FACTSHEET

MEDISEC

We look after you

Guide to Writing a Coroner's Report

Doctors are often asked to provide a medical report to the Coroner in relation to a deceased patient. A suggested template for a Coroner's report is provided below. The report should be confined to the purpose for which the report has been requested. You should distinguish clearly between facts identified and verified by you, and information provided to you by the patient or others.

Sometimes a report is all that is required and the doctor will not be required to attend an Inquest.

However, a doctor may be asked to attend an Inquest to give evidence in relation to their report and perhaps to answer further questions. Please see our related factsheet on *Coroners' Inquests* (available on our website) for further information regarding the nature of Inquests.

Releasing patient information

The Coroner's Court is a Court of Law and as such, where a report is requested, patient consent to release personal information is not necessary; the Coroner's request has a similar legal basis as a subpoena / Court Order and cannot be ignored.

Sometimes, An Garda Síochána will act as the agent for the Coroner, and will request / collect the report from the medical practitioner. It should be clarified with the Garda that the report has in fact been requested by the Coroner, and where any doubt exists a written request from the Coroner can be sought. In most cases, best practice would be to seek the request in writing from the Coroner.

Points to consider:

- Sometimes there is confusion about what the Coroner has requested, copies of records or a report etc. If you are unsure it is quite acceptable to ask for the request in writing from the Coroner.
- Be aware that the deceased patient's family members are likely to see a copy of or hear your report being read out at an inquest.
- If there is sensitive information that you feel is inappropriate to be read publicly, discuss this with Coroner in advance and they will advise on how to proceed.
- If you are called to an Inquest, bring a copy of your report with you, as you are likely to be asked to read it out.
- Remember to dress professionally and address the Coroner as "Sir / Madam".
- There may be a jury in place; this is at the discretion of the Coroner.
- The family may have legal representation present and they may question you.
- If you have already given a statement directly to an Garda Síochána in relation to the patient, base your medical report on the information already given in this statement, and be prepared to clarify any inaccuracies or contradictions.

Our suggested template for a report is at the end of this document.

Please contact Medisec if you are asked to provide a report or are called to an Inquest. We will be happy to guide you through the process of drafting the report and / or accompany you to the inquest if required.

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Template: Report for (*enter name of City / County*) Coroner

1. Details of Deceased:

Name of deceased:
Address of deceased:
Date of birth:
Date of death:
Date of Inquest if known:

2. GP details:

GP's name
Address of practice
IMC Registration number:

3. Expression of condolences to family:

e.g.: *I would like to offer my sincere condolences to the family of Ms X on her sad passing*

4. General introduction:

eg: *Ms X was a patient of mine for 20 years and I last saw her on [DATE] when she attended me for [INSERT]*

5. Past medical history:

E.g.
COPD x 20 years
Type 2 diabetes diagnosed 2000

6. Medical problems at time of death:

E.g.
Hypertension
Angina
COPD
Type 2 diabetes

7. Relevant family history:

Be careful to avoid referencing medical history of any third party and if you are in doubt, refer to the Coroner for guidance. Only relevant medical history should be included.

8. Medications:

9. Outline summary of recent and relevant patient attendances in your practice in chronological order with dates:

It is suggested that any relevant practice nurse / telephone / out of hours consultations also be included.

10. Clinical history

Consider the following:

Absence / presence of risk factors for illness attributed to death
Details of the final illness

Details of relevant investigations (bloods, ECG, imaging, other) at the time and especially if any abnormalities were identified
Presentations to out of hours / ED
Last consultation in detail (if appropriate)

11. Summary of patient's final illness and any appropriate comments about the likely cause of death if known.

Signed:
GP name:
IMC Registration Number:

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