# 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 and midwives.

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 and midwives 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 or midwife is likely to put patients at risk of harm in the future.

This will very often involve deciding whether or not a nurse, midwife 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 or midwife may repeat the conduct or failings that first caused the concern.

For this reason, we'll only focus on whether the nurse or midwife's clinical failings caused the death or serious injury of a patient if it's clear that the nurse or midwife 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 or midwife:

- 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 or midwife'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 or midwife 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 or midwife is to make similar mistakes in the future.

For example, where a nurse or midwife 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 or midwife'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 or midwife's fitness to practise is impaired.