**Example Statement 3**

My name is xxxxxxxxx; I have been a qualified midwife for 29years and 9 months. Prior to this I worked as a staff nurse on a general ward.

On 19th June 2015, I was told by the Head of Midwifery that she had received a complaint from a member of staff. I was told the complaint centred on the movement of women and staff from M2 to the labour ward. On the 1st August 2015, I had first sight of the complaint. How can I be expected to recall events that occurred weeks ago?

At the start of my night shift handover is given by the outgoing coordinator. Midwife Blue is correct the unit was busy that night, mainly due to staff shortages on triage and labour ward. Around 20.30 hrs, I and the out-going obstetric registrar hand over to the night registrar. The doctors discuss the activity on M1, M2, Triage and G5, so I am aware of all potential risks in the building. The registrar and I, do a ward round of all the high risk women on the ward to ensure that their plans are current and relevant.

Shortly after this or during, the triage midwife rang to say she had a labourer who needed to come to cds. I believe this is when I first spoke with midwife Blue who told me she was very busy with an epileptic patient and someone in preterm labour. I had just had medical hand over, and believed we were discussing the same patient. (This patient, was pre-term, had been “pushing” and had had a non-epileptic seizure the day before. A speculum examination ruled out labour.) Hence the correction, I assumed we were taking about the same patient.

If midwife Blue believed this patient to be in labour, my expectation is that the patient has an obstetric review and the cervix observed/assessed. Based on objective findings, a plan is made. This woman did not come to the labour ward that night. There is no mention of this patient when we speak again. Epilepsy is a totally different medical condition to someone who has non-epileptic seizures. The patient had “fitted” the day before. There is nothing to do for this patient, even if she had another fit, she would have been remained on M2. All midwife Blue had to do was keep her safe. For the purpose of my learning I would like to know what special care this/these patient(s) required. I asked the second on-call to come in as I believed the unit was too busy to cope with the triage phones.

The patient and triage midwife came to cds. This woman was in advanced labour. The community midwife chose to go to the ward and take the phones. She is entitled to work where she pleases. This is nothing new, and Midwife Blue is aware of this practice.

About 05.00hrs the activity on the labour ward was increasing. The induction ladies were now in labour. The midwives were now providing 1:1 care. There was a patient in the induction bay who was becoming very uncomfortable and needed a midwife. I was conscious that I was the only midwife free. I needed a midwife to assess the patient, and be around should one of the ladies

deliver. Again midwife Blue leads me to believe that the ward was heaving and she could not help. I phoned our second site and they were able to send a midwife. The diary entrant notes that a patient who is booked for elective section has been advised to make her way into the hospital. If this lady was found to be in labour, then the midwife from M2 would have been deployed. This is standard procedure. Midwife Blue clearly doesn’t appreciate what it takes to keep the hospital safe and opened. If I had called the Matron at this point, I am certain she would have agreed with my plan. In less than 2 hours, more staff would have been available.

The next night, I believe the hospital was closed when we came on duty. The unit was fully staffed. This enabled us to do some cleaning and restocking. I was called to the NNU, as a MSW had fainted/fallen, she was also pregnant. I spoke with the paediatric registrar who was most insistent that she accompany the MSW to A+E, as she had witness the faint/fall. A MSW from labour ward took her colleague to A+E in a wheelchair.

When it was brought to my attention, that both MSW was still on the ward, I asked one to go down to M1, which they did. It might not have been straight away as they were probably finishing off what they had started. I refute saying those words, not my vocabulary.

When I checked with the Matron her entry was that we had a lady in HDU, who had just come back from theatre, following evacuation of haematoma. The patient had been transferred back to CDS from M1, following a c-section earlier in the day. Her Hb had fallen to 40g/dl. This lady required blood transfusions and blood products before going to theatre at about 21.00hrs. I may well have accompanied the consultant to speak to the patient’s husband and just forgot to ask someone to go down. But looking at the times we are only talking 1 hour.

The previous night, midwife Blue worked on M2, the ward was busy, she was struggling to provide care and support. I never heard from M1. Tuesday night, she is on M1 which is heavy and again struggling to provide care and support. I did not get a call from M2.

The HOM’s letter inviting my statement referred to movement of staff and patients from M2 to labour ward. This did not happen on any night. At no time did I move any one, without the move being requested by a third party. I believed that all my actions on those nights were appropriate and no different to what any of my co-ordinator colleagues, would have done. No midwife, doctor, anaesthetist or consultant has ever made an allegation, or expressed concern about my practice. I have not worked with midwife Blue for years. Midwife Blue has not worked on the labour ward for years, or ever acted up as a co-ordinator. She cannot sit on level 3, and know the situation on labour ward on level 6, it is impossible. This is evident when she talks about speaking to ANP, I was there and it was a paediatrician. All I can say is, if you are going to complain, you have to get your facts right!