Coronavirus, Coroners & the Crown Office: does Scotland lead the way in investigating COVID-19 deaths?

written by Meelis Magland | 22 May 2020

***"Doctor, cast the water of my land, find her disease, and purge it to a sound and pristine health…"* Macbeth, Act V, Scene III**

Introduction

The difference between the Scottish and English approaches to managing coronavirus appears to be growing. Guidance from the Chief Coroner for England and Wales, HHJ Mark Lucraft QC, indicates that unless there are other factors, deaths caused by or suspected as being caused coronavirus don't need to be reported to coroners; and deaths from coronavirus contracted in the workplace "*may*" be reported to the Coroner, but not necessarily resulting in an investigation.

By stark contrast, Scotland's Lord Advocate, Sir James Wolffe QC, has announced that all confirmed or presumed COVID-19 deaths of residents in care homes or people who may have contracted the virus in the course of their work will be investigated by the Crown Office. The reasons for this difference of approach appear to lie in the different statutory remit of each office (Scotland doesn't have inquests or coroners). However, the outcome might strike many as resulting in an arbitrary postcode lottery.

The English position

Under the laws of England and Wales, a coroner must, as soon as practicable, investigate a death if the coroner has reason to suspect that the death was violent or unnatural, the cause of death is unknown, or the death occurred in custody or in state detention (s.1(2) Coroners and Justice Act 2009). Where the death has been after a period of illness, and the cause of death is known (and is neither violent, unnatural or in custody) the coroner is not required to hold an investigation. Rather, the doctor who attended the deceased during their last illness has a legal responsibility to complete a medical certificate of cause of death (MCCD) which enables the deceased's family to register the death, without any involvement of a coroner.

The advent of Coronavirus to the shores of England and Wales has added a new dimension to inquests. Hospitals have had to adapt services to deal with huge numbers of patients suffering with COVID-19; clinicians are hugely stretched; and people may be dying of COVID-19 in the community without the presence of Coronavirus being microbiologically established.

In late March 2020, the Chief Coroner of England and Wales released Guidance No. 34 in relation to COVID-19. This stated that "*COVID-19 is a naturally occurring disease and therefore is capable of being a natural cause of death*" [para 19]. It adds that "*every death from COVID-19 which does not in law require referral to the coroner should be dealt with via the MCCD process*" rather than being reported to the coroner, or investigated through an inquest [para 20].

The guidance provides some clarity about the MCCD process, recognising that, in community deaths (such as in care homes), "*[b]ecause 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" [para 21]. The Coronavirus Act 2020 has introduced amendments to the MCCD process, allowing a doctor who was not the attending doctor to sign the MCCD within 28 days after death – minimising the need for an inquest in such cases (changes discussed further in our earlier blog here).

However, where an MCCD cannot be provided, an investigation "*may be necessary*" [Guidance No. 34, para 23 (vi)] (although an inquest is by no means mandatory given the discontinuance provisions within s.4 CJA), and where post-mortems are not yet available, coroners are invited to consider proceeding to inquest and reaching a conclusion based on all other available evidence; or open and list the inquest for a future date, "*inevitably after the pandemic emergency has passed*" [Guidance No. 34, para 23 (ix)].

As a consequence of the changes introduced by the Coronavirus Act and the Chief Coroner's guidance, many deaths in the community, and in particular in care homes in England and Wales, will not be subject to a coronial investigation.

The need for a coronial investigation into a work place-based coronavirus death are also considered by the Chief Coroner in his Guidance No. 37 which considers COVID-19 deaths and possible exposure in the work place in more detail (also discussed in our earlier blog here). Guidance No. 37 stresses that "*[t]he vast majority of deaths from COVID-19 are due to the natural progression of a naturally occurring disease and so will not be referred to the coroner*" [para 4]. It reminds readers that whilst a coronavirus death in the workplace is notifiable to Public Health England, that does not render it notifiable to the coroner [para 5].

A coronavirus death "*may be reported to the coroner, such as where the virus may have been contracted in the workplace setting*" [para 7], but again, such a report is not mandatory. Even if reported, it will be for the coroner to determine whether their duty under section 1(2) Coroners and Justice Act 2009 is engaged: "*[i]f the medical cause of death is COVID-19 and there is no reason to suspect that any culpable human failure contributed to the particular death, there will usually be no requirement for an investigation to be opened*" [para 9]. The consequence of this is that many deaths of frontline NHS staff, public transport employees, care home workers, emergency services personnel etc. will not be subject to a coronial investigation. Any investigation into these deaths and deaths in care homes will have to occur in a different forum.

The Scottish position

In trying to determine what different forum that might be, we can look towards the approach in Scotland for guidance. Scotland does not have a system of coroners or inquests. Rather, where a death is deemed to be accidental, unexpected, unexplained, sudden, suspicious, or gives rise to '*public anxiety*', it is independently investigated by the local Crown Agent (known as a Procurator Fiscal). Such investigations are the constitutional responsibility of the Lord Advocate.

Where an inquest in England and Wales seeks to identify the specific issue of "*how the deceased came by their death*", an investigation by a Procurator Fiscal is broader. It is to "*investigate any death which requires further explanation*" – in that respect Procurator Fiscals have a broader statutory remit than coroners in England and Wales.

The Lord Advocate of Scotland has announced that, on the basis that these categories of death give rise to public anxiety in Scotland, the following deaths must now be reported to the Procurator Fiscal:

1. All Covid-19 or presumed Covid-19 deaths where the deceased might have contracted the virus in the course of their employment or occupation; and
2. All Covid-19 or presumed Covid-19 deaths where the deceased was resident in a care home when the virus was contracted.

As noted by the Lord Advocate, this is to "*ensure that all deaths within the two categories that I have described will be registered within the Crown system of death investigation, and that each of those deaths can be investigated*." The investigations will be carried out by a dedicated team under the Lord Advocate's remit.

The first category of deaths is incredibly broad. It captures all those who "*might*" have contracted coronavirus during the course of their employment and does not require there to be any suggestion that the deceased contracted Coronavirus because of any shortcomings in protection available at work. As well as capturing care workers and health staff, this category could feasibly include taxi drivers, delivery drivers, postal workers, supermarket staff and all others who have continued to work during the course of lockdown and may have come into contact with the virus through that work.

The second category will include persons who die in the community in the care homes, and also residents who were transferred from the care home to hospital. Care home deaths have been a significant concern in Scotland: at time of writing, 46% of COVID-19 deaths registered in Scotland to date relate to deaths in care homes.[1]

The consequence of the Lord Advocate's direction is that where a Scottish NHS worker dies as a result of confirmed or suspected COVID-19 which they may have picked up at work, that death will be investigated by the Procurator Fiscal regardless of the background circumstances. By comparison, where a NHS worker based in England or Wales dies as a result of confirmed or suspected COVID-19 which they may have picked up at work, that death is *unlikely* to be investigated by a coroner, unless there is some reason to suspect that a culpable human failure contributed to the particular death.

Every death deserves acknowledgment and recognition, and the tragedies unrolling across care homes and on the health care front line require the greatest acknowledgment and understanding. The bereaved of Scotland will, it seems, at least have the satisfaction of knowing that the state considers every case of fatal COVID-19 contracted at work or in a care home to be worthy of review. Meanwhile, in England and Wales, it will be a long time before any inquiry into the mounting death toll of this pandemic is held, if at all.

The process of reviewing and understanding each death in Scotland will have an important early role in learning and healing from these tragedies. As said by the Scottish Lord in the Bard's Play:

> *"…[b]ut here, upon this bank and shoal of time, we'd jump the life to come. But in these cases we still have judgment here; that we but teach bloody instructions, which, being taught, return to plague the inventor…"*

Footnotes

[1] National Records of Scotland, Deaths involving coronavirus (COVID-19) in Scotland, 20 May 2020