NHS
Greater Manchester

Information regarding changes to dealing with unexpected non-suspicious deaths in Greater Manchester - FAQs

Following the statutory implementation of the Medical Examiner (ME) system on 09 September 2024, Greater Manchester Police (GMP) in conjunction with the coronial offices implemented a change in processes relating to how unexpected (i.e. deaths where there was no Statement of Intent/Special Notes or equivalent in place), but nonsuspicious deaths are processed.

What was the previous process and why did it change?

Previously, where death was unexpected, GMP would attend ALL deaths which occurred in/out of hours, even if it was likely that the death could be anticipated, and a GP/Dr offer a cause of death the next day. The deceased would then be moved to the mortuary and the death would then be reported to the coroner.

There would then be a coroner contact to the GP to see if a MCCD could be issued. In many cases it was found that the deaths were natural and a MCCD could be issued. Often, GMP attendance was felt to be unnecessary. Families often found GMP attendance distressing.

The ME implementation gave an ideal opportunity to refine this process and to align with other areas of the country.

What is the new initial process at time of death?

If NWAS attend:

NWAS will be called initially (i.e. via the person who finds the deceased). NWAS will attend the scene and **VERIFY** the fact of death (also known as diagnosis of death). They will then call GMP with details of the person and circumstances.

NB: There is no requirement to contact GMP in circumstances where the death is expected and or anticipated through age or illness, and clearly does not fall into the category that requires reporting to a Coroner, (notwithstanding there is no statement of intent in place). NWAS will also advise family on scene that they can arrange for a funeral director to attend in these cases.

If GP or GP OOH attend:

If a GP or GP OOH service is contacted and is able to verify the fact of death. A GP or OOH service can also contact GMP (via 101) to discuss such cases.

All contact to GMP can be made via the Emergency Service, non-emergency number

What are the next steps following NWAS / GMP discussion

GMP will take details from NWAS/GP/OOH clinician as to the circumstances of the death, as known and any medical information which is available.

It will be for GMP to then decide if they consider the death to be natural or not. Police attendance will be required for all unnatural deaths, but not for natural deaths.

If GMP do attend and report the death to the Coroner the deceased will be taken direct it to the public mortuary. If GMP do not attend, the deceased's family will be advised to contact a funeral director of their choice to move the deceased.

NB: The family should not be advised to contact their funeral directors until after GMP confirm they are attending or not. IF GMP are not attending, the family must be informed to contact a funeral director.

When GMP are not attending, the GP should be notified as soon as possible once NWAS (or GP OOH) have verified death. See below for the current mechanism in place for this process.

The GP should then as soon as possible liaise with their local ME service to determine if a MCCD can be completed (i.e. use normal processes). GPs may also find it helpful to discuss verbally the case with the ME.

Should a cause of death not be able to be ascertained, then the GP should, after discussion with the ME service, refer the case to HM coroner (this is in line with updated Notifications of Death Regulations September 2024)

How is information communicated from NWAS or OOH services to GPs?

In core hours

Initially NWAS will attempt to call the GP surgery and hand over the information. Ideally this would be done with a clinician-to-clinician contact (i.e. paramedic speaking to GP). This will allow information around the circumstances of death to be documented (which will help in ME discussions). It may not always be possible to speak to a GP, and in such cases NWAS will leave details with the surgery staff to then inform the GP.

GP practices should consider how best to handle such calls.

Where GPs require access to the NWAS electronic patient record, this can be obtained from NWAS via Individual.Rights@nwas.nhs.uk In time, Medical Examiners, will have access to OneResponse software (OneResponse is a system used by NWAS to store electronic patient records), and GPs will be able to request details from them.

Outside of core hours

If a death occurs in an OOH timeframe, then NWAS will (after speaking to GMP) pass on relevant information to the local OOH provider, who will then create a case log which will notify the GP surgery of the death. **NWAS are unable to directly send electronic notifications**. GP practices should have processes to check incoming OOH communications and prioritise those that need action.

The information provided by NWAS both in and out of hours should contain key information such as:

- Time of death
- Place of death
- GMP log number
- Brief description of circumstances

Additional comments

The updated death certification guidance may also help GPs in assessing whether they are able to issue a MCCD. The new guidance states the QAP is somebody who has seen the patient in their lifetime and therefore does NOT need to have been seen within the last 28 days by a GP (or doctor) for a MCCD to be issued.

https://www.gov.uk/government/publications/medical-certificate-of-cause-of-death-mccd-guidance-for-medical-practitioners/guidance-for-medical-practitioners-completing-medical-certificates-of-cause-of-death-in-england-and-wales