reliable objective medical evidence

establishing the cause of death, witness statements of those who knew the deceased in life and can describe symptoms, etc. may enable a conclusion to be reached. When assembling evidence and calling witnesses in inquests, coroners should be understanding of the primary clinical commitments of medical staff.

viii. The coroner then has two options open to them. If it is possible to hold a short inquest (perhaps of the Rule 23 variety) soon after the report of death, which considers the evidence and arrives at a conclusion (possibly of natural causes) with a medical cause of death either providing COVID-19 as the cause, or if there is still uncertainty, an unknown cause, they should do so. By way of example, very often a pathologist may tell the coroner that the cause of death is unascertained. 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 to the coroner to a simple Form 100B, or a Form 100B with a Notice of Discontinuance of the investigation or an Inquest (of the Rule 23 variety) with a conclusion of natural causes depending on the circumstances. If the cause of death is still unascertained but the pathologist is unable to provide a cause of death, the coroner may have to open a short inquest of the Rule 23 variety.

ix. However, circumstances on the ground (such as the closure of public buildings or other factors such as judiciary or staff absence or the volume of reports of death) may make it impossible to hold an inquest. Similarly, a death, whilst being from COVID-19, may be in such a category as to require more detailed explanation, such as in a prison death (where an inquest is mandatory). In this situation the coroner will have little choice but to open an investigation (but possibly to delay opening the inquest itself until a later date), assemble all relevant evidence for the file, release the body for burial or cremation and then list the inquest at a future date. This may inevitably be after the pandemic emergency has passed.

x. In all these situations coroners will only be able to work with the medical and other evidence available to them. 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. For example, it may not be feasible to order a post-mortem examination on many (or indeed most) of the deaths where COVID-19 is either suspected as the cause, or where it may simply be present, or indeed where it cannot be ruled out. It may also not be possible given the significant pressure on the system overall for post-mortem examinations to be carried out for all those non-COVID-19 deaths where they might have been, under normal conditions. Coroners remain under their usual statutory duties and must conduct proper investigations, which may (as already observed) require adjournments. However, coroners have discretion and judgments to exercise in various respects (some addressed above) and can be expected to exercise them in a pragmatic way which takes account of the effects of the pandemic.

Post-mortem examination practice in general

24. The Royal College of Pathologists has issued Guidance for care of deceased during COVID-19 pandemic with the Association for Anatomical Pathology Technology in conjunction with Public Health England.

    https://www.rcpath.org/uploads/assets/0b7d77fa-b385-4c60-b47dde930477494b/G200-TBPs-Guidance-for-care-of-deceased-during-COVID-19-pandemic.pdf

25. The College's stance on post-mortem examinations generally can be summarised as:

    "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."

26. However, the serious issues with post-mortem examinations go much wider. It may very well be the case that routine coroner post-mortem examinations may not be ordinarily available during the pandemic. This is because in a case where an autopsy is required, it may not be possible to rule out the presence of COVID-19, either as a cause of death or simply because it may be present in the body. This could apply to (for example) an unexplained adult death where a cause would be revealed by autopsy where there is no diagnosis of COVID-19 in life.

27. Coroners may be able to pursue a CT scan, but that may depend on the scientific evidence for diagnosis from imaging. However, the availability of those facilities may be affected by the pandemic and some of the issues around infection risk may still apply. In principle greater use of scanning could helpfully take pressure off pathologists and others for non COVID-19 deaths.

28. In any case, during the pandemic, pathologist, mortuary and body storage capacity will be very limited which may mean that, on the ground, it is not possible to request a post-mortem examination even if, in principle, it could be performed.

29. The availability or lack of availability of post-mortem examination facilities and pathologists will be a factor for coroners to consider in deciding whether to order an examination (or a particular type of examination) in each case. Coroners may need to consider partial or external examinations by pathologists as well as non-invasive examinations, or no examination at all. Cases of particular complexity and sensitivity may need to be prioritised.

Other death management issues including Personal Protective Equipment (PPE)

30. The issue of PPE for those attending the scene of a community death or for mortuary staff and other related issues (such as the safe transport of the deceased) is not an issue the coroner should seek to manage or direct on their own. It is likely to be the product of an agreed multi-agency response for community deaths in a local area of which the coroner should play a full part.

31. It is not the role of the Chief Coroner to provide his own Guidance on PPE but he wishes to draw the attention of coroners to the following.

32. PPE breaks down in to two areas: (a) the PPE required when in proximity to a body and (b) PPE required for a mortuary and post-mortem examination setting.

33. The Public Health England position is that Guidance issued by the NHS for treating COVID-19 patients should be applied when in proximity to or handling the body, e.g. in a community death setting. The principles of Standard Infection Control Precautions (SICPs) and Transmission-Based Precautions (TBPs) continue to apply for bodies that are suspected or confirmed to be infected with COVID-19. No additional precautions are required unless autopsy or other aerosol generating procedures are being undertaken. Management of the deceased should follow usual HSE guidance. Additional consideration should be given to how social distancing can be adhered to in the context of managing a death in the community

34. There is a small section in the IPC Guidance written for the NHS IPC which assists:

    https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872745/Infection_prevention_and_control_guidance_for_pandemic_coronavirus.pdf

    (See 6.7 Handling dead bodies)

35. Recent Guidance from the European Centre for Disease Prevention and Control confirms the position (see https://www.ecdc.europa.eu/sites/default/files/documents/COVID-19-safe-handling-of-bodies-or-persons-dying-from-COVID19.pdf)

36. Separate RCPath Guidance deals with the necessary PPE at the mortuary, including at post-mortem examinations - see paragraph 24 above. This Guidance is particularly useful because it refers to specific items of kit depending on the activity.

37. Coroners should not issue their own local Guidance to the police, ambulance service, funeral directors or any other organisation in respect of PPE or infection control for attendance at community deaths etc; a collective multi-agency response, involving the senior coroner and following national guidance will be required to ensure that a consistent process for dealing with the detailed logistics of all deaths, but particularly community deaths during the COVID-19 emergency can be achieved.

Deaths in prison or otherwise in state detention

38. Section 1 CJA 2009 requires coroners to open an inquest even in the event of a natural death in prison or otherwise in state detention.

    There is no necessary requirement to have an inquest with a jury when the death is from natural causes – see the *Tainton*[2] case

39. All coroners will make decisions carefully on the facts and merits of each case. It is obviously important that deaths in custody or otherwise in state detention are

[2] R (Tainton) v HM Senior Coroner for Preston and West Lancashire [2016] EWDC 1396 (Admin)

scrutinised carefully. There may be deaths which occur which are not by natural cause and these should be given as much attention and resource as is available by investigators in the circumstances. A post-mortem examination may still be a necessity even if the death was from natural causes, but where there are some issues with care.

40. However, as discussed above, the nature of the COVID-19 emergency may mean that a post-mortem examination is not possible.

41. The Chief Coroner considers it important that sufficiency of inquiry should be maintained as much as possible in prison deaths. Coroners rely on others to gather information and to provide evidence in a death in prison, including HMPPS, the healthcare provider within the prison, the police and the PPO. Because of factors connected with infection risk, there is likely to be pressure on the normal multi-agency process after death.

42. The Chief Coroner is pursuing these issues at a national level but it will be for each senior coroner to ensure they are in dialogue with institutions in their jurisdiction and are that LRFs are aware of the issues and are actively managing them.

HHJ MARK LUCRAFT QC

CHIEF CORONER

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