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## Gathering information

Reference: INV-1 Last Updated: 31/08/2018

### In this guide

- Overview
- Requesting information from the nurse or midwife
- Requesting information from other parties

### Overview

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

We will continually assess what that information 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, 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.

### Requesting information from the nurse or midwife

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

They don't have to do this, but their response and reflection on the events can help us to understand the context in which the concerns came about. It's important that we always take any information we have about the context into account as we investigate.

A detailed response from the nurse or midwife can help us focus our investigation on the most serious issues, and any facts that are in dispute.

If the nurse or midwife 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 nurses and midwives engage with us early on, it's more likely that we'll be able to identify what they might be able to do through [remediation](#) to put the concerns in the case right.

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 or midwife doesn't send us a response about the concerns, these outcomes won't be appropriate.

We may share the nurse or midwife'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 or midwife 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**

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 or midwife 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 or midwife.

# How we investigate health concerns about nurses and midwives

Reference: INV-2 Last Updated: 12/10/2018

## In this guide

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

## Overview

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

Before we start to investigate a nurse or midwife's state of health, we'll already have decided, when screening the case, that there's a potential risk to the public, through careful consideration of how serious the health concerns appear to be.

## What kinds of health information might we need?

After seeking the nurse or midwife'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 or midwife to have a medical examination with an expert doctor, or testing, or sometimes both.

If they refuse to undertake testing or medical examination, the Fitness to Practise Committee can take this into account when deciding if the nurse or midwife is fit to practise.

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

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

One example is a nurse or midwife 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 or midwife 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 and midwives if the nurse or midwife 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

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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.

## Investigating concerns about language competence

Reference: INV-3 Last Updated: 12/10/2018

### In this guide

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

### Overview

When we investigate concerns about a nurse or midwife'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 or midwife's fitness to practise.

### How do we direct nurses and midwives to take language assessments?

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

We will request that the test be taken by a specific date and that the nurse or midwife 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 or midwife 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 or midwife chose to obtain their own [assessment provided by OET](#) we would also accept the result.

### What happens if the nurse or midwife doesn't comply?

If we direct a nurse or midwife 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 or midwife's failure to follow our direction to them to do the test and give us evidence of the result.<sup>1</sup>

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: 24/10/2018

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.

## Independent experts

Reference: INV-5 Last Updated: 31/08/2018

### In this guide

- When we instruct independent experts
- Specialised knowledge or expertise
- Independent opinion
- Expert evidence about a patient's death or serious harm

### 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 or midwife'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 or midwife'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.

### 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 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 or midwives, and we have reason to believe that the local investigation may not have been adequate or credible.

### Investigating health concerns

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.



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For example, although we'll usually ask for information from the nurse or midwife's GP or treating specialist, the therapeutic relationship might make it difficult for them to give us an independent opinion about the nurse or midwife's health, or how it could affect their fitness to practise. This can be particularly difficult if nurse or midwife 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 or midwife'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 or midwife's clinical duties. The expert will need to help us understand, any risk to patients, any risk of relapse, and what support the nurse or midwife may need to help them return to safe practice.

### **Expert evidence about a patient's death or serious harm**

When we investigate what caused the death or serious harm of a patient, we always need to think about the kind of evidence we'll need to explore.

If we consider that the nurse or midwife may have chosen to take an unreasonable risk with the safety of people in their care, which appears to have caused death or serious harm, we'll try to get expert evidence.

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.

The expert will need to consider whether there is evidence that clearly shows that the fault on the part of the nurse or midwife:

- led to the outcome
- made those outcomes more likely, or
- cost the patient a chance of survival.

We wouldn't need to gather independent expert evidence about whether the nurse or midwife's mistake caused the harm in cases where they made a genuine clinical mistake (for example, they did not deliberately choose to take a risk with patient safety).

However, we would usually want to refer to the adverse outcome as part of the background to the case. In these cases we would make clear that we were not looking to hold the nurse or midwife responsible. This means we would not need the specialist knowledge of an independent expert witness to give an opinion about whether the nurse or midwife's error caused the serious harm of death of the patient.

## Investigating at the same time as other organisations

Reference: INV-6 Last Updated: 31/08/2018

### In this guide

- If another organisation is carrying out an investigation
- When we may need to put a case on hold
- Deciding if we should proceed with our investigation
- What we'll do if our investigation is put on hold

### If another organisation is carrying out an investigation

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

If another organisation has started their own investigation, we'll continue with ours unless there are clear and compelling reasons for us to put this on hold.

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

### When we may need to put a case on hold

There are certain circumstances when it would be reasonable to delay our investigation. For example, if:

- there is a real and significant risk that our investigation will **prejudice** the other investigation
- it is **impractical** for our investigation to continue at the same time
- it is likely to be **more efficient** for us to wait because we can use the information the other organisation has gathered

Where one of these conditions is met, we will consider whether it is possible for us to investigate other aspects of the case while the other investigation continues.

We talk more about these conditions in the guidance below.

### 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 or midwife's practise, 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 or midwife 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

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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.

We'd also be unlikely to investigate any alleged criminal offending that happen outside a nurse or midwife's clinical practice, wasn't related to it in any way, or had no direct link to their professional registration as a nurse or midwife, unless they eventually received a criminal conviction or caution.

### **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 or midwife may have been able to remedy the problems in their practice under their employer's guidance.

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.

Putting our case on hold for an investigation to finish would be reasonable if we'd already looked at all other feasible lines of inquiry.

## **Deciding if we should proceed with our investigation**

We'll consider how long it's likely to take for the other organisation to conclude their investigation.

If there's any possibility that the other investigation could cast doubt on a decision to close the case, or could mean we are asked to reopen the case, and that investigation is likely to conclude quickly, it will normally be better to wait for it to conclude before we progress our case.

On the other hand, if the other investigation has no end in sight or its conclusion is still a significant length of time away, it is likely to be appropriate to conclude our investigation in the meantime.

We'll also consider if potential impact of the outcome of the other investigation on the nurse or midwife's fitness to practise when deciding whether to put in place a stopping point.

An example of this could be where another investigation finds major systemic failings within the nurse or midwife's place of employment. The result of this could be that the Fitness to Practise Committee is far less likely to find that the nurse or midwife's fitness to practise is currently impaired. If this is a real possibility, it will rarely be appropriate to conclude our investigation until the third party investigation has finished.

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 put on hold**

If our investigation is put on hold, we'll make sure to keep in contact with all relevant parties.

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.

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We'll also maintain contact with:

- the other investigating organisation – we'll use these regular updates to stay well informed of new and unexpected information which may inform our decision to keep the case on hold
- any witnesses – we'll often take witness statements at the beginning and then to contact witnesses to reconfirm them once the case is no longer on hold.

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