# Writing witness statements and reports

MPS

Putting members **first**

MALAYSIA FACTSHEET

Advice correct as of June 2014

**These guidelines are intended to cover general witness statements and reports, such as those for coroners, trust legal departments, hospital enquiries, adverse incident reports and so on. Separate advice should be sought on statements for use in civil or criminal court proceedings.**

## Witness statements

Statements may be headed 'Confidential' and should be addressed to the requesting individual or office. Remember that the reader will not necessarily know who you are, so your position must be defined.

A heading is helpful, something like: "Report Concerning …… by …… " or "Report on Clinical Incident, 25 December 2012, by ……".

The first few lines may be a potted biography of the writer, to set the writer's role in context for the reader. Two examples follow:

- I qualified in 1978 from the University of ……. and at the time in question was working as a consultant in …… for ……. at …… I had commenced this post on ……

- I qualified in 1982 from the University of ……. and have been in general practice since 1987.

Then should follow a paragraph on how each encounter with the patient came about, for example:

Mrs Ismail was referred by her GP for admission on 28 February 2013 and I saw her on her arrival as I was on call that day.

## Reports for coroners

Reports for coroners are likely to need much more background information, for example:

I first saw Frances Hamid at my surgery in Bund Road, Ferringhi in June 1987. Her past medical history comprised ……. I saw her five times in the year before her death …… etc.

The report or statement should then follow chronologically, sticking to facts and concentrating on the writer's involvement. It should normally end with the last encounter between the writer and the patient, unless further detail aids clarity.

Avoid uninvited criticism of colleagues, and use the first person singular, for example: (I intubated Mr Osman) rather than the passive (Mr Osman was intubated), as it minimises ambiguity.

Ideally, statements should not be written without access to the relevant records. Information may come from direct recollection, the medical records and also the writer's usual clinical practice. An example of the latter would be a record entry of:

"Head injury advice" after which the writer could add "By this I would usually say …….".

State the sources of information on which your statement relies. If exceptionally a report has to be written from memory, then say that you have not had access to the records. Alternatively, if you have no recollection of the patient, state that you are relying on the records.

Split the statement up into short paragraphs, which may be numbered for ease of reference. Sign and date it, and keep a copy. Seek advice from senior colleagues, partners and the MPS as needed, particularly if you have concerns about potential criticism.

## Further information

- Malaysian Medical Council, *Medical Records and Medical Reports* 2006 – www.mmc.gov.my