Coroners report template

Statement prepared by [add writer's name here]

Re: Name: [add patient's name here]
NHI: [add NHI]
Date of birth: [add date of birth here]
Date of death: [add date of death here]
CSU number: [add CSU number here, if available]

At the request of coroner [add name]

- My name is [add full name]. I qualified in medicine with [add degree] from the University of [add university] in [add year]. My further qualifications include [add any further qualifications, including specialist college etc]. I am currently working as [add position held], a position I have held since [add year].
- I was involved in the care of [name of deceased] from [add date] to [add date].
- I would like to start by expressing my sincere condolences of the family and friends of [name of deceased], for their sad loss.
- This statement has been prepared on the basis of the contemporaneous medical records and from my memory of my involvement in [name of deceased]'s care.
- [Name of deceased] had a past medical history which included [add paragraph here on past medical history of deceased, including all significant medical conditions and the dates they were diagnosed and any details which may be relevant. These conditions can be bullet-pointed. Pay particular attention to the past history which is relevant to the cause of death].
- At the time of [his/her] death, [name of deceased] was on the following regular medications [provide list of medications, including doses and indications and if relevant when started/stopped. This list can be bullet-pointed].
- Include a paragraph explaining the background or history of the patient if they have a medical history dating back many years.
- [Chronology – provide an outline of your involvement over the recent year(s) in the patient's care. This may be several paragraphs, usually one for each consultation. Alternatively it may involve a summarising paragraph on the management of each of their conditions. The consultations should be in chronological order with accurate dates. Begin with the most distant in time. A copy of the medical notes is **not** the appropriate format – the account should be written in a narrative style describing each relevant encounter with the deceased. If you recall details which are not in the notes, this should be clarified with 'I recall that…' For each consultation you should briefly outline the history, the examination findings, your working diagnosis and your rationale for that diagnosis. Your management plan should be outlined and any follow up that was arranged. Make sure you explain any medical terms used. If you have been involved in the patients care for many years, you do not need to cover every consultation in detail but you can summarise the earlier care and focus on the last year in more detail. If you are describing a consultation that the patient had with another clinician, include their full name and as a professional courtesy, you may ask them to review the draft before it is sent to the Coroner, so they can confirm the description of the care they provided is correct].
- [You should also include all relevant referrals and whether the patient was under the care of specialist or other services at the time or close to their death].
- I last saw [name of deceased] on [add date], when [he/she] presented with [include here a more detailed description of your last consultation/encounter with the patient. This should include details of the history and examination, diagnosis and management plan].
- [Here you need to address any specific questions which have been asked by the Coroner. Each question should have its own paragraph].
- [In many cases the Coroner may ask whether the patient was subject to any orders – use this paragraph, only if this question is asked of you]. To the best of my knowledge, [add name of deceased] was not subject to an order under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the Substance Addiction (Compulsory Assessment and Treatment) Act 2017 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2013 at the time of [his/her] death.
- I had no further involvement in [name of deceased]'s care after [add date]. [You may also want to make comment if anything significant occurred subsequent to your last consultation, or regarding how you heard about the death].
- I hope the information in this report has been of assistance to the Coroner, but I would be happy to provide further information or clarification, should it be required.

Signed:

[Insert writer's name]

Date: [add date]

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Notes:

- This template has been formulated with bullet points, but in your final draft, we would suggest that each paragraph should be numbered, for ease of reference.
- You can refer to the patient by their first name, or as Mr/Mrs/Ms X, depending on how well you knew them, however, you should remain consistent in using either one or the other.
- Bear in mind that this report may well be seen by the family of the deceased and you need to be sensitive to that, while keeping your report factually accurate.
- You should keep your report as concise as possible, bearing in mind that the purpose of the report is to help the Coroner determine what the cause of death was and whether there were any preventable factors in the death.
- In the case of patients who have died from suicide, it is important to record any risk assessments that were done.
- In most cases it is not necessary to send the clinical notes to the Coroner and you should only include the clinical notes with your response that have been specifically requested.
- If preferred you can copy and paste the template into a word doc to complete a draft of the report.

Contact Medical Protection

For membership enquiries, contact us on **0800 2255677** or **membership@mps.org.nz**

For assistance with a medicolegal matter, call **0800 2255677** or email us on **advice@mps.org.nz**

For more information visit **medicalprotection.org**