Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 1 September 2025 – Tuesday, 9 September 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ
(Monday, 1 September 2025)

Virtual Hearing
(Tuesday, 2 September – Tuesday, 9 September 2025)

Name of Registrant:	John Craigie
NMC PIN:	90E0289S
Part(s) of the register:	Nurses part of the register Sub part 1 RN3, Registered Nurse - Mental Health (02 September 1993)
Relevant Location:	Argyll and Bute Council
Type of case:	Misconduct
Panel members:	Chris Weigh (Chair, lay member) Isobel Leaviss (Lay member) Susan Ball (Registrant member)
Legal Assessor:	William Hoskins
Hearings Coordinator:	Eric Dulle
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Mr Craigie:	Not Present and unrepresented
Facts proved:	Charges 1a), b), c), d), e), f,) and g)
Facts not proved:	N/A
Fitness to practise:	**Impaired**

Sanction:	**Suspension order (12 months)**
Interim order:	**Interim Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Craigie was not in attendance and that the Notice of Hearing letter had been sent to Mr Craigie's registered email address by secure email on 31 July 2025.

Ms Da Costa, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and venue of the hearing and, amongst other things, information about Mr Craigie's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

In the light of all of the information available, the panel was satisfied that Mr Craigie has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Craigie

The panel next considered whether it should proceed in the absence of Mr Craigie. It had regard to Rule 21 and heard the submissions of Ms Da Costa who invited the panel to continue in the absence of Mr Craigie. She submitted that Mr Craigie had voluntarily absented himself.

Ms Da Costa submitted that there had been no engagement at all by Mr Craigie with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel also noted, that following day 1 of the in-person hearing, that an additional communication email was sent to Mr Craigie on 1 September 2025, informing him that this hearing will be continuing virtually and providing him with a virtual hearing link to participate in these proceedings.

The panel has decided to proceed in the absence of Mr Craigie. In reaching this decision, the panel has considered the submissions of Ms Da Costa and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Craigie;
- Mr Craigie has indicated in emails and during a phone call in March 2025 (that he terminated) that he no longer wishes to practise as a registered nurse and will not engage any further;
- Mr Craigie has not provided the NMC with details of how he may be contacted other than his registered addresses;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- The charges relate to events that occurred in 2021; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Craigie in proceeding in his absence. Although the evidence upon which the NMC relies has been sent to him at his registered email address,

he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Craigie. The panel will draw no adverse inference from Mr Craigie's absence in its findings of fact.

Details of charge

That you, a registered nurse:

1. On 17 August 2021, in relation to Resident A:

    a. Did not examine Resident A after they had a fall.

    b. Did not complete post-fall observations.

    c. Moved Resident A into their wheelchair using an inappropriate method in that you wrapped your arms around the resident's waist (bear hug) to lift them from the floor into the wheelchair.

    d. Did not complete an incident form in relation to their fall.

    e. Did not record their fall in the resident's notes.

    f. Did not instruct and/or ensure staff completed an incident form.

    g. Did not instruct and/or ensure staff recorded the resident's fall in the resident's notes.

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

Background

The charges arose whilst Mr Craigie was employed as a registered nurse by Kintyre Care Centre (the "Home"), a residential care home for the elderly which at the time of the alleged incident was run by HC-One. The panel was told that Mr Craigie had been working at the home for approximately 10 years and at the time of the alleged incident, he was the sole registered nurse on duty in charge of the nightshift. Concerns were raised about Mr Craigie's response following a resident's fall, and the panel had been provided with the local investigation interview and disciplinary meeting notes, documents gathered and the outcome report.

Decision and reasons on application to admit hearsay evidence

Ms Da Costa made an application under Rule 31 to allow the interviews of Colleagues 1, 2 and 3, along with an interview of Mr Craigie, into evidence. Specifically, Ms Da Costa has applied for the following exhibits to be admitted into evidence:

- JM-5: Record of Mr Craigie's local disciplinary meeting
- JM-6: Notes of local investigatory interview between Witness 1 and Colleague 1 (senior care assistant)
- JM-9: Notes of conversation between Witness 1 and Colleague 1
- JM-10: Notes of local investigatory interview between Witness 1 and Colleague 2 (night-shift care assistant)
- JM-12: Agency investigation interview notes with Colleague 3 (agency night-shift care assistant)

Ms Da Costa made reference to the case of *Thorneycroft V NMC* [2014] EWHC 1565 (Admin), which provides a guide as to how a panel should approach hearsay evidence.

Ms Da Costa submitted that the interviews with Mr Craigie and Colleagues 1, 2 and 3 are not the only evidence of the charges nor are they the decisive evidence. Ms Da Costa indicated that the core evidence of the charges is found in the evidence of Colleagues 1

and 2. She further submitted that there is also a range of evidence for the panel to refer to when determining the facts.

When questioned by the panel, Ms Da Costa stated that the NMC made one attempt to contact Colleagues 1, 2 and 3. She stated that only Colleague 1 replied, indicating that he was not a direct witness to the incident and would not provide a formal statement. Ms Da Costa otherwise stated that she could not provide any further information as to why the witnesses cannot attend.

In conclusion, Ms Da Costa submitted that the inclusion of the interview notes with Colleagues 1, 2 and 3 are relevant and fair.

The panel accepted the advice of the legal assessor.

The panel considered carefully whether it was relevant and fair to admit this hearsay evidence, and in doing so, had regard to the guidance contained in *Thorneycroft v NMC*.

Relevancy

The panel determined that all of the evidence applied for in this hearsay application is relevant. In particular, the panel concluded as follows:

- JM-5 is relevant to all charges as it records Mr Craigie's responses to the concerns raised at the time;
- JM-6 and 9 is relevant to the issue of whether Mr Craigie completed the incident form himself, or whether he asked anyone else to complete the incident form (Charges 1d) and 1f));
- JM-10 is relevant to the issue of whether Mr Craigie completed any checks after the fall of Resident A (Charges 1a) and 1b)); and
- JM-12 is relevant to the issue of whether Mr Craigie filled out an incident form following the incident (Charge 1d)).

Therefore, the panel concluded that all evidence applied for in this hearsay application is relevant to the charges.

Fairness

The panel considered the *Thorneycroft* principles and the guidance in *DMA-6* in relation to each piece of evidence subject to this hearsay application.

Evidence - JM-5

The panel noted that the evidence is important and relates directly to the charges. The panel further noted that the evidence is not sole and decisive, as there is also other evidence.

The local disciplinary meeting was held shortly following the alleged incident. Whilst the notes were not a verbatim record and had not been signed by Mr Craigie, this was a formal meeting conducted by the area director and the hearing manager from HC-One and the notes had been made by a note taker. Questions and answers were also recorded. The panel determined it was appropriate to admit this evidence as it contained Mr Craigie's position in relation to the concerns raised.

In addition, the panel noted that it is important that JM-5 relates to Mr Craigie's own account of what occurred and found that it is important and fair to Mr Craigie to consider his own account of the events.

Finally, the panel found that the accuracy of this record has not been challenged by Mr Craigie.

Therefore, the panel concluded that the evidence in JM-5 is relevant, and it is fair to admit it.

Evidence - JM-6

The panel determined that that the evidence is contemporaneous with the incident, as the interview was taken on the same day that the incident is alleged to have occurred. Further, the panel found that the evidence in JM-6 is not sole or decisive to establishing the charge; the evidence contained in JM-6 is reflected elsewhere in other evidence.

Further, the panel noted that the contents of this evidence has not been challenged by Mr Craigie.

Finally, there was no evidence before the panel to suggest that the evidence was falsified, or that there would have been any reason to falsify this evidence.

As a result, the panel concluded that the evidence in JM-6 is relevant, and it is fair to admit it.

Evidence - JM-9

The panel noted that the conversation in JM-9 occurred the day after the incident, as opposed to on the same day. Nonetheless, the panel still concluded that this evidence is contemporaneous with the incident in that it was recorded on the following day.

Therefore, the panel concluded that the evidence in JM-9 is relevant, and it is fair to admit it.

Evidence - JM-10

The panel concluded that the evidence is not sole and decisive as it is reflected elsewhere, including in Mr Craigie’s own account.

Further, the panel found that although aspects of this evidence are in dispute, Mr Craigie has not directly challenged the evidence. Mr Craigie has in fact admitted and agreed to parts of the evidence in JM-10. To the extent that this evidence is in dispute, the panel found that the evidence is not sole and decisive, and can be considered alongside the entire evidentiary record. Furthermore, the panel concluded that the evidence should be admitted as Colleague 2 was a direct witness of the events and her veracity has not been challenged by Mr Craigie.

The panel therefore concluded that JM-10 should be admitted as it is relevant, and it is fair to admit it.

Evidence - JM-12

The panel determined that it would also be fair to admit the evidence JM-12. The evidence is not sole and decisive, and is reflected by the other available evidence.

While the panel noted that the evidence in JM-12 and Mr Craigie's account differs in some areas, there are no discrepancies insofar as the Mr Craigie's involvement in the incident is concerned.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Ms Da Costa on behalf of the NMC.

The panel has drawn no adverse inference from the non-attendance of Mr Craigie.

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 heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Senior staff nurse currently working at the Home

At the time of the incident, Witness 1 had been working as the Moving and Handling Instructor at HC-One Highgate Care Home. This was in the same ownership group of homes as the Home and she told the panel that the same training was provided across the group reflecting the policies of the group.

- Witness 2: Registered nurse and manager at the Home currently and at the time of the incident

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

It considered the witness and documentary evidence provided by the NMC.

The panel then considered each aspect of the charge in dispute and made the following findings.

Charge 1a)

"That you, a registered nurse:

a. *Did not examine Resident A after they had a fall*."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, the written and oral evidence of Witnesses 1 and 2, the hearsay evidence of the interviews of Colleague 2, and Mr Craigie's interviews in the investigatory and disciplinary meetings.

The panel heard that conducting a post-fall examination was particularly important in the case of this specific resident, who was described by Witness 2 as being immobile, having advanced dementia and needing assistance with mobilisation and meals. Witness 2 stated that from memory, the resident was not able to speak and therefore may not have been able to articulate any injuries to Mr Craigie or the Home's staff.

The panel noted that it was not in dispute that Mr Craigie was the only registered nurse on duty, had not witnessed the fall, and had responded to the emergency call bell rung by one of the care assistants, and attended to the resident in the presence of Colleagues 2 and 3.

The panel considered the witness statement of Witness 1 as well as her oral testimony, who stated that a post-fall examination of any resident prior to moving them requires as follows:

> *"If I saw a resident on the floor, I would firstly check if they were bleeding. If they were, I would try to stop the bleeding. If they were not, I would try speaking to them to check if they were conscious and if they were ok or if they were in any pain. I would then do a thorough head-to-toe assessment. I would start by checking their head for any lumps or bumps to ensure that there was nothing indicating a head injury. Black eyes, nausea and vomiting may also indicate a head injury. I would next check the resident's body. I would also be mindful that fractured hips are a very common consequence of falls. I would check if the resident had normal mobility in both legs and if they could rotate to their sides. One leg shorter than the*

other one could also be a sign of a broken hip. Before moving the resident, we should always check if the resident did not sustain any injuries and check if they were in any pain."

The panel accepted the evidence of Witness 1. While she was not present at the time of the incident, the panel accepted her evidence as to what an examination would entail in the circumstances.

The panel also considered the evidence of Witness 2 who was a manager of the Home at the time. She gave evidence regarding the proper conduct required when examining a patient that was consistent with what the panel heard from Witness 1.

The panel considered Mr Craigie's responses to the local investigation as to the steps he took after Resident A's fall, which he explained as follows:

'I checked her over quickly, she looked bright, legs moving
…
'*I quickly checked her over, legs fine, nothing broken, she was chirpy*'

The panel further noted that Colleague 2 was interviewed by Witness 2 on 18 August 2021. When asked whether Resident A was fully examined, Colleague 2 replied as follows:

'Witness 2: Do you know how she was transferred?
Colleague 2: she was carried from floor onto the chair by [Mr Craigie]
Witness 2: Did [Mr Craigie] check her over for any injuries?
Colleague 2: No, not like I've seen other residents be checked over.
Witness 2: Can you tell me if her checked her legs and hips?
Colleague 2: No he didn't touch her legs
Witness 2: What about her arms.?
Colleague 2: No, not the way I saw you check over CC when she fell.

Witness 2: Did he check her head?
Colleague 2: No he just lifted her up.'

The panel found the evidence to be credible, and that since the interview took place soon after the incident it was contemporaneous. Further, the panel found that there was no evidence that she would have embellished the evidence and found it to be consistent with Mr Craigie's own account.

When considering the totality of the evidence, the panel concluded that the steps taken by Mr Craigie do not constitute an examination in the context of what would be required following a fall as described by Witnesses 1 and 2. In other words, Mr Craigie did not conduct an examination of Resident A.

As such, the panel found charge 1a) proved.

Charge 1b)

"That you, a registered nurse:

b. Did not complete post-fall observations."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and the written and oral evidence of Witnesses 1 and 2.

The panel considered the evidence of Witness 1, who described in her written evidence the actions which should have been taken after a fall, and observations that should be made. She described these as follows:

'… a full set of observations including blood pressure, heart rate, oxygen, temperature and respiratory rate to check if everything was ok.'

The panel also considered the evidence of Witness 2, who confirmed the post-fall observation requirements as indicated by Witness 1, while also indicating that a Glasgow Coma Scale examination should have been performed if a head injury was suspected.

The panel heard from Witness 2 that as part of her investigation, she had reviewed the resident's record and no post-fall observations had been recorded.

The panel was told by Witnesses 1 and 2 that post-fall observations should be completed as follows:

- Every 15 minutes for the first hour;
- Every 30 minutes for the next 2 hours;
- Every hour for a further two hours; and
- Every four hours for 24 hours.

The evidence before the panel was that the fall had occurred shortly before 07:15 towards the end of Mr Craigie's night shift (which finished at 08:00) and concluded that he would have been expected to complete at least two sets of observations.

In addition, the panel considered the evidence of both Witnesses 1 and 2, that Mr Craigie did not complete either of these observations following Resident A's fall. Again, the panel found the evidence of Witnesses 1 and 2 credible on this point. There was no evidence in front of the panel that the witnesses have any reason to fabricate or exaggerate their explanations of what observations are required following a resident's fall.

The panel noted that Mr Craigie admitted during his local disciplinary meeting that he did not perform any post-fall observations when interviewed during his disciplinary hearing on 2 September 2021, where Mr Craigie said as follows:

'Q: you didn't do obs

Mr Craigie: No need for obs, she was just sitting on the floor'

As a result, the panel found that Mr Craigie did not complete post-fall observations.

The panel therefore found charge 1b) proved.

Charge 1c)

"*That you, a registered nurse:*

c. Moved Resident A into their wheelchair using an inappropriate method in that you wrapped your arms around the resident's waist (bear hug) to lift them from the floor into the wheelchair."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, the written and oral evidence of Witnesses 1 and 2, the interview of Mr Craigie, and the hearsay evidence of Colleagues 2 and 3.

The panel first considered what Mr Craigie had said in the investigatory and disciplinary meetings. On both occasions, he admitted to using this 'bear hug' technique to lift Resident A from the floor to the wheelchair. In particular, he described his conduct as follows:

'Q: who transferred [Resident A] from the floor?
Mr Craigie: Me and Colleague 4 lifted her from the floor she was on her knees
Q: How? Can you show me?
Colleague 5 [sic] demonstrated on Colleague 6 was by bear hug type lift
…
Q: … How did you get the resident off the floor?
Mr Craigie: Me and another carer picked her up

Q: How?
Mr Craigie: Bear hug – arms around the waist'

The panel also considered the hearsay evidence of Colleague 2, who said in her interview

'… he just lifted her up'

And the hearsay evidence of Colleague 3, who said in her interview:

'… *he just scooped her up and put her into the chair*'

As a result, the panel found that Mr Craigie used a bear hug technique to lift Resident A from the floor.

The panel further found that this technique was inappropriate. It reviewed and accepted the written evidence from Witness 1, who stated that the bear hug technique was a '*banned move'*, and is not permitted except in cases of emergency. She particularly notes the risks of this manoeuvre as follows:

> *'As I understand, John lifted the resident off the floor using the bear hug method. A bear hug is a method of manual handling, which we are not allowed to use unless in an emergency. Bear hugs can only be justified if someone was choking or having a seizure and the time was of essence. Manual manoeuvres should not be regularly used as they are not safe. If the resident was unable to hold onto John's neck, they could have been easily dropped. Bear hugs are also extremely risky as if the resident had injured themselves, a bear hug could have caused further harm to them.'*

The panel heard no evidence that this was an emergency situation.

The panel considered Mr Craigie's account in the investigatory and disciplinary meetings that a hoist would not have been possible in the circumstances as there was not enough space in the room to do so, without moving furniture.

During this hearing, the panel made specific inquiries of the witnesses about this point, to which Witness 1 stated that a hoist could have been used in the circumstances. Specifically, Witness 1 stated that despite Resident A's room being a smaller room, there were numerous ways in which a hoist could have been employed, including:

1. Confirming that there was sufficient room to use the hoist in this case;
2. Even if there was not sufficient room, there were multiple ways in which Mr Craigie could have safely manoeuvred Resident A to a position so that a hoist could be used, such as using a slide sheet; and
3. Even if Resident A could not have been removed, Mr Craigie could have safely moved the chest of drawers in the room to a position where a hoist could have been used.

In summary, Witness 1 indicated that there were many ways in which a hoist could have been employed and confirmed there was no reason why a hoist could not have been used. Witness 2 gave consistent evidence about the way in which a hoist could have been used for this resident. The panel accepted this evidence.

As a result of the above, the panel found that Mr Craigie used a bear hug technique to lift Resident A and that this technique was unsafe, unwarranted and unnecessary in the circumstances, and therefore inappropriate.

Therefore, the panel found charge 1c) proved.

Charge 1d)

"That you, a registered nurse:

d. Did not complete an incident form in relation to their fall."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and the written account in the investigatory and disciplinary meetings with Mr Craigie.

The panel first considered the account in the investigatory and disciplinary meetings with Mr Craigie, who admitted that he did not complete the form, as follows:

'Q: No accident form was done
Mr Craigie: That's the carers job
Q: As an RGN is it not your responsibility?
Mr Craigie: Yes
Q: You made sure it was done?
Mr Craigie: No I didn't. Generally it policy [sic] for carers to do, no policy for nurses to fill in.
…
Q: It's not for you to know what happened to them, we're here to discuss your part in this. It wasn't reported. [Colleague 1] was filling in the form, 8 hours after nightshift should have done it. It's not dayshift responsibility. As a registered nurse you are directed by the policy. If that task is delegated to an individual who is able to do it, but if you are saying they weren't experienced or trained.
Mr Craigie: No not my responsibility.'

The panel further considered the documentary evidence, namely the incident and accident reporting form, and found there is no evidence that Mr Craigie filled in the form.

Finally, the panel considered the evidence from Colleague 1, who stated that he assisted Colleague 3 in completing the form, indicating that Mr Craigie did not complete the form himself.

In considering the totality of the evidence, the panel was satisfied on a balance of probabilities that Mr Craigie did not complete an incident form in relation to Resident A's fall.

Therefore, the panel found charge 1d) proved.

Charge 1e)

"That you, a registered nurse:

e. Did not record their fall in the resident's notes."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and the written and oral evidence of Witnesses 1 and 2.

The panel first considered the evidence of both Witnesses 1 and 2, who both indicated that there was an expectation that a written record in the resident's notes of up to half a page recording the incident in detail, would have been expected in these circumstances. The panel accepted this evidence and was satisfied that Mr Craigie had a responsibility to ensure that a record of the fall was made in the notes.

The panel noted that the daily record of care was incomplete, in that the final entry right at the bottom of the page provided as evidence referred to Resident A's condition earlier during the night shift (by 05:20) in question. Unfortunately, the next page of these notes was not provided to the panel during this hearing. When questioned by the panel, Witness 2 stated that she had checked the next page of the nursing care record and nothing was recorded in relation to Resident A's fall.

In addition, the panel considered the interview of Mr Craigie, who was specifically asked whether he recorded the fall in the resident's notes, to which he replied that it was not his responsibility.

> *'Q: No report done prior to you leaving*
> *Mr Craigie: It's the carers job*
> *Q: It's your job as the registered nurse to make sure the accident form and notes are done accurately. They didn't write anything in the daily notes – 'has had a settled night and slept well'. The post fall obs form is blank*
> *Mr Craigie: Check with them*
> *Q: we have checked*
> *Mr Craigie: It wasn't a serious fall, she's being transferred*
> *Q: She was dropped, when a staff member transferred her on her own according to the carer you were told this.*
> *Mr Craigie: different stories.*
> *End – it wasn't a serious fall.'*

After considering all of the evidence in front of it, the panel found that on a balance of probabilities, it was more likely than not that Mr Craigie did not record the fall in the resident's notes.

The panel therefore found Charge 1e) proved.

Charge 1f)

> *"That you, a registered nurse:*
>
> *f. Did not instruct and/or ensure staff completed an incident form."*

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, including the interview of Mr Craigie.

The panel first found that while a form was completed, there was no evidence that it was completed on the instruction of Mr Craigie. On the contrary, the panel found that Colleague 1 initiated the completion of the incident form during the following day shift, without the instruction of Mr Craigie.

Further, the panel considered the evidence of Mr Craigie during his interview on 2 September 2021, wherein he indicates that he did not delegate or ensure that the staff completed an incident form. Specifically, Mr Craigie states as follows:

> *'Q: No accident form was home*
> *Mr Craigie: That's the carers job*
> *Q: As an RGN is it not your responsibility?*
> *Mr Craigie: Yes*
> *Q: You made sure it was done?*
> *Mr Craigie: No I didn't. Generally it policy [sic] for carers to do, no policy for nurses to fill in.*
> *Q: You are delegating to the carer?*
> *Mr Craigie: No I'm not the home is*
> *Q: As RGN is it not your responsibility to make sure records are kept appropriately*
> *Mr Craigie: Maybe it's home policy*
> *Q: You didn't check*
> *Mr Craigie: No'*

In the absence of any evidence that Mr Craigie completed the form, and after considering the direct statement from Mr Craigie that he did not check to ensure a form was done, the panel was satisfied on a balance of probabilities that Mr Craigie did not instruct or ensure the staff completed the form.

Therefore, the panel found Charge 1f) proved.

Charge 1g)

"That you, a registered nurse:

g. Did not instruct and/or ensure staff recorded the resident's fall in the resident's notes."

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence, including the interviews with Mr Craigie, and the written and oral evidence of Witness 2.

The panel considered the interview with Mr Craigie, where he specifically indicated that it was not his responsibility to instruct or ensure that staff recorded the resident's fall in the resident's notes. When it was specifically put to him that he was responsible for ensuring the notes were recorded, he responded that it was the responsibility of the Home and its staff to ensure this was done:

'Q: No notes were recorded. If it was you who checked her over then you must record all details in the residents daily life notes and there are no post fall observations recorded on the accident form. It is your pin, you are the nurse with the responsibility for these residents, there is no evidence to say that you did. This is a frail vulnerable lady who has been dropped on the floor.

Mr Craigie: Can't help if staff don't work properly, she was tired which is normal behaviour for [Resident A]. This is being blown out of proportion, we need more staff to do thing properly, she never actually fell. Theres nothing even wrong with the woman.'

Further, the panel considered the interview on 2 September 2021, wherein Mr Craigie states it is the Home's responsibility to record the notes:

> *'Q: You said the staff were not trained to complete forms, knowing that you could have used this as a training opportunity*
> *Mr Craigie: you need to sort out training*
> *Q: [Mr Craigie] you should have done it, you are the person in charge of the building, it's your responsibility to ensure the paperwork is completed*
> *Mr Craigie: They should be fully trained before going on nightshift*
> *…*
> *Q: You delegated that task its your fault the paperwork wasn't done*
> *Mr Craigie: No it's yours, skill mix need to be looked at.'*

When considering the totality of the evidence, the panel was satisfied on a balance of probabilities that Mr Craigie did not instruct or ensure that the staff recorded the resident's fall in the resident's notes.

The panel therefore found charge 1(g) proved.

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 Mr Craigie'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, Mr Craigie's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

Ms Da Costa invited the panel to take the view that the facts found proved amount to misconduct. Ms Da Costa referred the panel to several sections of the code which she submitted were engaged in this case. She submitted that Mr Craigie's conduct had breached 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) and was serious.

Ms Da Costa referred the panel to its findings of fact that Mr Craigie failed to examine a vulnerable patient after a fall, and further failed to ensure that the necessary observations and records were completed following the fall. She emphasised that the 'bear hug' technique Mr Craigie used to lift Resident A was a prohibited move, and was particularly dangerous given the vulnerability of Resident A. She further highlighted that Mr Craigie's omissions in not completing the observations and records was not acting in the best interest of Resident A, who was vulnerable. She concluded by stressing that Mr Craigie's flippant attitude towards the fall displayed a disregard for its potential seriousness, given the vulnerability of Resident A, and heightens the seriousness of his misconduct. She emphasised that this falls short of the conduct that would have been expected by a nurse in the circumstances.

In conclusion, Ms Da Costa submitted that Mr Craigie's behaviour was a serious departure from the standards expected of a registered nurse.

Ms Da Costa therefore invited the panel to conclude that the facts found proved in this case amount to misconduct.

Submissions on impairment

Ms Da Costa moved on to the issue of impairment and addressed the panel on the need to have regard to protecting 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.

Ms Da Costa submitted the first three limbs of the test set out in *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin) are engaged. She submitted that Mr Craigie's conduct of failing to conduct a proper examination, undertake observations, failing to use proper techniques when lifting a vulnerable resident, and then omitting to ensure the proper observations and reports were completed and recorded following the incident which put Resident A at an unwarranted risk of harm. This misconduct would bring the medical profession into disrepute, and breached fundamental tenets of the profession by failing to promote professionalism and trust in the profession.

Ms Da Costa further submitted that Mr Cragie had demonstrated no insight and there was no evidence of remediation. As a result, Ms Da Costa submitted that this conduct is highly likely to be repeated, and that a finding of impairment on the grounds of public protection should follow.

Finally, Ms Da Costa submitted that the conduct was sufficiently serious and a finding of impairment on public interest grounds is also necessary in this case.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000]

1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), and *General Medical Council v Meadow* [2007] QB 462 (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. It was satisfied that Mr Craigie's actions amounted to breaches of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
>
> *1.1 treat people with kindness, respect and compassion*
>
> *1.2 make sure you deliver the fundamentals of care effectively*
>
> ***8 Work co-operatively***
>
> *8.2 maintain effective communication with colleagues*
>
> *8.5 work with colleagues to preserve the safety of those receiving care*
>
> *8.6 share information to identify and reduce risk*
>
> ***10 Keep clear and accurate records relevant to your practice***
>
> *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*
>
> *10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need*

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

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

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

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people'

The panel was mindful that breaches of the Code do not automatically result in a finding of misconduct, and went on to consider the seriousness of the conduct it had found proved.

The panel acknowledged that whilst this was a single incident involving a single resident, it found that both individually and when looked at as a whole, the acts and omissions that have been found proved amount to a serious departure of what would be expected of a registered nurse.

The panel considered the totality of Mr Craigie's misconduct and concluded that the care he delivered to Resident A fell seriously below the standard expected of a registered practitioner in every respect. Mr Craigie failed to examine Resident A immediately after a fall that he had not witnessed. Mr Craigie knew Resident A, who was an elderly, vulnerable, frail patient who could not speak, and in the circumstances, knew or should have known that an examination was necessary. He went on to use a 'bear hug' technique to lift her from the floor which was "banned", unless in exceptional life-threatening circumstances. No such circumstances existed at the time, and his use of this technique exposed Resident A to an unwarranted risk of harm and indeed put himself at risk. Furthermore, he failed to undertake post-fall observations or record the incident or enter

any observations in the appropriate records. Mr Craigie did not ensure there was a record of the fall completed by others, which resulted in the dayshift not being immediately aware of the fall and its potential consequences. Taking all of these compounded failures into account, the panel found that Mr Craigie's misconduct was a significant departure of what would be expected, and therefore amounts to a serious misconduct. All of these acts and omissions put Resident A at a real and unwarranted risk of harm.

The panel found that Mr Craigie's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

Prior to considering the matter of impairment the panel considered the context in which Mr Craigie found himself working at the time. In particular, the panel noted Mr Craigie's assertions during the local investigation that staffing levels were below the level he claimed were required. He also alleged that the training of some staff may have been less than adequate. The panel heard from Witness 2 that the Home used dependency tools and safe staffing levels for Scotland in order to assess the staffing needs of the Home. The panel accepted Witness 2's evidence that staffing levels were adequate on the night in question. Additionally, the panel inquired into the adequacy of the training of carers and heard evidence that their training was adequate. In any event, the panel considered that the training levels of colleagues were not relevant to Mr Craigie's failings.

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

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 3 March 2025, 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 fitness to practise is impaired in the sense that S/He:

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*

d) *…*

The panel found that the first three limbs of the *Grant* test were engaged in this case. It found that Mr Craigie put Resident A at a risk of harm numerous times throughout the incident, including by failing to examine her for injuries, failing to pick her up using the appropriate technique after she had fallen, failing to record her observations, and failing to properly record her fall in the resident's notes. All of these failures contributed to an unwarranted risk of harm to Resident A both at the time and in the future.

The panel went on to consider the second limb of *Grant*, and found that by breaching the Code to the extent that he has and to the serious degree that he has, Mr Craigie has indeed brought the medical profession into disrepute.

When considering the third limb of *Grant*, the panel found that Mr Craigie breached fundamental tenants of the profession by failing to:

- Prioritise the patients that he was overseeing;
- Practise effectively by performing appropriate techniques when caring for fallen residents and recording the Resident's observations appropriately, along with the incident in the required documentation.
- Preserve the safety of Resident A; and
- Promote professionalism and trust of nurses who are there to protect vulnerable

residents.

The panel concluded Mr Craigie has breached fundamental tenets of the profession.

The panel considered that the final limb of *Grant* which relates to dishonesty was neither charged nor engaged in this case.

The panel went on to consider the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin), and whether Mr Craigie's conduct was remediable. The panel found that this misconduct is potentially remediable and capable of being addressed in the sense that post-fall procedures can be the subject of training.

The panel first considered whether he has shown any insight into his misconduct, in particular whether there was any evidence that Mr Craigie had reviewed and reflected on his own performance, recognised that he should have behaved differently and put measures in place to ensure he had strengthened his professional practice so as to ensure it would not be repeated. The only insight the panel has seen is Mr Craigie's admission during his disciplinary meeting where he said *"I'm guilty at not checking paperwork. For that I hold my hands up*". The panel does not regard this as meaningful insight. In fact, there is evidence during his investigatory interviews that he has attempted to minimise the incident, deflect the blame on others and make excuses. He did not take responsibility for his role or as the registered nurse in charge to deal with the fall of Resident A appropriately. The panel considers this to be evidence of an attitudinal issue which is of concern.

There is no evidence that Mr Craigie has taken any steps to address his misconduct. He has informed the NMC that is not practising as a registered nurse and has no intention of resuming practice.

Therefore, the panel is of the view that there is a high risk of repetition because he has not taken any steps to address these concerns, there is no meaningful evidence of his insight

into why what he did was serious and wrong, and there is evidence of deep-seated attitudinal issues. 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.

In addition, the panel concluded that a reasonable well-informed member of the public would be shocked and troubled if a finding of impairment were not made in these circumstances, and therefore, the panel concluded that it is necessary in order to maintain public confidence. Furthermore, the panel concluded that fellow practitioners would find the conduct deplorable and therefore a finding of impairment is also needed to maintain and uphold proper standards of conduct in the profession. For these reasons, the panel considered a finding of impairment on public interest grounds is appropriate.

The panel gave consideration to NMC guidance: Impairment: What factors are relevant when deciding whether a professional's fitness to practise is impaired? (Reference: DMA-1), specifically the following section:

> *'However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.'*

The panel determined that a finding of impairment on the ground of public interest is necessary. It concluded that failure to practise the utmost care and caution when caring for patients – particularly those who are as vulnerable as Resident A and following a fall –

needs to be taken seriously, and the lack of meaningful insight on the part of Mr Craigie needs to be addressed.

The panel determined that not to make a finding of impairment would significantly undermine the public's trust and confidence in the nursing profession. It is also necessary to mark the seriousness of the misconduct and to uphold proper standards and conduct for members of the nursing profession.

Having regard to all of the above, the panel was satisfied that Ms Craigie'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 12 months. The effect of this order is that the NMC register will show that Mr Craigie'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.

Submissions on sanction

Ms Da Costa informed the panel that the NMC sought a suspension order for 12-months with a review.

Ms Da Costa submitted that the following were aggravating features in this case:

- Mr Craigie has demonstrated a lack of insight, remorse and remediation; and
- The catalogue of errors found proved above placed a vulnerable patient at risk of harm.

Ms Da Costa submitted that the following were mitigating features in this case:

- This was an isolated incident; and
- This relates to a single patient.

Ms Da Costa confirmed that Mr Craigie has no previous regulatory findings.

In respect of taking no action or imposing a caution order, Ms Da Costa submitted that, given the panel's findings, this was not a case where either of those sanctions are appropriate as they do not mark the gravity of Mr Craigie's actions or address the current risks posed to members of the public.

Ms Da Costa went on to submit that a conditions of practice order would also not be appropriate in this case. She noted that Mr Craigie has provided limited insight into his misconduct and there is no evidence that he has taken any steps to address the concerns regarding his practice. She further noted that Mr Craigie does not wish to continue being a nurse, and has displayed attitudinal issues. She submitted therefore that no workable conditions could be formulated that would address the concerns, and a conditions of practice order would not be sufficient to mark the gravity of the case.

Regarding a suspension order, Ms Da Costa submitted that such an order would be sufficient to address the risk posed to patients or the public's trust and confidence in the nursing profession or the NMC as a regulator.

Ms Da Costa also submitted that a suspension order is necessary to mark the importance of maintaining public confidence in the nursing profession and the NMC as a regulator, and to send a clear message as to the standards required of a registered nurse. She further submitted that a suspension order would protect the public from the risk of harm, and afford Mr Craigie time to develop insight and possibly remediate his conduct.

Finally, she submitted that Mr Craigie's conduct is not incompatible with him remaining on the register, and therefore a strike-off order is not warranted in this case.

Decision and reasons on sanction

Having found Mr Craigie'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 accepted the advice of the legal assessor.

The panel considered the following to be aggravating features:

- The panel has seen no evidence of any insight beyond Mr Craigie's acknowledgment that he should have checked the relevant documentation.
- There is no evidence of remorse, apology, remediation or efforts to strengthen his professional practice.
- The panel concluded that Mr Craigie attempted to deflect blame and failed to take accountability at the time of the incident and during the local investigation, which indicated an attitudinal issue.
- There were multiple clinical errors and omissions in his care of Resident A following the fall.
- The conduct put a vulnerable resident at unwarranted risk of suffering harm.

The panel considered the following to be a mitigating feature:

- This is a single event involving one resident.

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the misconduct found proved and the ongoing risk of repetition. 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 misconduct, and the public protection issues identified, an order that does not restrict Mr Craigie'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 Mr Craigie's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the 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 Mr Craigie'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 considered that this was not a suitable case for conditions for the following reasons:

1. Mr Craigie has not engaged with these proceedings;
2. Mr Craigie has told the NMC that he is not working and no longer wishes to resume practice as a registered nurse; and
3. Conditions would not be sufficient to mark the seriousness of the misconduct.

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:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident; and*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour.*

The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register because the nature of the misconduct is, in principle, remediable.

In view of the fact that this was a single incident, the panel was of the view that a strike-off at this stage would be disproportionate.

Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in Mr Craigie'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 considered that this order is necessary to mark the seriousness of the misconduct and is the least restrictive required to protect the public, maintain public confidence and promote and maintain proper professional standards.

The panel determined that a suspension order for a period of 12 months with a review was appropriate to mark the seriousness of the misconduct. It would also give Mr Craigie further time to develop insight, remediate his misconduct and address the risk to the public.

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 any of the following, and particularly where they address the misconduct and concerns in this case:

- Documentary evidence of professional development;
- Testimonials which can relate to paid or unpaid work;
- Evidence of reflection related to the incident and demonstrating his insight into the misconduct found proved; and
- Anything else that Mr Craigie feels appropriate that might assist the panel.

This will be confirmed to Mr Craigie in writing.

Interim order

As the suspension order cannot take effect until the end of the 28-day appeal period or the resolution of any appeal, 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 Mr Craigie's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the representations made by the NMC that an interim suspension order of 18 months should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest. Ms Da Costa informed the panel that she sought an interim order of 18 months as if an appeal was launched, it might take that period for the appeal to be resolved.

The panel heard and accepted the advice of the legal assessor. The panel made reference to the Guidance at INT-1, 2 and 4.

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, the risk of repetition and the risk of harm, 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 the only suitable interim order would be that of a suspension order, as to do otherwise would be incompatible with its earlier findings. The panel concluded that 18 months was the appropriate period for an interim order for the reasons explained by Ms Da Costa.

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

That concludes this determination.