Investigating what caused the death or serious harm of a patient (causation)

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We take it extremely seriously when patients suffer harm, and recognise that past actions which led to death or serious injury could undermine the reputation of nurses, midwives or nursing associates.

However, we need to balance this with our need to help keep patients safe by avoiding a culture of blame or cover up. This means we do not punish nurses, midwives and nursing associates for making genuine clinical mistakes if there is no longer a risk to patient safety, and they have been open about what went wrong and can demonstrate that they have learned from it.

When we investigate and present these types of fitness to practise cases, we should focus on whether the nurse, midwife or nursing associate is likely to put patients at risk of harm in the future.

This will very often involve deciding whether or not a nurse, midwife, nursing associate or their team has put patients at risk of harm in the past. However, focusing on what harm resulted from a past incident won't help us understand how likely it is that the nurse, midwife or nursing associate may repeat the conduct or failings that first caused the concern.

For this reason, we'll only focus on whether the nurse, midwife or nursing associate's clinical failings caused the death or serious injury of a patient if it's clear that the nurse, midwife or nursing associate deliberately chose to take an unreasonable risk with the safety of patients or service users in their care.

Before gathering evidence about whether or not the clinical failing did cause or contribute to death or serious harm, there would need to be evidence that the nurse, midwife or nursing associate:

- was aware that something they were about to do could put the safety and wellbeing of others at risk
- was aware that it was unreasonable to take the risk, and
- chose to take the risk.

In these circumstances, there is either a clear connection between the nurse, midwife or nursing associate's state of mind, how they acted, and any harm they caused. These principles apply to individual clinical decisions, as well as decisions taken in the management of a healthcare setting.

On the other hand, if a nurse, midwife or nursing associate made a genuine clinical mistake which led to a patient suffering harm, we would not say that the outcome makes the case more serious. This is because it doesn't tell us anything about how likely the nurse, midwife or nursing associate is to make similar mistakes in the future.

For example, where a nurse, midwife or nursing associate made a genuine clinical mistake during a course of treatment that ended with a patient's death or serious injury, we can refer to the outcome, but only if it's relevant as background context.

When we present cases like this, we would make clear that we're only referring to the serious injury or death of the patient as part of the background because it would be artificial to hide this from decision makers. We would be very clear we're not saying that the nurse, midwife, or nursing associate's conduct caused the death or serious harm, and we would be clear that the death or harm should not be used as a reason to decide that the nurse, midwife or nursing associate's fitness to practise is impaired.