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RCM Statement Writing Guidance

A statement is a factual narrative account of your involvement in a specific incident either as a care giver or as a witness to a significant event. It should complement not simply duplicate the medical records allowing for greater understanding of your involvement and decision making.

No statement regarding a clinical incident should be written entirely from memory without access to the maternity records. It is important to reference the notes and make clear any information which is additional and from memory.

It may be required as part of an internal investigation or in response to a complaint. Once submitted it is disclosable to third parties including, but not limited to, the patient, their legal representative, the Coroner or the NMC.

It is a requirement of The Code (NMC 2015) that registrants cooperate with internal and external investigations however you are entitled to access to the maternity records and adequate time to prepare the statement. Advice should be sought from your local RCM representative when preparing a statement before submission.

You may be required by your employer to use an agreed template; if not it is recommended that each page and paragraph is numbered for ease of reference.

Your statement should include the following information:

- Your full name, qualifications (with dates), role and pay banding, your employer details and the length of employment
- The purpose of the statement and the person requesting the statement for example:

‘This statement is prepared at the request of (insert name) who is undertaking an investigation under the Trust’s Serious Untoward Incident Policy/Complaints Policy/Disciplinary Policy (delete as appropriate). I write this statement having reviewed the maternity records of (insert name). I have personal recollection/have no recollection (delete as appropriate) of my involvement in this client’s care.

- Your specific involvement in the case for example whether you were the lead carer and the specific time-frame during which you were involved; this is particularly important if your involvement was transient for example if you were relieving a colleague or you were involved in a co-ordinating capacity



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- Identify other staff involved in the client's care using their full name and status ie Mr John Smith (Consultant Obstetrician) and the care they gave but avoid statements of opinion on their care
- Full medical terminology (no abbreviations) as your statement may be disclosed to non-medical personnel and abbreviations used locally may not be universally applied
- An explanation of decision making in relation to the care given if not obvious from the records
- Reference to midwifery practice/ clinical guidelines in existence at the time if the incident occurred sometime previous and practices have changed

Always:

- Be completely honest and state clearly what you can/cannot recall
- State facts
- Be as specific as possible avoiding ambiguous statements
- Avoid making comments expressing your personal opinion or speculation
- Sign and date each page of the statement
- Keep a copy