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

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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)