## Witness Statement Template

Statement of [name of witness] for [name or role of person requesting statement, for example, case manager or coroner]

Date

Statement Number 1

**Name and professional address**

**Professional Qualifications**

1. This can, in most cases, be limited to one or two paragraphs. A fuller curriculum vitae can be added as an appendix if appropriate. Specify the date you qualified.

**Purpose**

2. Why you are writing the statement

**Resources**

3. What documents and records you had access to when writing the statement

**Current job title**

4. What is your current job title and how long have you held this?

Also include when you started working at your organisation.

**Professional role**

5. What does your role involve on a day to day basis.

**Professional involvement**

6. Your involvement in the treatment/management of the patient.

How you know the patient and how long you’ve known them.

**Background and context**

7. What does the patient’s diagnosis mean? Describe the treatment administered/surgery performed in general (not patient specific) terms.

8. Explain the nature of the unit/ward/team and the patient group that you work with. If it is a ward set out its size and the type of patients on the ward.

9. Give details of your role on the ward or team. For example, are you a manager? Or if you are under supervision, say by whom.

10. Throughout the document, when referring to others, use their name and job title.

**Chronology**

11. Provide a story of your involvement in chronological order.

12. Use the first person singular (I intubated Mrs Brown), rather than the passive voice (Mrs Brown was intubated)

13. You will need access to the medical records in order to write this section. This is because your task is to clarify any ambiguity in the contemporaneous record. Specifically:

* + - all contemporaneous opinion words need to be clarified. For example, if your note says ‘patient used abusive language’ – you will need to specify exactly what words were used. If the records says ‘there was a considerable quantity of pus’ – you will need to quantify how much there was.
		- Where you have only described half of what you did, you will need to provide a full record. For example if the , ‘head injury advice given’ – you will need to specify exactly what you said. Patient reassured – you will need to specify how you reassured the patient and how the patient responded.
		- You will also need to explain all abbreviations and jargon used in the contemporaneous record.

14. Say when you started and finished your shift.

15. Say who else was present at any given time.

16. Sub-headings may be appropriate.

17. If you can’t remember something, say so.

18. Do not assume the reader has a medical background nor any knowledge of hospital routines. An intelligent lay person should be able to understand the content.

19. When mentioning a drug explain what type it is, (for example anti depressant) and give its full name, dosage and route of administration.

20. If normal procedures were not followed, set out what the normal procedures are and why they were not followed in this instance.

21. When describing tasks that are covered by protocol stipulate which protocol and attach a copy to your statement.

22. Would a photograph or plan of the ward/theatre/recovery room help the reader understand what happened?

**10. Statement of truth**

23. This statement is true to the best of my knowledge and belief.

**11. Signature**

12. **Attachments**

**Format Guidelines**

Statements should:

1. Be double spaced
2. Be on one side of the paper only
3. Have decent margins (on both side of the text) of at least 2.5 cms
4. Bound in a manner which does not inhibit photocopying and filing
5. Be paginated and have numbered paragraphs
6. Have headings and subheadings
7. Have font size of at least 12
8. Have short paragraphs; no more than 3 sentences per paragraph. A sentence which exceeds two lines is probably too long
9. Have attachments; policies, maps, photos and guidance documents
10. Be typed