Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 10 February 2025 – Monday, 17 February 2025

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	Alison Jane Rogers
NMC PIN	89K0022E
Part(s) of the register:	Registered Nurse - Adult RN1 (25 January 1993)
Relevant Location:	Staffordshire
Type of case:	Misconduct
Panel members:	Gregory Hammond (Chair, lay member) Elizabeth Coles (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	Simon Walsh
Hearings Coordinator:	Bartek Cichowlas
Nursing and Midwifery Council:	Represented by Stephanie Stevens, Case Presenter
Ms Rogers:	Not present and unrepresented
Facts proved:	Charges 1(b), 1(d), 1(e) and 4
Facts not proved:	Charges 1(a), 1(c)(i), 1(c)(ii), 1(c)(iii), 2, 3(a) and 3(b)
Fitness to practise:	Impaired
Sanction:	**Caution Order (2 years)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Rogers was not in attendance and that the Notice of Hearing letter had been sent to Ms Rogers' registered email address by secure email on 9 January 2025.

Ms Stevens, 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, amongst other things, information about Ms Rogers' right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Rogers 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 Ms Rogers

The panel next considered whether it should proceed in the absence of Ms Rogers. It had regard to Rule 21 and heard the submissions of Ms Stevens who invited the panel to continue in the absence of Ms Rogers. She submitted that Ms Rogers had voluntarily absented herself. She submitted that Ms Rogers contacted the NMC on 27 September 2023, stating that she no longer wishes to practise as a nurse.

Ms Stevens submitted that there had been no engagement at all since September 2023 by Ms Rogers with the NMC in relation to these proceedings and, as a consequence, there

was no reason to believe that an adjournment would secure her attendance on some future occasion.

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 has decided to proceed in the absence of Ms Rogers. In reaching this decision, the panel has considered the submissions of Ms Stevens, the email from Ms Rogers on 29 September 2023, and the advice of the legal assessor. It has 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.

The panel took into account that in her email, Ms Rogers stated the following:

> *'I am writing in response to your email regarding allegations made about my fitness to practice by Four seasons Healthcare which in a full statement i forwarded to them i deny. I am not currently working and have no intention of working as a nurse again . After 34 years i will not be renewing my registration when it is due on 31/01/24 . I never want to put myself in a position where lies and twisting of the truth is the norm, which is what i encountered whilst working for Four seasons . I have never been in this situation in the whole of my carreer and have previous employers who will provide references regarding my fitness to practice' [sic]*

The panel noted that:

- No application for an adjournment has been made by Ms Rogers;
- Ms Rogers has not engaged with the NMC since 2023;
- There is no reason to suppose that adjourning would secure her attendance at some future date;

- A witness has attended today to give live evidence, and others are due to attend;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2023;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Rogers in proceeding in her absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address, she will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her 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. Furthermore, the limited disadvantage is the consequence of Ms Rogers' decisions to absent herself from the hearing, waive her rights to attend, be represented, and to not provide evidence or make submissions on her own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Stevens, on behalf of the NMC, to amend the wording of charges 1(a)(iii), 3(a) and 3(b).

It was submitted by Ms Stevens that the proposed amendment would provide clarity, more accurately reflect the evidence, and correct grammatical errors. The requested amendments are as follows:

That you, a registered nurse:

1) On 29 January 2023

    a. Pushed Resident A:

        i. …
        ii. …
        iii. ~~pulled~~ **while pulling** the door shut.

2) …

3) On unknown dates –

    a. Told unknown ~~R~~ **r**esident~~'~~s they couldn't have their pudding if they didn't finish their main course
    b. Told unknown ~~R~~ **r**esident~~'~~s that they could only have coffee at certain times of the day.

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

The panel heard from submissions from Ms Stevens that these are minor typographical and phrasing amendments which provide clarity and accuracy.

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 amendments, as applied for, were in the interests of justice. The panel was satisfied that there would be no prejudice to Ms Rogers and no injustice would be caused to either party by the proposed amendments being allowed. It was therefore appropriate to allow the amendments, as applied for, to ensure clarity and accuracy.

Details of charge

That you, a registered nurse:

1) On 29 January 2023:

    a. Pushed Resident A into a chair, grabbing him by his clothes.

    b. Confined Resident A to the lounge.

    c. Pushed Resident A:

        i. through the corridor
        ii. through a glass door
        iii. while pulling the door shut.

    d. Did not record Resident A's fall on the RADAR system.

    e. Slammed a plate down and shouted to Resident B words to the effect of '*Fuck it, if she won't sit down.*'

2) Your conduct at charge 1a), 1b) and 1c) was poor handling and / or moving of people receiving care.

3) On unknown dates –

    a. Told unknown residents they couldn't have their pudding if they didn't finish their main course
    b. Told unknown residents that they could only have coffee at certain times of the day.

4) On an unknown date referred to an unknown Resident as a '*pain in the arse'*.

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

Background

The charges arose whilst Ms Rogers was employed as a registered nurse at Windsor House, a care home. Ms Rogers had been on the register of the NMC since 6 November 1989, and had had no previous disciplinary proceedings against her. She commenced employment at Windsor House on 14 September 2020.

The NMC were informed by Four Seasons Health Care Group about concerns with Ms Rogers' fitness to practise in September 2023. The incidents which gave rise to the referral and subsequently the charges are reported to have occurred on 29 January 2023. An investigation was begun by the care home, but Ms Rogers resigned before the case could be put to her.

The allegations may be summarised as follows.

In relation to a patient with moderate to severe symptoms of dementia, Ms Rogers is alleged to have grabbed Resident A by his clothes and pushed him down into a chair. When Resident A left the toilet with no trousers on, later the same day, Ms Rogers is alleged to have pushed him through the corridor. Ms Rogers slammed a door and

Resident A subsequently fell to the floor. Ms Rogers is alleged to have failed to record the resident's fall on RADAR.

In relation to other residents, Ms Rogers is alleged to have told them that they will not receive their pudding if they do not eat their main course. Ms Rogers is also alleged to have roughly placed down a plate and shouted to Resident B "*fuck it if she won't sit down*", because they would not sit down at the table to eat.

Further, Ms Rogers is alleged to have routinely told residents that they can only have coffee at certain times of day, and referred to an unknown resident as a "*pain in the arse".*

Decision and reasons on application to admit hearsay evidence

The panel heard an application made by Ms Stevens under Rule 31 to
to allow the written witness statement of Witness 3 into evidence. Ms Stevens submitted that the evidence is relevant.

Ms Stevens referred the panel to the cases of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin), *Mohamed Lamin Mansaray v Nursing and Midwifery Council* [2023] EWHC 730 (Admin), and the NMC guidance on Evidence, reference DMA-6.

Ms Stevens submitted that the written statement of Witness 3 is not sole and decisive, She submitted that the panel had the evidence of another NMC witness who could and did corroborate much of what was said in the statement of Witness 3. Ms Stevens submitted that while the charges are very serious and may be attitudinal in nature, and the registrant has denied the charges, the statement can be tested against the statement of the other witness who have provided sworn evidence.

Ms Stevens submitted that despite knowledge of the nature of the evidence to be given by Witness 3, Ms Rogers made the decision not to attend this hearing. On this basis Ms

Stevens advanced the argument that there was no lack of fairness to Ms Rogers in allowing Witness 3's written statement into evidence.

Ms Stevens also submitted that the NMC had made every effort to secure the presence of Witness 3, but it is only in light of a serious medical condition accompanied by a doctor's note that the witness was not able to attend.

Ms Stevens submitted that the statement includes a signed statement of truth. Ms Stevens also submitted that Ms Rogers has been put on notice of the NMC's intention to read the witness statement during the hearing. She submitted that, as the panel had heard, Witness 3 had been good friends with Ms Rogers, and therefore would have little reason to lie about the evidence.

For those reasons, Ms Stevens submitted that it would be fair to admit the witness statement of Witness 3 into evidence.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is 'fair and relevant', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. The legal assessor also directed the panel to principles in *Thorneycroft.*

The panel determined that it would be fair to admit the written statement of Witness 3 into evidence.

The panel gave the application in regard to Witness 3 serious consideration. The panel noted that Witness 3's statement had been prepared in anticipation of being used in these proceedings and contained the paragraph, 'This statement … is true to the best of my information, knowledge and belief' and signed by her.

There was no question about the relevance of Witness 3's evidence. However, the panel considered whether Ms Rogers would be disadvantaged by the change in the NMC's position of moving from reliance upon the live evidence of Witness 3 to that of allowing her witness statement into evidence.

The panel noted the following test from the case of *Thorneycroft,* at paragraph 56:

1. *'Whether the statements were the sole and decisive evidence in support of the charges;*
2. *The nature and extent of the challenge to the contents of the statements;*
3. *Whether there was any suggestion that the witnesses had reasons to fabricate their allegations;*
4. *The seriousness of the charge, taking into account the impact which adverse findings might have on N's career;*
5. *Whether there was a good reason for the non-attendance of the witnesses;*
6. *Whether the Respondent had taken reasonable steps to secure the attendance of the witness;*
7. *The fact that N did not have prior notice that the witness statements were to be read.'*

The panel found that there were some aspects of this test that militated against the admission of Witness 3's statement into evidence. Regarding question 2, the panel noted that the registrant has challenged the statement of Witness 3 by denying all of the allegations. Regarding question 4, the panel considered that the allegations were in fact serious and could have far reaching consequences for Ms Rogers.

However, the panel determined that these factors were outweighed. Firstly the evidence was not the sole and decisive evidence, as the panel had the opportunity to question other witnesses who had provided similar evidence of the same event. Secondly, it has been suggested that Witness 3 had a good relationship with Ms Rogers and therefore would not have good reason to fabricate the allegations. Thirdly, the panel has had evidence of a

good reason for the witness's non-attendance, namely of a serious medical condition which could be exacerbated by attending the hearing. Fourthly, the panel found that the NMC had taken reasonable steps to secure the presence of the witness, but had failed due to a legitimate concern about the witness's health. Finally, the panel determined that the registrant did have notice of the statement.

The panel further considered the fairness to Ms Rogers. It had already determined that Ms Rogers had chosen voluntarily to absent herself from these proceedings, and she would therefore not be in a position to cross-examine this witness in any case. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings. The panel considered that the unfairness in this regard worked both ways in that the NMC was deprived, as was the panel, from reliance upon the live evidence of Witness 3 and the opportunity of questioning and probing that evidence. There was also public interest in the issues being explored fully which supported the admission of this evidence into the proceedings.

In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the statement of Witness 3 but would give what it deemed appropriate weight once the panel had heard and evaluated all the evidence before it.

Decision and reasons on facts

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.

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

The panel considered the following documents from the registrant: an emailed response to an internal investigation into her conduct dated 14 April 2023; an email responding to the NMC's notice of referral dated 29 September 2023; and an email responding to the NMC dated 24 June 2024.

The final email on 24 June 2024 was provided late, after the NMC had called and released the two witnesses. The panel found this to be potentially unfair in relation to their consideration of the registrant's position. The panel agreed with the NMC that recalling the witnesses would not align with the NMC's standards of fairness and kindness, and determined to mitigate any unfairness to Ms Rogers by the weight that it gave to the witnesses' evidence.

The panel heard oral evidence from the following witnesses called on behalf of the NMC:

- Witness 1: The manager of Windsor House, the care home at which the incidents took place.

- Witness 2: A care assistant working at Windsor House at the time of the incidents.

The panel considered the hearsay evidence of Witness 3, who was also a care assistant working at the home at the time of the incidents.

The panel disregarded the safeguarding report which was found in the exhibit bundle, but was labelled as 'Unexhibited'. The NMC conceded that this document could not be relied upon as proof of any facts alleged in the charge.

The panel also disregarded the whole of the handwritten witness statement of Witness 2 dated 5 February 2023. It determined that the provenance of the document was unknown, as Witness 2 said that she had not seen the document until she was sent the exhibits bundle, and that there were unexplained inconsistencies between the handwriting throughout the pages. Given the unknown origin of the document, and the fact that Witness 2 gave oral evidence, the panel decided to not consider this document. The panel considered this exhibit to have no evidential value.

The panel has drawn no adverse inference from the non-attendance of Ms Rogers.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. The legal assessor referred the panel to the cases of *El Karout (No 1)* [2019] EWCH 28, and *Suddock v NMC* [2015] EWCH 3612.

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

Charge 1(a)

> "That you, a registered nurse, on 29 January 2023 pushed Resident A into a chair, grabbing him by his clothes."

This charge is found not proved.

In reaching this decision, the panel took into account the oral evidence of Witness 2. Witness 2 described her view of how the registrant grabbed Resident A by the scruff of his clothes, pushed him into the chair and stumbled forwards. The panel found this witness's oral evidence to be broadly consistent with the allegations, and that the witness seemed believable at the time of her live evidence.

However, the panel considered the judgement of Mrs Justice Andrews DBE in *Suddock,* specifically at paragraph 59:

> '*Whilst demeanour is not an irrelevant factor for a court or tribunal to take into account, the way in which the witness's evidence fits with any non-contentious evidence or agreed facts, and with contemporaneous documents, and the inherent probabilities and improbabilities of his or her account of events, as well as consistencies and inconsistencies (both internally and with the evidence of others) are likely to be far more reliable indicators of where the truth lies. The decision maker should therefore test the evidence against those yardsticks so far as is possible, before adding demeanour into the equation*.'

The panel therefore considered whether the evidence of Witness 2 aligns with other evidence before it. The panel considered the response of the registrant to the allegation at the time that the internal investigation was being conducted, which states:

> *'I did not push Resident A into a chair by the scruff of his clothes'*

The panel also considered a denial of all of the allegations by the registrant in an email response to the NMC on 24 June 2024:

> *'I totally deny the allegations made about me from four seasons, Windsor house and have been interviewed under caution by the safeguarding team at south staffordshire police and found to have no further charges to answer and case has been dismissed. I feel the allegations made about me were due to me highlighting poor staffing levels and poor levels of care made by badly trained and incompetent care staff . Who have previously been investigated for lack of moving and handling skills , known drug use and constantly leaving the unit to smoke . The staff that I reported to management were the same staff that made the allegations about myself after the deputy manager and manager informed them of my concerns , which was no surprise knowing the lack of confidentiality lead by the manager and*

her deputy. The manager was made aware of my concerns and chose to take no action against these staff . I do not wish to continue working as a nurse and have baseless allegations made about me' [sic]

The panel was of the view that there may have been an ulterior motive for the evidence of Witness 2 which has not been properly addressed. The panel considered that the evidence provided by Witness 1, which speaks to a toxic culture at the workplace, and the allegations by the registrant, may undermine the reliability of the witness.

The panel also considered that the word 'push' as referred to in the context of a regulatory charge requires something more than minimal force or force that was appropriate in the particular circumstances. The panel considered the evidence of Witness 2 who referred to the amount of force as moderate, and the witness statement of Witness 3 who states that '*on a scale of 1 to 10 … [Ms Rogers] used a force of 5'*. The panel determined that there was insufficient evidence to show that more than a minimal amount of force, or force that was inappropriate, was used in the circumstances.

For those reasons, the panel finds the evidence provided by the NMC lacks cogency and the regulator has not discharged the burden of proof. Therefore, on the balance of probabilities, charge 1a is found not proved.

Charge 1(b)

"That you, a registered nurse, on 29 January 2023 confined Resident A to the lounge"

This charge is found proved.

In reaching this decision, the panel took into account the registrant's statement at the time of the internal investigation, during which she states:

'*I do recall Resident A was confused and agitated that day , wandering , going into other residents bedrooms and leaning over [PRIVATE] who were calling Resident A over to them, making him more agitated. I do recall myself and carers trying to get him to sit down and offer him drinks and snacks to calm him a little.'*

The panel took into account Witness 2's oral evidence, and was once again guided by the above principles of *Suddock.* In relation to this allegation, the panel determined that the witness was compelling, did not backtrack, and comprehensively described the way in which Ms Rogers stood at the door and physically prevented the resident from leaving the room.

The panel did consider whether the evidence of Witness 2 as regards this event was corroborated by other evidence, and found that it was not. However, the panel found it plausible that in the circumstances, and considering the resident's known challenges with incontinence and the tendency to urinate in the corridor, it was plausible that Ms Rogers would have confined the resident to the lounge.

For these reasons, the panel finds charge 1b proved on the balance of probabilities.

Charges 1(c)(i), (ii) and (iii).

"That you, a registered nurse, on the 29 January 2023 pushed Resident A:

i. through the corridor
ii. through a glass door
iii. while pulling the door shut."

These charges are found not proved.

As these charges related to a single incident, the panel decided to consider these charges together. The panel noted that there was no disparity among the evidence that there had been an incident involving a glass fire door, and that Ms Rogers was present at that time.

The panel also considered that to find the charge proved, it would need to find more than a minimal amount of force, or force that was inappropriate in the particular circumstances, to be used for the action to amount to a ‘push’.

The panel examined the evidence of Witness 2, who, during her oral evidence, thoroughly described the events as seen from her point of view. She described Ms Rogers as pushing the resident through the corridor with two hands on his back, through an open fire door, and subsequently, when through or partway through the door, pushing it closed on the resident, causing him to fall.

However, the panel again noted the email of 14 April 2023 of Ms Rogers, and of particular relevance to the present charge was the following:

> ‘*When I went into the lounge, Resident A was standing … in a confused and agitated state. I asked the agency c/a to take Resident A to his room and get him some fresh clothes. She refused stating she was scared of Resident A hitting her. I told her to stay in the lounge and I would take Resident A to the his room to get dressed. Resident A was very agitated but I managed to hold his arm and guide him out of the lounge and into the corridor. When I got to the corridor area leading to Resident A’s room, he became agitated and aggressive towards me, trying to hit and kick me. I called for assistance and as I did Resident A pushed me against the fire door in the corridor which then closed behind us , I stepped back against the door. Resident A then tried to kick me but lost his footing and fell onto the floor outside the bathroom’ [sic]*

The panel determined that there were inconsistencies in Witness 2’s description of the event, which she said she saw from a position further down the corridor. It deemed that the manner in which the door is alleged to have been shut is incompatible with the self-closing mechanisms of a fire door, and inconsistent with the alleged positioning of Ms Rogers and the resident. The panel could not see how Ms Rogers may have caused a fall

by pulling a glass fire door shut. The panel also found that the evidence of Witness 2 was not corroborated, and that there were no other eye witnesses to attest to the alleged events to have occurred in that way. It also considered that the way Ms Rogers describes the event is plausible.

Consistent with its approach in charge 1a, the panel also did not find that the NMC has provided sufficient evidence to show that more than a minimal amount of force, or more force than was appropriate in the particular circumstances, was used and that, therefore, it was not proved that Ms Rogers 'pushed' the resident.

For these reasons, the panel finds that the NMC's evidence lacks cogency. On the balance of probabilities, the panel decided that the NMC has not discharged its burden of proof. Charge 1(c) is therefore found not proved.

Charge 1(d)

> 'That you, a registered nurse, on 29 January 2023, did not record Resident A's fall on the RADAR system'

This charge is found proved.

The panel began by examining the two contemporaneous documents written by Ms Rogers which claim that the RADAR system was filled in as required. Appendix 4 to the investigation report indicates that Ms Rogers signed the Daily Review stating that '*had fall this pm, RADAR completed',* and in appendix 6 to the same report the weekly handover states '*had fall pm RADAR completed'.*

However, the panel considered the evidence of Witness 1 who stated that it was not reported because she could not find it on the RADAR system when she looked later during her investigation. At paragraph 14, she states that:

‘[Ms Rogers] failed to record this fall on the RADAR system. [Ms Rogers] recorded on Resident A’s handover notes that she had recorded the fall on the system, but there was no record of this’

The panel found that there was no reason to question the reliability of Witness 1, since she was the manager of the Care Home and would have had no reason to lie about the absence of the requisite information on the RADAR system. The panel noted that there are many reasons for which such an omission may have been made.

The panel determined on the balance of probabilities that Resident A’s fall was not recorded on the RADAR system. Charge 1(d) is therefore found proved.

Charge 1(e)

“That you, a registered nurse, on the 29 January 2023, slammed a plate down and shouted to Resident B words to the effect of ‘*Fuck it, if she won’t sit down.*’”

This charge is found proved.

The panel considered Ms Rogers’ description of the allegation in her witness statement for the internal investigation at the care home, in which she states:

‘*I was given Resident A’s lunch to take to her in the lounge. She was wandering around. I put my hand on her to guide her to a chair and she started screaming at me “*you bastard” “I’m telling my mom”. *I knew I couldn’t get her to sit down whilst she was so agitated so I took her lunch back to the dining room put it back on top of the hot trolly and told c/a [PRIVATE] who was serving the meal that Resident B wouldn’t take her meal from me and someone else needed to try. I do not recall swearing.’ [sic]*

The panel bore in mind that Ms Rogers' account did not align with slamming the plate down, and Ms Rogers does not '*recall swearing'*.

However, the panel considered the witness statement of Witness 3, and specifically paragraph 8 where she states that '*[Ms Rogers] banged a plate down on top of the serving trolley because she couldn't get a resident to sit down'.* The panel found that this was corroborated by the oral evidence of Witness 2.

Witness 2 during her evidence was questioned about the words used during this incident. She stated that she used both the words '*fuck it'* and '*forget it'.*

For these reasons, on the balance of probabilities, the panel found this charge proved.

Charge 2

> "Your conduct at charge 1a), 1b) and 1c) was poor handling and/or moving of people receiving care"

This charge is found not proved.

The panel determined that, since it had found charges 1a) and 1c) not proved, the only charge which may be considered to be poor handling and/or moving of people in care would be 1b). While the phrasing of the charge is a combination, and not a choice of the three charges, the panel nonetheless considered the evidence provided in support of this charge.

The panel considered the statement of Witness 1 at paragraph 10, where she states:

> '*I believe that Alison escalated the situation when she restricted Resident A causing him to feel suffocated. He was not a threat and not causing any harm so she should have calmly led him out of the room*.'

The panel found that the tone of criticism was corroborated by the oral evidence she gave. The panel also found that such handling of residents may not be best practice for a nurse working at a care home with vulnerable patients.

However, the panel found that there were no policy documents which would guide them regarding the expectations of a nurse in such a situation. The panel had regard to the oral evidence of Witness 1, who referred the panel to some training that Ms Rogers may have received. The panel did not conclusively find what training she could reasonably have been expected to have, nor what training she did in fact have.

The panel also considered whether the actions of confining Resident A to the lounge could in the circumstances be reasonable, and found that it could.

For these reasons, on the balance of probabilities, the panel found that the charge is not proved.

Charge 3a

> "That you, a registered nurse, on unknown dates told unknown residents that they couldn't have their pudding if they didn't finish their main course.

This charge is found not proved.

The panel considered the evidence of Witness 2, who during her oral evidence said that Ms Rogers often told residents that they couldn't have their pudding if they didn't finish their main course. The panel found her demeanour to be believable, but had regard to the principles of *Suddock.*

However, the panel found that the evidence of Witness 2 was inconsistent with the written statement of Witness 3, in which at paragraph 10 she states that she does not '*recall any*

incidents where [Ms Rogers] told residents that they could not have pudding if they did not have their dessert'. In addition, Witness 1 told the panel that she had never directly witnessed Ms Rogers treating any residents unkindly. The panel also had regard to Ms Rogers' denial of the allegations.

The panel further considered that the charge refers to unknown dates and unknown residents, and therefore lacks the specificity to allow it to find the charge proved. The panel consequently determined that the NMC has not discharged its burden of proof relating to this charge.

The panel therefore finds that, on the balance of probabilities, this charge is not proved.

Charge 3b

> "That you, a registered nurse, on unknown dates told unknown residents that they could only have coffee at certain times of the day."

This charge is found not proved.

The panel considered the same evidence as for charge 3a. The panel further noted that at paragraph 10 of her written witness statement, Witness 3 states that she does not *'recall any incidents where [Ms Rogers] told residents … that they could only have coffee at certain times of the day*'.

The panel considered Ms Rogers' written response to the internal investigation in which she says:

> '*I have never told [PRIVATE] that coffee is only available at certain times of the day. In fact most mornings when i have been on shift and alone in the lounge doing morning medications i have made [PRIVATE] coffee and filled his water bottle up for him prior to giving him his medication.' [sic]*

The panel finds that the burden of proof was not discharged by the NMC with respect to this charge, given the denial of the charge by Ms Rogers, the lack of corroboration of Witness 2's evidence, and Witness 1's evidence referenced at charge 3a above.

The panel therefore finds charge 3b not proved.

Charge 4

> "That you, a registered nurse, on an unknown date, referred to an unknown resident as a '*pain in the arse*'. "

This charge is found proved.

Despite the denial of the charges by Ms Rogers, the panel found the oral evidence of Witness 1 to be compelling because she was able to set the comment in context, describing it as occurring during a morning meeting with the other staff on shift. As the manager of the care home, the panel found that there would be little reason for her to fabricate this allegation.

The panel therefore finds that on the balance of probabilities, it is more likely than not that this incident occurred.

For these reasons, the panel finds this charge 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 Ms Rogers' 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, Ms Rogers' fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council (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.'*

Ms Stevens invited the panel to take the view that the facts found proved amount to misconduct. She drew the panel's attention to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. Ms Stevens identified the specific, relevant standards where she said Ms Rogers' actions amounted to misconduct. Ms Stevens directed the panel towards the following parts of the Code: 1; 1.1; 2; 2.6; 10; 10.1; 10.2; 20; 20.1; 20.5. She submitted that Ms Rogers' conduct amounted to a breach of those parts of the Code.

Ms Stevens submitted that the charges found proved are both clinical, in failing to record an incident on the RADAR system, and attitudinal, in the loss of temper, slamming plates down and referring to patients in degrading terms. She submitted that in all of the

circumstances, these incidents are serious and fall far below the standards that are expected of a nurse. On that basis, Ms Stevens submitted, misconduct should be found.

Submissions on impairment

Ms Stevens 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 uphold proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Stevens submitted that there is no evidence to indicate that this conduct will not be repeated in the future. She submitted that Ms Rogers denies the concerns, has provided no evidence of reflection and has not acted on any feedback received. Consequently, she is liable to repeat the matters found proved in the future. Ms Stevens also submitted that the issues were in part attitudinal, and therefore not easily remediable. She submitted that Ms Rogers has put the profession into disrepute by breaching its fundamental tenets. Therefore, Ms Stevens invited the panel to make a finding of impairment on the grounds of public protection.

Given the seriousness of the charges found proved, Ms Stevens submitted that a reasonably informed member of the public would expect a finding of impairment to be found. Therefore, to maintain public confidence in the nursing profession and the NMC as a regulator, Ms Stevens also invited the panel to make a finding of impairment on the grounds of public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *General Medical Council v Meadow* [2007] QB 462 (Admin), *Mallon v GMC*

[2006] CSIH 17, *Holton v GMC* [2006] EWHC 2960, *Cohen v GMC* [2008] EWHC 581, and *Clarke v GOC* (CA) [2018].

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 Ms Rogers' actions did fall short of the standards expected of a registered nurse, and that Ms Rogers' actions amounted to a breach of the Code, specifically the following:

'1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 treat people with kindness, respect and compassion'

'2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.6 recognise when people are anxious or in distress and respond compassionately and politely'

'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'

'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

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

20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress

20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel went on to consider each charge found proved to determine whether it amounts to misconduct.

The panel considered Ms Rogers' conduct at charge 1b. The panel was of the view that confining Resident A to the lounge was not best practice, in the opinion of Witness 1, but in the circumstances, did not fall far so far short of the standard expected that her actions crossed the threshold to amount to misconduct.

The panel considered Ms Rogers' conduct at charge 1d. While the panel noted that failure to record incidents is usually serious, there was no evidence of an intention to conceal the events, as Ms Rogers had mentioned Resident A's fall twice in other documents. Therefore, the panel was of the view that the actions at charge 1d did not amount to misconduct.

The panel considered Ms Rogers' conduct at 1e. The panel determined that swearing and slamming a plate down before a resident is unprofessional and alarming to both colleagues and residents. The panel found that this behaviour is far below the standard of a reasonable nurse practising in the Care Home, and amounts to misconduct.

The panel considered Ms Rogers' conduct at charge 4. The panel was again of the view that referring to a vulnerable patient in a derogatory manner, even if in solely the presence of colleagues, was seriously unprofessional. The panel found that a nurse in Ms Rogers' position should be encouraging a positive culture and setting an example to other staff. The panel therefore found that the conduct in this charge amounts to misconduct.

The panel found that Ms Rogers' actions in relation to charges 1e and 4 did fall seriously short of the conduct and standards expected of a nurse. The panel therefore determined that Ms Rogers' conduct in relation to those charges amounts to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, Ms Rogers' 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 and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust 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 finds that patients were put at risk of emotional and psychological harm as a result of Ms Rogers' misconduct. The conduct at charge 1e, namely slamming a plate down while swearing, is likely to cause distress and anxiety, and therefore is likely to harm patients.

The panel further found that her misconduct was likely to bring the profession into disrepute. The panel determined that using offensive language with reference to patients, and a loss of temper by slamming plates and swearing would be shocking to a member of the public, and undermine public confidence in the profession. The panel also found that Ms Rogers' misconduct had breached the fundamental tenets of the nursing profession.

The panel then considered the case of *Cohen.* In particular, the panel had regard to the following:

> *'It must be highly relevant in determining if a* [practitioner's] *fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated*.'

The panel considered whether Ms Rogers' conduct is easily remediable. The panel was of the view that misconduct relating to attitudinal issues is not easy to remediate. The panel considered that the circumstances of the event may have been stressful and challenging. The panel also credited Ms Rogers for her 31 years of unblemished service, during which no prior attitudinal concerns had been raised. However, the panel determined that such concerns as were found were not easy to remediate.

The panel considered whether Ms Rogers has in fact remedied the conduct which led to the charges. The panel considered that it is difficult, if not impossible, to show insight into conduct which is denied. The panel also took into account that Ms Rogers had signed a 'Management Supervision Report' in which she accepts that she should '*manage stress levels as sometimes staff can sense if [she's] having a bad day'.* However, since there has been no acceptance of the actions, and no evidence to suggest any remediation, the panel found that the misconduct has not been remedied.

The panel then considered whether the conduct is highly unlikely to be repeated. The panel found that there was no evidence to suggest that it is highly unlikely that it would happen again. The panel was of the view that faced with similar stressful and challenging circumstances, Ms Rogers is likely to again react in the way she did. The panel therefore determined that the misconduct is likely to be repeated.

Given the findings of the panel on the tests in *Cohen,* the panel referred to whether limbs a, b and c in Dame Janet Smith's test were also liable to occur in the future. Since the panel had found that it was likely that the misconduct would happen again, the panel found that Ms Rogers was liable in the future to: put patients at risk of unwarranted harm; bring the nursing profession into disrepute; and breach fundamental tenets of the nursing profession. The panel determined that there was a risk of repetition of the misconduct which led to the charges found proved.

The panel bore in mind the overarching objective of the NMC which is the protection of the public. Pursuing this objective involves the following objectives: a) to protect, promote and

maintain the health, safety, and well-being of the public; b) to promote and maintain public confidence in the professions regulated under the Nursing and Midwifery Order 2001; and c) to promote and maintain proper professional standards and conduct for members of those professions.

Given the risk to patient safety, and the public protection issues identified, public confidence in the profession and in the NMC as a regulator would be undermined if a finding of impairment were not made.

Having regard to all of the above, the panel was satisfied that Ms Rogers' fitness to practise is currently impaired.

Sanction

Submissions on sanction

Ms Stevens informed the panel that in the Notice of Hearing, dated 9 January 2025, the NMC had advised Ms Rogers that it would seek the imposition of a striking off order if the panel found Ms Rogers' fitness to practise currently impaired. During the course of the hearing, the NMC revised its proposal and submitted that a suspension order would be more appropriate in light of the panel's findings.

Ms Stevens referred the panel to the NMC Sanctions Guidance ('SG') which states that taking no further action is rare and is not available where there is a continuing risk to the public. No further action would also not mark the public interest for the profession. Ms Stevens submitted that a caution order would be inappropriate for the same reasons.

Ms Stevens submitted that due to what she said were deep seated attitudinal issues, and due to the lack of clinical issues, there would be no relevant, workable, measurable and proportionate conditions of practice which the panel could impose that would protect the public and prevent the reoccurrence of the misconduct.

Ms Stevens submitted that a suspension order was the most appropriate order that the panel could impose. Ms Stevens submitted that this misconduct was attitudinal in nature and that there remained a risk of repetition. For these reasons, Ms Stevens submitted that a suspension order was proportionate in these circumstances.

Decision and reasons on sanction

Having found Ms Rogers' 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:

- Risk of emotional and psychological harm to residents
- The misconduct was attitudinal in nature

The panel also took into account the following mitigating features:

- Evidence of a toxic environment in the workplace
- Lack of continuity in leadership to resolve workplace issues

As required by Article 29(3) of the Nursing and Midwifery Order, 2001, the panel first considered (pursuant to Article 29(4)) whether to undertake mediation or to take no further action. It considered that neither of these outcomes would be appropriate as neither would restrict Miss Rogers' practice. The public would therefore not be protected and the public interest would not be satisfied. The panel then moved on to consider the four available sanctions set out in Article 29(5) of the Order.

In considering whether a caution order would be appropriate in the circumstances, the panel took into account the SG, which 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 has decided that a two year caution order would adequately mark the public interest. Ms Rogers' is currently retired and, but for the NMC's Fitness to Practise proceedings, she would not be on the register. Upon the imposition of the caution order, Ms Rogers will cease to be on the NMC register. If she were to reapply to be admitted to the register, for the next two years, the NMC registrar will be on notice that her fitness to practise had been found to be impaired and that her practice is subject to this sanction. The public is therefore protected.

Having considered the general principles above and looking at the totality of the findings on the evidence, the panel has determined that to impose a caution order for a period of two years would be the appropriate and proportionate response. It would mark not only the importance of maintaining public confidence in the profession, but also send the public and the profession a clear message about the standards required of a registered nurse.

The panel considered whether it would be proportionate to impose a more restrictive sanction and looked at a conditions of practice order. The panel noted that there were no workable conditions that could be formed to address the attitudinal concerns in this case.

The panel concluded that no useful purpose would be served by a conditions of practice order. It would not be necessary to protect the public and would not assist Ms Rogers' return to nursing practice.

In making this decision, the panel carefully considered the submissions of Ms Stevens in relation to the suspension order that the NMC was seeking in this case. However, the panel considered that a suspension order would be wholly disproportionate. The panel considered the NMC sanction guidance reference SAN-3d. The panel determined that

while not a single incident, this was not a prolonged period of misconduct. The panel also found that whilst the concerns were attitudinal in nature, there was no evidence of harmful deep seated personality or attitudinal problems, nor any evidence of repetition of behaviour since the incident. For these reasons, the panel determined that the seriousness of the case did not require temporary removal from the register, and therefore a suspension order would be disproportionate.

This decision will be confirmed to Ms Rogers in writing.

That concludes this determination.