**PUBLIC LAW | ARTICLE**

*INQUESTS: THE IMPACT OF COVID-19, WORK RELATED DEATHS AND ARTICLE 2 ECHR*

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**Synopsis: Deaths from COVID-19 are likely to give rise to the requirement to hold inquests in a wide variety of cases. This will likely pose a substantial challenge to coroners in both the timing and scope of these inquests, particularly where deaths are also linked to arguable breaches of Article 2 of the ECHR and alleged failures by the state to protect from infection.**

At the end of April 2020, a month which saw the number of deaths of those with COVID-19 exceed 26,000 in the UK and growing concern that the government was failing to protect those on the frontline from infection, the Chief Coroner issued some timely guidance: *'COVID-19 Deaths and Possible Exposure in the Workplace'*.[1] The Guidance reminds coroners that, '*an inquest is not the right forum for addressing concerns about high-level government or public policy'* and the Chief Coroner opines, by analogy to flak jackets in Afghanistan, that an inquest is not 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*'.

[1] https://www.judiciary.uk/wp-content/uploads/2020/04/Chief-Coroners-Guidance-No-37-28.04.20.pdf

Nevertheless, HHJ Lucraft QC emphasises that coroners must make decisions *'on a case by case basis'* as it is *'for the individual coroner to decide on the scope of each investigation'*.

None of this is new: concerned with individual deaths, inquests are limited in their scope and coroners enjoy considerable judicial discretion in determining whether an investigation is necessary and the extent of any such investigation. But the COVID-19 epidemic reveals once again the uncertainty inherent in such discretion and challenges the coronial system's capacity to respond coherently, consistently and effectively to the crisis. This article will explore the issues that may arise in respect of COVID-19 deaths and how existing case law is likely to determine which deaths are investigated as well as the potential scope and limitations to subsequent inquests.

**COVID-19: "*Unnatural death",* investigating and opening an inquest**

The first issue in COVID-19 cases will often be whether the coroner should investigate at all. A coroner can only open an investigation into a death if he or she has "*reason to suspect that–*

a) *The deceased died a violent or unnatural death,*
b) *The cause of the death is unknown, or*
c) *The deceased died while in custody or in state detention'.*[2]

It follows that not all deaths attributable to COVID-19 will require an investigation. The Chief Coroner, in guidance issued on 26 March 2020 provides that *'COVID-19 is a naturally occurring disease and therefore is capable of being a natural cause of death*.'[3] In certain cases, the decision as to whether an investigation is necessary will be clear: there is unlikely to be any issue as to whether a deceased died in custody or in unknown

[2] Section 1 Coroners and Justice Act 2009.
[3] The Guidance, issued on 26 March 2020, is here at paragraph 19.

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circumstances. But whether a death from COVID-19 is an *"unnatural death"* may appear more uncertain.

An *"unnatural death"* is not defined in statute although it is clear it is wider than a death from unnatural causes. For instance, where neglect contributes to death, the underlying cause of which is otherwise natural, the death is unnatural death for the purposes of section 1 of the Coroners and Justice Act 2009 ['CJA 2009']. Moreover, whenever a wholly unexpected death, albeit from natural causes, results from some culpable human failure, this would also be considered unnatural.[4]

In addition to considering the medical cause of death, when COVID-19 has been identified as a factor the coroner will need to consider whether infection may be related to the person's occupation. A disease contracted by reason of work will often be an '*unnatural death',* as is reflected in the Regulations that govern when a death must be reported to a coroner and which include circumstances where *'the person's death was due to… (ix) an injury or disease attributable to any employment held during the person's lifetime'.*[5] When considering whether injuries or diseases were caused during employment, coroners should adopt a broad approach and should look at the situation in the round,[6] and it is likely the same will apply when investigating the manner in which someone may have contracted and died from COVID-19. Whether there are other possible causes of contraction, should not pre-determine the issue: a suspicion that COVID-19 was contracted during the course of employment should provide sufficient grounds for a coroner to investigate.

[4] *R (Touche) v Inner North London Coroner* [2011] QB 1206.
[5] Regulation 3(1)(a) of the Notification of Deaths Regulations 2019.
[6] *Nancollas v Insurance Officer* [1985] 1 All E.R. 833.

The threshold under s. 1 CJA 2009 for opening an investigation - *reason to suspect* - is low and does not even require a *prima facie* case.[7] Yet necessarily, more discretion is granted to the coroner when deciding whether to hold an inquest if the death is thought to be unnatural, as opposed to, for instance, where it may have occurred in custody. Not only does the terminology impart a degree of uncertainty as to its interpretation, but the questions the coroner must subsequently consider are matters of value-judgments: a culpable failure to prevent death from natural causes is an unnatural death, but a non-culpable failure is not.[8] Assessing whether there is reason to suspect a death is unnatural requires an early appreciation of the issues in the case in circumstances where there may be very limited information. The coroner's decision in this regard is likely to be final and will only be interfered with if *Wednesbury* unreasonable.[9]

The threshold of *"reason to suspect"* should be met where a person may have contracted the virus in the course of their duties as an employee. Examples could include not just frontline NHS staff, but any key worker and many more possible examples. In London alone, it has been reported that a total of 33 bus workers have died after contracting COVID-19.[10] Further, figures produced by the Office for National Statistics show a number of deaths in England and Wales across a range of professions:[11] teachers, social workers, security guards, shop assistants, delivery drivers and prison officers are just some examples of cases which may give rise to consideration of whether the contraction of the disease was attributable to the deceased's employment.

[7] *Canning v HM Coroner for the County of Northampton* [2006] EWCA Civ 1225 and *Hussein v Choung Fook Kam* [1970] AC 942.
[8] *R v Birmingham and Solihull Coroner ex p. Benton* (1997) 162 JP 807.```

**[9]** *R (Touche) v Inner North London Coroner* [2011] QB 1206.
[10] https://www.bbc.co.uk/news/uk-england-london-52752022
[11] The Office for National Statistics has published a Dataset for Coronavirus related deaths by occupation in England and Wales which is here.

Where deaths relate to occupation it is also likely that there will be a range of other investigations and enquiries at varying levels which will also need to be considered by any inquest. For example, Transport for London (TFL) has already announced that an independent review by University College London will examine coronavirus infections and deaths among London's bus workers.[12] The Health and Safety Executive (HSE) have also made clear that they will continue to investigate work related deaths where there are concerns around social distancing and COVID-19.[13]

Alternatively, if there were reason to suspect that some failure in clinical care caused or contributed to the death, this would also give reason to suspect the death was unnatural., Another substantial category of inquests is therefore likely to be those where issues arise in respect of the treatment for COVID-19 in hospital or elsewhere. In these cases, no doubt, any treating clinician or hospital, faced with allegations of failings in treatment would wish to highlight potential systemic failings outside of their control. Given the restrictions, discussed below, in addressing concerns about political decisions or public policy, this could also prove difficult in practice.

**COVID-19 deaths and Article 2 ECHR**

Article 2 of the European Convention on Human Rights ('ECHR') provides that *'everyone's right to life shall be protected by law'*. The guarantee has two aspects: substantive and procedural protections. The substantive duty obliges the UK government to have in place systems or regulations to safeguard against certain risks ('the systemic duty') and to protect certain individuals from a real and immediate risk to life ('the operational duty'). To establish a breach, it is not necessary to prove that but for the

[12] https://www.bbc.co.uk/news/uk-england-london-52752022
[13] https://www.hse.gov.uk/news/hse-regulatory-activity-during-coronavirus.htm

state's failings, the victim would not have died. Instead the test is whether a victim lost a substantial chance of survival.[14]

When an arguable breach of the state's substantive duty occurs, Article 2 requires an *effective* investigation into the breach. If the investigation takes the form of an inquest, the process will need to explore the circumstances in which the deceased met their death in order to discharge the procedural duty.[15] The threshold for engaging the procedural duty is low: *'arguable'* means anything more than *'fanciful'*. [16]

The state cannot, save in times of war, derogate its duties under Article 2.[17] Inevitably during the COVID-19 crisis there will be cases where the state has arguably failed in either its systemic or operational duty and this has deprived the deceased of a substantial chance of survival of COVID-19. The death of a member of frontline NHS staff or another state employee dealing with the crisis, such as members of the emergency services personnel or the military, may trigger Article 2 where there is an arguable basis to suggest they have been inadequately protected from infection from the disease by the state.

Patients are also protected by a systemic duty on the state to put in place an effective regulatory framework requiring healthcare providers to adopt appropriate measures for the protection of lives.[18] Thus, where failures to protect patients from infection result from failings in the healthcare system, rather than those of individual clinicians, there will be an arguable Article 2 breach.

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[14] *Van Colle v Chief Constable of Hertfordshire* [2009] 1 AC 225 paragraph 138 and *Savage v South Essex Partnership NHS Foundation Trust* [2010] HRLR 24 paragraph 82.
[15] *R (Middleton) v HM Coroner for the Western District of Somerset* [2004] UKHL 10. The extent to which an Article 2 inquest imposes a different investigative duty to a statutory or *Jamieson* inquest is arguable. Practically, an Article 2 inquest will ensure that legal aid is available.
[16] *R (AP) v HM Coroner for Worcestershire* [2011] EWHC 1453 (Admin) at paragraph 60.
[17] Article 15 ECHR.
[18] *Lopes de Sousa Fernandes v Portugal* (56080/13) confirmed in *R (Parkinson) v HM's Senior Coroner for Kent* [2018] EWHC 1501 (Admin).

The scrutiny is greater when the deceased was detained by the state at the time of death, such as those in custody, immigration detention or certain psychiatric units. The EHCR has consistently emphasised the state's direct responsibility under Article 2 for the welfare of those deprived of their liberty where death occurs through a naturally occurring health problem.[19] Where there are reports of prisoners without COVID-19 symptoms having to share cells with those displaying them,[20] it is not hard to foresee arguable breaches of the Article 2 operational duty if deaths occur in these circumstances.

**COVID-19: Article 2 and limitations of scope where matters of policy**

PPE shortages, allegations that the PPE available is not fit for purpose and reports that NHS England downgraded guidance in respect of the PPE required to treat those infected with COVID-19 are likely to be reoccurring themes in cases where the deceased's family seeks to argue the UK breached its Article 2 duties.[21] Whether any such breaches are justiciable in an inquest, or other forum, could prove one of the most contentious and important of issues.

Questions purely of politics or policy will remain beyond the scope of Article 2. Where the line lies is hard to define, although Lord Bingham's observation in *A v Secretary of State for the Home Department* [2005] 2 AC 68 at paragraph 29, is perhaps the most conceptually useful: '*the more purely political (in a broad or narrow sense) the question is, the more appropriate it would be for political resolution'*. At the other end of the spectrum, where the death is caused by an individual's failings, and questions of systems

[19] *Slimani v. France* 57671/00 at paragraph 27 and *Kats and Others v. Ukraine* 29971/04 at paragraph 104.
[20] https://www.theguardian.com/society/2020/apr/07/coronavirus-thrive-british-jails-prisoners-face-death-sentence
[21] https://www.theguardian.com/society/2020/mar/16/not-fit-for-purpose-uk-medics-condemn-covid-19-protection

failure or operational duty do not arise, the state's duty will not be breached. In the healthcare context, save in certain exceptional cases, the positive duty will not be breached by an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient.[22]

Issues that fall within what has been termed the '*middle ground',* between individual human error and those related to political or policy decisions, may be investigated by an inquest. Lord Hope in *Smith v Ministry of Defence* [2014] AC 52 at paragraph 7, identified these limitations as book-ends on Article 2's scope:

*'It will be easy to find that allegations are beyond the reach of article 2 if the decisions that were or ought to have been taken about training, procurement or the conduct of operations were at a high level of command and closely linked to the exercise of political judgment and issues of policy. So too if they relate to things done or not done when those who might be thought to be responsible for avoiding the risk of death or injury to others were actively engaged in direct contact with the enemy. But finding whether there is room for claims to be brought in the middle ground, so that the wide margin of appreciation which must be given to the authorities or to those actively engaged in armed conflict is fully recognised without depriving the article of content, is much more difficult.'*

The Court of Appeal, in *Long v Secretary of State for Defence* [2015] EWCA Civ 770, considered the boundaries of Lord Hope's *middle ground.* The deceased had died whilst serving in the Royal Military Police during Operation Telic in Iraq. At the time of death, the deceased's patrol was not equipped with an iridium satellite phone, despite a

[22] *Powell v. the United Kingdom* (2000) 20 EHRR CD 362; *Fernandes v Portugal* (Application no. 56080/13), 19 December 2017. Even as regards the exceptional cases *"... the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities, and must not merely comprise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly"* (*Fernandes* at [195]).

Communications Order issued by the Battle Group Commander that patrols be equipped with the same. There was no dispute that if the deceased's patrol had been in possession of such a satellite phone, his life may have been saved. The Court considered whether the failure to provide the satellite phone was a systemic issue, or was an allegation of *'individual human error'* or a *'combination of events over which the state has no control and for which it cannot be held responsible'.*[23] Lord Justice Lewison held that the Royal Military Police's *'failure to comply with the Communications Order was a failure of system or control'* such that Article 2 was arguably breached. This was because the practice was *'not occasional or sporadic'* but normal. The justiciable issue was therefore *'a system failure by the military authorities to permit soldiers routinely to disregard the order'*.[24]

*Long* offers some assistance in determining where matters of provision of PPE may engage Article 2. A failure to deliver necessary PPE which has been paid for may fall within a systemic failure, as opposed to a political decision. This could therefore apply to allegations that the state has obtained PPE for NHS staff but has failed to adequately ensure its distribution or that it is fit for purpose.[25] Such issues may also be classed as systemic where failures arise from ineffective guidance and control of a state operation or function at a level beyond individual human error. A potential example of this would be failings in government guidance in respect of COVID-19 where this is inconsistent with WHO guidelines.[26]

**COVID-19 deaths, Article 2 and Public Inquiries**

[23] *Long v Secretary of State for Defence* [2015] EWCA Civ 770 at paragraph 15.

[24] *Long v Secretary of State for Defence* [2015] EWCA Civ 770 at paragraph 28.

[25]For instance: https://www.theguardian.com/world/2020/may/07/government-confirms-400000-turkish-gowns-are-useless-for-nhs

[26] In submissions to the Joint Committee of Human Rights, Dr Lewis of Doughty Street Chambers and Dr Kirby argue that, *"When lives are at stake, the UK is likely to be in breach of its international human rights obligations if its guidance is inconsistent with WHO guidance such that it undermines the aim of preventing and controlling infection"*. See the submissions here.

An inquest is not the only, and may not be the best method for the state to meet the procedural duty under Article 2. Inquests are used to dealing with individual deaths and, whilst a coroner may consider numerous deaths following a major disaster or terrorist incident, it is far from the norm. The coronial system is not designed or equipped to deal with these types of cases on a national scale. Whilst the state's Article 2 procedural duty requires an appropriate investigation, it does not mandate the form which this should take.

This is recognised in the Chief Coroner's April 2020 guidance:

*'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.'*

A coroner may request a public inquiry into a death where they consider it the more appropriate forum to discharge the state's Article 2 procedural duties, given the scope and the type of evidence an inquiry can hear.[27] Where there is a public inquiry which is likely to adequately investigate a death, upon request from the Lord Chancellor, a coroner must suspend an investigation unless there appears to be an exceptional reason for not doing so.[28] Necessarily, in order for the flexibility to be effective, any plans to hold a public inquiry into deaths relating to COVID-19 must be published sooner rather than later and the scope of such an inquiry will need to be clearly identified if individual coroners are to

[27] As in *R (Litvinenko) v Secretary of State for the Home Department* [2014] EWHC 194 (Admin).
[28] S. 11 and Schedule 1 Coroners and Justice Act 2009.

make informed decisions as to the timing and scope of inquests involving Article 2 and COVID-19 deaths.

**Conclusion**

The Chief Coroner's encouragement that investigations into work related COVID-19 deaths proceed in a prompt and timely way, whilst entirely appropriate, may prove somewhat difficult in practice.

There will inevitably be large numbers of instances of deaths from COVID-19 where there is reason to suspect the virus has been contracted in the course of the deceased's work, where there are arguable Article 2 breaches, or both. Where Article 2 has arguably been breached, the need to keep the scope to the notoriously difficult to define *'middle ground',* somewhere between politics and low-level individual failings, will make it essential that coroners liaise at an early stage with other local or national investigations into these deaths. They will also need to be kept fully informed of any moves towards a public inquiry and its scope.

Deciding the point at which an inquest into a COVID-19 death ought to take place and the scope of that inquest will likely require some form of initial investigation by a coroner followed by early Pre-Inquest Review Hearings (PIRH) in order for Interested Persons to effectively participate in proceedings.

As Lord Hope noted, when determining whether Article 2 is engaged, *'no hard and fast rules can be laid down. It will require the exercise of judgment. This can only be done in the light of the facts of each case'.*[29] The challenge for the coronial system in the wake of the current crisis will be ensuring the system is not overwhelmed, whilst protecting the

[29] *Smith v Ministry of Defence* [2014] AC 52 at paragraph 76.

right to a full and fearless investigation into the means by which the deceased met their death.

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*This briefing note was produced by Thomas Coke-Smyth and Ruth Broadbent, counsel at QEB Hollis Whiteman Chambers. This note should not be taken as constituting formal legal advice. To obtain expert legal advice on any particular situation arising from the issues discussed in this note, please contact our clerking team at barristers@qebhw.co.uk. For more information on the expertise of our specialist barristers in criminal and regulatory law please see our website at https://www.qebholliswhiteman.co.uk/.*

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