Consultants may occasionally be required to prepare a report to assist in the investigation of a death by a coroner, personal injury claims, criminal proceedings, patients' complaints or disciplinary proceedings.

**Background**

You may be required to write a report if you have witnessed an event as a member of the public or as a professional witness, for example if you were the doctor involved in some aspect of a patient’s care.

The following are general guidelines in writing professional witness reports such as for coroners or the investigation of other incidents.

Members are encouraged to seek specific MDU advice about professional witness reports and statements on an individual basis. Guidance for expert medical witnesses is provided elsewhere (see our factsheet ‘Acting as a medical expert witness’).

**General principles**

You must be familiar with the GMC’s publications *Good Medical Practice* (2013) and *Acting as a witness in legal proceedings* (2013).

In particular, paragraph 72 of *Good Medical Practice* (2013) says the following.

- You must be honest and trustworthy when giving evidence to courts or tribunals. You must make sure that any evidence you give or documents you write or sign are not false or misleading.
- You must take reasonable steps to check the information.
- You must not deliberately leave out relevant information.

The GMC requires of you in paragraph 4 of *Good Medical Practice explanatory guidance – Acting as a witness in legal proceedings* (2013) the following.

- Whether you are acting as a witness of fact or an expert witness, you have a duty to the court and this overrides any obligation to the person who is instructing or paying you.

Consideration needs to be given to patient confidentiality, which extends beyond death. In the case of a formal inquiry such as a coroner’s investigation, you have a professional duty to assist as set out in paragraph 73 of the GMC’s *Good Medical Practice* (2013). However, in other circumstances you may need to assure yourself that you have appropriate informed consent for providing a report.

**Members are encouraged to seek specific MDU advice about professional witness reports and statements on an individual basis.**

You are also expected to provide formal reports and statements in a timely manner. If you can foresee a delay in completing your report, you should inform the relevant person of this and indicate when you expect to be able to provide it.

If you are asked to give an opinion, you should only comment within your knowledge and expertise. You should identify yourself with your full name and professional medical qualifications written in full, for example, Bachelor of Medicine rather than MB. Describe your status, such as consultant surgeon.

Indicate at the start of your report who has requested it and for what purpose. It may also be helpful to list the supporting documentation you have used to compile your report, for example the medical and nursing records and drug charts. In most instances, you should ensure that you have sight of all the relevant records before completing any formal report or statement.

Describe events in a chronological order and as you saw them, referring to the clinical notes whenever you can. Describe each and every relevant consultation or telephone contact in turn and include your working diagnosis or your differential diagnoses.
Specify the nature of your contact with the patient, for example, if you saw the patient on the NHS (or privately) for clinical or forensic purposes, or for a combination of reasons. Where appropriate, state if you saw the patient alone or accompanied by another person during each and every consultation. Give the name and status of the other person, such as spouse, mother, social worker and so on.

Concentrate on your observations and understanding, rather than quoting word-for-word what the patient told you happened, though your understanding of a case will be significantly influenced by the history the patient gave you.

A description of the presenting symptoms is important in a medico-legal report, but is likely to be used to put the interpretation of your examination into context. This is in contrast to a good clinical report, where the history is central to the consultation.

Outline any referrals, identifying the name of the relevant practitioner. Identify any other clinician involved in the care of the patient (or deceased) by their full name and professional status. Describe your understanding of what they did and the conclusions they reached on the basis of your own knowledge of the clinical notes. However, it is not usually appropriate to comment on the adequacy or otherwise of the performance of other healthcare staff.

If you mention a drug, give some sort of idea what type of drug it is, for example, antidepressant or antihypertensive. Give the full generic name, dosage and route of administration of it as well, such as capsules, inhaler, intra-muscular injection or suppository.

Say not only what you found, but also what you looked for, and failed to find. If your evidence is challenged, it may be on the basis that you failed to put yourself in a position to make an adequate assessment. If your report at the outset clearly demonstrates that your history and examination were thorough, you are less likely to be called to give evidence in person.

The absence of an entry may be important. For example, you may be reporting on a case of a child who has died. If the pathologist finds healed fractures at post mortem, but the notes do not indicate that the parents had sought medical advice for these injuries, then this would raise the question of non-accidental injury and could have serious and immediate implications for surviving children in the family.

You are not expected to make copious clinical notes of every last detail, nor will you be expected to remember every detail of a consultation that at the time appeared to be routine. However, the report should be a detailed factual account based as far as possible on the clinical records made at the relevant period of time. (Paragraph 9 of Acting as a witness in legal proceedings 2013).

Where that is not possible, you may have to rely on your memory, or where appropriate on your usual practice, provided you make it clear in your report what the basis of your statement is.

We have a video on report writing. Please visit themdu.com to view this and all our other videos.

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**Report writing tips**

- The report should be typed and on headed paper, where possible, and must be signed and dated.
- The report should be capable of standing on its own. Do not assume the reader has any background knowledge of the case.
- People who do not have a medical background may rely on your advice and evidence to help them make decisions. Where it is possible to do so without misleading anyone, use language and terminology that people who are not medically qualified will understand. Explain any abbreviations and medical or other technical terminology you use.
- Write in the first person. The reader should have a good idea of who did what, why, when and to whom, and how you know this occurred. In other words, rather than ‘The patient was examined again later in the day’, it is far more helpful to say ‘I remember asking my registrar, Dr John Smith, to examine the patient again later on the same day, and according to the notes he did so.’
- Finally, keep a copy of your report and the notes in case you are called upon to give evidence in person about the incident.

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**For medico-legal queries**

24-hour advisory helpline
Call freephone 0800 716 646
Email advisory@themdu.com
Visit themdu.com

This information is intended as a guide. For the latest medico-legal advice relating to your own individual circumstances, please contact us directly.

Our medico-legal team are available between 9am-5pm Monday to Friday and provide an on-call service for medico-legal emergencies or urgent queries 24 hours a day, 365 days a year.