Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Tuesday, 2 April 2024 - Tuesday, 23 April 2024
Monday, 21 October 2024- Wednesday, 30 October 2024

Virtual Hearing

Name of Registrant:	**Rokeya Hussain**
NMC PIN:	98I6731E
Part(s) of the register:	Registered Nurse - Sub Part 1 RNA: Adult Nurse, Level 1 (25 March 2002)
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Bryan Hume (Chair, Lay member) Shorai Dzirambe (Registrant member) Barry Greene (Lay member)
Legal Assessor:	Charles Conway (2 April 2024-18 April 2024) Tracy Ayling KC (23 April 2024) Charles Conway (21 October 2024-30 October 2024)
Hearings Coordinator:	Samantha Aguilar (2 April 2024- 23 April 2024) Hazel Ahmet (5 April 2024) Samantha Aguilar (21 October 2024-30 October 2024)
Nursing and Midwifery Council:	Represented by Omar Sabbagh, Case Presenter
Mrs Hussain:	Present and represented by Anna Renou, instructed by the Royal College of Nursing (RCN) (2 April 2024-23 April 2024) Not present but represented by Laurence Harris at the hearing, instructed by the RCN (21 October 2024 and 30 October 2024)

	Present and represented by Laurence Harris, instructed by the RCN (22 October 2024-29 October 2024)
No Evidence to Offer:	Charges 4 and 6b
Facts proved by way of admission:	Charge 5
Facts proved:	Charges 1a, 1b, 2a, 2b, 6a, 7a, 7b, 7c, 8a, 8c, 9, 10 and 11 (only in respect of Charges 8a and 8c).
Facts not proved:	Charges 3, 8b)i), 8b)ii) and 8b)iii)
Fitness to practise:	Impaired
Sanction:	**Striking off order**
Interim order:	**Interim suspension order (18 months)**

Details of charges (as read out on 3 April 2024)

That you, a registered nurse:

1. Between March 2019 – June 2019, you breached professional boundaries and/or abused your position of trust in respect of Patient A, in that you attempted to coerce Patient A to enter a care home owned by you:
    a) without clinical justification;
    b) for the purpose of financial gain

2. On the following dates, you visited Patient A alone when you were aware that Patient A's Power of Attorney had requested no home visit take place without a second person present:
    a) 20 May 2019;
    b) 3 June 2019

3. In or around May 2019, you breached patient confidentiality in that you disclosed a patient's confidential information to a third party without the authority to do so.

4. In or around 2019 you demonstrated poor record keeping in that you recorded your contemporaneous observations in respect of patient/s in a notebook/diary.

5. Between 7 March 2019 to 4 June 2019, you failed to record your observations in respect of Patient A on SystmOne in a timely way/within 24 hours.

6. In December 2020, you failed to record:
    a) A clear plan regarding Patient B's Transfer into Greenmantle Care Home;
    b) That you had informed Patient B that you owned Greenmantle Care Home.

7. On or about 19 December 2020, you failed to follow correct procedural and/or legal requirements when placing Patient B in your care home, in that you:
    a) Failed to refer Patient B to social services for an assessment to be undertaken as to whether Patient B should be placed in a care home;
    b) Failed to ensure that legislation was followed in terms of assessments for Patient B under the Mental Capacity Act and Deprivation of Liberty Safeguards;
    c) Failed to contact Patient B's next of kin.

8. Failed to act with integrity and/or honesty, in that you:
    a) Failed to declare a potential conflict of interest to your employer regarding Patient B's placement into Greenmantle Care Home, which you own;
    b) Arranged for Patient B to be admitted into a care home which you own:
        (i) When this was beyond the scope of your role;
        (ii) Without following the correct procedures you should have followed in identifying Patient B's care needs;
        (iii) Without advising Patient B that you owned the home.
    c) Set up a payment arrangement directly with Patient B in relation to her care, without ensuring an assessment had been undertaken in relation to her financial capacity.

9. Between 20 December 2020 – 25 March 2021, you failed to safeguard Patient B because a capacity assessment was not completed;

10. Between 1 January 2021 – 1 April 2021, you incorrectly prevented or attempted to prevent Patient B from leaving Greenmantle Care Home for 90 days;

11. Your actions at one or more of the charges at 6a) – 10 above, were for the purpose of your own financial gain.

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

Decision and reasons on the NMC's application to offer no evidence in respect of Charge 4

At the outset of the hearing, Mr Sabbagh submitted that there is no evidence to offer in respect of Charge 4. The panel therefore found this charge not proved.

Decision and reasons on application for hearing to be held partially in private

During Ms 3's live oral evidence, Mr Sabbagh made a request that this case be held in private on the basis that he intended to make refences to [PRIVATE]. The application was made pursuant to Rule 19 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

Ms Renou indicated that she supported the application.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session when matters regarding [PRIVATE] are raised.

Decision and reasons on application to amend the charge

The panel heard an application made by Mr Sabbagh, on behalf of the NMC, to amend the wording of Charges 2 and 7(c).

> ‘2. On the following dates, you visited Patient A alone when you were aware that **a person who held a** ~~Patient A’s~~ Power of Attorney **in respect of Patient A** had requested no home visit take place without a second person present:
>
> a) 20 May 2019;
>
> b) 3 June 2019’

Mr Sabbagh submitted that there is no prejudice to you in this amendment. The amendment is sought simply to clarify the ambiguous phrasing which refers to a person as a *‘Power of Attorney’*. Mr Sabbagh further submitted that even if Patient A had capacity, the person who held a Power of Attorney in respect of Patient A should not have been ignored.

> ‘7. On or about 19 December 2020, you failed to follow correct procedural and/or legal requirements when placing Patient B in your care home, in that you:
>
> a) Failed to refer Patient B to social services for an assessment to be undertaken as to whether Patient B should be placed in a care home;
>
> b) Failed to ensure that legislation was followed in terms of assessments for Patient B under the Mental Capacity Act and Deprivation of Liberty Safeguards;
>
> c) Failed to contact Patient B’s **appropriate** next of kin.’

Mr Sabbagh submitted that there is no prejudice to you in this amendment. The amendment is sought simply to clarify the NMC’s case, which is that the error made by you was to contact [PRIVATE], in respect of whom there was a note on the system suggesting that she ought not to be contacted, and who was not Patient B’s nominated next of kin.

Ms Renou told the panel that she does not oppose the application.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules.

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

Details of Charges (as amended on 16 April 2024)

That you, a registered nurse:

1. Between March 2019 – June 2019, you breached professional boundaries and/or abused your position of trust in respect of Patient A, in that you attempted to coerce Patient A to enter a care home owned by you:
    a) without clinical justification; **[FOUND PROVED]**
    b) for the purpose of financial gain **[FOUND PROVED]**

2. On the following dates, you visited Patient A alone when you were aware that **a person who held a** Power of Attorney **in respect of Patient A** had requested no home visit take place without a second person present:
    a) 20 May 2019; **[FOUND PROVED]**
    b) 3 June 2019 **[FOUND PROVED]**

3. In or around May 2019, you breached patient confidentiality in that you disclosed a patient's confidential information to a third party without the authority to do so. **[FOUND NOT PROVED]**

4. In or around 2019 you demonstrated poor record keeping in that you recorded your contemporaneous observations in respect of patient/s in a notebook/diary. **[NO EVIDENCE TO OFFER]**

5. Between 7 March 2019 to 4 June 2019, you failed to record your observations in respect of Patient A on SystmOne in a timely way/within 24 hours. **[FOUND PROVED BY WAY OF YOUR ADMISSION]**

6. In December 2020, you failed to record:
    a) A clear plan regarding Patient B's Transfer into Greenmantle Care Home; **[FOUND PROVED]**
    b) That you had informed Patient B that you owned Greenmantle Care Home. **[FOUND NOT PROVED]**

7. On or about 19 December 2020, you failed to follow correct procedural and/or legal requirements when placing Patient B in your care home, in that you:
    a) Failed to refer Patient B to social services for an assessment to be undertaken as to whether Patient B should be placed in a care home; **[FOUND PROVED]**
    b) Failed to ensure that legislation was followed in terms of assessments for Patient B under the Mental Capacity Act and Deprivation of Liberty Safeguards; **[FOUND PROVED]**
    c) Failed to contact **appropriate** Patient B's next of kin. **[FOUND PROVED]**

8. Failed to act with integrity and/or honesty, in that you:
    a) Failed to declare a potential conflict of interest to your employer regarding Patient B's placement into Greenmantle Care Home, which you own; **[FOUND PROVED]**

b) Arranged for Patient B to be admitted into a care home which you own:

(i) When this was beyond the scope of your role; **[FOUND NOT PROVED]**

(ii) Without following the correct procedures you should have followed in identifying Patient B's care needs; **[FOUND NOT PROVED]**

(iii) Without advising Patient B that you owned the home. **[FOUND NOT PROVED]**

c) Set up a payment arrangement directly with Patient B in relation to her care, without ensuring an assessment had been undertaken in relation to her financial capacity. **[FOUND PROVED]**

9. Between 20 December 2020 – 25 March 2021, you failed to safeguard Patient B because a capacity assessment was not completed; **[FOUND PROVED]**

10. Between 1 January 2021 – 1 April 2021, you incorrectly prevented or attempted to prevent Patient B from leaving Greenmantle Care Home for 90 days; **[FOUND PROVED]**

11. Your actions at one or more of the charges at 6a) – 10 above, were for the purpose of your own financial gain. **[FOUND PROVED]**

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

Admission of Charge 5

The panel heard from Ms Renou, who informed the panel that you made admissions to Charge 5.

The panel therefore finds Charge 5 proved, by way of your admission.

Submissions on application to admit hearsay evidence

The panel heard an application made by Mr Sabbagh under Rule 31 to allow hearsay evidence which has been adduced during the oral evidence of the live witnesses. Mr Sabbagh provided written and oral submissions:

'3. There are two main parts of the evidence which form the hearsay which is contested:

a) The signed written statement, and reported statements, of Patient A.

b) The reported statements of patient B.

4. Statements made by Patient A have been presented in one of two ways: they have either been recorded in a statement directly signed by Patient A, or they have been reported by other witnesses.

5. First, on the 7th June 2019, [Ms 8] *and* [Ms 9] *attended the home address of Patient A and took a statement from her. Exhibit JS/2 shows a signed version of that statement, on which a declaration of truth is handwritten and signed, the NMC say by Patient A. The reliability of this document is supported by the following evidence:*

a) [Ms 8] *gives direct evidence that she attended the meeting on the 7th June 2019 in order to obtain a statement from Patient A. She explained that* [Ms 9] *also attended to support her with notetaking.*

b) [Ms 8] *describes her focus as being the account of Patient A, that she only remembers speaking to Patient A, because she wanted to take her views and to hear the account of Patient A and nobody else. She confirmed that the statement represented an accurate account of what was said by Patient A in that meeting.*

c) The statement was not signed by Patient A on the 7th June 2019. [Ms 5] *– who was conducting an investigation in relation to the allegations – described causing the signed version of the 7th October 2019 to be*

obtained by asking for the statement to be taken back to Patient A to confirm and sign that she agrees it is true.

d) [Ms 5] *describes that the individuals who went to get the statement signed were* [Ms 8] *and* [Ms 9]*. In evidence, however,* [Ms 8] *said that she was not involved in obtaining the signature on the statement.* [Ms 9] *has been contacted but has responded explaining that she cannot remember as it was so long ago, and that she has no recollection of getting a statement signed.*

e) In light of the above, the NMC submit that there is a very strong inference which the Panel can draw that the statement was signed by Patient A.

6. Second, within their statements and exhibits, and during live evidence, witnesses have made repeated reference to what was said to them by Patient A, in particular (but non-exhaustively), the accounts of [Ms 1]*,* [Ms 2]*, and* [Ms 8]*.*

7. In relation to Patient B, the evidence that is relied upon largely amount to records and documentation (e.g. Patient B's care plan, her electronic records, cheques signed by patient B), and less so the account or recollection of events given directly by Patient B. However, there is some mention, in particular in the evidence of [Ms 4] *and* [Ms 6]*, of things said by Patient B upon their attendance at Greenmantle Care Home, and it is such statements which the NMC would apply to admit into the evidence.'*

Mr Sabbagh referred the panel to the principles of law as set out in *Thorneycroft v NMC* [2014] EWHC 1565 (Admin), and provided the following submissions on admissibility:

'Submissions on Admissibility

12. […]

13. *Relevance. Plainly, the accounts of Patient A and Patient B are both highly relevant to the charges. The main question to be addressed is whether or not it is fair to admit the evidence.*

14. *There is good and cogent reason for the absence of the witnesses, and the NMC took all the reasonable steps which it could have taken in the circumstances. Both Patient A and Patient B* [PRIVATE] *around the time when they were in the registrant's care. Unfortunately, both patients* [PRIVATE].

a) *The case concerning Patient A was investigated from 2020 at which time patient A* [PRIVATE]*. By September 2021,* [PRIVATE]*. The NMC were informed that the ongoing investigation was having an impact on patient A. Concerns were raised about the patient's health and the impact of these ongoing investigations. By that point an interview had not taken place between the NMC and patient A, the reason was due* [PRIVATE]*. It was communicated in July 2023 that* [PRIVATE]

b) *As regards Patient B, the Panel have heard evidence that even as of the time of these concerns, Patient B was already very frail, lacked capacity and had been referred to the dementia pathway. Shortly after being discharged from Greenmantle Care Home in May 2021, Patient B was hospitalised and entered into a further care home. It was communicated in December 2021 that Patient B* [PRIVATE].

15. *The hearsay evidence of Patient A and Patient B, though no doubt very important to the NMC case, is not the sole and decisive evidence in the case. The Panel are assisted by the accounts of other witnesses, investigation reports, expert reports, and contemporaneous records,*

which may help the Panel build a broader picture of the events and also test and assess the hearsay evidence which is presented before it. Moreover, the Registrant has been very ably represented by her counsel and may also in due course give evidence herself of what she says transpired.

16. *The absence of the witnesses can be reflected in the weight to be attached to their evidence. The admission into evidence of the hearsay in question does not mean that the evidence must be accepted. The Panel will no doubt receive robust legal advice on how to treat hearsay evidence and the attachment of weight to such evidence.'*

Ms Renou provided the panel with a written and oral submission. She referred the panel to the relevant case law which included *El Karout v NMC* [2019] EWHC 28 (Admin), *Ogbonna v Nursing and Midwifery Council* [2010] EWHC 272 (Admin) and *Thorneycroft.*

'8. It is submitted that the two main parts of hearsay evidence which the NMC apply to rely on, namely

i. The signed written notes, and reported statements, of Patient A

ii. The reported statements of Patient B – the reported statement of Patient B are admitted by agreement

9. It is accepted that Patient A [PRIVATE]*. Notwithstanding this good and cogent reason for her non-attendance it is submitted the NMC have not taken all reasonable steps which it could in the circumstances in relation to Patient A.*

<u>Exhibit JS/2 – Signed notes from meeting on 7 June 2019 by Patient A</u>

10. *This document is a copy of notes taken in a meeting between Patient A,* [Ms 2], [Ms 9] *and* [Ms 8]*. The NMC seek to adduce this document as the statement of Patient A.*

11. *It is relevant to Charge 1 and Charge 2.*

12. *This document is dated 7th October 2019, following a meeting on 7th June 2019. It is not clear when Patient A* [PRIVATE]*, or what steps if any the NMC took to take a fuller statement in the first person. The NMC argue the investigation was having an impact on Patient A's* [PRIVATE]*. There is no evidence before the Panel to support such a submission. The only evidence before the Panel about what steps were taken to secure a statement from Patient A is from* [Ms 5]*, who was shown the notes from the meeting and asked for it to be endorsed by Patient A because it is "not worth the paper it is written on". The NMC are silent on what steps, if any, they took to secure a statement from Patient A. It is submitted this is an extension of the principle in Ogbonna, and the NMC have not taken all reasonable steps in the circumstances. If, despite reasonable efforts, the NMC could not arrange a statement from the defendant then the application to admit hearsay would have a stronger basis.*

13. *Had Patient A been available for cross-examination the details and what was said at the five meetings between her and the registrant, the subsequent discussion she had with* [Ms 1] *and* [Ms 2] *and the meeting on the 7th June 2019 would have been challenged under cross examination. In short, the entirety of the JS/2 would have been challenged.*

14. *JS/2 is the sole and decisive evidence in respect of the details and what was said between the registrant and Patient A. The registrant has*

entered clinical notes into system1 in relation to clinical observations, however these notes are not a record of what was said between the parties. What was said to [Ms 1]*) and* [Ms 2] *also amounts to hearsay and is opposed.*

15. *The NMC argue that handwritten paragraph at the bottom of page 5 is a signature of Patient A. No evidence is before the panel that this is*

    i. *Patient A's signature*

    ii. *The circumstances in which the handwritten words appears at the bottom of the page, nor how Patient A signed the documents*

16. [Ms 5] *said in her evidence that she requested the notes be endorsed by Patient A if they are an accurate reflection of what was said. However it is submitted that no evidence has been produced of how this signature (while not agreed to be Patient A's) was obtained.*

17. *If the Panel are persuaded that there is a reliable inference that the witness statement is Patient A's then the panel must go onto to consider what weight can be given to it as per El Karout. It is submitted that the Panel can attach little weight to it for the following reasons*

    i. *The Panel has no evidence before it what paragraphs Patient A read. For example, the Panel has no evidence if the whole document or part of the document was read to her, or if she read the document herself*

    ii. *The Panel are aware it is recorded in Patient A's system1 notes that she is deaf and can pretend to hear (ex.p 37). Evidence is therefore before the Panel that Patient A can present like she understands something when she does not. There is no evidence before the Panel about what if anything, Patient B understood she was signing*

[Ms 1]

18. *The relevant paragraph of* [Ms 1]*'s statement is paragraph 11.*

19. *Arguments in relations to the steps the NMC have taken to secure Patient A's attendance at paragraph 14 are adopted.*

20. *The seriousness of the charges lies in what the registrant said to Patient A. It will be apparent to the Panel that an adverse finding which will have a significant impact on the registrant's career. In such circumstances upmost caution should be taken.*

21. *It is in evidence that Patient A is almost deaf (ex. P 37). It is of note that this entry on Patient A's system1 notes if form a telephone call from* [Ms 2].

22. *If Patient A is a deaf as the system1 notes record, then as a matter of logic anything Patient A told* [Ms 1] *she heard the registrant say is inherently unreliable, and therefore it would be unfair to admit it.*

23. *It is submitted Patient A's hearing is a significant factor that would have been challenged and explored had she been available for cross examination.*

24. *The contradictory evidence before the Panel about Patient A's hearing increases the unreliability of the hearsay in paragraph 11.*

25. *It is submitted that Patient A's account is inconsistent with the system1 notes. At paragraph 10,* [Ms 1] *states Patient B told her the registrant had not taken any bloods or vitals. The Stem1 notes reflect vitals been taken on 7 March 2019, 29 April 2019, 16 May 2019 (ex.p 36-39). The registrant offered to take vitals on 3 June 2019, Patient A declined (ex.p 40). The*

demonstrates that Patient A's account to [Ms 1] *is unreliable, at least in part. It is submitted that little weight can be attached to it due to the unreliability and in those circumstances should not be admitted (El Karout)*

[Ms 2]

26. The relevant paragraphs of [Ms 2] *statement are paragraphs 9, 13, 18 and 19.*

27. The arguments set out at paragraph 14 and 20 – 26 are adopted insofar as they relate to this witnesses hearsay.

28. In respect of the comment at paragraph 19, "last chance, you can go into a home now" was said to have been said when the registrant was on the doorstep and Patient A inside. Patient A's hearing issue would be even more significant in an exchange where she is speaking to someone outside her home, making the statement inherently unreliable, and it would be unfair to admit it.

[Ms 4]

29. The relevant paragraphs are paragraphs 14 and 15 and the witness' live evidence.

30. [Ms 4] *gave evidence about conversations she had with the care home manager and* [Ms 10]*'s response.*

31. It appears the NMC have made no efforts to contact nor take a witness statement from [Ms 10]*.* [Ms 10]*'s understanding on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty (DOLs) assessment has been criticised. It is submitted this is hearsay as the NMC seek to rely on the*

contents of what [Ms 10] *is purported to have said for the truth of its contents, i.e the staff had limited understanding on DOLs and MCA. Where the NMC have made not attempt to secure this witnesses attendance or evidence in any way, the evidence should not be admitted (Ogbonna)*

[Ms 6]

32. Where [Ms 6] *referred to comments* [Ms 6] *has made about the MCA and DOLs, the argument at paragraph 32 is adopted.*

Panel decision and reasons on hearsay

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.

Hearsay evidence in relation to Patient A

The panel heard during the live evidence of the NMC's witnesses that Patient A [PRIVATE] and therefore was unable to attend the hearing to provide evidence. The panel accepted that there is a good and cogent reason for the non-attendance of Patient A.

Exhibit GGS/3 (Member of Public Statement) and Exhibit JS/2 (Signed notes from meeting on 7 June 2019 by Patient A)

The panel noted that these two exhibits relate to Charges 1, 2 and 3. The panel drew distinctions between the unsigned meeting notes and signed meeting notes (purportedly signed document, Exhibit JS/2, by Patient A at the behest of Ms 5 during the local investigation). The panel bore in mind the principles of *Thorneycroft* when considering each version of the document.

The panel considered whether the meeting notes dated 7 June 2019 which included an account given by Patient A supporting the Charges was the sole and decisive evidence. The panel acknowledged that the meeting took place on 7 June 2019, but the document purportedly signed by Patient A was dated 7 October 2019.

Ms 2, Ms 8 and Ms 9 attended Patient A's home to discuss your previous visits, and the complaints made by Ms 1 and Ms 2. The panel took the view therefore that the account given by Patient A in the meeting of 7 June 2019 was not the sole and decisive evidence. The panel also noted that during the meeting on 7 June 2019 that apart from Patient A there were three other people present at this meeting, two of whom gave oral evidence before the panel. Ms 8 and Ms 9 attended the meeting within their role as a nurse, both of whom were unknown to Patient A. The panel therefore received no indication that Ms 2 and Ms 8 both had reasons to fabricate their accounts. When considering the nature and extent of challenging this evidence, the panel took the view that given that both Ms 2 and Ms 8 gave independent accounts of the meeting on 7 June 2019, and whilst the document was dated 7 October 2019, it considered that this material is not demonstrably unreliable that it could not be admitted into evidence.

The panel next turned its attention to the signed version of the meeting notes dated 7 June 2019 which was administratively exhibited by Ms 3 during her live evidence. The panel again considered whether this was sole and decisive evidence. The panel also heard from Ms 8, having been shown the signed document during her oral evidence, that she was uncertain as to why and when this document was signed by Patient A, whilst Ms 5 told the panel that she had asked that the contents of this meeting notes was put to Patient A, so she could confirm whether the contents were true. However, the panel decided that this evidence is not sole and decisive in considering Charges 1, 2 and 3. The panel considered the submissions made by Ms Renou that there was no evidence of any efforts made by the NMC to obtain a witness statement from Patient A. The panel determined however that this was a factor they can take into account when considering the weight it can attach to the statement, but it did not consider that was a sufficient reason or reject the

submission that JS/2 should not be admitted as hearsay. As such, the panel was of the view that it would be fair and relevant to admit Exhibit JS/2 and Exhibit GGS/3.

There is no evidence before the panel to indicate that either of these notes had been fabricated, as the nurses who were present had attended this meeting as part of their role to investigate the concerns from Ms 1 and Ms 2. The panel concluded that Exhibit JS/2 and GGS/3 were not demonstrably unreliable and that your counsel already was able to cross examine Ms 2 and Ms 8 as to the reliability of the evidence given by Patient A at that meeting.

The panel carried out a balancing exercise and noted the principles in *Thorneycroft*. The panel noted that the allegation against you is serious and if it was found proved, could have serious consequences on your professional reputation. The panel will apply the appropriate weight to their evidence in due course once it has heard and seen all of the evidence. The panel was of the view that it would be fair and relevant to admit this and later assess the evidence in full.

Evidence of Ms 1 and Ms 2

The panel carefully considered whether it would be relevant to admit Ms 1 and Ms 2's evidence in relation to conversations they had with Patient A, which goes to proving Charges 1, 2 and 3. It noted that SystmOne recorded Patient A on 9 April 2019 as *'very deaf and 'pretends' to understand when calling* […] *she does have the ability to understand when speaking to patient face to face.'* It rejected the suggestion that due to the record contained in SystmOne that anything said to Patient A was inherently unreliable and unfair to admit.

The panel noted that Ms 1 and Ms 2 are both well acquainted with Patient A and saw evidence suggesting that there were some difficulties during telephone conversations but heard evidence from Ms 2 that there was no difficulty during face-to-face conversations. The panel heard from Ms 1 that Patient A did not use hearing aids and in Ms 2's oral

evidence, she said that Patient A did experience a degree of hearing loss, however, "[Patient A] *would answer and talk on the phone,* […] *it would surprise me if she pretended to hear".* The panel was therefore of the view that this evidence was not demonstrably unreliable given the two distinct accounts from Ms 1 and Ms 2, and when considering the nature and extent of the challenge.

The panel also noted that Ms 2 stated in her oral evidence that during the meeting on the 7 June 2019, Patient A was very clear and *"straightforward",* she also found her memory *"particularly good".*

The panel carried out a balancing exercise and noted the principles in *Thorneycroft*. The panel noted that the allegation against you is serious and if it was found proved, could have serious consequences on your professional reputation. The panel will apply the appropriate weight to their evidence in due course once it has heard and seen all of the evidence. It decided that it would be fair to admit Ms 1 and Ms 2's evidence of conversations they had with Patient A.

Hearsay evidence in relation to Patient B

The panel heard during the live evidence of the NMC's witnesses that Patient B [PRIVATE] and therefore was unable to attend the hearing to provide evidence. The panel accepted that there is a good and cogent reason for the non-attendance of Patient B.

Evidence of Ms 4 and Ms 6

The panel noted that Ms Renou has accepted that the reported statements of Patient B are admitted by agreement.

Objection was taken however to parts of the statements which referred to conversations they had with Ms 10 who was not called as a witness by the NMC. The panel considered whether the evidence of Ms 4 and Ms 6 are sole and decisive evidence, and whether it is

fair and relevant to admit. The evidence provided by Ms 4 and Ms 6 relate to Charges 6, 7, 8 and 9.

The panel noted that Ms 4 became involved in Patient B's case having been asked to attend Greenmantle Care Home to obtain a blood test for Patient B. Ms 4 stated that she raised concerns about Patient B's admission at Greenmantle Care Home due to a comment in which Patient B allegedly said that she wanted to go home but was not allowed to do so. Having raised safeguarding concerns, Ms 4's referral led to the involvement of Ms 6. The panel noted that Ms 4 and Ms 6 were unknown to Patient B and had attended Greenmantle in their capacity as healthcare professionals, as such, they had no reason to fabricate their accounts. Ms 4 and Ms 6 both had conversations with Ms 10, the Care Home Manager at the time, and provided a good level of detail. Their evidence was independent of each other and therefore not sole and decisive evidence. The panel placed importance in the seriousness of the charges against you and carefully weighed the fact that Patient B is deceased, hence, not available to attend this hearing.

The panel therefore took the view that there was no evidence to suggest that the accounts of Ms 4 and Ms 6 had been fabricated, and that therefore their evidence is not demonstrably unreliable. The panel decided to admit the evidence of Ms 4 and Ms 6 in respect of Patient B.

The panel also noted that whilst the NMC has not contacted Ms 10, who was the Manager of Greenmantle Care Home at the time of the alleged charges, Ms 10's non-attendance does not make Ms 4 and Ms 6's evidence demonstrably unreliable in recollecting what was said to them.

The panel carried out a balancing exercise and noted the principles in *Thorneycroft*. The panel noted that the allegation against you is serious and if it was found proved, could have serious consequences on your professional reputation. The panel will give the appropriate weight to their evidence in due course once it has heard and seen all of the evidence.

Following the end of Mrs Hussain's live oral evidence, Ms Renou told the panel that she had difficulties in contacting Mrs Hussain to obtain further instructions about the subsequent process and whether she planned to attend the rest of the hearing on the afternoon of 23 April 2024.

The panel decided to adjourn this hearing to a resuming date.

Mr Sabbagh made his application for an interim order in the absence of Mrs Hussain under rule 32(5) of the Rules.

Interim order (23 April 2024)

The panel heard an application from Mr Sabbagh for an interim suspension order. He submitted that whenever a panel adjourns, it must consider whether an interim order is necessary. He submitted that the NMC are asking for an interim suspension order and that this would mean that Mrs Hussain would not be able to practise as a nurse for a short period of time until the hearing reconvened. He submitted that as the panel has not yet heard closing submissions, and possibly not heard the end of the respondent's evidence, it would not be appropriate at this stage for the panel to be expressing views about the facts and their findings.

Mr Sabbagh submitted that an interim order is appropriate in cases where there are concerns about a nurse and where the concerns are so serious that they may place patient safety at risk, and where there would be serious damage to public confidence in the nursing profession if they were allowed to practise without any restrictions.

Mr Sabbagh submitted that the panel now knows that this case concerns allegations of pressuring a patient into entering a care home by effectively bullying or putting pressure on Patient A in various ways and making threats that scared the patient. In relation to Patient B, the concerns relate to Mrs Hussain acting for her own benefit where there was a

conflict of interest and taking money directly from a patient. Mr Sabbagh submitted that both patients were vulnerable elderly [PRIVATE] and that the allegations themselves are of such serious nature which require temporary suspension. Mr Sabbagh submitted that in considering the risks to the public, the interim order is also necessary to consider the degree of risk and likelihood of serious damage to public confidence in the profession if Mrs Hussain was allowed to continue to work with patients pending the panel's decision on facts.

Mr Sabbagh submitted that an interim order spanning to a couple of months would be relevant to cover the period until the hearing reconvenes.

Ms Renou told the panel that she does not accede to the application. However, she submitted that it is plainly a matter of risk, and not an opportunity to prejudge the facts. Ms Renou invited the panel to consider what risk when conducting the balancing exercise, consider the age of these allegations and the amount of time it has taken to come before a panel. She submitted that whilst it may only be an adjournment through to October 2024, the proposed new dates are still a significant period of time in the future. She submitted that the panel must balance all of those factors when determining risk and that it is the risk the panel must consider and not a prejudgment of the facts.

Decision and reasons on interim order (23 April 2024)

The panel heard and accepted the advice of the legal assessor. The panel has not yet determined the facts of the case and has assessed the risk based only on the information it has at present.

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 considered the nature, and the circumstances of the concerns contained in this case. The panel was of the view that an interim order is necessary to protect the public.

The charges alleged amongst other things relates to placing vulnerable patients under pressure, possible abuse of power by keeping Patient B at Greenmantle Care Home longer than needed, and Mrs Hussain's failure to make the appropriate referrals for patient B's mental capacity. The panel considered the seriousness of the allegations put forward by the NMC and noted that they relate to vulnerable elderly patients. In light of this, the panel determined that there is a risk of harm and repetition and therefore an interim order is necessary to protect the public.

The panel determined that an interim order is also necessary in the wider public interest. A member of the public would be concerned to learn that a registered nurse facing these allegations would be allowed to practise whilst a substantive hearing is ongoing to establish the facts of the case.

The panel next considered an interim conditions of practice order and in all the circumstances determined that such an order would be insufficient to protect the public and to meet the wider public interest considerations of this case. The panel was not satisfied that an interim conditions of practice order could be devised which would be sufficient to protect the public given the seriousness of the allegations.

The panel is satisfied that, in the particular circumstances of this case, an interim suspension order is appropriate and proportionate. It has decided to make this interim suspension order for a period of 8 months whilst Mrs Hussain awaits the resumption of her hearing.

Resumption of the hearing (21 October 2024)

The hearing resumed on 21 October 2024. Mrs Hussain was represented by Mr Harris, who was instructed by the Royal College of Nursing (RCN). Mrs Hussain was not present at this stage but had been available to join the hearing. Mr Harris informed the panel that he had an application he wished to make before the hearing resumed in its entirety.

Mr Harris made a joint application with Mr Sabbagh for some time to read the transcripts and given that they received on the morning of the hearing, and it has been sometime since the evidence was heard. He submitted that in a case like this, it would be beneficial to review the transcript and having more time with his client having come into this case late. He informed the panel that it is likely that it would take the rest of the day to review the transcript and if there were no issues that he would be in a position to proceed to closing submissions.

Mr Harris informed the panel that there is also a defence witness who was warned to attend in person, and after speaking to Mrs Hussain, it is her wish for the witness to give evidence.

Mr Sabbagh was invited to comment, and he confirmed that Mr Harris has indeed made a joint application and that he believed that it would take him longer than the morning to get through the transcript. Mr Sabbagh informed the panel that he would be content to provide an update around lunchtime if the panel found this helpful.

The panel has accepted and allowed both counsel the day to read through the transcript.

Decision and reasons on application to admit written statement from Person A

The hearing resumed on 22 October 2024. You were present with your representative, Mr Harris.

The panel heard an application made by Mr Harris under Rule 31 to allow the written statement of Person A into evidence. Person A was not present at this hearing and, whilst Person A was available to provide oral evidence on 18 April 2024, she is unable to attend today.

Mr Harris provided the panel with written and oral submissions. Mr Harris informed the panel that Person A is a practitioner who was in a similar role to you and her evidence

supports your case. It is regrettable that she is not able to give live evidence at the resumption of the hearing and if she had, her evidence would have been admissible. He submitted that the reason that she could not give evidence is because she is currently abroad. She had previously been able to attend the hearing on 18 April 2024 from 14:00 but due to the delay, she had not been able to do so.

Mr Harris submitted that whilst Person A could not be cross-examined, that is not of itself a good reason to justify as to why her witness statement should not to be admitted. He submitted that when looking at the real substance of the potential unfairness, there was only one section of Person A's statement that is in contention and that is when a Mental Capacity Assessment (MCA), MCA 1 and MCA 2 is carried out which is addressed in paragraph 9 to 10 of her statement. Person A further stated that it is only in an exceptional circumstance that a change of accommodation would lead to an MCA 2. He submitted that this is consistent with your evidence and Ms 6's evidence. He submitted that this is a case where in weighing the evidence in balance, the interest of justice and fairness in this case falls in your favour.

Mr Sabbagh reminded the panel that fairness is a key issue here. He submitted that it is unfair for the evidence to be admitted as it cannot be tested through cross examination. The section of the statement which Mr Harris referred to is paragraph 9 to 11. He further submitted that the problem with this statement is because it is incredibly vague and opens up many questions such as what would be considered exceptional circumstances for a Matron to complete an MCA 2 and what level of doubt needs to be present regarding a patient's capacity before an MCA 2 would ordinarily need to be undertaken. Mr Sabbagh submitted that this statement cannot be challenged. He cannot question Person A about the nuances of the factual circumstances and determine whether or not it does assist your case or undermine it. That ambiguity is misleading and unhelpful rather than simply being neutral.

Mr Sabbagh referred to the case of *Thorneycroft* and reminded the panel that it must be satisfied that the evidence is demonstrably reliable, or alternatively, that there will be some

means of testing its reliability. He submitted that in these circumstances, there is very little information about the expertise of Person A, whether her knowledge of the standards is different and as to what her experience is in these roles.

Mr Sabbagh submitted that there is insufficient information to confirm the reliability of Person A's evidence, given that there is no written report, an explanation of what material she was asked to look at and how much information has been given to Person A relating to this case. Mr Sabbagh submitted that the uncertainties would have been manageable had Person A been here to provide oral 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. He also referred the panel to *El Karout v NMC* and *Thorneycroft* and the principles the panel had to consider as set out in those cases which the panel had borne in mind in determining the admissibility of Person A's evidence.

The panel gave the application regarding Person A its careful consideration. The panel noted that Person A'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'. Since Person A had no means of physically signing the document, she sent a further email dated 18 April 2024 to confirm her statement.

The panel bore in mind the case of *El Karout* and *Thorneycroft*. It noted that the evidence of Person A is relevant to the charges, and it is not the sole and decisive evidence supporting your case. In these circumstances, the panel came to the view that it would be fair and relevant to accept into evidence the written statement of Person A but would give what it deemed appropriate weight in due course.

Background

The charges arose whilst you were employed as a Band 7 Community Matron at Essex Partnership University NHS Foundation Trust (the Trust). At the time of alleged incidents, you were also the owner of Greenmantle Care Home Limited (Greenmantle).

You were referred to the Nursing and Midwifery Council (NMC) by Ms 1 and Ms 2 in relation to matters relating to Patient A. In March 2019, Patient A had a fall. She went into a local nursing home for three weeks for some respite care. Patient A recovered after the three weeks and was subsequently discharged back to her home address. After Patient A came out of respite care, the Trust was asked to carry out some assessments of her needs. Patient A's General Practitioner (GP) was also spoken to, and made a referral to the Community Matron, which led to your involvement with Patient A.

On 3 May 2019, Ms 1 called Patient A to check up on her. Patient A was allegedly very anxious and upset due to a visit she received from you. Ms 1 visited Patient A later that evening. Patient A allegedly described that you attended her home, did not leave your card or any advice leaflets. You also allegedly did not take any basic observations such as her blood pressure. Patient A allegedly stated that you had not asked her about her past medical history or medication, nor provided any advice or support about living independently or adapting her home after a fall. Patient A allegedly stated that you had been very insistent that she needed to go to a care home at Woodford Green on Mornington Road for two weeks. The care home that you owned (Greenmantle) was located on Mornington Road. Despite Patient A having expressed to you that if she were to go to a care home it would be to Lugano Care Home (Lugano) where she had spent her last three-week respite stay, you apparently told her that Lugano had no vacancies, and that '*if you don't go,* […] *will find you on the floor with a fractured hip.*'

It was also alleged that you had requested Patient A's gardener's telephone number. You then allegedly disclosed another patient's confidential information to the gardener, without the authority to do so.

According to Patient A's SystmOne Records, you visited Patient A again on 16 May 2019, where Patient A complained of back pain but was noted by you to have good support from close friends and able to manage her bedroom on the first floor. Ms 2 alleged that she was told by Patient A that on one occasion that you visited, Patient A had complained of a sore back. At that point, you allegedly suggested to Patient A that she would be better off going into a care home.

Due to concerns that you were allegedly trying to pressure Patient A to go into Greenmantle without clinical justification, Ms 2 wrote a letter to you outlining that she was Patient A's Power Of Attorney (POA) and requested that you do not visit Patient A without an appointment, without a second person present and that you do not telephone Patient A about concerns. Ms 2 sent a copy of this note to Patient A's GP and your line manager, Ms 8, and delivered the letter by hand to the Rectory Lane Health Clinic (Rectory Lane), where you were based on 20 May 2019.

Thereafter, you allegedly visited Patient A on at least two further occasions. On 20 May 2019, after receiving the letter from Ms 2, then on 3 June 2019. On the last occasion, Patient A had allegedly refused to let you into her home. You allegedly stood at the doorstep and talked to Patient A, telling her that she had lost weight and that the back pain would not get better due to being caused by arthritis. You also allegedly said words to the effect of, *'last chance, you can go into the home now'*.

Your line manager noted that after having conducted her own visit to Patient A on 7 June 2019, that it was clear that Patient A could walk independently and did not need the frequent visits that you had been undertaking.

You became subject to an investigation. Further, you allegedly failed to record your observations in respect of Patient A on SystmOne in a timely way/within 24 hours.

You denied ever mentioning to Patient A needed to go into a care home and you stated the only reason for the visits was in your capacity as Community Matron to ascertain her wellbeing.

Following the events that unfolded with Patient A, an Integrated Clinical Team Manager, Ms 7, was reviewing Patient B's record and became concerned about your involvement with Patient B. Ms 7 became aware that Patient B was placed at Greenmantle whilst they were still your patient. Patient B was very vulnerable and was referred to your team by their GP. You made your first visit to Patient B's home on 9 December 2020. The following concerns were raised:

- A conflict of interest in Patient B attending Greenmantle.
- You may have tried to coerce Patient B to be admitted into Greenmantle.
- Appropriate MCA assessments were not carried out on Patient B before her admission to Greenmantle.
- There was no indication of other options being discussed with Patient B, nor any indication that you told Patient B that you owned Greenmantle.

On 4 March 2021, a nurse, Ms 4, attended Greenmantle. She had been asked to attend due to concerns around whether the patient had been placed in a care home that was owned and managed by a member of the Trust. Upon her arrival, Patient B allegedly seemed visibly upset and kept saying that she wanted to go home but that she was not allowed to go home. During observations, Ms 4 expressed concern that no one had ensured that the Patient B's capacity to make financial decisions had been assessed, but Greenmantle was nevertheless happy to accept her payments. Moreover, Ms 4 was concerned that Patient B was not allowed to leave, even though she was not subject to deprivation of liberty safeguarding (DoLs). A safeguarding concern was raised using the relevant form.

On 30 March 2021, a clinical team manager at the specialist dementia and frailty service attended Greenmantle to investigate a safeguarding concern that had been raised and to

complete a Mental Capacity Assessment in respect of finances for Patient B. There were concerns about the view taken by Greenmantle that Patient B had capacity, despite the fact that there had been two mental capacity assessments done on 25 March 2021 and 30 March 2021, in which Patient B was found to be suffering with undiagnosed cognitive impairment and lack capacity. There was also concern expressed about the staff at Greenmantle's understanding of the COVID legislation, which was cited as the reason for Patient B not being allowed to leave the care home. The psychiatric nurse found that Patient B had written two cheques to Greenmantle, one for £6,000 and one for £9,000, which was especially concerning given the assessment that Patient B deemed to lack capacity.

During the Trust's local investigation, you denied the allegations relating to Patient B.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Sabbagh behalf of the NMC and Mr Harris on your behalf.

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:

- Ms 1: Friend of Patient A
- Ms 2: Friend of Patient A, and also had Lasting Power of Attorney over Patient A

- Ms 3: Investigating Manager at the Trust during the events involving Patient B.
- Ms 4: Community Psychiatric Nurse at the Trust during the events involving Patient B.
- Ms 5: Head of Community Nursing for Integrated Services for Adults and Older People and Investigation Lead at the Trust during the events involving Patient B.
- Ms 6: Clinical Team Manager of the Specialist Dementia and Frailty Service at the Trust during the events involving Patient B.
- Ms 7: Clinical Team Manager at the Trust and your line manager for around 18 months to two years and during the events involving Patient B.
- Ms 8: Clinical Team Manager at the Trust and your line manager during the events involving Patient A.

The panel also heard evidence from you under oath.

The panel also heard live evidence from a witness called on your behalf:

- Dr 1: Former colleague who worked with you for approximately 8-10 months. Provided evidence regarding your character.

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 and you which included the witness statement of Person A.

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

Charge 1

1. Between March 2019 – June 2019, you breached professional boundaries and/or abused your position of trust in respect of Patient A, in that you attempted to coerce Patient A to enter a care home owned by you:
   a) without clinical justification;
   b) for the purpose of financial gain

Charge 1 is found proved in its entirety.

The panel first considered your role in respect of Patient A. You were employed as a Community Matron and part of your duty at the Trust included visiting patients to monitor their health and wellbeing. The panel has not been provided a job description; however, it was satisfied that you had a professional duty to visit Patient A after she was discharged following a short three-week respite stay at Lugano Care Home in your capacity as Community Matron and to assess her needs. According to Ms 2, the referral was made in respect of assessing any possible adaptations to her own home and prevent any further fall. Her previous Community Matron managed Patient A's care by way of sporadic phone calls. Apart from the fall documented in respect of Patient A and a three-week respite stay,

the panel heard no information to justify a change in the management of care that Patient A had previously.

In considering Charge 1a, the panel took into account the evidence of Ms 1 and Ms 2 regarding the nature of their friendship with Patient A. The panel was informed that the friendship between Ms 1 and Patient A spanned around '*20 years'* and Ms 1 frequently called Patient A to check on her. Ms 2 told the panel that she had also known Patient A for a significant amount of time and would often visit her. The panel was satisfied that Patient A had a good network of friends around her who would periodically check on her.

Ms 1 told the panel that she visited Patient A following a visit from you as her new Community Matron and having heard that Patient A was upset by your visit, Ms 1 attended Patient A's home and recorded what Patient A said in her diary. The panel had sight of Ms 1's handwritten diary. Within the diary entry of 3 May 2019, it stated, *'just turned up no appointment', 'Go to Woodford', 'No vacancies* […] *Lugano'* and *'if you don't go* […] *will find you on the floor with* [broken] *hip'*. Ms 1 and Ms 2 provided evidence that you had allegedly told Patient A that she must go to a care home located in Woodford Green/Mornington Road and upon carrying out some research, Ms 1 and Ms 2 discovered that the care home which you had allegedly been referring to was Greenmantle, the care home which you owned.

Following the visits, the panel heard from Ms 1 and Ms 2 that Patient A had become upset by your visit and alleged that you were pressuring her into attending the care home that you owned. This prompted Ms 2 to write a note which she delivered to Rectory Lane on 20 May 2019 asking you not to visit without a second person present and not to contact Patient A about concerns.

The panel noted that a meeting was held on 7 June 2019 at the home of Patient A in which Patient A, Ms 2, Ms 8 and Ms 9 were present. The notes for the meeting stated:

'[Patient A] *was visited by RH, unannounced following referral from GP. During the visit RH suggested to* [Patient A] *she would be better placed in a care home in Woodford green.* [Patient A] *said she had been in a care home for a bit of respite, Lugano, and if necessary she would go back there but she wanted to stay at home.* [Patient A] *stated that RH insisted she needed to go to the care home in Woodford Green, namely Greenmantle for 2 weeks, as there would be no vacancy in Lugano.* [Patient A] *insisted she wanted to stay home.*

[Patient A] *felt pushed and harassed to go into a care home and relayed this information to her friends.* [Ms 2] *(POA) consequently visited Rectory Lane, and left a note for RH with instructions (manager copied in) to not visit* [Patient A] *unannounced and to contact* [Ms 2]. *These instructions were not followed and RH continued to visit* [Patient A].

[…]

RH visited [Patient a] *last on 3rd June. On this occasion* [Patient A] *did not allow entry into the house.*

[Patient A] *feels that in all visits RH undertook her main concern was for her to go into Greenmantle care home for 2 weeks.* [Patient A] *stated RH "went on and on" about going into the care in Woodford Green. On one occasion on leaving RH said to* [Patient A] *"last chance, you need to go into the home, if not* […] *will find you on the floor with a broken hip* […]

[Patient A] *stated RH had also "threatened" her with having social services input.*

[Patient A] *did not feel scared but pushed and harassed.* […]*'*

The notes of this meeting contained the following statement and a signature from Patient A dated 7 October 2019:

> *'I do hereby declare that the above information is a true a/c of events that occurred soon after my fall regarding Rokeya Hussain'*

The panel acknowledged that the evidence provided by Ms 1, Ms 2, and Ms 8 of what Patient A said was hearsay evidence. Patient A was approximately [PRIVATE] when these matters were raised and [PRIVATE] therefore, she is not able to provide direct evidence of her own account of the incident. However, the panel found the evidence before it consistent in that Patient A provided a clear recollection of your visit. It is clear from the evidence before the panel that Patient A was an intelligent lady who was largely independent. No concerns were raised about her cognitive ability, and it appeared that she was able to coherently communicate her wants and needs. The panel accepted that Patient A was hard of hearing. However, the evidence from Ms 1 and Ms 2 suggested that she understood what was said to her either face-to-face or over the telephone and the panel accepted that evidence. It noted in your evidence that you stated that Patient A may have misheard what was alleged to have been said by you. However, it accepted the evidence from Ms 1 and Ms 2 (who had a longstanding friendship with Patient A) that although she was hard of hearing, she would have understood what was said to her.

When considering the term *'coerced'* the panel carefully considered the words used and the impact that it had on Patient A. The panel found that the use of the phrase, *'If you don't go* […] *will find you with a broken hip'* and *'last chance'* was threatening and amounted to attempted coercion and Patient A must have felt pressured and vulnerable given that you went onto visit her a few more times uninvited. The panel had regard to the impact that it had on Patient A as contained in Ms 2's statement to the NMC dated 16 March 2020:

> *'The whole episode has had an awful effect on Patient A. She is really quite traumatised.* [Ms 1] *and I have had to do lots of reassuring that no one is*

doing anything over my head as [Patient A's] *POA and that I will decide when and how she goes if she cannot do this for herself.'*

The panel referred to the NMC's argument that there were a number of inconsistencies in your account. Whilst acknowledging the burden of proof lies with the NMC, it did not find your account compelling. The panel did not accept your evidence that you only visited Patient A in your capacity as Community Matron to assess her wellbeing. The panel accepted what Patient A said in the presence of Ms 1, Ms 2 and Ms 8 in the meeting on 7 June 2019 of which a contemporaneous record was made which the panel found compelling. The panel further accepted that what Patient A said at this meeting was consistent with what she had said earlier to Ms 1 and Ms 2 and it determined that what was said by Patient A in this meeting was true. The panel therefore found Ms 1, Ms 2 and Ms 8's account reliable in proving charge 1a. It saw no evidence to undermine Patient A's credibility and despite her age at the time and had no reason to doubt her hearsay evidence nor any reason for her to lie or be mistaken.

For the reasons stated above, the panel preferred the hearsay evidence of what Patient A said throughout to your evidence that you did not pressure her at all that she should go into a care home.

The panel found that on the balance of probabilities, it is more likely than not that you breached professional boundaries and having attempted to coerce Patient A to enter a care home owned by you without clinical justification.

Therefore, Charge 1a is found proved.

In considering Charge 1b, the panel noted that Patient A had stated that you had referred to a care home on Mornington Road and not specifically Greenmantle. Ms 1 and Ms 2 carried out their own research and found that you owned Greenmantle which was on Mornington Road. The panel heard that although there was a number of other care homes in the area, it rejected the argument that it was merely a coincidence that Greenmantle

happened to be on Mornington Road. The panel inferred on the balance of probabilities that your reference to a care home on Mornington Road was a reference to Greenmantle.

The panel therefore concluded on the balance of probabilities that you were attempting to coerce Patient A into entering Greenmantle, a care home owned by you, without clinical justification, the panel found that you would be gaining financially if she were to do so.

The panel therefore found Charge 1b proved.

Charge 2

2. On the following dates, you visited Patient A alone when you were aware that a person who held a Power of Attorney in respect of Patient A had requested no home visit take place without a second person present:
    a) 20 May 2019;
    b) 3 June 2019;

Charge 2 is found proved in its entirety.

The panel received evidence from Ms 1 and Ms 2 that Ms 2 had delivered a letter to Rectory Lane which was addressed to you which asked you to cease visiting Patient A. This letter was dated 20 May 2019:

> *'1. Please do not under any circumstances visit* [Patient A] *without an appointment.*
> *2. Please always have someone else present when you do visit* [Patient A].
> 3. Please do not telephone her about concerns.
>
> *My name is* [Ms 2]
> *Power of Attorney'*

The panel heard you disputed that there was any legal POA because there was no signed POA document ever produced to the panel. However, the panel heard oral evidence from Ms 2 that her appointment as Patient A's POA was in respect of Patient A's financial affairs and well-being. When tested as to the legality of this, Ms 2 stated that this was drafted in Patient A's presence, her presence, as well as an independent witness. She further stated that Patient A had collated a blue folder which contained information that Ms 2 required in the event she was to act in this role and that this document remained with Patient A at her own home. This was supported by her statement to the NMC dated 16 March 2020:

> *'I have power of attorney (POA) in respect of* [Patient A] […] *became her POA when she decided at age 90* […] *that she wanted someone to look after her affairs if this was ever required.* [Patient A] *was not aware she had any living relatives at the time as she had been placed in an orphanage at the age of three* […] *hence chose me to act for her as I am one of her oldest friends*.'

The panel was satisfied that there was sufficient evidence before it to support the NMC's case that Ms 2 had POA over Patient A. The panel rejected the argument put forward on your behalf that there was no evidence that Ms 2 held a POA because the actual signed POA was not produced by Ms 2.

The panel noted Patient A's clinical record which showed an entry on 20 May 2019 made by you which was entered on 22 May 2019 at 09:35:

> '[PRIVATE]'

The panel found that you had in fact seen the note from Ms 2 on 20 May 2019 and yet you continued to visit Patient A. This was supported by the local investigation notes held on 27 June 2019 which stated:

'*RH accepts and agrees she did see and receive the note at the start of her shift on the 20th May.*
RH informed […] *that* [Ms 8] *(RH line manager) was aware of the note but RH states she was not told by her line manager not to visit further.'*

In your subsequent clinical record entry on 6 June 2019, you recorded again attending Patient A's home on 3 June 2019:

'[PRIVATE]'

This was supported by the local investigation notes held on 27 June 2019 which stated:

'*Why after receiving the note did you attempt to visit again on the 3rd June whereby you were denied entry by when you had been requested not to?*

Re visit 3rd June – [Patient A] *opened the door but did not allow RH into home.*
RH informs that [Patient A] *spoke politely and* [Patient A] *informed RH that pain had improved.*
[…] *asked RH why did she visit* [Patient A] *after the note – RH explains that did not consent to the letter as it was not signed by* [Patient A]*. RH has her patient's interests at heart and* [Patient A] *did not express any concerns.'*

The panel determined that you had visited Patient A on 20 May 2019 and 3 June 2019 even after you had been asked by Patient A's appointed POA not to visit Patient A without a second present.

Accordingly, Charges 2a and 2b is found proved.

Charge 3

2. In or around May 2019, you breached patient confidentiality in that you disclosed a patient's confidential information to a third party without the authority to do so.

Charge 3 is found NOT proved.

The panel had regard to the text message that you sent on 20 May 2019 to Patient A's gardener:

> *'Hi* […] *I have two old dears lives in Loughton at* [redacted] *IG10, looking for a gardener, is there anyway you can take their gardening, she is happy to pay you £15 per hour*
>
> *Ricky*
>
> [Redacted], *That's the contact number. Thanks'*

The panel noted that you accepted sending these messages, and that the number that you had passed on was the landline number of the patient's friend. The panel determined that you had not provided any information about your patient to the gardener, except to state that there were *'two old dears'* living at that address who required a gardener.

There was no other evidence to support the allegation and therefore does not find Charge 3 proved.

Charge 6

6. In December 2020, you failed to record:

a) A clear plan regarding Patient B's Transfer into Greenmantle Care Home;
b) That you had informed Patient B that you owned Greenmantle Care Home.

Charge 6a is found proved.

There is no case to answer in respect of Charge 6b.

The panel first considered whether you had a duty to record a clear plan regarding Patient B's transfer into Greenmantle. The panel was aware that following the events which occurred with Patient A, you were no longer being managed by Ms 8 and were being managed by Ms 7. You remained in your Band 7 role as a Community Matron. Ms 7 stated in her statement to the NMC dated 12 September 2022:

> '[…] *As part of her role, she would have liaised with GPs, attended MDT meetings, provided proactive care to prevent hospital admissions and liaised with social care. The patients in Rokeya's caseload would either have been referred by their GP or by other colleagues on the team, with Rokeya picking them up through MDT meetings. Rokeya would then be expected to go and assess these patients in their home and put any support they required in place.'*

The panel considered Charge 6a and your recorded entry on 9 December 2020, 10 December 2020 and 16 December 2020 which was retrospectively entered on 21 December 2020:

9 December 2020 entry:

> '[PRIVATE].'

10 December 2020 entry:

‘[PRIVATE].

16 December 2020 entry:

‘[PRIVATE].’

The panel heard from you that you had experienced internet connectivity issues during this period, and that you had uploaded your notes when you regained connection. The panel was of the view that this was a relatively common experience with the nature of your community work. However, it was not satisfied that it should have taken you over 10 days after the event to finalise your notes. At that stage, Patient B had already signed the Service User Agreement for Greenmantle and was already admitted into your care home. The panel concluded that there was no contemporaneous entry on Patient B’s record about a clear plan in relation to their admission, which made it impossible for other healthcare professionals to consider, review and change the plan (if necessary).

The panel therefore found Charge 6a proved.

In respect of Charge 6b, the panel heard from Mr Sabbagh during his closing submissions that the NMC was not offering any evidence in respect of this charge as presently worded. The panel accepted this on the basis that it was not the NMC’s case that you had informed Patient B that you owned Greenmantle and that you had not recorded that.

Therefore, the wording of this charge was misconceived and the panel found there was no case to answer in relation to Charge 6b.

Charge 7

7. On or about 19 December 2020, you failed to follow correct procedural and/or legal requirements when placing Patient B in your care home, in that you:
    a) Failed to refer Patient B to social services for an assessment to be undertaken as to whether Patient B should be placed in a care home;
    b) Failed to ensure that legislation was followed in terms of assessments for Patient B under the Mental Capacity Act and Deprivation of Liberty Safeguards;
    c) Failed to contact Patient B's appropriate next of kin.

Charge 7 is found proved in its entirety.

The panel noted that your case was that Patient B was a privately paying patient with capacity, as such Social Services would not necessarily be involved at that stage. It noted Person A's written statement dated 17 April 2024 and found this vague and therefore, it could not test the reliability of Person A's evidence. The panel therefore could only place limited weight on this piece of evidence in respect of Charge 7.

In deciding as to whether or not Charge 7a is found proved, the panel noted your submission that Social Services had not been involved because *'She has cancled* [sic] *her care package few days ago as she feels the care package was 'Waste of her time'.*

However, the panel considered your other observations during your first visit to Patient B on 9 December 2020:

'[PRIVATE]'

The panel also noted Ms 7's statement dated 12 September 2022:

'If there were concerns that [Patient B] *was at risk of self-neglect, the expectation would be that Rokeya would have raised a safeguarding concern and completed a datix. Nothing was raised by Rokeya as far as I can see. I would have expected her to know to do this; I have junior staff who know this process.'*

The panel had regard to the NMC's submission and distinguished between Patient B cancelling her own care package and Patient B allegedly not wanting Social Services involvement. The panel decided that it does not follow that because the care package was cancelled this meant that you did not have a duty to involve Social Services. Although the panel was not provided with evidence setting out a legal requirement to involve Social Services, it was normal practice and therefore a procedural requirement that it would have been entirely appropriate to contact them given the circumstances in this case, namely that you had established that Patient B was self-neglecting, had clear memory issues and had previous Social Services input.

The panel also noted the social worker's response to the NMC during the investigation stage, in which she confirmed that she believes that Patient B's GP may have advised her to go into respite care. Notwithstanding certain observations made by the social worker, the panel were of the view that although the GP may have advised Patient B to go into a care home, you were not absolved in your duty in involving Social Services as it would have been part of your role to do so.

The panel therefore found Charge 7a proved.

The panel next considered Charge 7b. The panel noted that you had a duty to carry out the assessments given that Patient B was part of your caseload, and you attended her home address on 9 December 2020 to carry out initial observations following a referral.

The panel was informed that an MCA 1 would be completed in respect of a person's daily living needs and an MCA 2 would be carried out in relation to a person's change in

accommodation. The panel considered Person A's statement dated 17 April 2024. It noted that she referred to various guidelines set out in the Mental Capacity Act 2005. The panel were unable to place any great weight on this statement as it was unable to assess what exceptional circumstances would be as stated in her statement but also whether in fact Person A was discounting the need for an MCA 2 in the particular circumstances of this case. However, when considering the legislation in isolation, the panel found there is no mention as to when an MCA 1 and MCA 2 should be carried out.

The panel also had regard to your notes dated 9 December 2020 which was entered on 21 December 2020, *'MCA1 Form 1 - questionnaire started - (finalised: 09 Dec 2020 17:30)'* and the position advanced by your representative on your behalf:

> *'It is submitted that the Registrant did complete an MCA1 assessment (ex. pp 251 and 277), and because her patient had capacity she was not required to completed an MCA2. It would have been unnecessary. The Patient was making decision about her own health care, with her own free will. It is significant that Patient B's GP was involved in the discussion with Patient B about deciding to enter a care home (ex. pp 278). No concerns were raised by the GP about Patient B's capacity, lending wight to the Registrant's position that Patient B had capacity when she conducted he MCA assessment.'*

The panel accepted that an MCA 1 may have been completed by you, however, Ms 3 and Ms 4 both noted in their evidence that they were unaware that an MCA 1 document completed by you existed. The panel has not been provided with your MCA 1; therefore, it could not confirm that you had carried out an MCA 1 assessment but noted that you had started one and finalised this on 9 December 2020 when you made your retrospective entry on 21 December 2020. The panel noted that by not having seen your MCA 1, it had no evidence to indicate what the outcome was.

The panel heard evidence from Ms 4 and Ms 6 about Patient B's presentation during the course of their respective enquiries. Ms 4 said in her statement to the NMC dated 22 July 2022:

> '[…] *she kept saying she wanted to go home and she wasn't allowed to go home.*
>
> […] *Again, the patient kept saying that she wanted to go home and how she wasn't allowed. I tried to ascertain from the support worker what the patient's circumstances were and why she was in the care home setting. I was advised that the patient wasn't managing and that she was making payments for her care herself by cheque, as opposed to a direct debit being set up. When I asked the support worker if there had been a capacity assessment completed to see if the patient had the ability to formally consent or understand the payments she was making* […] *this support worker didn't know.*
>
> […]
>
> […] *it was very evident that the patient was paying privately for her care and that social care were not financially contributing. What I would have expected from the home was that they would have completed an assessment around the patient's capacity and her understanding of why she was being placed in a care home and that a DoLS would have been requested'*

The panel found that this was supported by Ms 6's oral evidence in which she told the panel that in circumstances where a patient is suffering with *"memory difficulties"* that an MCA 2 would have been appropriate to complete in terms of a change in accommodation.

The panel preferred the accounts of Ms 4 and Ms 6 and rejected your evidence. It has seen consistent evidence that there were doubts about Patient B's capacity, even during

her first interaction with you, as she was marking her light switches, informing you that she was having trouble with her memory and learning from her GP that she was being referred to a memory clinic. The panel also heard evidence that Patient B was on the Dementia Pathway. The panel decided that full assessments of Patient B's mental capacity was a procedural requirement. The panel was of the view that capacity should have been a matter that you addressed because of the several factors that you observed during your 9 December 2020 visit. Accordingly, it found Charge 7b proved.

In considering Charge 7c, the panel bore in mind your duty to contact Patient B's next of kin. It noted from your entry on 21 December 2020 that you had spoken to Patient B's friend and that you were unaware of Patient B's next of kin at that stage.

The panel took into account Ms 6's statement to the NMC dated 9 March 2023:

> *'Rokeya informed me that that they had liaised with* [Patient B's] [PRIVATE] *to write cheques. I informed her that* [Patient B's] [PRIVATE] *from her and was not her nominated next of kin* […] *It is very clearly documented in her records that* [Patient B] *is estranged* [PRIVATE]*. Rokeya didn't really offer an answer to this. If you needed to liaise with a friend or family member of a resident, you would always go to who they have detailed as their next of kin. When I spoke with* [Patient B] *she told me that her next of kin was* [PRIVATE] *and she showed me their contact details in her notebook'*

Ms 6 further reiterated in her oral evidence to the panel that there had been no contact for several years between Patient B [PRIVATE]. Ms 6 even said that there were no contact details on the system [PRIVATE].

The panel noted that this was contrary to your evidence. The panel found your account to be inconsistent. During your oral evidence, you told the panel that [PRIVATE] contacted Greenmantle and sent her a [PRIVATE] card.

The panel found Ms 6 and Ms 7's evidence to be compelling in that [PRIVATE] was not Patient B's next of kin. Whilst the panel acknowledges that the information provided by Patient B to Ms 6 was hearsay given that Patient B cannot give live evidence, the panel was satisfied that it is likely that Patient B did show Ms 6 her notebook which contained her next of kin's details. The panel therefore found Charge 7c proved.

Charge 8

8. Failed to act with integrity and/or honesty, in that you:
    a) Failed to declare a potential conflict of interest to your employer regarding Patient B's placement into Greenmantle Care Home, which you own;
    b) Arranged for Patient B to be admitted into a care home which you own:
        (i) When this was beyond the scope of your role;
        (ii) Without following the correct procedures you should have followed in identifying Patient B's care needs;
        (iii) Without advising Patient B that you owned the home.
    c) Set up a payment arrangement directly with Patient B in relation to her care, without ensuring an assessment had been undertaken in relation to her financial capacity.

Charges 8a and 8c are found proved.

Charge 8b is found NOT proved.

In considering Charge 8 in its entirety, the panel bore in mind *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club)* [2017] UKSC 67 and the NMC guidance (DMA-8) which relates to dishonesty. In addressing *Ivey v Genting Casinos (UK) Ltd (t/a Crockfords Club),* the panel noted that it must take a two-stage approach:

1) What was the Registrant's actual state of knowledge or belief as to the facts, and
2) Whether the conduct was dishonest by the standards of a reasonable person.

The panel first considered Charge 8a. The panel noted that the concern regarding Patient B took place after Ms 7 became your line manager who had been reviewing your cases whilst you were away. Upon later enquiries, it appeared that Patient B had been placed at Greenmantle and on a privately paid basis. The panel had sight of the Conflict-of-Interest Procedural Guidelines for the Trust and identified section 6.1 to be a relevant passage:

> *'If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:*
>
> - *restricting staff involvement in associated discussions and excluding them from decision making*
> - *removing staff from the whole decision making process*
> - *removing staff responsibility for an entire area of work*
> - *removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant'*

The panel noted the chronology of the events. You visited Patient B on 9 December 2020, there was a period between 9 December 2020 and 21 December 2020 in which there were no notes on the system about the contact you had with Patient B, and it was clearly indicated in your retrospective entry that you assisted in her change in accommodation. Further, you were the Community Matron who bore the responsibility for Patient B. Patient B then entered a contract (which contained your signature) on 21 December 2020 to stay at Greenmantle and around this time, you regained connectivity to Systm1 and entered your notes regarding your medical observation of Patient B and the need for Patient B to go into respite care.

In addressing your state of mind at the time in relation to the dishonesty, the panel was of the view that you were aware that there would have been an evident conflict of interest given that you owned Greenmantle. This was supported by Ms 6 as mentioned in her statement to the NMC dated 9 March 2023:

> *'At the point I understood that Rokeya was* [Patient B's] *district nurse I felt that there was a conflict of interest. Rokeya said to me that it was never her idea or intention for* [Patient B] *to come to her home. She said she only did it as she couldn't find anywhere else for her to go. She told me that* [Patient B's] *GP had begged her to take* [Patient B] *into her home. I asked Rokeya what other homes she had tried, and she only mentioned one and couldn't name others'*

The panel found that as an experienced nurse, you would have known it was your duty to have declared your conflict on interest to your employer and the panel found that you deliberately did not do so. The panel considered that a reasonably minded person would have found your state of mind to have been dishonest. It found that it is more likely than not that you were aware that by failing to declare the conflict of interest to your employer, you were being dishonest, and a reasonably minded person would have found your conduct dishonest.

Accordingly, the panel found Charge 8a proved.

In respect of Charge 8b)i), the panel noted Ms 7's statement dated 12 September 2022:

> *'I would not have expected Rokeya as a community matron to get involved in assisting a patient in choosing their care home. If it was felt a patient may require to be placed into a care home, the first port of call would be to contact social care. The team has a process where we would contact social care to support an assessment as to whether a patient may need to be placed into a care home. I feel that Rokeya absolutely would have known*

that process. This is not a written policy; however, I would say that it is an expected process. I think that any registered nurse would know that we don't have the authority to make decisions about suitable care homes for patients or to make financial decisions for the patient.

Someone in Rokeya's role would not be aware of the patient's financial circumstances, which would be relevant to any decision to place a person into a care home. I do not even know if [Patient B] *had the capacity to make such a decision and it would normally be social care who would complete a financial assessment (under the mental capacity act; "MCA") to establish if the patient did have capacity to make such decisions. A community matron would not complete a financial assessment on anyone.'*

However, in looking at the documentary evidence before it, it carefully considered the wording of this charge, with specific emphasis on the word *'arranged'.* It saw no evidence that you had taken physical steps to bring Patient B to Greenmantle, as such, the panel decided that the NMC has not discharged its burden of proof relating to Charge 8b)i). There is no evidence before the panel that you actively arranged for Patient B to come to your home and therefore it does not find Charge 8b)i) proved. Accordingly, the panel also does not find Charges 8b)ii) and 8b)iii) proved in light of its findings on Charge 8b)i).

In relation to Charge 8c, the panel firstly considered your state of mind at the time the dishonesty took place. The panel noted the documentary evidence. This included the contract agreement which was signed by you on 21 December 2020 which contained a clause which stated, *'All cheque made payable to: Ms Rokeya Hussain'.* The panel also had sight of a cheque from Patient B addressed to you dated 20 December 2020 for the sum of £6,000 and a further cheque for 20 January 2021 for the amount of £9,000.

The panel considered your state of mind in relation to this charge. It concluded that you had setup a payment arrangement in relation to Patient B's care knowing that you should have first carried out a full mental capacity assessment in relation to financial capacity.

The panel decided that doing this deliberately a reasonable member of the public would have found your state of mind to be dishonest.

The panel therefore found charge 8c proved.

Charge 9

9. Between 20 December 2020 – 25 March 2021, you failed to safeguard Patient B because a capacity assessment was not completed;

Charge 9 is found proved.

The panel noted that you gave oral evidence that you were prompted to make an MCA 1 assessment due to the issues that Patient B had mentioned during your initial interaction and concluded that Patient B had capacity. In your retrospective entry on 21 December 2020 on Patient B's medical record, you alluded to have *'started'* and *'finalised'* the MCA 1 assessment. However, the panel was not provided with this form. Ms 4 and Ms 6 said in their oral and written evidence that they had not seen an MCA 1 from you. Whilst the panel had sight of the Risk Assessment (an internal document for Greenmantle) which stated, *'*[Patient B] *has capacity to make her own decisions, as she has no impairment of, or disturbance in, the functioning of the mind or brain as determined by stage 1 of the MCA test'*, the panel did not deem this document to be satisfactory to justify why an MCA 2 was not carried out.

The panel noted that Person A's written statement dated 17 April 2024 stated that there were exceptional circumstances in which a matron would be expected to complete a change of accommodation MCA 2. However, given this evidence is hearsay and extremely vague, the panel has no means of testing its reliability. The panel therefore could only place limited weight on this piece of evidence in respect of Charge 9.

The panel had sight of Ms 4's statement to the NMC dated 22 February 2022:

'*Normally when someone is placed in a care home, what happens is that whatever professional is involved with the placement, would conduct a capacity assessment around that patient's change in accommodation (MCA 2). It was very evident that the patient was paying privately for her care and that social care were not financially contributing. What I would have expected from the home was that they would have completed an assessment around the patient's capacity and her understanding of why she was being placed in a care home and that a DoLS would have been requested. I would have expected a 7 day urgent application for a DoLS to have been made. When you deem a person to lack capacity (this patient was going through the specialist dementia and frailty service) you request a 7 day DoLS to be imposed, and within 7 days an assessor from the DoLS team would complete a formal assessment. Equally I would have expected the home to have completed an MCA 1 around the patient's personal care delivery and activities of daily living.*'

Ms 6 stated in her statement to the NMC dated 9 March 2023:

'[Ms 10] *told me that* [Patient B] *was paying for her care by cheque on a weekly basis.* [Ms 10] *also told me that there had been no assessment of* [Patient B's] *finances as she was deemed to have capacity. I asked* [Ms 10] *to show me the formal assessment of* [Patient B] *capacity that was completed by the home and* [Ms 10] *told me that no formal assessment was done. In my experience, when a resident enters a care home and there are concerns they may have dementia, a financially capacity assessment will be completed with the resident by a manger within the home or by the resident's GP if they are privately funded.*'

The panel preferred the evidence of Ms 4 and Ms 6 to your evidence. Given their observations of Patient B and the circumstances of her admission to Greenmantle, it

would have been appropriate to carry out a full Mental Capacity Assessment. Ms 4 and Ms 6 had been consistent in their position throughout their oral evidence.

The panel therefore found Charge 9 proved.

Charge 10

10. Between 1 January 2021 – 1 April 2021, you incorrectly prevented or attempted to prevent Patient B from leaving Greenmantle Care Home for 90 days;

Charge 10 is found proved.

The panel noted from Ms 6's evidence that you had prevented or attempted to prevent Patient B from leaving Greenmantle due to your own misunderstanding of the COVID-19 Guidelines at the time. The panel took into account the Guidelines provided by you to Ms 6 which contained a copy of the email dated 16 February 2021 from the Department of Health and Social Care:

> *'From now on, if someone tests positive with a PCR test, they should not be tested using PCR or LFD for 90 days, unless they develop new symptoms during this time, in which case they should be retested immediately using PCR. This 90 day period is from the initial onset of symptoms or, if asymptomatic when tested, their positive test result.'*

Ms 6 said in her statement to the NMC dated 9 March 2023:

> '[Ms 10] *told me that* [Patient B] *was unable to leave the home as she had tested positive for Covid on 2 January 2021 and therefore had to stay at the home for 90 days.* [Ms 10] *suggested that this was the government guidance that was being followed in the home. I expressed my surprised at it was my understanding that the guidance dictated that it was a re-test that should not*

be performed within ninety days unless new symptoms appeared. I did not think it was correct that a resident would be unable to leave the home for 90 days

[…]

Rokeya's interpretation of the government guidance was the same as [Ms 10] *she also told me that if someone in the home had tested positive for Covid then they had to remain in the home for 90 days. I challenged this and she just told me that she was just following the legislation that was given to her. I asked if she could show me the guidance and she said she would send it to me. Rokeya did send me the legislation, but it didn't marry with her interpretation of it the guidance advised that a resident should not be retested within 90 days after having Covid as it may result in a false reading*

[…]

When I spoke to [Patient B] *directly, she was telling me that she was really fed up and wanted to go home. She didn't understand why she couldn't'*

The panel had regard to Ms 4's statement, who spoke directly to Patient B during her assessment. In her statement to the NMC dated 22 July 2022, she stated:

'[…] *she seemed visibly upset she kept saying that she wanted to go home and that she wanted to go home.*

[…]

I asked the senior carer, in light of the patient saying to me that she wants to go home, if the patient was allowed to leave the home – the senior carer informed me that the door to the home was locked. I observed that on the

front door to the home, there was a latch type lock placed on top of the door so residents weren't able to open the door'

You told the panel that Patient B was *"free to leave"* anytime and that it was the request of the warden from her home not to allow Patient B to return to her accommodation. The text message from the warden was sent to you on 14 January 2021:

'I have heard that [Patient B] *has the virus and is unhappy at Greenmantle and wants to leave. Please ensure that she is negative for Covid before she returns here. Thanks'*

The panel was aware that this was a very difficult period for many care homes operating during the COVID-19 pandemic. However, in light of the evidence before the panel, specifically Ms 4 and Ms 6 and within the text message that you received from the warden on 14 January 2021, that Patient B was consistent in that she wanted to leave Greenmantle. The panel accepted that what was relayed at this hearing which was said to have come from Patient B was hearsay evidence, but it found Ms 4 and Ms 6's evidence clear and reliable. Whilst Patient B's warden may not have wanted Patient B to return home, it was not within the warden's remit to make this decision for her particularly as there was no legislation in place that prevents her from doing so.

The panel therefore found Charge 10 proved.

Charge 11

11. Your actions at one or more of the charges at 6a) – 10 above, were for the purpose of your own financial gain.

Charge 11 is found proved in respect of charges 8a and 8c.

In reaching this decision, the panel took into account Ms 7's statement to the NMC dated 12 September 2022:

> *'Rokeya has documented that she and the GP agreed to hold a joint visit with the patient to discuss their concerns about her welfare. Rokeya has also documented that the patient may be at risk of self-neglect and that she had spoken with a friend of* [Patient B] *and the accommodation warden about potentially admitting into a care home. I believe it was inappropriate for Rokeya to have any conversations with friends and the warden with regards to* [Patient B]. […]
>
> *If there were concerns that* [Patient B] *was at risk of self-neglect, the expectation would be that Rokeya would have raised a safeguarding concern and completed a datix. Nothing was raised by Rokeya as far as I can see. I would have expected her to know to do this; I have junior staff who know this process.*
>
> *I would not have expected Rokeya as a community matron to get involved in assisting a patient in choosing their care home. If it was felt a patient may require to be placed into a care home, the first port of call would be to contact social care. The team has a process where we would contact social care to support an assessment as to whether a patient may need to be placed into a care home. I feel that Rokeya absolutely would have known that process. This is not a written policy; however, I would say that it is an expected process. I think that any registered nurse would know that we don't have the authority to make decisions about suitable care homes for patients or to make financial decisions for the patient.'*

The panel accepted that it would have been inappropriate for you to have involved yourself into financial matters concerning Patient B or assist Patient B in finding a care home. Having found that you had been dishonest at Charges 8a and 8c, the panel

concluded that it was clear that your actions were for your own financial gain. Had you escalated your concerns about the decline in Patient B's memory as you first observed, and appropriately referred her to Social Services, there was a likelihood that Patient B would not have attended Greenmantle or that you would have received payment. The panel saw clear evidence of the cheques that were addressed to you by Patient B.

Accordingly, the panel found that your actions in Charges 8a and 8c was for the purpose of your financial gain and therefore Charge 11 is found 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 your 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, your fitness to practise is currently impaired as a result of that misconduct.

Your oral evidence

You provided the panel with oral evidence under oath.

You told the panel that by nature, you are a caring person and try your level best to treat people with kindness. You have done well in your nursing career and have always cared for your patients wholeheartedly. You said that caring for patients is what has given you the most pleasure when you return home after a long shift.

You provided the panel your certificate dated 6 March 2023 for '*Preparation for Independent and Supplementary Prescribing V300'* course and outlined what you learned. You stated that you would like to remain as a registered nurse and work in a remote working role, such as a clinical advisory role and also progress your business. You reiterated that the caring part of nursing is the most important to you.

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.'*

Mr Sabbagh provided the panel with written and oral submissions. He invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Mr Sabbagh identified the specific, relevant standards where your actions amounted to misconduct. This included sections 1.1, 1.2, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 4.1, 4.2, 4.3, 4.4, 6, 6.1, 6.2, 20.1, 20.2, 20.3, 20.4, 20.5, 20.6, 20.7, 20.8, 20.9, 20.10, 21.1, 21.2, 21.3, 21.4, 21.5, and 21.6. He submitted that your actions were a serious departure from the Code and therefore amounted to misconduct.

Mr Harris provided the panel with written and oral submissions. He provided the panel with the definition of the term *'misconduct'* as provided in the case of *Roylance* and submitted

that not every falling short of standards will amount to misconduct. The act must be considered serious before such a finding can be properly sustained. He accepted that dishonesty will often be considered a serious falling short of the NMC standards. However, he invited the panel to consider the extent and culpability involved when assessing the seriousness of the allegations.

Submissions on impairment

Mr Sabbagh 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. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Sabbagh submitted that you disputed the allegations and continue to do so. As such, there is no indication of any insight. He submitted that dishonesty and a lack of integrity is very serious and reveal an attitudinal problem. Throughout the investigation and hearing process, you suggested that the witnesses were lying or *"out to get"* you. Mr Sabbagh submitted that you maintained your position and gave a dishonest account to the panel, which reflects your continued impairment. He submitted that the most concerning part of your conduct was after attempting to coerce Patient A into entering your care home, you went onto admit Patient B into Greenmantle for the purpose of your own financial gain.

Mr Sabbagh submitted that limbs a), b), c) and d) of *Grant* are engaged. In addressing limb a), Mr Sabbagh submitted that you placed Patient A and B at risk of unwarranted harm by acting in a manner which was not in their own interest. You also failed to safeguard them by carrying out the appropriate procedural steps and given the lack of reflection and insight, you are liable to do so again in the future. In addressing limb b), he submitted that you have brought the profession into disrepute by acting inappropriately in circumstances where there is a clear conflict of interest for your own benefit and given

your lack of insight, you are liable to do so again in the future. In addressing limb c) and d), he extended the same argument in that there has, in the past, been a breach of one of the fundamental tenets of the medical profession, particularly, the treatment of Patient A and the threatening of Patient A and similarly, acting dishonestly in respect of Patient B.

Mr Sabbagh submitted that the charges found proved against you were very serious and fall short of what would be proper in the circumstances. He invited the panel to find that your fitness to practise is impaired.

Mr Harris addressed the nature of the concern. He referred the panel to Charges 8a and 8b. He submitted that you continued to deny the allegations in your reflective statement. He referred the panel to the case of *General Medical Council v Awan* [2020] EWHC 1553 (Admin):

> *'It seems to me that an accused professional has the right to advance any defence he or she wishes and is entitled to a fair trial of that defence without facing the jeopardy, if the defence is disbelieved, of further charges or enhanced sanctions'*

Mr Harris submitted that the above case demonstrates an important principle, namely that your denial of the charges cannot be held against you. You maintained the account you gave in evidence and expanded on the context within your reflective piece, as you are entitled to do so. He invited the panel to bear in mind the case of *Awan* when considering your reflective piece.

Mr Harris drew the panel's attention to the character evidence that relates to your honesty, integrity, compassion and competence throughout your long career. You undertook a prescribing course whilst you have not been able to practise as a nurse, and this was clear evidence of someone who is clearly capable of practising safely. You continue to seek to strengthen your practice. You have received a litany of glowing references that have been submitted on your behalf by a variety of practitioners. He submitted that the charges found

proven are, on the NMC's case, a wholly uncharacteristic course of conduct in an otherwise unblemished career.

In addressing the public interest consideration, Mr Harris submitted that a well-informed member of the public, with knowledge of the facts of the case and its proper context, would not find their confidence in the nursing profession diminished if a finding of impairment was not made 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, *CHRE v NMC, Grant* and *Sawati v General Medical Council* [2022] EWHC 283 (Admin). He also referred the panel to the relevant NMC guidance, *'Impairment'* (DMA-1), *'How we determine seriousness'* (FtP-3) and *'Making decisions on dishonesty charges and the professional duty of candour'* (DMA-8).

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 your actions did fall significantly short of the standards expected of a registered nurse, and that your actions amounted to a breach of the Code. Specifically:

> *'**1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
>
> *1.1 Treat people with kindness, respect and compassion.*
>
> *1.2 Make sure you deliver the fundamentals of care effectively.*

1.3 Avoid making assumptions and recognise diversity and individual choice.

1.5 Respect and uphold people's human rights.

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

2.1 Work in partnership with people to make sure you deliver care effectively.

2.2 Recognise and respect the contribution that people can make to their own health and wellbeing.

2.3 Encourage and empower people to share in decisions about their treatment and care.

2.4 Respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care.

2.5 Respect, support and document a person's right to accept or refuse care and treatment.

2.6 Recognise when people are anxious or in distress and respond compassionately and politely.

4 Act in the best interests of people at all times

To achieve this, you must:

4.1 Balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment.

4.2 Make sure that you get properly informed consent and document it before carrying out any action.

4.3 Keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.1 Make sure that any information or advice given is evidence-based including information relating to using any health and care products or services.

6.2 Maintain the knowledge and skills you need for safe and effective practice.

8 Work co-operatively

To achieve this, you must:

8.4 Work with colleagues to evaluate the quality of your work and that of the team.

8.5 Work with colleagues to preserve the safety of those receiving cares.

8.6 Share information to identify and reduce risk.

10 Keep clear and accurate records relevant to your practice

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.

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must

16.1 Raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

17.1 Take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse.

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.

20.2 Act with honesty and integrity at all times, treating people fairly and without […]*, bullying or harassment.*

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

20.4 Keep to the laws of the country in which you are practising.

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

20.6 Stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers.

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

21.3 Act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care.

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. The panel considered each of the charges found proved and decided on whether or not your actions amounted to misconduct.

In respect of the charges relating to Patient A, the panel decided that breaching professional boundaries, and/or abusing your position of trust in attempting to coerce Patient A into entering a care home owned by you (Charges 1a and 1b) was a very serious act and fellow colleagues would have found your actions deplorable. Your misconduct follows into Charges 2a and 2b in which, despite being asked by Patient A's appointed POA not to undertake any visits unaccompanied, you continued to do so on two other occasions, causing distress to a vulnerable Patient A. In considering Charge 5 (which you admitted at the outset of the hearing), the panel bore in mind that internet connectivity could sometimes be an issue which impacted when you can update your notes. In Patient A's circumstances, the panel concluded that this charge is not serious enough to amount to misconduct.

In respect of the charges relating to Patient B, the panel found that your actions in Charges 6a, 7a, 7b and 7c amounted to serious misconduct. You were an experienced nurse who bore the responsibility of ensuring that you managed Patient B's care and wellbeing in their best interest and follow the correct procedure in ensuring a clear plan is put in place. By failing to do so, Patient B, an exceptionally vulnerable patient with undiagnosed cognitive impairment, was deprived of her liberty and her money. Whilst the panel accepted that eventually it may have been appropriate for her to attend a care home given the concerns regarding her capacity, you took advantage of this, not having made contact with the appropriate next of kin at the time of your interaction and prior to her admission to Greenmantle. The panel took the view that members of the public and colleagues would have found your actions completely unacceptable and therefore amounted to serious misconduct.

The panel bore in mind that nurses are in a highly regarded position in which part of that fundamental role includes honesty. However, your actions in Charges 8a, and 8c were deliberate acts to conceal your actions which was financially motivated. The panel took the view that your misconduct demonstrated a lack of respect for the Code and exploitation of Patient B's vulnerability. You had a duty to act in the best interest of Patient B, which you failed to do. The panel therefore found your actions in Charges 8a and 8c amounted to serious misconduct.

The panel had regard to the period during which the incidents relating to Patient B took place namely, between December 2020 to March 2021. It acknowledged that it was a difficult period due to the government restrictions relating to COVID-19 and considered that there could have been a misunderstanding of the regulations (Charges 9 and 10). However, you had a duty to make relevant enquiries to ensure that you were addressing Patient B's needs. It is clear from the evidence before the panel that Patient B clearly wanted to return to her home, and as a nurse, you should have been able to recognise that. Had you carried out the relevant assessment, multi-disciplinary teams would have been alerted to Patient B's condition, rectified any misunderstanding regarding the

COVID-19 guidelines and undertook the appropriate steps to safeguard Patient B. Therefore, the panel determined that your actions in Charges 9 and 10 amounted to serious misconduct.

In respect of Charge 11 (in relation to Charges 8a and 8c), the panel determined that there was a considerable amount of money paid by Patient B without having the requisite assessments and safeguarding carried out. It noted that the amount of money was not only substantial, but you failed to take appropriate steps to declare this conflict of interest to your employer and to carry out a mental capacity assessment relating to whether or not Patient B was capable of managing her own financial affairs. The panel therefore determined that your actions in Charge 11 amounted to serious misconduct.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, your 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, nurses must be honest and open and act with integrity. 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) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found all four limbs of *Grant* were engaged. Patients A and B were caused emotional distress as a result of your misconduct. Patient A felt distressed by your attempted coercion. Patient B suffered harm in that she was prevented from leaving Greenmantle despite her wishes. Further, the absence of the appropriate mental capacity assessment at the time prevented her access to the relevant services and safeguarding. Your misconduct breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. It was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Regarding insight and remorse, the panel considered your reflective piece dated 29 October 2024. The panel did not hold the fact that you disputed the charges against you in the hearing. The panel considered your reflective piece and determined that you failed to demonstrate an understanding of how your actions affected Patients A and B, your colleagues and the reputation of the nursing profession. Your reflective piece centred around what you believe was unfairness within your workplace instead of providing reflection as to how you would have handled the situation differently and how you could improve in the future. Whilst it is not for the panel to comment on your suggestion of unfairness within the workplace, you failed to recognise the core issues identified in this case, and therefore the panel determined that you have not sufficiently demonstrated insight and remorse.

The panel considered whether or not the misconduct in this case is remediable. The panel bore in mind the NMC guidance on '*seriousness'* (FtP-3) and the relevant passage regarding vulnerability:

‘Protecting people from harm, abuse and neglect goes to the heart of what nurses, midwives and nursing associates do. Failure to do so, or intentionally causing a person harm, will always be treated very seriously due to the high risk of harm to those receiving care, if the behaviour is not put right. Where professionals are shown to be involved in serious neglect or abuse outside their professional practice, there is likely to be a risk of harm to people receiving care. Such behaviour also has the potential to seriously undermine the public’s trust and confidence in the professions we regulate.’

The panel was of the view that the misconduct in this case demonstrated behaviour that is inherently more difficult to put right, specifically, dishonesty and lack of integrity. However, it is capable of being addressed with appropriate training and reflection. None of which has been put forward by you thus far.

The panel carefully considered the evidence before it in determining whether or not you have taken steps to strengthen your practice. The panel took into account your training certificate for *‘Preparation for Independent and Supplementary Prescribing V300’* dated 6 March 2023, the nine character references from various former colleagues and Dr 1’s oral evidence given to the panel on 22 October 2024. The panel found that given the lack of remorse, insight and strengthened practice in the form of training relating to the charges found proved, there remains a risk of repetition. This was further exacerbated by the fact that you had been made aware about the issues relating to Patient A in March 2019 - June 2019 in which a concern was raised about your attempts to coerce Patient A into attending Greenmantle, yet, you went onto actually admit Patient B knowing that you made no effort to contact Patient B’s appropriate next of kin and there were concerns about her memory. The panel therefore concluded 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 public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore also finds your fitness to practise impaired on the grounds of public interest.

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

On the morning of 30 October 2024, Mr Harris informed the panel that Mrs Hussain would not be attending [PRIVATE]**. Mr Harris submitted that no discourtesy was intended by her absence and confirmed to the panel that he has her consent to attend the hearing on her behalf.**

Sanction

The panel has considered this case very carefully and has decided to make a striking-off order. It directs the registrar to strike Mrs Hussain off the register. The effect of this order is that the NMC register will show that Mrs Hussain has been struck-off the register.

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

Mr Sabbagh informed the panel that in the Notice of Hearing, dated 28 February 2024, the NMC had advised Mrs Hussain that it would seek the imposition of a striking-off order if it found Mrs Hussain’s fitness to practise currently impaired.

Mr Sabbagh provided the panel with written submissions. He referred the panel to the NMC Guidance on Sanctions (SAN-3) and submitted that it would not be appropriate to take no action, or a caution order given Mrs Hussain's lack of integrity.

In addressing a Conditions of Practice Order, Mr Sabbagh submitted that this would not be appropriate given the presence of harmful deep-seated personality or attitudinal problems in Mrs Hussain's attempts to coerce Patient A into entering her care home and the admission of Patient B without the appropriate procedure for the purpose of her own financial gain. Further, he submitted that there is a real risk that patients will be placed in danger either directly or indirectly given that Mrs Hussain wished to keep her care home and showed no real insight into her actions. Mrs Hussain deflected the blame on her colleagues and the Trust.

In considering whether a Suspension Order is appropriate, Mr Sabbagh submitted that this sanction is not appropriate. This was not a single instance of misconduct, the presence of harmful deep-seated personality or attitudinal problems and there is a real risk of harm to patients given her intention to keep the care home.

Mr Sabbagh submitted that the most appropriate sanction is a Strike-Off Order. He referred to the relevant NMC Guidance on *'striking off orders'* (SAN-3e) and the relevant case law which included *Professional Standards Authority for Health and Social Care v NMC (Chawo-Banda)* [2014] EWHC 4677 and *Atkinson v General Medical Council (GMC)* [2009] EWHC 3636 (Admin).

Mr Sabbagh submitted that there is no evidence of insight or presence of mitigating factors which the panel could rely on to take a course that is alternative to a strike off. The case falls into the category of more serious forms of dishonesty in that Mrs Hussain coerced a vulnerable elderly patient to go into her care home for her own financial gain. In Patient B's case, despite being warned about the risk of conflict of interest in relation to Patient A,

Mrs Hussain continued to admit Patient B, one of her vulnerable elderly patients, to her care home without the proper procedure carried out and for her own financial gain.

Mr Sabbagh submitted that the two instances represent a breach of the fundamental tenets of nursing by abusing her position to benefit herself. She has also shown limited insight. He submitted that there is a real risk that if a strike-off is not imposed, that she will continue to pose further risk of harm to her patients into the future and bring the profession into disrepute. He submitted that in the absence of insight and remediation, the only sanction that would protect the public, maintain public confidence and uphold the appropriate standards would be a Striking-Off Order.

The panel also bore in mind Mr Harris' written submissions. He referred the panel to the relevant NMC Guidance, *'How we determine seriousness'* (FtP-3) and *'Proportionality'* (Reference SAN-1).

Mr Harris submitted that the NMC's Striking-Off Order bid is unnecessary. He submitted that it is accepted on Mrs Hussain's behalf that no order or a caution order are not appropriate given the seriousness of the charges found proved.

Mr Harris submitted that there is no evidence of general incompetence. Mrs Hussain has had a long and unblemished professional history, and there is no proper basis in evidence to conclude that patients would be placed in danger as a result of her continuing to practice either on conditions of practice or after a period of suspension.

Mr Harris invited the panel to place significant weight on the references provided on Mrs Hussain's behalf in which the authors consistently spoke of her excellence and integrity and that the panel do not necessarily have evidence of *'deep seated personality or attitudinal problems'.* Mrs Hussain's misconduct represents a wholly uncharacteristic lapse in professional judgment.

In addressing the seriousness of the dishonesty, Mr Harris submitted that it is not accepted that the dishonesty in this case fall in the category of more serious forms of dishonesty but rather an uncharacteristic incident with elements of opportunism that places the misconduct around the middle or towards the lower end of dishonest conduct.

Mr Harris referred the panel to the case of *Atkinson.* He submitted that this is a case where the dishonesty in question is out of character and limited to a degree in its duration, as such, there is a prospect of Mrs Hussain returning to practise without the reputation of the profession being disproportionately damaged.

Mr Harris asked the panel to consider Mrs Hussain's successful completion of a prescribing course as evidence of her following the principles of good practice, which is capable of amounting to a mitigating factor.

Mr Harris invited the panel to bear in mind the case of *Awan* following an adverse factual finding. He asked the panel to bear this in mind when reflecting on Mrs Hussain's objectively construed lack of reflection and insight.

Mr Harris concluded his submissions and invited the panel not to accede to the NMC's bid for a strike off. He submitted that the panel should impose a proportionate sanction which will allow Mrs Hussain to practise given her outstanding references and her long history of being recognised as a committed and competent practitioner.

Decision and reasons on sanction

Having found Mrs Hussain'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 heard and accepted the legal advice, which included references to the NMC's guidance on *'Proportionality'* (SAN-1), *'Considering sanctions for serious cases'* (SAN-2). He referred to a number of relevant case law including *Sawati.*

The panel took into account the following aggravating features:

- Abuse of position of trust as Patient A and Patient B's Community Matron in that Mrs Hussain worked autonomously.
- Mrs Hussain lacked insight into her behaviour.
- A pattern of misconduct over a period of time, namely between 2019-2021.
- Conduct which put patients at risk of suffering harm. Patient A was distressed by Mrs Hussain's attempt to coerce her into attending Mrs Hussain's care home. Patient B was denied access to the relevant services and safeguarding.

The panel also took into account the following mitigating features:

- Mrs Hussain had a previous good professional history with no concerns raised against her.
- Mrs Hussain provided a number of positive character references.

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mrs Hussain's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where *'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.'* The panel considered that Mrs Hussain's

misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mrs Hussain's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the serious nature of the charges in this case. The panel noted that the misconduct in this case does not specifically relate to Mrs Hussain's clinical practice. However, it found evidence of deep-seated attitudinal issues which is inherently difficult to put right. The panel concluded that the placing of conditions on Mrs Hussain's registration would not adequately address the seriousness of this case and would not protect the public.

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;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. This was not a single incident of misconduct, and there was evidence of deep-seated attitudinal concerns.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, in looking at a striking-off order, the panel took note of the following paragraphs of the SG:

- *Do the regulatory concerns about the nurse or midwife raise fundamental questions about their professionalism?*
- *Can public confidence in nurses and midwives be maintained if the nurse or midwife is not removed from the register?*
- *Is striking-off the only sanction which will be sufficient to protect patients, members of the public, or maintain professional standards?*

The panel determined that Mrs Hussain's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. Mrs Hussain has not demonstrated sufficient insight or remorse into her conduct, and as such, poses significant risk of repeating her behaviour. The panel bore in mind that nurses who work in the community can have a great deal of influence over their vulnerable elderly patients, particularly due to the autonomous nature of Mrs Hussain's role. Having found charges proved relating to dishonesty which were financially motivated, and an attempted coercion of an elderly vulnerable patient, the panel was not satisfied that any other sanction would sufficiently protect the public and the wider public interest. The panel was of the view that the findings in this particular case demonstrate that Mrs Hussain's actions were serious and to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Mrs Hussain's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mrs Hussain in writing.

Interim order

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

Submissions on interim order

The panel took account of the submissions made by Mr Sabbagh. He invited the panel to impose an interim suspension order for 18 months to cover the period of time in which an appeal may arise. He submitted that this was on the basis that the panel have reached a view that the circumstances of the case are such that a strike-off is necessary, and if an appeal were to be lodged, it would effectively postpone or suspend for a short period of time the striking-off order. He submitted that in those circumstances, an interim suspension order would run alongside it in that case.

Mr Harris informed the panel that he had no representations in respect of the application for an interim order.

Decision and reasons on interim order

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

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months on the grounds of public protection and the wider public interest and to cover the appeal period.

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

That concludes this determination.