Appendix 3

Guidance on Writing Statements

These guidelines are to be used when preparing general witness statements for:

- the Coroner after a sudden or unexpected death
- in response to a claim for clinical negligence
- Court Hearings

Requests for statements may come from your manager, your Professional Indemnity (PI) Insurers, the police, the Coroner or the Trust Legal Services Department. Anybody who has been directly or sometimes indirectly involved in an incident or event can be asked to provide a witness statement.

If you are writing the report as a result of a claim, make sure that you have seen the claim letter.

In all cases the purpose of a witness statement is to preserve information that is not apparent from the medical records in a form that can be used to give evidence in a formal hearing such as an Inquest or a trial.

- It is important to remember that your statement might be disclosed to a third party.

- Make sure you know who is asking you to provide a statement and why and what will happen to it.

- Write your statement as soon as you are asked to prepare it - memories can fade very quickly even over a short period of time.

You may wish to record your actions after an untoward incident or event, even before a statement is requested. If you decide to do this, then ensure you record the date you wrote the account. You may use this as the basis for any formal statement at a later date.

Content

The statement should only contain information known personally to you: ie what you did, saw and heard - not what others may have done, seen or heard. However, occasionally you may need to record something that somebody said or did if it is an integral part of what happened and it corroborates (supports) other evidence.

- First of all, think carefully about the case and make a careful review of the relevant medical, paramedical, clinical and nursing records.

- Refer to Trust policies and procedures if appropriate.

- If you discover any inaccuracies in a patient's records, then explain these as part of your statement and prepare an amendment for the records, which you must sign and date

- Under no circumstances should you alter the records after the event.

- Ideally the statement should be typed use a minimum of size 12 font, paragraphs should be used to break up the text and date and sign your statement.

How to write a witness statement

- Introduce the statement (e.g. Report to HM Coroner).

- Give your report a heading e.g. Report Concerning the Care of Mr Smith by Dr Sharon Jones, Senior House Officer, 21 March 2009 or "Report on the clinical incident of 1 March 2009 relating to Mr Smith by Staff Nurse Jane Black, RN, 1 March 2009"

- Include your full name, professional qualifications, position held and length of employment.

- State your location on the day in question and period of duty.

- Give details of the date and time throughout the statement (using the 24 hour clock). Give actual dates, do not say 'Wednesday afternoon'.

- Identify the patient (if relevant) using their full name and date of birth and use the patient's name throughout (i.e. not "the deceased" or "the patient").

- State that the account is written from a review of the medical records, any other documents that you might have and/or personal recollection. Make clear any points elements which are solely from memory or solely from records.

- Deal with the relevant matters in chronological order and with logical structure. Your narrative should describe precisely what you did, who you spoke with and when you ceased involvement with the situation.

- Explain why you made the decisions that you did or took certain action if it is not readily apparent.

- Use and explain the words that you have recorded in the records if relevant

- If reporting speech, as far as possible try to recall the actual words used.

- Use full sentences.

- Stick to the facts or explain where you deviate from your own knowledge.

- Use the first person singular e.g. "I intubated Mr Jones." Not "Mr Jones was intubated." to avoid ambiguity.

- Avoid using jargon explain any medical terminology or abbreviations, write the report as if you were writing to a lay person.

- Where test results are referred to, explain whether these were in normal range, high or low, etc.

- Identify any other staff involved by name and role.

- Include details on exceptional or unusual (e.g. the fire alarm had gone off or the ward was being redecorated).

- Your statement should reflect your knowledge of the event and not the thoughts of others.

- Your statement should be accurate and complete. You must tell the truth and the whole truth.

- Sign and date the statement at the end and print your name after the signature, give your full job title and place of work.

- Keep a copy for your own record – take it with you to any Inquest or hearing you may attend.

- Remember to store this confidentially and only destroy via a blue confidential waste bag or by shredding.

Hints and Tips

- Never refer to the subject of the report/statement as 'the patient' always by name.
- Do not exaggerate/minimise events.
- Avoid criticism of colleagues/other departments.
- **Avoid jargon and abbreviations. Where possible explain medical terms in layman's language, this will help the coroner but mainly the family.**
- Always check dates and times to ensure that they are correct. Dates should be written in full i.e. 17th January 2014 and times should be written in 24 hour format i.e. 21.00 (dates on reports submitted area very often incorrect)
- Please ensure that you proof read your report prior to sending to Legal Services to check for spelling and grammatical errors.
- You are not being called as an expert so don't give opinions (leave that to senior consultants) just stick to facts.
- Remember if you have done this procedure before (and since) it would be helpful to say so.

- Do not repeat what is already in the notes – expand and clarify if appropriate.
- Do not leave out significant information.
- Nursing reports should always be shared with Senior Nurse Management.
- Only sign your statement when you are 100% satisfied with it.
- Do not file a copy in the patient's notes
- **Please ensure that the pages of your report are numbered**