Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 11 August 2025 – Monday, 18 August 2025

Virtual Hearing

Name of Registrant:	Daniel Hussey
NMC PIN:	13A2796E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health – Level 1 (23 January 2013)
Relevant Location:	South West Yorkshire
Type of case:	Misconduct
Panel members:	Anica Alvarez Nishio (Chair, lay member) Sarah Jane Freeman (Registrant member) Matthew Wratten (Lay member)
Legal Assessor:	Neil Fielding
Hearings Coordinator:	Fionnuala Contier-Lawrie
Nursing and Midwifery Council:	Represented by Yusuf Segovia, Case Presenter
Mr Hussey	Not present and unrepresented
No case to answer	**Charges 1b)i, 1c)iii, 6**
Facts proved:	**Charges 1b)ii, 1b)iii, 1c)ii, 2, 4, 5, 7**
Facts not proved:	**Charges 1a, 1ci, 3, 8**
Fitness to practise:	**Impaired**
Sanction:	**Strike-off order**
Interim order	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Hussey was not in attendance and that the Notice of Hearing letter had been sent to Mr Hussey's registered email address by secure email on 10 July 2025.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mr Hussey's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Hussey

The panel next considered whether it should proceed in the absence of Mr Hussey. It had regard to Rule 21 and heard the submissions of Mr Segovia who invited the panel to continue in the absence of Mr Hussey. He submitted that Mr Hussey had voluntarily absented himself.

Mr Segovia referred the panel to the documentation from Mr Hussey which included an email dated 15 July 2025 stating the following:

> *'I can confirm notification of my hearing date. At this point I see little benefit of attending the hearing'*

Mr Segovia referred the panel to a follow up email dated 16 July 2025 which stated Mr Hussey was content with the panel proceeding in his absence.

The panel accepted the advice of the legal assessor.

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

- No application for an adjournment has been made by Mr Hussey;
- Mr Hussey has informed the NMC that he has received the Notice of Hearing and confirmed he is content for the hearing to proceed in his absence;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- A number of witnesses have attended today to give live evidence, and others are due to attend;
- Not proceeding may inconvenience the witnesses, their employers and, for those involved in clinical practice, the clients who need their professional services;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Hussey in proceeding in his absence. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any

inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Hussey's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application on no case to answer

The panel heard and accepted the advice of the legal assessor concerning its powers to stop a case if there is no case to answer in accordance with Rule 24(7) Nursing and Midwifery (Fitness to Practise) Rules 2004 and the case of *R v Galbraith* [1981] CR App R. 124 CA.

On reviewing the charges, the panel considered that there was no case to answer in respect of charges 1b)i, 1c)iii and 6.

In relation to charge 1b)i, the panel referred to Patient A's notes dated 7 March 2019, which state that, although Mr Hussey arranged to visit Patient A, Mr Hussey could not have met with Patient A in a clinical environment, as Patient A's notes later show that the ward staff did not allow Mr Hussey to visit. The panel therefore found there was no case to answer in relation to this charge.

In relation to charge 1c)iii, the panel referred to Patient A's notes which reflect that Mr Hussey was already in A&E assessing a different patient on the ward and was subsequently called over by Patient A, who was on a trolley in the same A&E department. As this was the only documentary evidence for this charge, and the evidence presented by the NMC contradicts the charge itself, the panel found that there is no case to answer in relation to this charge.

In relation to charge 6, the panel noted that in Mr Hussey's response bundle, the NMC asserts that Mr Hussey receives a text from Patient C, not Patient D, and as

such, no evidence has been presented of messages exchanged with Patient D. The panel therefore found that there was no case to answer in relation to this charge.

The panel was satisfied that there was a case to answer in respect of each of the remaining charges.

Decision and reasons on application to amend charge

The panel heard and accepted the advice of the legal assessor concerning its powers to amend charges in accordance with Rule 28 Nursing and Midwifery (Fitness to Practise) Rules 2004.

On reviewing the charges, in light of the available evidence and the nature of the regulatory concerns, the panel decided that amendments should be made to charges 1b)ii, 1b)iii and 7.

The first proposed amendment was to change the wording of charge 1b)ii to the following:

> "1b)ii Travelled alone ~~in your personal car with them on the occasions set out in Schedule 1~~ **with them in your personal car on one or more occasions on a date or dates unknown"**.

The panel determined that the change is a more accurate reflection of the evidence in the regulatory case.

The panel was satisfied that it was fair to Mr Hussey to amend this charge as in response to questions on this matter, Mr Hussey accepted that he travelled in his personal car with Patient A on a number of occasions.

The panel considered if any injustice would be caused and was satisfied that there would be no injustice as the alleged mischief within the charge remained the same and appeared not to be disputed by Mr Hussey.

The second proposed amendment was to change the wording of charge 1b)iii to the following:

> "1b)iii Spent time alone with them in their bedroom or home on ~~the occasions set out in Schedule 2~~ **one or more of the occasions set out in Schedule 2"**.

The panel determined that the change is a more accurate reflection of the evidence in the regulatory case.

The panel was satisfied that it had considered the fairness to Mr Hussey as he does not appear to contest the facts of the allegation.

The panel considered if any injustice would be caused and was satisfied that there would be no injustice as the amendment simply clarifies the charge with regard to whether it is necessary for the NMC to establish each of the matters in the Schedule, as it does not alter the substance of the charge or the regulatory concern it seeks to address.

The final proposed amendment was to change the wording of charge 7 to the following:

> "Your actions in charges 4 and/or 5 were inappropriate as:
> a. they did not relate to clinical care **and/or**
> b. the patients were no longer in your care"

The panel considered fairness to Mr Hussey and whether any injustice would be caused and was satisfied that it was fair and there would be no injustice as the alleged mischief within the charge remained the same and this change does not alter the substance of the charge or the regulatory concern it seeks to address.

Mr Segovia did not oppose the amendments and accepted they would be fair to the registrant and that no injustice would be caused.

Details of charge

That you, a registered nurse:

1. In respect of Patient A:

a) On 6 March 2019, ensured they were admitted to Barnsley Hospital when you were not on call.

b) Whilst they were under your care:

ii. Travelled alone with them in your personal car on one or more occasions on a date or dates unknown.

iii. Spent time alone with them in their bedroom or home on one or more of the occasions set out in Schedule 2

c) After they had been discharged from your care:

i. Met with them on the occasions set out in Schedule 3.

ii. On 14 October 2021 spoke to them on the telephone.

2. Your actions in charge 1(b) were inappropriate as they did not relate to clinical care.

3. Your actions in charge 1(c) were inappropriate as:

a. They did not relate to clinical care.

b. Patient A was no longer in your care.

4. On 1 October 2019 in respect of Patient B allowed them to sit on your lap and cuddled them.

5. Attended the home of Patient C with your daughter, to provide them with baby clothes.

7. Your actions in charges 4 and/or 5 and/or 6 were inappropriate as:

a. they did not relate to clinical care and/or

b. the patients were no longer in your care.

8. On 15 June 2021 you shouted at Family Member A.

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

Background

Mr Hussey worked as the Band 7 Clinical Lead for the Eating Disorders Pathway in the Barnsley CAMHS Crisis and Home-Based Treatment Team. A report was made by a service user on 15 October 2021 that Mr Hussey had engaged in an inappropriate relationship with her friend, Patient A. The Trust interviewed Patient A, who denied any inappropriate relationship with Mr Hussey.

On 4 November 2021 Person 1 (Clinical Lead, CAMHS Crisis Team) and Person 2 (Senior Mental Health Practitioner) submitted a formal complaint to the Trust about Mr Hussey, raising concerns about his attitude, his relationships with colleagues, his relationships with service users in his care, and that service users remained on his caseload after the age of 18 when they should have been discharged. A concern was also raised that Mr Hussey had been on the phone to a service user during a work night out, when he was not on call.

Concerns had previously been raised within the Trust when Mr Hussey accompanied Patient A to hospital, when she was admitted to an inpatients ward, and that he remained with her on the ward until late. The ward manager saw Mr Hussey and Patient A together the following day and said that Mr Hussey was within Patient A's personal space.

Patient A's patient record records that Mr Hussey saw her at home, alone, on a number of occasions after she turned 18. Mr Hussey accepted during an interview with the Trust that there was no risk assessment for this. Mr Hussey accepted during interview

that he sometimes gave Patient A a lift in his car, to facilitate her attendance at appointments.

Concerns had previously been raised about Mr Hussey's boundaries with service users and former service users. In 2017 he sent a message to a former service user suggesting that they meet for lunch. On 1 October 2019 it was alleged that Mr Hussey was seen cuddling Patient B, whilst she was sitting on his lap, during her attendance at A&E.

It was alleged by Person 1 that Mr Hussey had visited a former service user at her home "regularly" and that he had taken his daughter with him twice. In the complaint submitted by Person 1 and Person 2 to the Trust, they referred to a complaint from the parent of a service user in May 2021 that they felt bullied by Mr Hussey, and a subsequent incident where it was suggested that Mr Hussey had said to the same parent "I'm not here to see you", whilst attending hospital in September 2021. From documents supplied by the Trust to the NMC, we understand that Mr Hussey was suspended from clinical duties following receipt of the complaint. The parent in question was Family Member A. Person 3 (CAHMS Team Manager) met with Family Member A to discuss his complaint. The notes of that meeting record Family Member A saying that Mr Hussey shouted at him, and that he was sure that his daughter would have heard their altercation. Family Member A also referred to a meeting where his daughter's doctor said that she could be discharged from hospital and Mr Hussey was not happy about this. Person 3 concluded that Family Member A’s complaint was about the CAMHS service more widely, not specifically about Mr Hussey, so Mr Hussey was reinstated.

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 Segovia, on behalf of the NMC.
The panel has drawn no adverse inference from the non-attendance of Mr Hussey.

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

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

- Witness 1: Investigator – South West Yorkshire Partnership NHS Foundation Trust.
- Witness 2: General Manager – Barnsley CAMHS
- Witness 3: Ward Manager – Kendray Hospital
- Witness 4: A&E Nurse – Barnsley Hospital

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

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

Charge 1a)

That you, a registered nurse:

In respect of Patient A:

a) On 6 March 2019, ensured they were admitted to Barnsley Hospital when you were not on call.

This charge is found **not** proved.

The panel considered the evidence from Witness 1's statement which stated:

'I have not seen the on-call rota myself, but I have been told that Mr Hussey was not the on-call practitioner that day.'

and the patient notes for Patient A. This was the only evidence presented concerning Mr Hussey's status at the relevant time. Therefore the panel was not satisfied there was sufficient evidence to establish whether Mr Hussey was on call or not. The panel also noted that the events alleged began during normal working hours and Mr Hussey was part of a multidisciplinary discussion concerning Patient A's need for admission to hospital, and therefore found this charge not proved.

Charge 1b)ii

In respect of Patient A:

Whilst they were under your care:

ii. Travelled alone with them in your personal car on one or more occasions on a date or dates unknown.

This charge is found **proved.**

In reaching this decision, the panel took into account Mr Hussey's statement in his response to the NMC and Witness 1's written statement in which Mr Hussey accepted that he had transported Patient A to appointments.

The panel therefore found this charge proved.

Charge 1b)iii

In respect of Patient A:

Whilst they were under your care:

iii. Spent time alone with them in their bedroom or home on one or more of the occasions set out in Schedule 2.

This charge is found **proved.**

In reaching this decision, the panel took into account the patient notes for Patient A which show Mr Hussey was alone either in their bedroom or home with Patient A on the following dates:

- 5 November 2018
- 23 November 2018
- 30 November 2018
- 3 December 2019
- 8 January 2019
- 8 February 2019

The panel found the evidence about these matters compelling as it came from notes Mr Hussey made himself at the time.

The panel further noted that when questioned by Witness 1 and in his response to the NMC, Mr Hussey had admitted seeing Patient A alone in her bedroom and therefore found the charge proved.

Charge 1c)i

In respect of Patient A:

After they had been discharged from your care:

i. Met with them on the occasions set out in Schedule 3.

This charge is found **not** proved.

In reaching this decision, the panel took into account the patient records for Patient A and noted that the only evidence that shows that Mr Hussey and Patient A were in physical proximity on only one of the occasions listed, and that this was not a planned meeting. The said event took place on 12 December 2019 and it was a chance meeting as Patient A was receiving treatment in hospital and Mr Hussey was also in the same department assessing another patient. The panel also took into account that the other dates in the Schedule all relate to phone contact from Patient A, not meetings, the panel therefore found this charge not proved.

Charge 1c)ii

In respect of Patient A:

After they had been discharged from your care:

ii. On 14 October 2021 spoke to them on the telephone.

This charge is found **proved.**

In reaching this decision, the panel took into account the Datix report completed by Mr Hussey on 22 October 2021 which confirmed that Patient A had contacted him. The panel found this compelling evidence alongside Mr Hussey's own admissions when questioned about this matter and therefore found this proved.

Charge 2)

Your actions in charge 1(b) were inappropriate as they did not relate to clinical care.

This charge is found **proved.**

The panel noted that it did not view the actions in 1b) as relating to clinical care as they were not necessary for the delivery of that care. It noted that although

transporting patients to and from appointments and visiting patients in their bedroom or home may have been preferable to the patient, it was Mr Hussey's responsibility as a professional to make appropriate choices and there were other options or measures available within the remit of clinical care. It also took into account the patient notes for Patient A which indicate that on other occasions Mr Hussey took taxis with Patient A and that no explanation was given as to why a taxi might not be a viable option on the occasions when Mr Hussey's private car was used, and no risk assessment was made before using his private car.

The panel determined that the actions were inappropriate as it was not necessary for Mr Hussey to be alone with the patient, nor was it in the care plan to convey unaccompanied service users in his private car. The panel considered that by taking these actions, Mr Hussey put himself at risk, the patient at risk, and the reputation of the CAMHS service and the profession at risk. The panel therefore found this fact proved.

Charge 3)

Your actions in charge 1(c) were inappropriate as:

a. They did not relate to clinical care.
b. Patient A was no longer in your care

This charge is found **not** proved.

The panel took into consideration the Datix entry submitted by Mr Hussey which explained the nature of the call and the clinical context behind it. The panel considered the fact that the manager who reviewed the entry acknowledged that the entry was appropriate and that Mr Hussey had ensured there was appropriate health care escalation and did not see this as an issue.

The panel recognised the length of time since Patient A had been discharged from Mr Hussey's care and the length of the call itself. However it noted that there was an emergency context to the call and that it was within Mr Hussey's professional duty to

answer and remain on the call until he was assured that the patient was not in danger of immediate harm. The panel determined that these actions were not inappropriate as Mr Hussey's actions in these specific circumstances fell within the expectations of the duty of care of a registrant. The panel therefore found this charge not proved.

Charge 4)

> On 1 October 2019 in respect of Patient B allowed them to sit on your lap and cuddled them

This charge is found **proved.**

In reaching its decision, the panel gave due consideration to both the written and oral evidence of Witness 4 and the account given by Mr Hussey. On the balance of probabilities, it was satisfied that the evidence given by Witness 4 was more credible and that the incident is more likely than not to have taken place, as it seems improbable that the nurse could have mistaken the events she described as those being described by Mr Hussey.

The panel considered Mr Hussey's response in which he stated:

> *'Whilst in A&E became increasing agitated; at which point she pulled out her canula - which was sited in in the right arm. I moved from my position on the other side of the cubicle to sit next to and applied pressure and a dressing to her arm as she was bleeding from forcibly removing the canula'*

The panel also considered the evidence given by Witness 4 and Witness 4's responses to questioning by the panel and noted that both her written and verbal evidence was entirely consistent and unequivocal. The panel further considered that Witness 4 would be able to differentiate between the incident described within this charge and the incident described by Mr Hussey where Patient B removed their cannula, and therefore on the balance of probabilities the panel found this charge proved.

Charge 5)

Attended the home of Patient C with your daughter, to provide them with baby clothes.

This charge is found **proved.**

In reaching this decision, the panel took into account Mr Hussey's written response where he states:

'In relation to giving a former patient some children's clothes, this is something that i[sic] did do. I did this as I had bumped into her, over two years post discharge; at the time my wife and I wear clearing out old baby clothes and this YP had limited access to finances and as a gesture of kindness I gave her the old clothes from our children as they were surplus to requirement.'

The panel therefore accepted this and found the charge proved.

Charge 7)

Your actions in charges 4 and/or 5 were inappropriate as:

a. they did not relate to clinical care **and/or**
b. the patients were no longer in your care

This charge is found **proved.**

With regard to charge 4, whilst the panel took into consideration the agitated state of Patient B as recorded within their patient notes, it determined that Mr Hussey's actions did not relate to the clinical care of Patient B and was not appropriate behaviour when interacting with a vulnerable CAMHS patient.

With regard to charge 5, the panel had due consideration of Mr Hussey's actions and noted that Patient C had been discharged from his care in March 2018. Patient C had

their baby in 2019 and the incident took place at an unknown time after the birth of the child, significantly after Patient C had been discharged from Mr Hussey's care. The panel considered that his actions did not relate to clinical care of Patient C. The panel gave consideration to Mr Hussey's statement:

> *'A human being. I thought that's what people did, pass things onto people. She was no longer a patient.'*

and that Mr Hussey asserted that the clothes were given as a gesture of kindness, but determined that even something which might at face value appear well intentioned was inappropriate and did not relate to clinical care of Patient C. In the circumstances and taking into consideration the nature of Patient C's history of CAMHS care, the panel determined these actions were potentially intrusive and went beyond normal professional boundaries. The panel particularly considered the vulnerabilities of Patient C, and therefore the potential harm that could have been caused to their wellbeing by this type of interaction.

The panel therefore found this charge proved.

Charge 8)

> On 15 June 2021 you shouted at Family Member A.

This charge is found **not** proved.

In reaching this decision, the panel took into account the evidence given by Family Member A in a meeting with CAMHS which stated:

> *'Dan then began shouting at him and Family Member A asked him why he was taking that tone with him.'*

The panel also considered the evidence within the investigation of Mr Hussey which stated that Family Member A's complaint was directed generally at CAMHS and not specifically Mr Hussey.

The panel determined that neither of the accounts provided evidence of sufficient weight to prove on balance that Mr Hussey had carried out this action and therefore it found this charge not proved**.**

Fitness to practise

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

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

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

Submissions on misconduct

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

Mr Segovia 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 Segovia identified the specific, relevant standards where he submitted Mr Hussey's actions amounted to misconduct. Mr Segovia submitted that the inappropriateness of Mr Hussey's actions was sufficiently serious that there is a clear breach of professional boundaries and therefore of misconduct.

Submissions on impairment

Mr Segovia 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 cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Mr Segovia submitted that Mr Hussey had shown no insight in the provided submissions and due to lack of attendance, he has not been able to show insight following the findings of the panel on the facts.

Mr Segovia submitted that given the panel's findings on Mr Hussey's misconduct in the past, there remains a clear risk of repetition of breaching professional boundaries and putting patients at risk.

Mr Segovia concluded that given the risk of repetition and the risk of potential harm to the public should these actions be repeated, that a finding of impairment is necessary on the grounds of both public protection and public interest.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments.

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

> *'1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.5 respect and uphold people's human rights*
>
> *5.1 respect a person's right to privacy in all aspects to their care*
>
> *13.4 take account of your own personal safety as well as the safety of people in your care*
>
> *19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public*
>
> *20.1 keep to and uphold the standards and values set out in the Code*
> *20.2 act with … integrity at all times, treating people fairly and without … harassment*
> *20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people*
> *20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress.*
> *20.6 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*
> *20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to'*

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, given the findings of the panel, it determined that Mr Hussey's actions did amount to serious misconduct.

In relation to charges 1bii), ib)iii and 2, the panel considered these together as they are all concerned with issues of professional boundaries, appropriate professional behaviour and adherence to professional policy. The panel determined that these amounted to serious misconduct as there was a clear breach of the Code through becoming emotionally over involved, blurring boundaries and fostering overprotective and personalised relationships with patients, which put Mr Hussey, the patients and the profession at risk. The panel determined that this was compounded as it followed several instances of managerial feedback given to Mr Hussey around similar conduct and was directly against policies which were put in place to protect patients and staff. Mr Hussey did not deliver the fundamentals of care effectively and did not properly consider the safety of those in his care, nor his own safety. As a senior care practitioner, Mr Hussey's actions also were not in keeping with those of a role model to which more junior practitioners could aspire. Mr Hussey's standards fell far below those expected of a nurse, the panel therefore found that the charges in 1bii), 1b)iii and 2 amounted to serious misconduct.

In relation to charge 1cii, the panel considered that Mr Hussey took a call and recorded it appropriately and therefore determined that Mr Hussey's actions in 1c)ii did not amount to misconduct.

The panel considered charge 4 and determined Mr Hussey's actions fell far below standards, amounted to a fundamental and egregious breach of the Code and thus serious misconduct. Mr Hussey's actions:

- did not respect and uphold the patient's human rights in respect of their personal physical boundaries nor did it respect the patient's right to privacy in all aspects of their care;
- failed to treat the patient in a way that did not take advantage of their vulnerability and posed risk of harm to a vulnerable patient;
- did not maintain clear and objective personal boundaries
- and did not promote professionalism and given Mr Hussey's seniority did not provide a role model to others in the profession.

A reasonable member of the public or a fellow professional who viewed these actions would be shocked to have witnessed Mr Hussey's behaviour.

The panel determined that Mr Hussey's behaviour in charge 5, amounted to serious misconduct in that it was not in keeping with professional boundaries and professional codes of conduct to go to a former patient's address. It did not promote kindness in that it sent a wholly inappropriate message, which easily could be misunderstood by a highly vulnerable individual and potentially put them at risk of emotional harm. It did not take account of how the behaviour could affect and influence the behaviour of other people, both the patient and fellow professionals. By approaching a vulnerable individual and a former patient at their home, it potentially put the individual in a position to be unable to avoid the contact and bordered on harassment. As Witness 1 said:

> *'There is a power differential between a service user and their care practitioner. Mr Hussey had been the care practitioner for younger patients with trauma in their past and you cannot assume what is going on in the service user's mind as to what their care practitioner would represent to them. To open yourself up to something that is what friends do together was not appropriate for a nurse to do with a former service user.'*

The panel accepts and endorses this viewpoint.

Taking charges 4 and 5 together as the basis on which charge 7 has been formed, the panel determined that taken together, this amounted to serious misconduct for the reasons listed above.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Hussey's fitness to practise is currently impaired.
In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional 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) *…'*

The panel found that there was a risk that patients have been put at risk of emotional harm as a result of Mr Hussey's misconduct. Mr Hussey's misconduct had breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute. Evidence from the investigation states:

> *'He handed cases over that he couldn't work coercively with, he worked a lot, didn't take holidays and wouldn't let others see the people on his case load. He was hiding in plain sight. It was about power and control, being a ''white knight'' ''only I can fix this person''. This led to blurred boundaries, hampered recovery, and damaged family relationships.'*

Based on all of the evidence the panel considered, it accepts this as an accurate summary of the position.

The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to misconduct extremely seriously. The panel therefore found limbs a, b, and c of the *Grant* test were engaged in relation to your past conduct.

The panel determined that the conduct which led to the charges are not easily remediable. The panel noted that Mr Hussey was a band 7 practitioner, was well aware of safeguarding practice and the policies relating to the CAMHS service and

despite this, Mr Hussey made a wilful decision to go against policy, in plain sight. The panel determined that Mr Hussey's conduct is indicative of a deep-seated attitudinal behaviour which Mr Hussey has normalised over a prolonged period of time as being in his own words ''unorthodox'', when managerial concerns have been raised with him he has acknowledged these concerns but has given no reasonable explanation and has repeated the behaviour.

The panel determined that Mr Hussey has shown no insight into why his behaviour was of concern. It noted that over a period of years Mr Hussey has continued to exhibit the same behaviour, despite discussions and understanding of professional policy, he continued to behave in ways which breached policies.

The panel drew reference from Witness 1's statement which stated that Mr Hussey had been challenged on his behaviour previously, which was also referenced in Witness 2's statement which states that following:

> *'I spoke to … as this was now the third time this was raised about his boundaries.'*

The panel also noted that Witness 2 stated:

> *'during the second meeting he appreciated through the discussion the seriousness of the concerns'*

and that this showed Mr Hussey was aware of these concerns which had been addressed on a number of occasions and despite this he continued to behave inappropriately.

The panel noted that Mr Hussey's actions were especially egregious as given his role as a mental health nurse, many patients he worked with would be highly likely to have some degree of vulnerability, in a CAMHS setting or otherwise.
Mr Hussey has not submitted any written evidence of insight; by contrast the written materials submitted, show that no insight has developed:

‘I appreciate that at times my approach may appear to be a little unorthodox, however I have never tried to hide this. In fact, I am proud of the fact that I have been able to work with so many young people in a way which helped them feel safe, loved and hopeful of a future’

The panel noted that in the initial internal investigation report, Witness 1 states:

‘Mr Hussey denied doing anything wrong and his view was that he did not act in any way that was out of line with how he should have been behaving’

Further, the panel agreed with evidence that indicated a pattern of behaviour:

‘He’s been left to grow into this maverick and lead young people to think he’s the only person who can work with them.’

The panel therefore determined that Mr Hussey appears to have had full understanding of his behaviour and the potential consequences of his actions but by normalising and continuing this behaviour and refusing to accept and learn from feedback provided demonstrates little if any insight.

The panel is of the view that in light of the lack of remorse and insight, that it is highly likely the behaviour would be repeated and as a result, Mr Hussey continues to pose a risk to the safety of patients, the reputation of the profession and the public confidence. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection and public interest.

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 Mr Hussey’s fitness to practise impaired on the grounds of public interest.

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

Sanction

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

Submissions on sanction

Mr Segovia submitted that in recent correspondence with the NMC, Mr Hussey stated that he would accept the decision of the panel and in particular he stated he had no intention of working as a nurse again. Mr Segovia noted that given this response from Mr Hussey, it is clear that he has no intention of involving himself in demonstrating any remediation or insight into his regulatory concerns moving forward. Mr Segovia therefore concluded that a striking off order is an entirely proportionate outcome to the misconduct and impairment the panel has found.

The panel accepted the advice from the legal assessor.

Decision and reasons on sanction

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

The panel took into account the following aggravating features:

- A pattern of misconduct over a prolonged period of time
- Lack of insight and remorse into the regulatory concerns
- Deep-seated and ongoing attitudinal concerns
- No evidence of learning or remediation
- Abuse of a position of power
- Abuse of a position of trust involving vulnerable patients
- Significant safeguarding concerns and concerns of ongoing risk of harm

The panel considered that there was some evidence of an inconsistent approach from management in addressing concerns over Mr Hussey's behaviour, but noted that Mr Hussey was a band 7 nurse with a significant level of experience and seniority, and therefore discounted this as a mitigating factor.

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

nature of the charges in this case and Mr Hussey's statement that he had no intentions of working as a nurse again. Furthermore, the panel concluded that the placing of conditions on Mr Hussey's registration would not adequately address the seriousness of this case and would not adequately 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 panel reflected that a suspension order would not address the gravity or the persistence of concerns. It further noted that there is a risk of future harm, which is made more acute given his position of trust with regard to vulnerable patients. Furthermore, there is evidence of ongoing and deep-seated attitudinal problems. Taking these into consideration, the panel considered that while a suspension would give temporary protection to patients, it would not do so in the long term, nor protect the public interest.

The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breach of the fundamental tenets of the profession evidenced by Mr Hussey's actions is fundamentally incompatible with Mr Hussey remaining on the register, and 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 a striking off order is the only sanction which reflects the gravity of the concerns and that no lesser sanction would be sufficient to protect patients and members of the public while also maintaining the standards of the profession.

In making the determination, the panel gave special consideration to Mr Hussey's level of seniority and experience and, in the face of this, his:

- persistent attitudinal behaviour including his unilateral decisions to breach policies which were in place to safeguard vulnerable patients as well as to protect Mr Hussey and his colleagues;
- lack of any insight or remediation;
- abuse of a position of power and trust, particularly with regard to vulnerable patients.

The panel refers back to these issues addressed in detail in earlier parts of its reasoning.

Mr Hussey's actions were significant departures from the standards expected of a registered nurse. They have brought the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct themselves and by undermining public confidence in the profession and in the NMC as a regulatory body. They have put both patients and the public at risk of serious harm, and are fundamentally incompatible with him remaining on the register.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order.

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 Mr Hussey 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 Mr Hussey'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 Segovia. He invited the panel to impose an interim suspension order for a period of 18 months on the grounds of public protection and otherwise in the public interest. He submitted that as the suspension order will not take effect until after the 28-day period, an interim order is necessary to cover this intervening period to protect the public and meet the public interest in light of the panel's findings.

Decision and reasons on interim order

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

The panel concluded that an interim suspension order would be appropriate in this case and that not to not put an interim order in place would be inconsistent with its earlier findings. The panel therefore imposed an interim suspension order for a

period of 18 months to allow for the possibility of an appeal to be made and determined.

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

That concludes this determination.