Results 2021/22 ME vs. QAP cohort:

<table>
<thead>
<tr>
<th>MEs</th>
<th>QAPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 males, 2 females</td>
<td>1 males, 4 females</td>
</tr>
<tr>
<td>3 General Practitioners</td>
<td>1 Trust Palliative Medicine consultant</td>
</tr>
<tr>
<td>1 Gastroenterology consultant</td>
<td>1 Clinical Fellow</td>
</tr>
<tr>
<td>1 Emergency Department consultant</td>
<td>1 Senior House Officer</td>
</tr>
<tr>
<td>1 retired Practitioner</td>
<td>1 GP trainee</td>
</tr>
<tr>
<td>1 Full-time ME Officer</td>
<td>1 Foundation doctors</td>
</tr>
<tr>
<td>Week-day, 1 PA</td>
<td>Week-day, 9am -5pm</td>
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</tbody>
</table>

Total expected deaths = 54; scrutinised by MEs (85%).
All deaths on MC:

Age 43–100y
Males 22 (41%)
Length of stay on MEs: 0–22days

Reason for admission End-of-life Care 43
Symptom control 10
Outlier 1

Scrubinised in retrospect and real-time (46)
Monday – 22%; Tuesday – 46%; Wednesday – 9%; Thursday – 17%; Friday – 6%

Not-scrubnised (8) Weekend (62%)
[Other reasons: Outlier (25%); Family pressures (25%);
Direct coronial referral (12%)]

Coronial decisions (6)
Port-mortem (50%), Advice (33%), Inquest (17%)
MC QAP response to scrutiny of ‘expected deaths’
‘Is it necessary’
‘Sometimes laborious’
‘A valuable process’ – after witnessing the first successful body donation to LAO
‘On-call service is desirable’

Conclusion Pre-empptive and preparatory scrutiny of deaths is valued by all, and appears to have reduced complaints somewhat. Research is required to evaluate Trust-wide acceptability of the practice.

Introduction The COVID-19 pandemic has impacted people’s personal and professional lives, with many people experiencing various forms of loss including bereavement. The Open University (OU) is a large organisation with many students and staff impacted by the pandemic. The Open Thanatology group at the university noted a gap within the institution to collect and share experiences of death and dying during the pandemic; death as a result of COVID-19; grief, loss and funerals during COVID-19; other experiences of grief during COVID-19. Contributors commented that the process was therapeutic and that it recognised and honoured their experiences. For some it was their first-time publishing. It captures a ‘moment in time’ and the difficulties people faced.

Conclusion Publishing the Narratives of Covid book has been a useful way of bringing people together within the Open University and connecting with and sharing people’s experiences of death, loss and grief during the pandemic. Subsequent events at libraries have broadened the conversations beyond the university. Since the book is available as a free download, it has been used in education, research, reading groups, and public engagement.


References

NARRATIVES OF COVID: LOSS, DYING, DEATH AND GRIEF DURING COVID-19
Sharon Mallon, Erica Borgstrom. The Open University
10.1136/spcare-2023-PCC.22

INTRODUCTION OF MEDICAL EXAMINER
Rachel Hughes, Jo Brown. St Oswald’s Hospice
10.1136/spcare-2023-PCC.23

Background St Oswald’s Hospice strives to ensure high standards of communication and documentation after death, in line with Hospice UK’s Care after Death guidance, to support bereaved relatives, meet legal requirements and for coronial processes. From April 2023 it will be statutory law that all non-coronial deaths must be reviewed by a medical examiner (ME). The ME role was integrated into our practice from September 2022. This audit aimed to assess our communication and documentation prior to ME introduction and as the role was established.

Methods 100 patients who died in the inpatient unit prior to ME and 19 patients after initial introduction of ME role had documentation reviewed with a standard of 100% in recording:
• Cause of death as stated on the Medical Certificate of Cause of Death (MCCD) and discussion with family
• Whether the patient was for burial or cremation
• External health professionals notified of the death
• Details of any discussion with the Coroner’s office or ME and subsequent explanation to the family

Results (Pre ME and post ME/amending documentation):
• Cause of death as stated on the MCCD was recorded in medical notes in 97% and 100% respectively.
• Burial or cremation was documented in 84% and 89%.
• 100% of GPs were notified of patients’ deaths.
• Prior to ME 25% of deaths were discussed with Coroner of which 40% had details documented. Post ME 37% of deaths were discussed with Coroner and 63% with ME, 53% of those had details of discussion with family documented overall.
• Documentation of discussions with family regarding content of MCCD was present in 15% and 53% respectively.

Conclusion Introduction of ME and amending documentation templates following initial audit has led to an improvement in communication and documentation after death. Further improvement and re-audit continues.