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An Insight into Justice System during Covid Quests

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Introduction

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 [1]. 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.

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 corona virus times, might hamper the investigation progress even more [2].

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 [3].

Discussion

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. 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 [4]. 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. The difficulty coroners 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 [5].

Conclusion

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.

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