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Gathering information

Reference: INV-1 Last Updated: 30/08/2024

In this guide

- Overview
- Requesting information from the nurse, midwife or nursing associate
- Requesting information from other parties

Overview

Our investigation will usually begin by seeking documentary evidence of the factual issues and speaking to those involved.

When we investigate a concern about somebody's fitness to practise, we recognise that it is important that we also look at the bigger picture. We will not just focus on investigating the actions of the nurse, midwife or nursing associate, but instead will also try to understand the context in which they were working at the time.

We have developed a set of eight guiding principles that we will apply whenever we look into a concern. For more details, see our guidance on taking account of context.

We will continually assess what the information we receive is telling us, whether it changes the level of risk and what further investigative steps are required as a result.

If we are unable to obtain the information or documentation required in respect of the incident(s) giving rise to the concern, or key witnesses are not willing to assist, it is likely the case examiners will conclude that the concerns are not capable of being proved.

Our guidance on Our culture of curiosity sets out our approach to investigating concerns.

Requesting information from the nurse, midwife or nursing associate

We always ask the nurse, midwife or nursing associate to send us a response to the regulatory concerns about their practice at the start of our investigation, and again at the end.

We'll also send them a form at the start of our investigation which focuses on information we would be interested to hear about so we can try and understand the context within which a concern may have arisen. The form does not provide an exhaustive list, and the nurse, midwife or nursing associate can tell us anything they think is important for us to know about the background to an incident.

The nurse, midwife or nursing associate does not have to send a response at these times, or provide a response to the concerns at all during our investigation.

However, a detailed response from the nurse, midwife or nursing associate received early on in our investigation can help us focus our investigation on the most serious issues, and any facts that are in dispute. It can also help us to understand the context in which the concerns came about, and help us to decide whether we need to make any further investigations specifically into any of the context raised.

If the nurse, midwife or nursing associate raises issues that we need to look into, we can follow up on them early

on to make sure we have all the relevant background facts. Waiting until the end of our investigation to tell us about relevant information usually means we won't have the chance to properly look into it before case examiners consider the case.

If the nurse, midwife or nursing associate does not provide us with a detailed response, or provides no response at all during our investigation, then this may mean that we are not aware of lines of enquiry that we need to make about context. It could also mean that we are not aware of the significance of information that we do have, which could have an impact on what further enquiries we think it is reasonable or proportionate to make.

We may be able to get evidence about context from other sources, such as from other people involved in an incident or from a nurse, midwife or nursing associate's manager. However, without the nurse, midwife or nursing associate's response, it may be difficult for us to establish a link between that background information and the concern. If we are unable to establish a clear link this could affect our decision on whether it is proportionate to look into that background information any further.

If nurses, midwives or nursing associates engage with us early on, it's also more likely that we'll be able to identify what they might be able to do to put the concerns in the case right (see our guidance on insight and strengthened practice). We encourage the nurse, midwife or nursing associate to send us evidence of any insight or reflection they've undertaken in relation to the concern, but they aren't required to do so (see Engaging with your case).

It may become clear that an outcome like undertakings, warnings or advice will be the appropriate way to resolve a case instead of sending it to the Fitness to Practise Committee. If the nurse, midwife or nursing associate doesn't send us a response about the concerns, these outcomes won't be appropriate.

We may share the nurse, midwife or nursing associate's response with the person who first raised the concerns with us, especially if that person is a patient, or a family member or loved one.

Whether they choose to respond to us or not, the nurse, midwife or nursing associate does have a duty, under the Code, to cooperate with our investigation. They must provide us with details of where they are working and any arrangements they have to provide nursing and midwifery services.

Requesting information from other parties

Our referral forms will ask the referrer to provide us with information about a concern which includes any background information that could be relevant to the concern being raised. If the referrer is not the nurse, midwife or nursing associate's employer we may also send a form to their employer seeking information about context.

We may liaise with referrers, employers and witnesses to ensure we have a full picture of what happened and how serious it was. Given the sensitive nature of much of the information and documentation required, we consider that all requests for information should be relevant, reasonable and proportionate.

Our powers to request information are set out in Article 25(1) of the Nursing and Midwifery Order 2001. This authorises us to require any person, other than the nurse, midwife or nursing associate who is the subject of our concerns, to provide information and documents which appear relevant to our investigation.

We may require those who supply us with information or documentation to provide a witness statement which contains a statement of truth and confirmation that they are willing to attend a hearing to give evidence. If this happens, we will offer additional support or information to assist with this process. We will send the statements we obtain to the nurse, midwife or nursing associate.

Where we identify a potential witness who is already the subject of a linked referral or could be the subject of a referral, we will carefully consider whether we need to contact them to take a witness statement. We will always consider asking someone to provide a statement if it is necessary for us to establish what has happened whether it supports the allegations or not.

How we investigate health concerns about nurses, midwives and nursing associates

Reference: INV-2 Last Updated: 06/05/2025

In this guide

- Overview
- What kinds of health information might we need?
- What happens if the nurse, midwife or nursing associate has done something wrong because of their health condition?

Overview

If the regulatory concern is about the health of a nurse, midwife or nursing associate, we'll need to carefully balance our duty to protect the public, with the nurse, midwife or nursing associate's right to privacy when we investigate.

Before we start to investigate a nurse, midwife or nursing associate's state of health, we'll already have decided, when screening the case, that there's a potential risk to the public as a result of the health concerns.

What kinds of health information might we need?

During our investigation, after seeking the nurse, midwife or nursing associate's agreement we'll gather information about the health concern, from their GP, occupational health professional, or a specialist or consultant who's treating them.

With some kinds of health condition we may ask the nurse, midwife or nursing associate to have a medical examination with an expert doctor, or testing, or sometimes both.

We'll only ask for information that we need to help us understand if and how a health condition has an impact on the nurse, midwife or nursing associate's fitness to practise. A nurse, midwife or nursing associate should co-operate with our investigation. Our guidance on engaging with your case sets out why it is important that we get engagement during an investigation.

If a nurse, midwife or nursing associate doesn't co-operate with our investigation into their health, we'll carefully consider whether we need to add a separate regulatory concern relating to their failure to cooperate. Before doing this, we'll give the nurse, midwife or nursing associate every opportunity to engage and seek to understand why they may be unable to.

We will usually only need to add a regulatory concern in relation to non-cooperation if we feel that the failure to cooperate isn't linked to the health condition. If the nurse, midwife or nursing associate is unable to cooperate due to their health, and we have evidence of the health condition, it is likely to be more appropriate for a panel to take the failure to cooperate into account when considering impairment by reason of health[1]. Our guidance on drafting charges in health cases sets this out.

What happens if the nurse, midwife or nursing associate has done something wrong because of their health condition?

Often, investigations about a nurse, midwife or nursing associate's health begin because of a specific incident or series of incidents which, on their own, might suggest a regulatory concern about the nurse, midwife or nursing associate's practice or conduct.

One example is a nurse, midwife or nursing associate who attends work in an unfit state because they've been drinking, and who has a dependency on alcohol. In these circumstances, we'd need to explore, and gather evidence about, both the background health condition, and any relevant incidents.

We'd do this to help ensure we have a clear picture of exactly what occurred, how serious it was and whether there is a link that shows the incidents happened because of the health condition.
In such cases we'll ask an expert to comment on whether the incidents would have happened if the nurse, midwife or nursing associate didn't have the health condition.

Unless there are exceptional circumstances, we'll usually say the health condition should be the focus of our concern, as opposed to any possible misconduct.

'Exceptional circumstances' means where the incidents are so serious that there would be a real risk to the public's trust in all nurses, midwives and nursing associates if the nurse, midwife or nursing associate was not removed from the register immediately, and includes examples like deliberately harming patients.

By focusing on the underlying health condition in cases like this, we can act in a way which best addresses the root cause of the problem, and which will best protect the public.

Also, because we'll have evidence of the specific incidents, this enables decision makers to fully consider how the effects of the health condition could cause risks to patients or members of the public, which in turn, will help them make good decisions about what outcomes or action is needed to keep patients and members of the public safe.

1 Rule 31(5)(b)

Investigating concerns about language competence

Reference: INV-3 Last Updated: 03/02/2021

In this guide

- Overview
- How do we direct nurses, midwives and nursing associates to take language assessments?
- What happens if the nurse, midwife or nursing associate doesn't comply?

Overview

When we investigate concerns about a nurse, midwife or nursing associate's knowledge of English, we can direct them to take a language assessment.

In such cases we use the outcome of the assessment as our key evidence about the nurse, midwife or nursing associate's fitness to practise.

How do we direct nurses, midwives and nursing associates to take language assessments?

We give a direction for them to take a language assessment in writing.

We'll pay for the cost of the test which we have directed they need to take. We will request that the test be taken by a specific date and that the nurse, midwife or nursing associate give us the results within a timeframe of around 60 days, depending on the circumstances of the case. For example, we could extend the time if a nurse, midwife or nursing associate needed a reasonable adjustment to allow them to take the assessment.

Usually we specify that the test should be an assessment provided by IELTS. However, if the nurse, midwife or nursing associate chose to obtain their own assessment provided by OET we would also accept the result.

What happens if the nurse, midwife or nursing associate doesn't comply?

If we direct a nurse, midwife or nursing associate to take a language test, but they don't do it, or don't give us the results, we can use this as evidence that they are not fit to practise because they don't have the necessary knowledge of English.
This is because the Fitness to Practise Committee can draw conclusions from the nurse, midwife or nursing associate's failure to follow our direction to them to do the test and give us evidence of the result.[1]

1. Rule 31(6A) of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004

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

Reference: INV-4 Last Updated: 03/03/2025

Our primary focus in fitness to practise hearings will always be the misconduct alleged rather than the consequences of that misconduct.

Focusing on what harm resulted from a past incident won't necessarily help us understand how likely it is that the nurse, midwife or nursing associate will repeat the conduct or failings that led to the concern being raised. Our function is not to punish professionals for past conduct, but to protect the public from harm, maintain public confidence in the professions and to uphold professional standards. So a serious outcome will not always mean that the professional's fitness to practise is impaired.

Nevertheless, some harm is so serious that confidence in the profession may be undermined if the impact of a professional's misconduct isn't fully explored in our regulatory proceedings. If it can be demonstrated that a professional's misconduct caused death or serious harm, it is right that our Fitness to Practise Committee should be able to record and explore that fact.

Proving causation can:

- allow the full story of the misconduct and its consequences to be told[1];
- help to evidence just how serious the underlying conduct was; and
- guide decision-makers in their assessment of a professional's reflection and strengthened practice.

When considering whether to add a charge of 'causing death or serious injury', we'll weigh the strength of evidence, the public interest in putting the harmful consequences of the misconduct on the record, and the extent to which exploring causation is necessary for a panel to properly evaluate the seriousness of the misconduct alleged, against the time and resources required to pursue a charge of causation. We will only include an additional causation charge where we consider there is a clear public interest in doing so.

The test for causation

We will carefully consider whether to pursue a case of causation. We would *only* do so where there is clear evidence that

1. The professional's misconduct caused serious harm or death (factual causation); and
2. Any reasonable and competent professional in the professional's circumstances would have known that their misconduct could result in serious harm (foreseeability)

Evidencing factual causation

'But for' causation

We will consider bringing an additional causation charge if the evidence demonstrates that death or serious harm would not have occurred 'but for' (without) the misconduct alleged.

Example 1

> A nurse is involved in a prolonged face down restraint of a patient. The dangers of face down restraint are known and this is not an approved technique. The patient shows clear signs of difficulty in breathing, but the

> nurse fails to act on this or check that they are ok. The patient dies due to positional asphyxia.

The serious injury would not have occurred ‘but for’ the professional’s misconduct.

Example 2

> A nurse is responsible for checking in the weekly medication. She has recently been warned by her manager about the risks of leaving a medication trolley unlocked and unattended. Before finishing the job, she takes a call on her mobile phone. On finishing the phone call the nurse decides to go on their break, leaving medication unattended. A resident with dementia subsequently ingests a quantity of medication and suffers serious harm as a direct result.

The serious harm would not have occurred ‘but for’ the professional’s misconduct.

‘Loss of chance’ causation

Sometimes it is the professional’s failure to respond appropriately to a particular risk or clinical issue that forms the basis of the regulatory concern. We will bring a causation charge if, as a result of the misconduct, the person receiving care lost any real prospect of survival.

Example 3

> A nurse administers insulin to a diabetic patient with very low blood sugar readings. On identifying the error, the nurse fails to report this, and the hypoglycaemia worsens, and the patient dies shortly afterwards. Had a doctor been informed straight away they could have initiated corrective treatment which would have been likely to reverse the hypoglycaemia

Example 4

> A private midwife is providing care for a pregnant person, carrying out antenatal appointments at home, compiling a birth plan and being on call for a homebirth. When called multiple times by the pregnant person, who reports continuous abdominal pain and fresh red vaginal bleeding, the midwife neither attends, nor advises the person to call 999 for an ambulance or to access emergency maternity care. When they do eventually attend the hospital, sadly it is found that the baby has died. The pregnant person suffers serious post-birth complications as a result of a placental abruption. Expert evidence is clear that a reasonable and competent midwife would have recognised the need for emergency medical intervention; and that it is likely that the baby would have survived and the person would not have suffered serious harm had the midwife requested emergency medical intervention in a timely manner.

Example 5

> A senior midwife is overseeing what they know to be a high-risk labour. During the labour there are consecutive suspicious Cardiotocograph (CTG) categorisations which mean that escalation to a doctor is required. The senior midwife delays escalation, despite there being no clinical justification for the delays. The baby is born in poor condition and sadly dies soon after. Expert evidence confirms that the delay amounted to a gross failure in basic care, the risk of serious harm would have been obvious to a reasonable and competent midwife, and that had escalation taken place sooner it was more likely than not that the baby’s death would have been avoided.

In these scenarios the member of the public lost a real chance of survival or not sustaining serious harm because the professional failed to identify clear warning signs and take appropriate action.

Contribution

Sometimes the alleged misconduct is one of multiple factors that *could have contributed* to serious harm or death but we cannot prove on the basis set out above. The NMC does not pursue additional charges of ‘contribution’. In such cases we will charge the underlying misconduct alone.

Was the harm caused reasonably foreseeable?

We will consider an additional causation charge when there is serious misconduct and it would have been clear to

a reasonable and competent professional in the circumstances that their conduct could result in serious harm or death to the person receiving care. We'll rely on expert evidence to establish this.

Where a reasonable and competent professional would not have anticipated the serious harm caused and sought to avoid it, we will not pursue an additional causation charge.

Example 6

> A nurse on night shift in a care home disables alarm bells and goes for a nap. One of the residents receiving care suffers serious harm as a result of not being able to operate the alarm bell to seek assistance.

Example 7

> Despite their lack of prescribing qualifications, a nurse decides to provide a patient with prescription medication on their own initiative. They secure the medication, administer it, and the patient subsequently has a serious adverse reaction.

Example 8

> A nurse decides not to raise a baby's cot side as she is "only leaving the bedside momentarily". The baby falls from the cot and suffers a serious head injury.

Example 9

> A nurse attends a patient on blood thinning medication who suffers an unwitnessed fall. The nurse fails to check the patient for signs of a head injury and record neurological observations in line with the clinical protocol. She puts the patient to bed and carries out no further checks in the night. In the morning the patient is found dead of a significant intracranial haemorrhage. We receive evidence that taking observations after the fall and escalating as appropriate would have been likely to have saved the patient's life.

The risk of serious harm in these scenarios would have been clear to any reasonable and competent professional.

Example 10

> A nurse administers the wrong drug to a patient. The name of the drug actually administered by the nurse sounds very similar to the drug which was prescribed to the patient. The packaging of both drugs is very similar and the wrong drug was issued by pharmacy.

We would judge the actions of a reasonable professional according to the information known to them at the time. There are contextual factors in this scenario –the fact that the two drugs had similar names and similar appearance and that the pharmacy had issued the incorrect drug. Based on these facts, we would be unlikely to bring any charge of either misconduct or causation.

Example 11

> The same nurse notices the error soon afterwards and enters it in the patient notes. However, they fail to escalate the incident appropriately or monitor sufficiently. The patient suffers significant complications as a result of this error. An expert gives evidence that a reasonable and competent nurse would have been aware of the risk of serious harm caused by failing to escalate the incident appropriately when they became aware of it and that the failure to escalate led to the loss of any real prospect of survival.

In their failure to escalate the issue when they became aware of it, the nurse exposed the patient to the risk of serious complications. There do not appear to be contextual factors to explain the error; this is a case of misconduct that is likely to impair. As we have evidence to indicate that a reasonable and competent nurse would have been aware of the risk of serious harm caused by failing to escalate the incident appropriately, we are likely to bring an additional charge of causation.

To decide whether a professional's misconduct caused death or serious harm, the panel will usually need to see independent medical evidence. However, we may be able to rule out a potential causation charge early on in an investigation by securing materials from third party proceedings (such as coroner's inquests) and seeking the

opinion of our own internal qualified clinical advisers.

A panel cannot adopt wholesale the findings of third-party proceedings (such as inquests or civil claims) as to whether the professional caused the harm; that is because we are interested in causation from a regulatory perspective. It will often, however, rely on the same evidence as was led in other proceedings. We'll usually ask any independent experts involved in other investigations (such as those held by employers, the police, other regulators, or the coroner) to help with our investigation if they can.

Referring to serious outcomes in non-causation cases

Where we are not pursuing an additional causation charge we may sometimes mention that the person receiving care subsequently died or suffered serious injury, but only if it's relevant as background context and it would be artificial to conceal these facts from decision-makers. We would be very clear that we're not suggesting that the nurse, midwife, or nursing associate's conduct caused the death or serious harm.

1 R (El-Baroudy) v General Medical Council [2013] EWHC 2894 (Admin)

Independent experts

Reference: INV-5 Last Updated: 03/03/2025

In this guide

- When we instruct independent experts
- Specialised knowledge or expertise
- Independent opinion

When we instruct independent experts

We don't always need independent expert evidence. We sometimes need help to understand the basic facts of what happened, and whether it was serious enough to cause concerns about the nurse, midwife or nursing associate's fitness to practise. We can usually discuss these issues with professionals at a local level who have the qualifications and technical expertise to help us with these issues.

Sometimes, however, we'll need the opinion of an independent expert during our investigation, and because of the issues involved, it's proportionate for us to instruct one.

We'll usually do this if we need:

- specialised knowledge or expertise that we cannot obtain locally
- an independent opinion
- evidence to help us decide whether a nurse, midwife or nursing associate's actions were directly responsible for patient death or serious harm

Specialised knowledge or expertise

In our most complex cases we may need input from someone with technical expertise and experience. This is particularly likely if the concerns are about practice in a specialised setting or involve very technical issues. In these cases, we are more likely to need help to determine exactly what happened, what should have happened and how serious it was.

If there is no local person with the qualifications, specialised knowledge and expertise who is able to help us, we will need to think about instructing an independent expert can provide us with necessary evidence to assist our decision makers. We would also ask the expert to comment on any contextual factors that they consider relevant to the issues and how they may have impacted on what happened.

Independent opinion

Independent experts do not have any connection with or interest in one part or side of the case or another. They are expected to give their opinion based only on their expertise and experience.

For this reason, independent experts can provide objective evidence in cases which involve a wide ranging factual or contextual dispute.

We may need the independence and objectivity of an expert if the case is about the conduct or practice of one or more nurses, midwives or nursing associates, and we have reason to believe that the local investigation may not have been adequate or credible.

Investigating health concerns

Investigations

When we investigate health concerns, we may often need the opinion of an independent medical expert. This could be because of their specialist knowledge, their independence, or for both reasons.

For example, although we'll usually ask for information from the nurse, midwife or nursing associate's GP or treating specialist, the therapeutic relationship might make it difficult for them to give us an independent opinion about the nurse, midwife or nursing associate's health, or how it could affect their fitness to practise. This can be particularly difficult if nurse, midwife or nursing associate doesn't have insight into their condition, or isn't engaging well with local services.

Sometimes, we may need evidence about how health conditions can pose risks to patients, or comprehensive evidence on untreated or complex illnesses, meaning we need the specialist knowledge of an expert.

When we get a report from a medical expert, they'll give us evidence of the nurse, midwife or nursing associate's health condition using an International Classification of Disease (ICD) diagnosis. We will also need a clear picture of how any symptoms may present, and how this could impact on the nurse, midwife or nursing associate's clinical duties. The expert will need to help us understand, any risk to patients, any risk of relapse, and what support the nurse, midwife or nursing associate may need to help them return to safe practice.

Investigating at the same time as other organisations

Reference: INV-6 Last Updated: 27/02/2024

In this guide

- Overview
- When is an investigation by another organisation likely to affect our own investigations?
- Deciding if we should proceed with our investigation
- What we'll do if our investigation is delayed

Overview

All investigations into a nurse, midwife or nursing associate's fitness to practise should begin without delay.

We understand that our proceedings can be stressful and have an impact on all the people involved in them, so we want to resolve our cases as soon as we can.

However there can be times when our own investigations are affected by investigations that are being done, or that need to be done, by another organisation. This may mean that we have to think about limiting our own investigations, or even delaying them.

When is an investigation by another organisation likely to affect our own investigations?

The circumstances when investigations by another organisation may affect our own investigations are likely to be when:

1. There is a real and significant risk that our investigation will the other investigation
2. It is for our investigation to continue at the same time
3. It is likely to be for us to wait because we can use the information the other organisation has gathered
4. The outcome of the other investigation is likely to have an impact on our decision on the fitness to practise of the person we are investigating

We talk about these circumstances in more detail in the guidance below. These circumstances should not be viewed in isolation from each other, as there may be times when there is some overlap between them or more than one of them is relevant to our own case.

Our investigation might risk prejudicing another investigation

It's most likely that our investigation can risk prejudicing an investigation by another organisation when the other investigation has criminal prosecution functions, such as the police, Serious Fraud Office (SFO) or Health and Safety Executive (HSE).

For example, there can be a risk that the evidence we've gathered could conflict with or taint the evidence being gathered by their investigation, or it could interfere with their ability to prosecute or start other proceedings.

Our investigators will always contact the other organisation to understand their view on the matter. If there's a real risk of the other investigation being prejudiced, it may still be possible for us to investigate some areas because our investigations often have a broader scope. For example, criminal proceedings might focus on an allegation of assault while our related proceedings might include other aspects such as the quality of the care provided.

If we are actively considering continuing with our investigation into other areas of the nurse, midwife or nursing

associate's practice, our investigators will always discuss with the other organisation to agree which areas we can investigate. This could include agreement on which witnesses can be contacted and what subjects we can and cannot discuss with particular witnesses.

It's unlikely that our investigation will cause prejudice in cases where the nurse, midwife or nursing associate is not being directly investigated by the other investigating organisation. This could be where the setting in which they practise is the focus of the investigation. In these cases we'll still contact the other organisation as a precaution, and because disclosure of documents or information from that party may help our investigation.

It's impractical to proceed

In some cases the nature and scope of an investigation by another organisation will mean that it's not practical for our investigation to proceed. An example of this is where the police have seized all medical records as part of an ongoing investigation and there are no other lines of inquiry for us to look into.

It's more efficient to wait

It can sometimes be significantly quicker, or otherwise more efficient, if we put our investigation on hold to allow the other organisation's investigation to conclude.

For example, if an employer is investigating a concern they may already have interviewed many of the witnesses we'd need to contact. This would have an impact on our case in terms of how much of the evidence is likely to be available.

Similarly, the nurse, midwife or nursing associate may have been able to address the problems in their practice under their employer's guidance. This might impact on whether we need to take the case any further (which ties in with the impact it has on our own fitness to practise decision - discussed below).

The other organisation may be better placed than us to carry out the investigation because of the nature or scale of the allegations. A good example of this might be a wide-ranging investigation into a serious public safety incident within a setting or healthcare organisation.

When we are considering efficiency we will need to think about the relevance of the evidence being gathered by the other organisation to our own investigations, and what benefit we think there would be to waiting for that investigation to conclude. We have separate guidance on the admissibility of such evidence in our guidance library.

It is likely to impact on our own decision about someone's fitness to practise

The outcome of an investigation by another organisation may impact our own decision making in respect of the fitness to practise of the professional we are investigating.

For example, if the police were investigating alleged criminal offending whether this was in a nurse, midwife or nursing associate's professional practice or outside their professional practice, the outcome of the criminal investigation could be relevant to on our own decision on whether we need to take regulatory action at all.

See our guidance on criminal convictions and cautions.

Another example of this could be where another investigation is being carried out into major systemic failings within the professional's place of employment, which is relevant to the issues in the professional's practice that we are investigating. The result of this could be that we better understand the "context" in which the issues occurred, and this in turn could impact on the view we take of the professional's fitness to practise. If this is the case we will need to carefully consider the impact that has on our own investigations, as it may be fairer for us not to conclude our investigation until the third party investigation has finished.

As we explain in our guidance on "context" there may be times when we will need to proactively share information with other organisations if we identify that systems issues caused or contributed to a situation. When we do so we will also need to ask the other organisation whether they intend to conduct their own investigations into those systems issues and consider the impact that has on us progressing our own investigations.

We have separate guidance on the admissibility of the findings of other organisations.

Deciding if we should proceed with our investigation

Where one or more of the four circumstances outlined above is met, this does not mean that we will automatically limit or stop our own investigations. What we will do is carefully consider what it means for our own investigation and then take the steps we think are appropriate in each individual case.

We will look at whether it is possible for our own investigations to continue in full, or whether we need to limit our investigations. This might mean that we only investigate certain parts of our own case which are not linked to the other investigation. Alternatively it might mean that we investigate our whole case but up to a certain point which we have agreed with the other organisation.

We may need to ultimately wait for the other investigation to conclude before we can conclude our own investigations, but there will often be things we can do so that we are in a good position to progress our own case when the other investigation has finished.

For example we may not be able to interview certain witnesses but it may be possible to make initial contact with them at an early stage to let them know that we will need to speak to them after the other investigation has been completed. Another example is that we could seek disclosure from the police about criminal offending for a prosecution that hasn't yet concluded.

As we say above, we may reach a point where we cannot progress our own case any further until the other investigation has finished. There may also be some cases where we cannot progress our case at all until that other investigation is completed. This will mean that our own investigation will need to be paused or delayed.

When we delay an investigation, we must be clear on why we have decided this and why we consider that it's in the public interest for us to do this.

If we decide that our investigation should go ahead, we'll consider whether we should identify a later point in our own process at which we will hold our case, to allow the investigation by the other organisation to conclude, before we would then allow our case to proceed. This will most often be when the case is ready to be considered by case examiners.

What we'll do if our investigation is delayed

If our investigation is delayed this does not mean that we will be doing nothing in the meantime.

We'll need to make sure that we keep in contact with all relevant parties, and in particular the other organisation whose investigation we are waiting to conclude so that we can try and minimise the time our own case needs to be delayed. We should be proactively seeking updates from that organisation so that we can continue to assess whether we can resume our own investigations. This will help us to make sure that we resume our own investigations as soon as we can.

We will also need to consider any new information received from any of the parties, so that we make sure that we are carrying out any necessary risk assessments. This is so that we can make sure that any interim order that is in place remains appropriate, or that we can apply for an interim order if one is not in place and is now needed.

Any time we recommend that a case is closed while another organisation's investigation is ongoing, we will take care to avoid giving any party the impression that the matter has been finally dealt with.

In some cases we can reconsider allegations where new information has surfaced, including outcomes of other investigations.