Hampshire NHS
Primary Care Trust

GUIDANCE FOR STAFF

REQUESTS FOR REPORTS AND WITNESS STATEMENTS IN CORONIAL LAW, LEGAL PROCEEDINGS OR INCIDENTS

1 Aim of Guidance

This document is produced as guidance for staff who are approached for written information in statements or reports in respect of their patients/clients. A witness statement may be required for:

- The Coroner, after a death has been referred to him/her
- Following an accident or untoward event
- In response to a claim against the PCT

Requests for Coroner's/Solicitor's reports should be routed via the PCT's Litigation Manager; and any request you receive or contact made direct to you should be notified to your manager and advice sought from the PCT's Litigation Manager. The reason for this is to ensure that all PCT staff representing the PCT are supported through the report-writing process and through any subsequent appearance in Court as a witness. The author of a report can be required to appear as a witness and if they refuse they could be summoned to attend. The PCT is committed to supporting its staff through legal processes as set out above.

Any information you provide may be used as evidence in connection with legal proceedings. These requests may initially be made by telephone but should be followed by a written request for a written report.

In all cases, the aim of a witness statement is to preserve the information that is not apparent from the case notes; in a form that can be given in evidence should the witness not be available for investigation, inquest or trial.

2 Summary:

- Write down your full name, address (place of work, although you may be asked to provide your home address by the Coroner/Police) and brief CV details.
- Remind yourself of the case/incident by referring to the medical/nursing notes (if applicable)
- Write a narrative of precisely what you recall of the events, what you did and did not do, whom you spoke to, who you contacted and at what stage you ceased to be involved. Use and explain the words that you recorded in the patients notes.
- UNDER NO CIRCUMSTANCES ALTER THE NOTES AFTER THE EVENT.
- Document your reasons for any actions or omissions.
- Record the facts only, do not include hearsay or opinion.
- Consider whether sensitive or potentially distressing information is relevant to the inquest, or investigation (e.g. allegation of abuse, difficult family relationships) before including such detail in the statement.
- It is desirable that your statement is typed, however if this is not possible then a hand written statement will suffice, but it must be legible and written in black pen which assists with any photocopying required. Use one side of A4 for each page. Do not use Tippex to delete an entry in your report/statement.
- Any alterations to a witness statement must be initialled by the person making the statement or by an authorised person (a person able to administer oaths and take affidavits). Contact the PCT's Litigation Manager for advice if necessary.
- You may ask your line manager and the PCT's Litigation Manager to look through your statement prior to signing. You may also consult your professional body if you wish. When you have read through your statement and are happy with the contents then sign and date it. (Some statements need to be signed witnessed and dated at the bottom of each page.)

- UNDER NO CIRCUMSTANCES SHOULD YOUR STATEMENT BE FILED IN THE PATIENTS NOTES.
- Ensure that you keep a copy of your statement and provide a copy to the PCT's Litigation Manager when appropriate.
- DO NOT USE ABBREVIATIONS.

Information about Coronial Law can be found in **Appendix 1**, requests for reports/statements for other purposes are outlined in **Appendix 2**. Appendix 3 provides information about Access to Health Record requests and **Appendix 4** provides a generic template that can be adapted as necessary.
If you have any queries or need assistance please contact:

Document produced by Elaine Williams
Complaints and Litigation Manager (South East)

17 October 2006

APPENDIX 1

Coronial Law – request for reports for the Coroner and witness appearances at Inquests

Coroners are required to inquire into deaths reports to them, which appear to be violent, unnatural, or of sudden and unknown cause. The Coroner will seek to establish the medical cause of death; if the cause remains in doubt after a post mortem, an inquest will be held. Not all deaths are reported to the coroner. In many cases a GP or hospital doctor can certify the medical cause of death and the death can be registered by the Registrar of Births and Deaths in the usual way. However, these Registrars must report deaths to the Coroner in certain circumstances. For example if a doctor cannot give a satisfactory cause of death; if the death occurred during or shortly after an operation; was due to industrial disease; occurred whilst the person was in custody, or if the death was unnatural or due to violence or occurred in other suspicious circumstances.

An Inquest is an inquiry into who has died and how, when and where the death occurred and more recently the addition of "and in what circumstances the death occurred" has been added. An inquest is not a trial and does not apportion blame for a death. Possible verdicts include: natural causes, accident, suicide, unlawful or lawful killing, industrial disease and open verdicts (where there is insufficient evidence for any other verdict) or if death is as a result of neglect. The Coroner may bring a narrative verdict, in which case additional text will be included in the verdict.

General Principles:

- The Coroner will expect a report within a certain timescale, usually within 28 days of the written request.
- If in any doubt about the amount of detail required in a report, contact the PCT's Litigation Manager for advice.
- The report should be capable of standing on its own. Do not assume that the reader has any background knowledge of the case. Several people may have to read the report from the Coroner. A draft of the report should be emailed to the Litigation Manager before a signed copy is sent to the Coroner.
- Remember that the Coroner may not be a clinician so the report should be written so that a lay person can understand it.

Clinical Records:

- The Coroner may require disclosure of the whole medical record. In any event, take a full photocopy set, including the front and back cover of the Lloyd George envelope if appropriate (even if the back has nothing written on it), for your own records before disclosing or returning the records. Also keep a printout of all information held on computer.
- You may need to keep copies before destroying them in accordance with the PCT's Retention and Destruction of Records policy.
- It can be helpful to give the exact dates spanned by the notes because it will not always be obvious from the entries.

Style of report:

- Avoid using any abbreviations in your report, unless the meaning is written out in full on first usage. If you mention a drug, explain what type of drug it is, give the full generic name, dosage, method of administration, when started or stopped and why it was prescribed or stopped.
- Write your report in the first person. It is tempting to write in the passive tense because that is the accepted format in a clinical report. However, it is easier for the Coroner to get the full picture of events if the report is written in the first person.

First hand evidence:

- The Coroner is most interested in first hand evidence. Hearsay evidence carries less weight. Concentrate on your observations and understanding of the case, provide factual evidence not supposition.
- Clearly your understanding of a case, and the interpretation you place on your examination, will be significantly influenced by the history given to you by the patient or from what you have read, for example, in medical notes, referral letters. Whilst the patient's description is important and provides the context for your interpretation, it is less important than your observations and understanding.

The involvement of colleagues:

- Where another clinician has been involved in the care of the deceased you should identify them with their full name and professional status. You may describe your understanding of what they did and the conclusions they reached purely on a factual basis.
- It may be necessary for colleagues to write individual reports. If so, you may wish to draw this to the attention of the reader of your report.

Negative information:

- Your description of both the history and the examination should enable a third person to relate them in your place. It is important, therefore, to say not only what you found, but also what you looked for, but failed to find.

Notes, your memory and your "usual" practice:

- In your report you should specify which details are based on (1) your memory, (2) the contemporaneous notes you, or (3) others have written and (4) your "usual" or "normal" practice.

Conclusion:

- Take the necessary time to produce a comprehensive, accurate report, this will minimise the need of further correspondence with the Coroner. If your report clearly demonstrates that your history and examination were thorough, it may not be necessary for you to be called as a witness to have your evidence tested at Inquest.
- If you are called to give evidence at an Inquest you will not be able to consult your report whilst giving evidence, however, you will be allowed to read your contemporaneous notes. It is therefore worth re-reading your report before you take the witness stand to refresh your memory, and hence the importance of keeping a copy of your report.
- You may, if you wish, notify your defence organisation, and, if so please inform the PCT's Litigation Manager that you have done so.

APPENDIX 2

Requests for Statements for other purposes

Members of staff may not be obliged to make a written statement in circumstances other than outlined above. If staff are prepared to assist, as will sometimes be the case, they should reply that they are required to seek the advice of their manager before they respond verbally or in writing. Advice must be sought in all cases.

Managers may also be expected to be generally co-operative but they will need to take into account such matters as patient confidentiality, prejudice to the interests of the employee or the PCT before making a decision. Managers should take advice from the PCT's Litigation Manager when approached to give statements.

Requests for Reports for other purposes

The PCT would advise that all staff, other than Consultants, refrain from agreeing to write reports or professional witness statements for solicitors without first seeking advice from a manager. The manager should take advice from the PCT's Litigation Manager when necessary.

In the event that a Court of Law requests a statement or report, then the recipient of the Court Order should comply with the request, ensuring firstly that they are provided with a copy of the Order if it was not received with the request. If in doubt, seek the advice of the PCT's Litigation Manager.

In the event that a report is used as evidence by Solicitors, staff are reminded that they would not automatically have the legal or financial support of the PCT if the PCT were not a party in the particular legal proceedings or had not agreed to the provision of a statement.

All requests from Solicitors for reports should be referred to the Consultant or lead professional responsible for the patient's care.

It is important to remember that verbal discussions with third parties who are not involved with a patient's care would breach the patient's confidentiality unless the patient consented to the disclosure. In exceptional cases disclosure of information may be necessary without the patient's consent but this should first be discussed with the line manager or PCT's Information Governance Manager.

APPENDIX 3

Requests for Access to, or Disclosure of Health Records

All written requests for access to patient's medical records for anyone other than the patient must be forwarded to the PCT's Information Governance Manager. (Refer to PCT's Access to Health Records Policy)

Hampshire NHS
Primary Care Trust

TEMPLATE **APPENDIX 4**

CORONER'S REPORT / WITNESS STATEMENT IN THE MATTER OF

Patient name (if applicable) – Incident Date:
(e.g. This report relates to the death of .... who died on ....)

NAME:

JOB TITLE AND EMPLOYER:

ADDRESS:

QUALIFICATIONS:

SUMMARY OF EXPERIENCE:

BODY OF REPORT: (see sections below)

STATEMENT OF TRUTH:

This report/statement (consisting of .... page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it, which I know to be false, or do not believe to be true.

Signature: **Date:**

....

Your report should include information about the following:

Background Summary
Specify the nature of your contact with the patient, e.g. state if you saw the patient on the NHS or privately, for clinical purposes or for forensic purposes or 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(s) present, e.g. spouse, mother, social worker, ward sister, etc.

Documents
List all the documents you have relied on in writing your report.

Factual Account of Events
Set out a chronological description of recent illnesses and/or events leading to death/incident. Give a factual description of events as you saw them using the clinical notes as a framework. Refer to the notes in your report whenever you can. Describe each and every consultation or telephone contact in turn and this description should include your working diagnosis or your differential diagnosis. Outline any hospital referrals, identifying the name of the relevant practitioner or consultant. Ensure there are no gaps in the sequence of events or where there are provide an explanation, e.g. during May I was on annual leave and did not therefore see the patient.

Clinical Record
For Coroner's reports it may be helpful to disclose a photocopy of the contemporaneous clinical notes when requested. Where appropriate it might even be necessary to provide a word for work, line-by-line type written transcript of notes plus abbreviations written out in full.

Hampshire NHS
Primary Care Trust

GUIDANCE FOR STAFF

REQUESTS FOR REPORTS AND WITNESS STATEMENTS IN CORONIAL LAW, LEGAL PROCEEDINGS OR INCIDENTS

1 Aim of Guidance

This document is produced as guidance for staff who are approached for written information in statements or reports in respect of their patients/clients. A witness statement may be required for:

- The Coroner, after a death has been referred to him/her
- Following an accident or untoward event
- In response to a claim against the PCT

Requests for Coroner's/Solicitor's reports should be routed via the PCT's Litigation Manager; and any request you receive or contact made direct to you should be notified to your manager and advice sought from the PCT's Litigation Manager. The reason for this is to ensure that all PCT staff representing the PCT are supported through the report-writing process and through any subsequent appearance in Court as a witness. The author of a report can be required to appear as a witness and if they refuse they could be summoned to attend. The PCT is committed to supporting its staff through legal processes as set out above.

Any information you provide may be used as evidence in connection with legal proceedings. These requests may initially be made by telephone but should be followed by a written request for a written report.

In all cases, the aim of a witness statement is to preserve the information that is not apparent from the case notes; in a form that can be given in evidence should the witness not be available for investigation, inquest or trial.

2 Summary:

- Write down your full name, address (place of work, although you may be asked to provide your home address by the Coroner/Police) and brief CV details.
- Remind yourself of the case/incident by referring to the medical/nursing notes (if applicable)
- Write a narrative of precisely what you recall of the events, what you did and did not do, whom you spoke to, who you contacted and at what stage you ceased to be involved. Use and explain the words that you recorded in the patients notes.
- UNDER NO CIRCUMSTANCES ALTER THE NOTES AFTER THE EVENT.
- Document your reasons for any actions or omissions.
- Record the facts only, do not include hearsay or opinion.
- Consider whether sensitive or potentially distressing information is relevant to the inquest, or investigation (e.g. allegation of abuse, difficult family relationships) before including such detail in the statement.
- It is desirable that your statement is typed, however if this is not possible then a hand written statement will suffice, but it must be legible and written in black pen which assists with any photocopying required. Use one side of A4 for each page. Do not use Tippex to delete an entry in your report/statement.
- Any alterations to a witness statement must be initialled by the person making the statement or by an authorised person (a person able to administer oaths and take affidavits). Contact the PCT's Litigation Manager for advice if necessary.
- You may ask your line manager and the PCT's Litigation Manager to look through your statement prior to signing. You may also consult your professional body if you wish. When you have read through your statement and are happy with the contents then sign and date it. (Some statements need to be signed witnessed and dated at the bottom of each page.)

- UNDER NO CIRCUMSTANCES SHOULD YOUR STATEMENT BE FILED IN THE PATIENTS NOTES.
- Ensure that you keep a copy of your statement and provide a copy to the PCT's Litigation Manager when appropriate.
- DO NOT USE ABBREVIATIONS.

Information about Coronial Law can be found in **Appendix 1**, requests for reports/statements for other purposes are outlined in **Appendix 2**. Appendix 3 provides information about Access to Health Record requests and **Appendix 4** provides a generic template that can be adapted as necessary.
If you have any queries or need assistance please contact:

Document produced by Elaine Williams
Complaints and Litigation Manager (South East)

17 October 2006

APPENDIX 1

Coronial Law – request for reports for the Coroner and witness appearances at Inquests

Coroners are required to inquire into deaths reports to them, which appear to be violent, unnatural, or of sudden and unknown cause. The Coroner will seek to establish the medical cause of death; if the cause remains in doubt after a post mortem, an inquest will be held. Not all deaths are reported to the coroner. In many cases a GP or hospital doctor can certify the medical cause of death and the death can be registered by the Registrar of Births and Deaths in the usual way. However, these Registrars must report deaths to the Coroner in certain circumstances. For example if a doctor cannot give a satisfactory cause of death; if the death occurred during or shortly after an operation; was due to industrial disease; occurred whilst the person was in custody, or if the death was unnatural or due to violence or occurred in other suspicious circumstances.

An Inquest is an inquiry into who has died and how, when and where the death occurred and more recently the addition of "and in what circumstances the death occurred" has been added. An inquest is not a trial and does not apportion blame for a death. Possible verdicts include: natural causes, accident, suicide, unlawful or lawful killing, industrial disease and open verdicts (where there is insufficient evidence for any other verdict) or if death is as a result of neglect. The Coroner may bring a narrative verdict, in which case additional text will be included in the verdict.

General Principles:

- The Coroner will expect a report within a certain timescale, usually within 28 days of the written request.
- If in any doubt about the amount of detail required in a report, contact the PCT's Litigation Manager for advice.
- The report should be capable of standing on its own. Do not assume that the reader has any background knowledge of the case. Several people may have to read the report from the Coroner. A draft of the report should be emailed to the Litigation Manager before a signed copy is sent to the Coroner.
- Remember that the Coroner may not be a clinician so the report should be written so that a lay person can understand it.

Clinical Records:

- The Coroner may require disclosure of the whole medical record. In any event, take a full photocopy set, including the front and back cover of the Lloyd George envelope if appropriate (even if the back has nothing written on it), for your own records before disclosing or returning the records. Also keep a printout of all information held on computer.
- You may need to keep copies before destroying them in accordance with the PCT's Retention and Destruction of Records policy.
- It can be helpful to give the exact dates spanned by the notes because it will not always be obvious from the entries.

Style of report:

- Avoid using any abbreviations in your report, unless the meaning is written out in full on first usage. If you mention a drug, explain what type of drug it is, give the full generic name, dosage, method of administration, when started or stopped and why it was prescribed or stopped.
- Write your report in the first person. It is tempting to write in the passive tense because that is the accepted format in a clinical report. However, it is easier for the Coroner to get the full picture of events if the report is written in the first person.

First hand evidence:

- The Coroner is most interested in first hand evidence. Hearsay evidence carries less weight. Concentrate on your observations and understanding of the case, provide factual evidence not supposition.
- Clearly your understanding of a case, and the interpretation you place on your examination, will be significantly influenced by the history given to you by the patient or from what you have read, for example, in medical notes, referral letters. Whilst the patient's description is important and provides the context for your interpretation, it is less important than your observations and understanding.

The involvement of colleagues:

- Where another clinician has been involved in the care of the deceased you should identify them with their full name and professional status. You may describe your understanding of what they did and the conclusions they reached purely on a factual basis.
- It may be necessary for colleagues to write individual reports. If so, you may wish to draw this to the attention of the reader of your report.

Negative information:

- Your description of both the history and the examination should enable a third person to relate them in your place. It is important, therefore, to say not only what you found, but also what you looked for, but failed to find.

Notes, your memory and your "usual" practice:

- In your report you should specify which details are based on (1) your memory, (2) the contemporaneous notes you, or (3) others have written and (4) your "usual" or "normal" practice.

Conclusion:

- Take the necessary time to produce a comprehensive, accurate report, this will minimise the need of further correspondence with the Coroner. If your report clearly demonstrates that your history and examination were thorough, it may not be necessary for you to be called as a witness to have your evidence tested at Inquest.
- If you are called to give evidence at an Inquest you will not be able to consult your report whilst giving evidence, however, you will be allowed to read your contemporaneous notes. It is therefore worth re-reading your report before you take the witness stand to refresh your memory, and hence the importance of keeping a copy of your report.
- You may, if you wish, notify your defence organisation, and, if so please inform the PCT's Litigation Manager that you have done so.

APPENDIX 2

Requests for Statements for other purposes

Members of staff may not be obliged to make a written statement in circumstances other than outlined above. If staff are prepared to assist, as will sometimes be the case, they should reply that they are required to seek the advice of their manager before they respond verbally or in writing. Advice must be sought in all cases.

Managers may also be expected to be generally co-operative but they will need to take into account such matters as patient confidentiality, prejudice to the interests of the employee or the PCT before making a decision. Managers should take advice from the PCT's Litigation Manager when approached to give statements.

Requests for Reports for other purposes

The PCT would advise that all staff, other than Consultants, refrain from agreeing to write reports or professional witness statements for solicitors without first seeking advice from a manager. The manager should take advice from the PCT's Litigation Manager when necessary.

In the event that a Court of Law requests a statement or report, then the recipient of the Court Order should comply with the request, ensuring firstly that they are provided with a copy of the Order if it was not received with the request. If in doubt, seek the advice of the PCT's Litigation Manager.

In the event that a report is used as evidence by Solicitors, staff are reminded that they would not automatically have the legal or financial support of the PCT if the PCT were not a party in the particular legal proceedings or had not agreed to the provision of a statement.

All requests from Solicitors for reports should be referred to the Consultant or lead professional responsible for the patient's care.

It is important to remember that verbal discussions with third parties who are not involved with a patient's care would breach the patient's confidentiality unless the patient consented to the disclosure. In exceptional cases disclosure of information may be necessary without the patient's consent but this should first be discussed with the line manager or PCT's Information Governance Manager.

APPENDIX 3

Requests for Access to, or Disclosure of Health Records

All written requests for access to patient's medical records for anyone other than the patient must be forwarded to the PCT's Information Governance Manager. (Refer to PCT's Access to Health Records Policy)

Hampshire NHS
Primary Care Trust

TEMPLATE

APPENDIX 4

CORONER'S REPORT / WITNESS STATEMENT IN THE MATTER OF

Patient name (if applicable) – Incident Date:
(e.g. This report relates to the death of .... who died on ....)

NAME:

JOB TITLE AND EMPLOYER:

ADDRESS:

QUALIFICATIONS:

SUMMARY OF EXPERIENCE:

BODY OF REPORT: (see sections below)

STATEMENT OF TRUTH:

This report/statement (consisting of .... page(s) each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it, which I know to be false, or do not believe to be true.

Signature: **Date:**

....

Your report should include information about the following:

Background Summary
Specify the nature of your contact with the patient, e.g. state if you saw the patient on the NHS or privately, for clinical purposes or for forensic purposes or 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(s) present, e.g. spouse, mother, social worker, ward sister, etc.

Documents
List all the documents you have relied on in writing your report.

Factual Account of Events
Set out a chronological description of recent illnesses and/or events leading to death/incident. Give a factual description of events as you saw them using the clinical notes as a framework. Refer to the notes in your report whenever you can. Describe each and every consultation or telephone contact in turn and this description should include your working diagnosis or your differential diagnosis. Outline any hospital referrals, identifying the name of the relevant practitioner or consultant. Ensure there are no gaps in the sequence of events or where there are provide an explanation, e.g. during May I was on annual leave and did not therefore see the patient.

Clinical Record
For Coroner's reports it may be helpful to disclose a photocopy of the contemporaneous clinical notes when requested. Where appropriate it might even be necessary to provide a word for work, line-by-line type written transcript of notes plus abbreviations written out in full.