MRSA Action UK response to the Ministry of Justice draft charter for bereaved people who come into contact with a reformed coroner system

Introduction

MRSA Action UK is a registered charity that supports people who have been affected by healthcare infections. We provide advice and information to people who enquire on the best way to prepare and reduce the risks of contracting an infection.

We provide a patient voice to those who influence and regulate the delivery of high quality, safe patient care.

We work in partnership with healthcare providers, both in the public and private sector in the United Kingdom. We are an independent organisation and advise and work with government, the public, patients and other professions to promote awareness of healthcare infections and how to prevent them.

Response

MRSA Action UK welcomes the commitment to a strengthened obligation on organisations to respond to coroners' recommendations to prevent future deaths. We believe that the accurate recording of the cause of death and contributory factors on death certificates is crucial in assisting the coroner make those recommendations.

We welcome the revised provisions summarised in the draft Charter, and the proposed enabling legislation in the Coroners and Death Certification Bill.

We particularly welcome the provision afforded to bereaved relatives to bring a report to the attention of the coroner's office personally, where they believe that a professional agency should have made a report and has failed to do so.

We would like this opportunity to be extended to other professionals caring for people in establishments or in the community, for example in a hospital setting where death from an infectious pathogen may present risks to colleagues or relatives, failure to disclose or to record such pathogens should be avoided. Appropriate measures to contain infectious pathogens should be taken within the healthcare setting, be that in a primary care or acute setting, if patients or staff are exposed unnecessarily a significant risk to public health may be presented. Coroners' recommendations to prevent deaths coupled with a strengthened obligation for organisations to act on them would have a significant impact in such instances.

The *National Confidential Study of Deaths Following Meticillin-Resistant (MRSA) Infection* identified significant anomalies with non-recording of MRSA or septicaemia.[1] Together with our own experience from the public contacting us, we believe published figures are greatly underestimated and may be at least double the numbers reported by the ONS, an accurate picture is needed so that actions can be taken to avoid preventable deaths in the future.

---

[1] National Confidential Study of Deaths Following Meticillin-Resistant (MRSA) Infection, Page 7, Health Protection Agency - November 2007

Furthermore the study identified that of the clinicians interviewed none were aware of whether their Trust had a policy or procedure regarding death certification. The majority stated that death certificates were usually completed by the most junior members of the team. Training for doctors completing death certificates varied and mainly consisted of a short training session during induction, with a few others stating that training was also provided during the final year of pre-registration training.[2]

The ONS recognise that death certification practices differ between doctors and establishments. This means that some establishments may be more likely to record MRSA and *Clostridium difficile* than others. Some establishments may undertake more comprehensive screening or testing for MRSA and *Clostridium difficile*, and may do this more often than others. The ONS in its publishing of causes of death in establishments also recognises a number of factors influencing recording of healthcare associated infections including as a result of varying standards of care.[3]

It is the public interest on the grounds of safety for deaths attributable to outbreaks of healthcare infections to be recorded so that recommendations made by Coroners and relevant agencies are acted upon. We believe that bereaved relatives will come forward where they have evidence to suggest that healthcare infections were a contributory factor or cause of death, and as such guidance and standards should be set out on how to deal with this matter sensitively and in a manner that is in the best interest of everyone involved.

MRSA Action UK ask that any relatives who believe their loved one either died from MRSA or another healthcare infection, or that it was a contributory factor in their death have the right for the death certificate to be amended. If bereaved people come forward the case notes should be reviewed, this will allow a true picture to be given and then there will be transparency for the public, and an assurance that everything is being done to reduce avoidable deaths from healthcare infections – without a baseline figure how will we know what improvement and saving lives looks like. It is also the final posthumous thing that the bereaved can do for their loved ones.

The draft Charter has been amended stating “The Chief Coroner will be responsible for setting national minimum standards across a range of coroner functions. In terms of the services to bereaved families, this could include standards in relation to particular types of deaths or suspected deaths (for example – deaths on active military service, deaths from particular illnesses such as mesothelioma, epilepsy or sudden adult death syndrome). These are matters for the Chief Coroner to determine when he or she is appointed.”

As an organisation supporting sufferers of healthcare infections and their carers and dependants, we would like healthcare infections included in the script of the Charter as an example. We believe there is significant scope to improve the recording of healthcare infections on death certificates, and any encouragement to do so is welcomed.

---

[2] National Confidential Study of Deaths Following Meticillin-Resistant (MRSA) Infection, Page 13, Health Protection Agency - November 2007

[3] Deaths involving *Clostridium difficile* by communal establishment, England and Wales, 2001-07 - Office for National Statistics - 28 August 2008;
Deaths involving *MRSA* by communal establishment, England and Wales, 2001-07 - Office for National Statistics - 28 August 2008

Considerable distress has been caused to bereaved relatives where the review of case notes has shown that patients have died as a result of a healthcare infection, or where infection has been a contributory factor and this has not been included in the certification, or disclosed to relatives caring for patients who have died.

The draft charter states “When coroners request additional scientific examinations on specific organs or tissues to assist with establishing the cause of death or the identity of the person who has died, the appropriate next of kin will be informed. Again, if they have queries or concerns, they should be directed to the coroner or the coroner’s officer at the earliest opportunity, although the coroner’s decision as to whether the examination should take place will be final.”

In these instances bereaved relatives may find the support of an independent medical referee helpful to explain the processes and help relatives if they need help in understanding what is involved. We have in the past had experience of this in respect of organ retention, and found this helpful when relatives have had to come to terms with this situation. This support would underpin the work of the retained organs commission and the development of the new legislation in the Human Tissue Act 2004. This is particularly pertinent to where the draft charter states “If organs or tissue are retained, the coroner should reach advance agreement with the appropriate next of kin as to what should happen when it is no longer required for coroners’ purposes. The coroner should convey the wishes of the next of kin to the relevant pathologist.”

We welcome the recognition that family members will have a right, on request, to see reports of any post-mortems carried out. Support may be needed in understanding the reports and the opportunity for this to be discussed with the assistance from relevant support organisations should be readily available. Many charitable and voluntary organisations would be in a position to offer help in this area, MRSA Action UK are available to help anyone with queries on healthcare infections, where a contributory factor or a cause of death.

Chair
Derek Butler
MRSA Action UK
Registered Charity 1115672
8 September 2008

Contact: derek.butler@mrsaactionuk.net
Telephone: 07762 741114
Website: http://mrsaactionuk.net