INQUESTS AND INQUIRIES IN THE COVID-19 ERA

Covid-19 and the right to life

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Article 2 ECHR – basic principles

- Article 2(1) ECHR: "*Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law*."
- This 'positive' duty is formed of two substantive duties, the general duty and the operational duty.
- The classic formulation of the **general duty** is in *Savage v South Essex NHS Trust* [2009] 1 AC 681 at §69:

  > "*In the first place, the duty to protect the lives of patients requires health authorities to ensure that the hospitals for which they are responsible* ***employ competent staff and that they are trained to a high professional standard. In addition, the authorities must ensure that the hospitals adopt systems of work which will protect the lives of patients****. Failure to perform these general obligations may result in a violation of article 2. If, for example, a health authority fails to ensure that a hospital puts in place a proper system for supervising mentally ill patients and, as a result, a patient is able to commit suicide, the health authority will have violated the patient's right to life under article 2."*
- There has to be a sufficient relationship of proximity between the state and the deceased so as to engage the general duty, based upon the vulnerability of the deceased and an assumption of responsibility by the state. Prisoners and mental health patients are classic examples. It also extends to soldiers and looked after children.
- The duty is to put reasonable and proportionate systems in place to reduce the risk of loss of life. It is not an impossible or disproportionate burden; *R (Long) v Secretary of State for Defence* [2015] EWCA Civ 770; [2015] 1 WLR 5006.

- Individual errors must not be equated with a failure of the system – it is the latter that is required to establish a breach of the duty.
- Although the nature of the relationship between an individual and state would not otherwise give rise to the existence of the general duty, it can be engaged by the provision of healthcare where there has been a failure to provide emergency life-saving treatment in breach of professional obligations resulting from dysfunction in the hospital's services relating to structural deficiencies in the regulatory framework; *R (Parkinson) v Kent Senior Coroner* [2018] EWHC 1501 (Admin), [2018] 4 WLR 106.
- The free-standing **operational duty** is a duty to take all reasonable steps to protect life where it is known or ought to be known that there is a real and immediate risk to life; *Rabone v Pennine Care NHS Trust* [2012] 2 AC 72.
- The Coroner will be under a duty to discharge the investigative duty under article 2 ECHR and s5(2) of the 2009 Act where it is established on the evidence that there is a **possible** breach by the State of the general duty to put effective systems in place to protect life and/or the operational duty; *R (Middleton) v West Somerset Coroner and another* [2004] UKHL 10; [2004] 2 AC 182.
- The practical significance of such an investigation is that the verdict can make judgmental findings relating to the circumstances in which the deceased died and will not be limited to the direct chain of causation.

Care Homes

Coroner's duty to investigate

- A preliminary issue is when the Coroner's duty under s1 of the Coroner's and Justice Act 2009 is engaged. The Coroner has to have reason to suspect an unnatural death – that includes a person who dies of a natural disease but where some culpable human failure has contributed to death.
- The Shipman safeguards of two signatures on a Medical Certificate of Cause of Death have been suspended by the Coronavirus Act 2020. Temporarily, any doctor can sign the certificate provided that the deceased was seen by a doctor within 28 days before death or after death;

- This modified procedure creates a risk that unnatural deaths will not be reported by medical practitioners to the Senior Coroner. A doctor may have attended up to 28 days before death, may not have seen any symptoms of Covid-19 at the time of visit, and certified Covid-19 as the cause of death based on enquiries with care home staff. Any culpable human failures that may have occurred may be overlooked. If that happens in respect of a care home death, someone else will need to bring it to the attention of the Senior Coroner.
- In relation to any death in a care home, in my view there will be reason to suspect that it was unnatural and an investigation should begin.
- In certain circumstances, the lockdown may constitute a compulsory detention that will trigger the duty to investigate (it is not engaged where there is a lawful authorisation under ss 4A or 4B of the Mental Capacity Act 2005 – see s48 of the Coroners and Justice Act 2009). A person in a care home may not be the subject of an authorisation but may lack capacity to make the complex decision of whether to consent to lockdown in a care home which requires knowledge of the risks and the ability to balance considerations.
- Likewise, children in care homes etc will be compulsorily detained during lockdown.
- Further, young adults with learning difficulties at residential colleges may well lack capacity to consent to being locked down at college.
- Where there is an arguable breach of article 2 ECHR, there will also be reason so suspect a death is unnatural so that the Coroner must investigate.

<u>Arguable breaches of article 2 ECHR</u>

- Local authorities are under a duty to meet the needs of adults if there is a risk of neglect; s35 of the Social Services and Well-being (Wales) Act 2014 ('the 2014 Act'). They are also under a duty to make enquiries where there is reasonable cause to suspect that a person is at risk of neglect; s126. Neglect is defined is s197 as a failure to meet basic needs which is likely to result in an impairment of well-being. Part 1 of the statutory code of practise makes it plain that a

failure to obtain healthcare can amount to neglect. There are similar duties in respect of children; ss 37 and 130.

- When a person dies in a care home, it may be arguable that a local authority had reason to suspect that they faced an increased risk of contracting Covid-19 by virtue of their accommodation / placement in a care home. It may also be arguable that a local authority had reason to suspect that care home residents were not receiving an equivalence of healthcare as those treated in hospital. It may be arguable that local authorities knew or ought to have known that there was a real and immediate risk to life but failed to take all reasonable steps to mitigate that risk. In other words, it may be arguable that a local authority has breached the operational duty under article 2 ECHR.
- The Care Inspectorate Wales has powers and duties of inspection of social care provision on behalf of the Welsh Ministers by virtue of the Regulation and Inspection of Social Care (Wales) Act 2016 ('the 2016 Act') and the 2014 Act. The statutory code of practise under the 2016 Act at §§ 5.5 and 6.7 guides CIW into 'focussed inspections' at any time in response to a specific concern. It may be arguable that; (i) there was a systemic failure of inspection of care homes in response to concerns about Covid-19 in care homes; and (ii) that CIW did not take all reasonable steps in circumstances where it knew or ought to have known that there was a real and immediate risk to life in any given care home.
- It may be arguable that the failure to ensure that agency workers did not work in more than one care home was a systemic failure by the state, who had powers and duties to ensure that safe systems of work were implemented in care homes. What constitutes a reasonable and proportionate system may vary between care homes.
- As Local Health Boards provide nursing care in care homes it may be arguable that they failed to take all reasonable steps to ensure that care home residents who required intensive treatment received it. An explanation may be required for the number of Covid-19 related deaths in care homes where there was no hospitalisation.
- It may be arguable that the discharge of patients from hospital to care homes without testing for Covid-19 was a failure to take all reasonable steps. The fact

that such testing was not standard practice for a period may indicate systemic failure. It may be arguable that the failure to routinely ensure that such patients were isolated upon their discharge into care homes was a failure to take all reasonable steps.

- The Welsh Government has stated that there were adequate stocks of PPE for distribution to front line nurses and carers in Wales. If that is correct, there may be arguable systemic failure to ensure PPE was distributed to all care homes that needed it.

Prisons

- Deaths in custody will have to be investigated.
- Coroners will want to receive evidence from the prison in their jurisdiction as to the systems adopted to reduce the spread of Covid-19 in the prison estate and to ensure adequate provision of PPE to prison and healthcare staff.
- Although not necessarily relevant to an inquest, an inquiry may want to look at the conditions in which prisoners were detained and the use that was made of the early release scheme.

Schools

- Schools play an important role in safeguarding;
    - Sections 25 and 28 of the Children Act 2004 requires local authorities to promote the well-being of children;
    - The Education Act 2002 creates duties to safeguard and promote the welfare of children in maintained schools;
    - This overlaps with duties under the 2014 Act;
    - The best interests of children have to be treated as a primary consideration;
    - Child protection issues arise under the Children Act 1989 where there is reasonable cause to suspect that a child or young person is suffering, or is likely to suffer, significant harm;

- Under the Education and Inspections Act 2006 headteachers have a duty to adopt measures to prevent bullying including cyber-bullying when children are at home. Anti-bullying statutory guidance has been issued by the Welsh Ministers under section 175 of the Education Act 2002 and local authorities must have regard to it.

- In the case of a child who has taken their own life during lockdown an inquest may well need to investigate what systems were put in place by schools during lockdown to discharge their statutory duties in relation to the welfare of children.
- A recent Guardian article indicated that referrals into CAMHS have decreased by 40% during lockdown and a large proportion of this is attributed to the closure of schools.

Welsh Statutory Inquiry

- The Welsh Government supports the principle of a public inquiry. Whether that means a Welsh statutory inquiry as opposed to either a non-statutory or UK wide inquiry, remains to be decided.
- It is my view that a public inquiry would have to be held under the Inquiries Act 2005 by the Welsh Ministers.
- The Inquiries Act 2005 s1 provides that "*A Minister **may** cause an inquiry to be held under this Act in relation to a case where it appears to him that– (a) particular events have caused, or are capable of causing, public concern, or (b) there is public concern that particular events may have occurred.*" Minister includes a Welsh Minister
- Section 27 provides (insofar as is relevant):

  "*(1) This section applies to an inquiry for which a United Kingdom Minister is responsible.*

  (2) The Minister may not, without first consulting the relevant administration, include in the terms of reference anything that would require the inquiry–

(a) to determine any fact that is wholly or primarily concerned with a Scottish matter or a Welsh matter"

- Section 29 provides (insofar as is relevant):

"*(1) This section applies to an inquiry for which the Welsh Ministers are responsible.*

(2) The terms of reference of the inquiry must not require it to determine any fact or to make any recommendation that is not wholly or primarily concerned with a Welsh matter.

…

(5) In this section "Welsh matter" means a matter in relation to which the Welsh Ministers have functions."

- Section 32 permits a joint inquiry.
- As most of the matters covered above (which include health, social care and education) are devolved matters and because the approach of the Welsh Government has differed from that of the UK Government, the only practical option is to have a separate inquiry into Welsh matters. There are few, if any, obvious benefits to those matters being investigated discretely as part of a UK inquiry and less focus may be given to Welsh matters in a larger inquiry. Conversely, an independent Welsh inquiry would finish sooner than a UK inquiry and lessons could be learned sooner.
- The 2005 Act gives the Welsh Ministers a discretion to hold an inquiry even when the criteria are met, although such criteria are statutory considerations and will carry more weight in the decision making process than non-statutory considerations.
- The discretion is converted into a duty if it is the only effective means by which the procedural duty under article 2 ECHR can be met. The focus of that consideration depends on what can be achieved by inquests. The Chief Coroner's Guidance 37 indicates that it is his view that issues of national policy, as opposed to local policy, are not suitable for determination at an inquest, although it is not suggested that issues of financial resources and policy do not fall within the article 2 ECHR investigative duty.

- When deciding upon the scope of their investigations, Coroners will have regard to the Chief Coroner's guidance. Coroners will have to draw the line between investigating the boundaries of reasonable systems and matters of national policy.
- If Coroners rule important matters out of the scope their investigations, such as policy on testing, then the article 2 ECHR investigative duty will fall upon the Welsh Ministers and that is likely to require an inquiry. When the time comes for a Coroner to address these considerations, representatives may wish to invite the Coroner to write to the Welsh Ministers requesting a public inquiry, as happened in the case of the Manchester bombing.
- Any negative decision by the Welsh Ministers in response may be susceptible to a judicial review. In any challenge, the claimant will be able to rely upon the Chief Coroner's guidance and the written reasons of the Coroner in the letter of request.
- The Welsh Ministers must exercise their discretion under the 2005 Act either way. As the Supreme Court held in *R (Keyu) v Secretary of State for Foreign and Commonwealth Affairs* [2015] UKSC 69; [2016] AC 1355 per Lord Neuberger PSC at §§ 117-121, the duties to hold investigations into deaths, as required by article 2 ECHR, are now legislated for and there is no free-standing duty under the common law.