One incident can be investigated in a number of different ways – as a complaint, a clinical negligence claim, a criminal case, a disciplinary matter by your employer, a Coroner’s inquest or a complaint to the GMC. An important starting point is your written report on the circumstances of the incident. This factsheet gives more information about writing this report.

Your report should be:

**Detailed** – it is better to provide too much information than too little  
**Clear** – avoid ambiguity and be clear about who did what and when  
**Objective** – state the facts. Do not use the report to criticise others or make general comments on hospital politics. The GMC states you must be honest and trustworthy when writing reports.

Your report should be based on:
- The medical records  
- Your own recollection  
- Your usual practice.

If you have any questions or concerns about what you have been asked to produce, you should contact MPS for further advice.

Why might a report be required?

There are various situations in which you may be required to write a report:
- for your employer, possibly after something goes wrong  
- for the coroner  
- for a solicitor  
- for the police  
- for a patient’s employer or insurance company.

You may be required to write a report, either as a lay witness or a professional witness. If you are writing as a lay witness, this means you are writing as a member of the public. If you are the doctor involved in some aspect of the patient’s care, you will be asked to provide a report as a professional witness.

Facts or opinions?
The majority of reports that you are asked to provide will be statements of fact – giving an account of what took place. You should only report the facts as you know them.

If you are asked to give an opinion, you must only comment within your expertise.

Disclosure of patient information
A report will, more often than not, involve the disclosure of confidential information about a patient. You need to make sure you have the authority to disclose this information, by getting your patient’s consent and checking they are clear about the information you will be providing and why it is necessary. The MPS factsheets on Confidentiality give further information about the disclosure of patient information.

What should the report include?

- Personal details – your qualifications, number of years working, relevant clinical experience and background  
- Relevant local factors – for example, if your hospital is on two sites and this affects the time taken to get to an incident  
- Details of other healthcare professionals involved  
- Patient details  
- Presentation and history – you should include dates and, where possible, times  
- Findings on examination  
- Diagnosis and whether a differential diagnosis was considered  
- Investigations and subsequent management, including dates  
- Follow up arrangements and information given to the patient or relatives.

The report should be clearly dated, and must be signed by you.

Do not…

- Exceed your level of competence.  
- Deliberately conceal anything – this will cast doubts on your integrity and will make subsequent comments less credible.
You should…

■ Write your report honestly; don’t be influenced by others

■ Write it as soon as possible after the event, while the incident is still fresh in your mind

■ If the report is a result of a complaint or claim, make sure you have seen the complaint or Letter of Claim, or details of any court proceedings, before writing

■ Only include details of events that you personally were involved in

■ Only include relevant facts; your opinion is only necessary if specifically asked for

■ Don’t comment on behalf of others – you can say “Dr X said… .”

Report writing tips

■ Write in the first person singular – “I did this…”

■ Address the report to an intelligent lay person; avoid jargon and abbreviations

■ Bear in mind that the patient or their relatives are likely to see the report; avoid any pejorative, humorous or unnecessary subjective remarks

■ Organise the report chronologically – give actual dates, and use either a 24-hour clock to give times, or state whether you are referring to am or pm

■ Give each incident or event a separate paragraph or section

■ Check spelling, punctuation and grammar before submitting

■ Your report should be typed, signed and dated

■ Keep a copy of the report in your notes and a note of how, when and to whom you submitted it.

If you are asked to change the report, you should think very carefully about the event before doing this, and only make changes if a factual mistake needs to be rectified.

Making a supplementary report

Sometimes it is necessary to make a supplementary report to deal with issues that come to light after you have written your original report. Before doing this, make sure that you review your report, the medical records and any new documentation.

Further information


■ MPS factsheet, Confidentiality – www.medicalprotection.org/uk/factsheets


■ MPS factsheet, Access to Medical Reports – www.medicalprotection.org/uk/factsheets


For medicolegal advice please call us on:
0800 561 9090
or email us at: querydoc@mps.org.uk
www.mps.org.uk