Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday 2 December 2024 – Wednesday 4 December 2024

Virtual Meeting

Name of Registrant:	**Linda Craymer**
NMC PIN:	07K0199E
Part(s) of the register:	Registered Nurse – RNA Adult Nursing – June 2008
Relevant Location:	Hampshire
Type of case:	Misconduct
Panel members:	Derek McFaull (Chair, lay member) Jonathan Coombes (Registrant member) Seamus Magee (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Eidvile Banionyte
Facts proved:	Charges 1, 2, 3, 4, 5 and 8
Facts not proved:	Charges 6, 7 and 9
Fitness to practise:	**Impaired**
Sanction:	**Suspension order (3 months)**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that that the Notice of Meeting had been sent to Mrs Craymer's registered email address by secure email on 24 October 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegations, the time, dates and the fact that this meeting was to be heard virtually.

In the light of all of the information available, the panel was satisfied that Mrs Craymer has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Details of charge as amended

'That you, a registered nurse:

1) On 1 January 2022 failed to give Resident 1 the correct dose of Morphine sulphate by administering 10mg/1ml instead of 1.25mg-2.5mg as prescribed.

2) On 1 January 2022 failed to accurately record the correct dose of Midazolam administered by the GP to Resident 1, by recording 10mg had been administered when the actual dose administered was 2.0mg.

3) On 2 February 2022 inaccurately recorded Resident 2 had been given their evening medication when they had not by pre-signing and/or completing the MAR chart.

4) On 2 February 2022 failed to discard Residents 2's medication by leaving it on the trolley and not disposing of it straight away.

5) On 27 April 2022 recorded Resident ‘3s insulin prescription on the ATLAS system as 20 units.

6) On 27 April 2022 administered Resident 3, 20 units of insulin instead of the prescribed dose of 10 units.

7) On 1 May 2022 administered Resident 4 with 4.5mg of prednisolone instead of the prescribed amount of 7mg.

8) On 6 May 2022 administered Resident 3, with 5mg/2.5ml of morphine instead of the prescribed amount of 2.5mgs/1.25ml.

9) On 6 May administered Resident 5, 5mgs of Memantine and not the 15mg as prescribed.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.’

Background

On 13 May 2022 the NMC received a referral from Alverstoke House Nursing Home (the Home) concerning Mrs Craymer who was employed as a registered nurse at the Home from December 2021 until her resignation on 11 May 2022.

The initial concerns relate to an incident which occurred on 1 January 2022. Mrs Craymer had requested the attendance of an out of hours General Practitioner (GP) for Resident 1 [PRIVATE]. [PRIVATE]. The GP administered 5mg/0.5ml of Midazolam during their visit. It is alleged that Mrs Craymer gave 10mg/1ml of Morphine Sulphate at 15:34 to Resident 1 (post the GP’s visit).

Mrs Craymer states that the GP told her to give 1ml of morphine to Resident 1 if their pain increased. However, it is noted that the prescription and white card for Resident 1, understood for anticipatory prescribing at end of life, stated to administer 1.25mg-2.5mg of morphine only. It is alleged that the dose which Mrs Craymer gave (10mg/1ml) was the

maximum dose for 24 hours. It is alleged that Mrs Craymer administered Midazolam to Resident 1 that day and her recording of the administration of Midazolam was inaccurate.

[PRIVATE]. Referrals were made by the Home to the Police, Safeguarding and the Care Quality Commission (CQC) but no further action was taken. [PRIVATE].

Mrs Craymer was suspended on 3 January 2022 by the Home, as a result of these initial concerns the Home undertook an internal investigation. A disciplinary meeting was conducted with Mrs Craymer on 7 January 2022 which resulted in a final written warning being issued to Mrs Craymer.

The following concerns were subsequently identified by the Home following investigation:

On 2 February 2022, it is alleged that Mrs Craymer had gone to give Resident 2 medication at around 20:30 and she signed that this had been administered, but the medication had not been administered as Resident 2 was sleeping. It is also alleged that Mrs Craymer did not discard the medication straight away.

On 27 April 2022, Resident 3 was admitted to the Home as a type 2 diabetic who was on Humulin Insulin 10 units. Pre-admission to the Home, Resident 3 was on 20 units with a reducing dose with dates noted to reduce the dosage. Resident 3's care plan stated 16 units, and the medication system stated 20 units. However, the Hospital Discharge Summary stated 10 units which was the correct dose.

On 1 May 2022, it is alleged that Mrs Craymer administered Resident 4 with 4.5mg of prednisolone instead of the prescribed amount of 7mg.

On 6 May 2022, it is alleged that Mrs Craymer gave Resident 3 a double dosage of oral Morphine which was 2.5ml/5mg when it should have been 1.25ml/2.5mg.

On 6 May 2022, it is further alleged that Mrs Craymer failed to give Resident 5 the correct dose of Memantine. Mrs Craymer gave 5mgs and not 15mgs as prescribed.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence in this case.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Registered Manager at the Home
- Witness 2: Specialist Safeguarding Nurse
- Witness 3: Senior Healthcare Assistant

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the documentary evidence provided by the NMC.

The panel then considered each of the charges and made the following findings.

Charge 1

> "That you, a registered nurse, on 1 January 2022 failed to give Resident 1 the correct dose of Morphine sulphate by administering 10mg/1ml instead of 1.25mg-2.5mg as prescribed."

This charge is found proved.

The panel determined that Mrs Craymer was the registered nurse on duty at the time of the allegation and that she was therefore responsible for the care of Resident 1. In determining this the panel had regard to Mrs Craymer's job description as well as her own acceptance in the local statements confirming that she was responsible for Resident 1 at

the time. The panel determined therefore that Mrs Craymer, as part of her duty as a registered nurse, was responsible to give Resident 1 the correct dose of the prescribed medication.

The panel had regard to the written evidence of Witness 1 and the exhibits within their witness statement.

The panel noted that the Resident 1's patient records and an entry in it clearly showing that the prescribed dose of Morphine sulphate was 1.25mg-2.5mg as required. The panel further noted the medication chart for Resident 1, and an entry on it at 15.34 on 1 January 2022, which indicated that 10mg/1ml of Morphine sulphate was administered by Mrs Craymer.

The panel also noted the evidence of Witness 3, who was present at the time and confirmed that Mrs Craymer had administered 10mg/1ml of Morphine sulphate to Resident 1.

The panel therefore found this charge proved, on the balance of probabilities.

Decision and reasons on amending the charge

During the panel's deliberations with regards to charge 2, the panel decided that it was necessary to amend the wording of the charge.

The amendment was to substitute 2.5mg to 2.0mg to accurately reflect the records before it within the patient records. It was determined that the proposed amendment would provide clarity and more accurately reflect the evidence.

"That you, a registered nurse:

2. "That you, a registered nurse, on 1 January 2022 failed to accurately record the correct dose of Midazolam administered by the GP to Resident 1, by recording 10mg had been administered when the actual dose administered was 2.~~5~~**0**mg"

And in light of the above, your fitness to practise is impaired by reason of your misconduct."

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel was of the view that such an amendment, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mrs Craymer and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

The panel then went on to consider the charge.

Charge 2

"That you, a registered nurse, on 1 January 2022 failed to accurately record the correct dose of Midazolam administered by the GP to Resident 1, by recording 10mg had been administered when the actual dose administered was 2.0mg"

This charge is found proved.

As per the charge above, the panel determined that Mrs Craymer had a duty to accurately record the correct dose of Midazolam administered by the GP to Resident 1.

In reaching this decision, the panel took into account witness statements of Witness 1 and 2 and the exhibits contained within them.

The panel had before it evidence that the doctor had drawn down but had discarded the surplus Midazolam, indicating that the full amount was not required.

The panel also had regard to written statement of Witness 2, in which they exhibit the local statement of the GP confirming that the correct dose administered was 2.0mg.

In contrast, the panel noted that Resident 1's patient records completed by Mrs Craymer indicated that 10mg had been administered.

The panel preferred the evidence of the GP doctor, as opposed to Mrs Craymer's account in her reflection.

The panel therefore found this charge proved, on the balance of probabilities.

Charge 3

> "That you, a registered nurse, on 2 February 2022 inaccurately recorded Resident 2 had been given their evening medication when they had not by pre-signing and/or completing the MAR chart."

This charge is found proved.

As previously outlined, the panel determined that Mrs Craymer had a duty to accurately record whether Resident 2 had been given their evening medication.

The panel had regard to the witness statement of Witness 1 and the exhibits.

The panel noted that the Medication Administration Record (MAR) chart had been signed at 20.00 by Mrs Craymer indicating that Resident 2 had been given medications.

The panel had regard to the evidence provided by Witness 1 that Resident 2's medicines had subsequently been found by another nurse still on the medicine trolley.

The panel also had regard to Mrs Craymer's reflective account where she accepted her error indicating that she had "*got distracted, not gone back to the resident or disposed of the medications leaving them on the trolley*".

The panel therefore found this charge proved, on the balance of probabilities.

Charge 4

> “That you, a registered nurse, on 2 February 2022 failed to discard Residents 2’s medication by leaving it on the trolley and not disposing of it straight away.”

This charge is found proved.

In reaching this decision, the panel took into account witness statement of Witness 1.

The panel noted that Witness 1 confirmed that Resident 2’s medications were left on the trolley and not disposed of.

The panel also noted that Mrs Craymer had recently been signed off as competent in Medication Policy and Procedure on 7 December 2021, so she would have known how to dispose of the medication in the correct manner.

The panel also noted Mrs Craymer’s admissions in her reflective account confirming that she had left the medication on the trolley and had forgotten about it.

The panel therefore found this charge proved, on the balance of probabilities.

Charge 5

> “That you, a registered nurse, on 27 April 2022 recorded Resident ‘3s insulin prescription on the ATLAS system as 20 units.”

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 and the exhibits contained within.

The panel recognised, that whilst there was no clear documentary evidence from the ATLAS system which goes to support this charge. Witness 1 provided evidence that they had seen the original document but indicated that they could not provide a copy of the

original entry made by Mrs Craymer. Witness 1 explained that they had amended it upon finding the error and the entry containing the original error no longer existed.

Additionally, Mrs Craymer's reflective account acknowledged that she had made an error.

The panel therefore found this charge proved, on the balance of probabilities.

Charge 6

> "That you, a registered nurse, on 27 April 2022 administered Resident 3, 20 units of insulin instead of the prescribed dose of 10 units."

This charge is found not proved.

In reaching this decision, the panel took into account witness statement of Witness 1 and the exhibits contained within.

The panel noted that 27 April 2022 the record of administration of insulin was made by Person 1, an unknown person, rather than LC, Mrs Craymer.

The panel determined that there was nothing before this panel to suggest that the 27 April 2022 entry was made by Mrs Craymer. Therefore, the panel could not be satisfied that she had administered 20 units of insulin to Resident 3 instead of the prescribed dose of 10 units. She was not the nurse who made the entry in the records, as the evidence from the MAR chart shows.

The panel further noted that the NMC's case in respect of this charge was further undermined by Resident 3's MAR chart records which indicated that all medications administered on the morning of 27 April 2022, which included the insulin, were not administered by Mrs Craymer but by another member of staff.

The panel therefore found this charge not proved, on the balance of probabilities.

Charge 7

"That you, a registered nurse, on 1 May 2022 administered Resident 4 with 4.5mg of prednisolone instead of the prescribed amount of 7mg"

This charge is found not proved.

In reaching this decision, the panel took into account Witness 1's witness statement and the exhibits contained within.

The NMC relies on this evidence and the NMC's case is that Mrs Craymer had administered an underdose of 2.5mg of prednisolone.

On examination of the MAR charts there are entries attributed to Mrs Craymer as follows: 8am, two times 1mg tablets, 8am, two times 2.5mg tablets, which together equate to the administration of 7mg of prednisolone.

The panel further noted that at lunch time on the same there is a further entry by Mrs Craymer of one 2.5mg tablet. All together in total this amounts to 9.5mg. It is unclear to the panel how the NMC allege that 4.5mg were given instead of 7mg.

The evidence provided by Witness 1, regarding conversations Mrs Craymer had regarding this alleged incident are hearsay and failed to establish the NMC case.

The panel also noted that subsequent entries would appear to indicate that 12mg of prednisolone was given to Resident 4 on the subsequent days following this alleged incident.

The panel therefore found this charge not proved, on the balance of probabilities.

Charge 8

"That you, a registered nurse, on 6 May 2022 administered Resident 3, with 5mg/2.5ml of morphine instead of the prescribed amount of 2.5mgs/1.25ml.

This charge is found proved.

In reaching this decision, the panel took into account the witness statement of Witness 1 and the exhibits contained within.

The panel noted that MAR records for Resident 3 suggested that the prescribed amount of morphine was 2.5mgs/1.25ml. The panel further noted that the medication administration entry on 6 May 2022 indicated, that 5mg/2.5ml of morphine was administered to Resident 3, and that this entry was attributed to Mrs Craymer.

The panel had no information from Mrs Craymer regarding this allegation.

The panel therefore found this charge proved, on the balance of probabilities.

Charge 9

> "That you, a registered nurse, on 6 May administered Resident 5, 5mgs of Memantine and not the 15mg as prescribed.

This charge is found not proved.

In reaching this decision, the panel took into account Witness 1's witness statement, the MAR charts as well as the patient records for Resident 5.

The panel determined that the evidence before it showed that Mrs Craymer had given the correct doses of Memantine, that being 15mg as prescribed, to Resident 5.

The panel further determined that there was nothing before it to show that an incorrect dose had been given to Resident 5.

The panel had no information from Mrs Craymer regarding this allegation.

The panel therefore found this charge not proved, on the balance of probabilities.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mrs Craymer's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage, and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Mrs Craymer's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (No. 2)* [2000] 1 AC 311 which defines misconduct as a 'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'

The NMC, in their written submissions, invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015' ("the Code") in making its decision.

The NMC identified the specific, relevant standards where Mrs Craymer's actions amounted to misconduct and referred the panel to the relevant provisions of the Code.

The NMC requires the panel to bear in mind its overarching objective to protect the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory

body. The panel has referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC, in their written submissions, invited the panel to find Mrs Craymer's fitness to practise impaired on the grounds of public protection and otherwise in the public interest:

> '*Mrs Craymer's actions put those receiving her care at unwarranted risk of harm. The incidents which occurred were serious particularly in respect of the poor medications practice as residents were placed a potential risk of ham by receiving medication in excess of their prescriptions. Such failures could result in a decline in health of those within Mrs Craymers's care and could lead to complications. Those within Mrs Craymer's care were vulnerable residents who depended on Mrs Craymer to provide them with the correct medication dosage. Mrs Craymer's actions compromised patient safety and had the potential to cause serious harm to residents in her care*.
>
> *Without access to current or accurate records, other professionals involved in the care of such residents may not have all the required information to access and care for a resident.*
>
> *The nursing profession is a caring profession. Mrs Craymer has breached individual provisions of the Code which constitute the fundamental tenets of the nursing profession, namely practising effectively and preserving safety. The conduct involved engaged and breached the above provisions.*
>
> *As per the guidance on impairment DMA-1, while not all breaches of the Code require a finding of impairment, but where a breach of the Code involves breaching a fundamental tenet of the profession, the FtPC would be entitled to conclude that a finding or impairment is required.*
>
> *The guidance at DMA-1 sets out the following three areas which will be important for the panel to consider in respect of context: personal factors relating to the profession, the professional's working environment and culture and the learning, insight and steps the professional has taken to strengthen their practice.*

When considering the issue of insight, the key criteria a registrant should address to demonstrate they have insight are as follows: they recognise what went wrong, they accept their role and responsibilities in the failings, and they understand how to act differently in the future. Mrs Craymer had made admissions regarding the identified concerns during the Home's internal investigation but, she has not provided a formal response regarding the regulatory concerns to the NMC. Mrs Craymer has not been able to provide evidence of remediation to demonstrate what she has learnt from her previous mistakes or to alleviate the risk of repetition

Mrs Craymer in an email dated 19 May 2022 stated [PRIVATE] and will no longer be looking for employment in the nursing profession: "[PRIVATE]" In the same email chain, in an email dated 25 May 2022, Mrs Craymer stated that she has decided not to renew her registration with the NMC [PRIVATE].

With regard to future risk, it is submitted that the panel will likely find assistance in the questions asked by Silber J in the case of R (on application of Cohen) v General Medical Council [2008] EWHC 581 (Admin), namely, is the misconduct easily remediable, has it in fact been remediated and is it highly unlikely to be repeated.

However, this insight is minimal and unsatisfactory. The medication errors were in relation to five residents and the record keeping errors were in relation to three residents which demonstrate a risk of repetition. Mrs Craymer has provided no evidence of recent training undertaken in relation to either medication administration or record-keeping.

Mrs Craymer is not currently working as a nurse and has indicated that she does not wish to return to nursing. She has not been able to provide evidence of remediation to demonstrate what she has learnt from her previous mistakes or to alleviate the risk of repetition. Mrs Craymer has provided no evidence of any steps taken by her to address the concerns in this case. Therefore, we are not satisfied that the concerns have been addressed and that the risk of repetition is low.

We consider there is a continuing risk to the public due to Mrs Craymer's lack of remediation and her limited insight, and failure to demonstrate any meaningful

reflection. There is a significant risk of harm to the public were the registrant allowed to practise without restriction. A finding of impairment is therefore required for the protection of the public.

Public interest

Mrs Craymer's conduct in failing to deliver appropriate care and documenting care that should have been provided accurately, calls into question her ability to preserve safety for those in her care. Registered professionals occupy a position of trust and must therefore act with integrity and promote a high standard of care at all times. Mrs Craymer's failure to do so has brought the profession into disrepute and is likely to bring the profession into disrepute in the future. Mrs Craymer's failings have also breached fundamental tenets of the profession.

Nurses are expected to provide a high standard of care at all times and uphold the reputation of the profession. The public expects nurses to practise safely and effectively, including ensuring their conduct, actions and any provided treatment is carried out with the utmost care and attention, with accurate administration of medication and records at all times. This therefore has a negative impact on the reputation of the profession, and, accordingly, has brought the profession into disrepute.

We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Mrs Craymer's misconduct engages the public interest because members of the public would be concerned to hear of a nurse failing in such basic nursing practice; not keeping accurate records of the care provided to patients and failing to administer the correct medication. Such conduct would severely damage and undermine public confidence in the nursing profession and the NMC, as the regulator.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included *R (Calhaem) v General Medical Council* [2007] EWHC 2606 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Mrs Craymer's actions did fall significantly short of the standards expected of a registered nurse, and that Mrs Craymer's actions amounted to a breach of the Code. Specifically:

*'**1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively.'

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event.

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements.'

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

18.4 take all steps to keep medicines stored securely.'

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place.

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that collectively, given the serious nature of some of the repeated mistakes being made, these breaches amounted to misconduct.

The panel found that Mrs Craymer's actions did fall seriously short of the conduct and standards expected of a nurse, it demonstrated a significant number of failures in respect of medications and consequently the panel found that it amounted to serious misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mrs Craymer's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

> *'The question that will help decide whether a professional's fitness to practise is impaired is:*
>
> *"Can the nurse, midwife or nursing associate practise kindly, safely and professionally?"*
> *If the answer to this question is yes, then the likelihood is that the professional's fitness to practise is not impaired.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and

the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/their fitness to practise is impaired in the sense that S/He/They:*
>
> *a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
>
> *b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
>
> *c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

The panel finds that particularly vulnerable patients were put at risk of physical harm due to Mrs Craymer's medication errors. The panel found that all three limbs of *Grant* were

engaged and as such Mrs Craymer's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel considered that Mrs Craymer had limited insight into her misconduct. The panel noted Mrs Craymer's reflective pieces written at the time of the allegations were limited in nature and did not address all of the concerns. The panel further noted that Mrs Craymer did make some admissions and did express some remorse into some of the misconduct at the time. However, it is Mrs Craymer's stated intention to the NMC that she has not been nursing since the time of these events and has no intention to return to nursing.

The panel was satisfied that the misconduct in this case is capable of being addressed. However, the panel had no evidence before it to suggest that Mrs Craymer has taken any steps to strengthen her practice. The panel is of the view that there is a risk of repetition based on the limited insight and limited information the panel has before it, as there was nothing before the panel to suggest that Mrs Craymer had learned from her errors. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because public confidence in the profession would be undermined if a finding of impairment were not made in this case.

Having regard to all of the above, the panel was satisfied that Mrs Craymer's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of three months. The effect of this order is that the NMC register will show that Mrs Craymer's registration has been suspended.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and had careful regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that the NMC is seeking the imposition of a suspension order for a period of 12 months with a review, if it found Mrs Craymer's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mrs Craymer's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- Conduct which put residents at risk of suffering harm;
- A pattern of misconduct over a period of time;
- Limited insight of an experienced nurse in a position of responsibility.

The panel also took into account the following mitigating features:

- Challenges in the home at the time of Mrs Craymer's appointment compounded by a Covid-19 outbreak resulting in limited induction or supervision;
- Acceptance at an early stage of some of the medicines failings.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the limited insight into her failings. The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Craymer's practice would not be appropriate in the circumstances.

The SG states that a caution order may be appropriate where '*the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'*

The panel considered that Mrs Craymer's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the clinical and medication issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Craymer's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*

The panel did consider a conditions of practice order appropriate in this case. However, due to the lack of Mrs Craymer's engagement with the NMC since May 2022 and lack of

up-to-date information with regards to her future intentions regarding nursing, the panel determined that there are no practical or workable conditions that could be formulated.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

It did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, the panel concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mrs Craymer's case to impose a striking-off order.

Balancing all of these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.

The panel noted the potential hardship such an order could inevitably cause Mrs Craymer. However, this is outweighed by the public interest in this case.

The panel considered that this order is necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

The panel determined that a suspension order for a period of three months was appropriate in this case to mark the seriousness of the misconduct.

At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.

Any future panel reviewing this case would be assisted by:

- Up-to-date information regarding Mrs Craymer's intentions with regards to her nursing career;
- Evidence of professional development, including documentary evidence of completion of any relevant courses, and testimonials from a line manager or supervisor that detail Mrs Craymer's current work practices;
- Engagement with the NMC.

This will be confirmed to Mrs Craymer in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Mrs Craymer's own interests until the suspension sanction takes effect.

The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took account of the written representations made by the NMC that invited the panel to impose an interim suspension order, on the basis that it is necessary for the protection of the public and otherwise in the public interest.

Decision and reasons on interim order

The panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. The panel had regard to the seriousness of the facts found proved and the reasons set out in its decision for the substantive order in reaching the decision to impose an interim order.

The panel concluded that an interim conditions of practice order would be inconsistent with its earlier findings in this case due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months to cover the appeal period.

If no appeal is made, then the interim suspension order will be replaced by the substantive suspension order 28 days after Mrs Craymer is sent the decision of this hearing in writing.

That concludes this determination.