Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Friday, 23 August 2024

Virtual Hearing

Name of Registrant:	John Joseph Brennan
NMC PIN	06H1466E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (Level 1) – 21 September 2006
Relevant Location:	West Northamptonshire
Type of case:	Misconduct
Panel members:	Jonathan Storey (Chair, lay member) Jane Jones (Registrant member) Anjana Varshani (Lay member)
Legal Assessor:	Hala Helmi
Hearings Coordinator:	Bethany Seed
Nursing and Midwifery Council:	Represented by Nawazish Choudhury, Case Presenter
Mr Brennan:	Not present and unrepresented at this hearing
Order being reviewed:	Suspension order (12 months)
Fitness to practise:	Impaired
Outcome:	**Suspension order (12 months) to come into effect on 4 October 2024 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Brennan was not in attendance and that the Notice of Hearing had been sent to Mr Brennan's registered email address by secure email on 10 July 2024. The panel noted that the Notice of Hearing was also sent to Mr Brennan's representative at Burton Copeland on 10 July 2024.

Mr Choudhury, 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 substantive order being reviewed, 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 Brennan'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 Brennan has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Mr Brennan

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

Mr Choudhury referred the panel to the hearing bundle which included emails from Mr Brennan's representative which state Mr Brennan is content for the hearing to proceed in his absence. Mr Choudhury noted that Mr Brennan has had time and notice to submit evidence in instead of attending the hearing but has chosen not to do so.

The panel accepted the advice of the legal assessor.

The panel has decided to proceed in the absence of Mr Brennan. In reaching this decision, the panel has considered the submissions of Mr Choudhury, the correspondence with Mr Brennan's representative and the advice of the legal assessor. It has had particular regard to the relevant case law and to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Brennan;
- Mr Brennan's representative 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; and
- There is a strong public interest in the expeditious review of the case.

The panel noted that Mr Brennan had previously expressed interest in attending the hearing. However, the panel referred to the most recent correspondence from Mr Brennan's representative, dated 31 July 2024, who confirmed that neither he nor Mr Brennan would attend at this time. The email stated:

> *"I have spoken to Mr Brennan and he does not feel that at the present moment he's in a position to successfully secure removal of the suspension and consequently will not be attending the review hearing. I have no instructions to attend on his behalf."*

The panel determined that, in this instance, Mr Brennan had waived his right to attend.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Mr Brennan.

Decision and reasons on review of the substantive order

The panel decided to impose a further suspension order of 12 months duration.

This order will come into effect at the end of 4 October 2024 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 12 months by a Fitness to Practise Committee panel on 6 September 2023.

The current order is due to expire at the end of 4 October 2024.

The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

> *"That you, a registered nurse, whilst employed at St Andrew's Healthcare on Pritchard Ward around 10 October 2017;*
>
> 1) *Retrospectively completed a seclusion pack for a seclusion that commenced on 18 September 2017.*
>
> 2) *Did not document that the seclusion pack had been recorded retrospectively.*
>
> 3) *Recorded an incorrect Datix number in the seclusion pack.*
>
> 4) *Recorded an incorrect date for the seclusion.*
>
> *On or around 18 August 2018:*
>
> 5) *…*

6) …

7) …

8) On one or more occasion entered the seclusion area;

a) Whilst being designated on a non-management and prevention of aggression period.

b) Alone/without another member of staff.

9) Did not record the administration of Co-Codamol to Patient A on the EMAS system, in that you did not record;

a) The timing of administration.

b) The dosage of the medication.

c) The route of administration.

10) Did not record the administration of Olanzipine to Patient A on the EMAS system, in that you did not record;

a) The timing of administration.

b) The dosage of the medication .

c) The route of administration.

11) Did not secure the clinic/medication keys, in that you;

a) Walked around with the keys in your hand.

b) Did not attach the keys to a designated belt/key ring.

c) Did not keep the keys in a designated pocket.

12) After dispensing medication to Patient A, left Patient A alone with the medication/in possession of the medication.

13) On one or more occasion left Patient A alone/unattended/unobserved, during Patient A's seclusion period.

14) At around 10:01 a.m. did not secure the clinic door.

15) Inaccurately recorded in Patient A's Rio notes that;

a) …

b) …

c) …

d) …

e) …

f) …

g) That Patient A's seclusion ended at 12.45p.m.

16) …

17) …

18) After calling Colleague Z into the office;

a) Raised your voice/shouted at Colleague Z.

b) Pointed your finger in Colleague Z's face.

c) Sat/stood in front of Colleague Z in an Intimidating manner.

d) Used words to the effect;

(i) 'Don't you ever question my word again.'

(ii) 'We sort this out now.'

(iii) 'Don't roll your eyes at me.'

(iv) 'I will have you punished.'

19) Between June 2018 and September 2018 on an unknown date, decided that Patient A would utilise his period of leave;

a) After agreeing with other staff members that Patient A would not be granted leave.

b) …

c) …

20) Between June 2018 and September 2018 on an unknown date;

a) …

b) …

c) …

21) On or around 04 August 2018;

a) Raised your voice/shouted at Colleague Y.

b) Inappropriately challenged Colleague Y's decision to restrict Patient B from utilising his period of leave on 31 July 2018.

c) Used word to the effect;

(i) 'OTs should not be involved in clinical decisions.'

(ii) 'You should not go over my head and change my decisions.'

d) Behaved in an intimidating/threatening manner towards Colleague Y.

That you, a registered nurse, whilst working at Mill Lodge, between 18 September 2019 and 11 November 2019 on Amrik Ward ('the Ward');

22) On or around 2 October 2019 used an inappropriate restraint technique on Patient C, in that you;

a) …

b) Pushed Patient C's feet/ankles to the ground.

c) Continued to grab/push Patient C ankles/feet to the grounds, despite being told by Colleague X that the restraint was incorrect.

23) On or around 3rd October 2019 during an incident where Patient C wielded a metal urn;

a) Instructed one or more colleagues to lock doors to the lounge/kitchen in an attempt to seclude Patient C.

b) When questioned by Colleague W about locking the doors, used words to the effect 'don't question me in the middle of an incident, yeah'

c) Instructed one or more colleagues to evacuate the Ward.

d) Left one or more patients in the Ward/lounge locked in with Patient C.

24) *Whilst speaking to Colleague W, used words to the effect; ‘Patients don’t decide when they go for a cigarette break, they can fit around our day’*

25) *Whilst speaking to Colleague V, used words to the effect that;*

a) ‘Colleague V wasn’t good enough to be a nurse’
b) ‘Colleague V wasn’t strong enough to be a nurse’

26) *Whilst speaking to Colleague U, on one or more occasion used words to the effect that;*
a) ‘You are only/just a support worker’
b) ‘You should only listen to me’
c) ‘You are not important’
d) ‘Why didn’t you achieve anything in life’
e) ‘Why are you a support worker’
f) ‘You will only ever be a support worker because you don’t have any potential’

27) *On one or more occasion;*
a) Unfairly dismissed the needs of other patients to spend time with Patient E
b) Disclosed information about your personal life to Patient E.
c) When describing Patient E to colleagues used words to the effect;
i) ‘Patient E was typical PD [personality disorder]’
ii) ‘Patient E was clingy’
iii) ‘Patient E was attention seeking’

28) *…*

29) *On one or more occasion, when referring to patients who self-harmed, used words to the effect;*
a) ‘they are a not doing it right’
b) That you would have to tell them to ‘do it properly’

30) *On or around 10 November 2019, in relation to an incident where Patient D had ligatured;*

a) …

b) …

c) …

d) …

e) …

f) …

g) …

h) …

i) …

j) …

k) …

l) …

31) *…*

32) *…*

The original panel determined the following with regard to impairment:

"The panel next went on to decide if as a result of the misconduct, Mr Brennan's fitness to practise is currently impaired. It took into account the submissions made, the advice of the legal assessor and also took note of the NMC guidance on impairment.

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

The panel determined that limbs a, b and c of the above test are engaged in relation to Mr Brennan's conduct. By its findings, the panel concluded that Mr Brennan had

put patients at unwarranted risk of harm and had brought the nursing profession into disrepute by crossing professional boundaries with a patient and by failing to behave in a professional manner with colleagues. The panel also determined that there is evidence to demonstrate Mr Brennan did fail to show kindness when dealing with colleagues.

The panel concluded that Mr Brennan breached numerous paragraphs of the Code as set out above and consequently undermined the fundamental tenets of the nursing profession across all charges found proved.

The panel had regard to the case of Cohen and considered whether the misconduct identified is capable of remediation, whether it has been remedied and whether there is a risk of repetition. In considering these issues, the panel had regard to the nature of the misconduct and considered whether Mr Brennan provided evidence of insight, remorse or strengthened practice.

The panel recognised Mr Brennan's right to deny the allegations relating to this hearing and to challenge facts and points of detail. The panel did not draw any inference from Mr Brennan's position, set out in his responses to the regulatory concerns. The panel however, must consider insight and the likelihood of conduct being repeated in considering the public interest.

The panel was satisfied that the misconduct in this case is capable of being remediated. However, it did not see any evidence of Mr Brennan's insight or to strengthening of practice. The panel therefore determined that it does not have evidence to show any steps have been taken by Mr Brennan to strengthen his practice.

The panel noted that it does not have a reflective piece provided by Mr Brennan which could have highlighted any insight into the facts found proved, or how he would do things differently to ensure that these events are not repeated.

The panel was of the view that the matters subject of this hearing are capable of remediation through strengthened practice and insight. However, there remains a

risk of repetition based on the evidence available and the panel believes it likely that Mr Brennan will, in the future, act so as to put patients at unwarranted risk of harm, bring the nursing profession into disrepute and/or breach one or more fundamental tenets of the nursing profession.

The panel bore in mind 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.

It therefore found that Mr Brennan's fitness to practise is currently impaired on the grounds of public protection. In addition, it determined that public confidence in the nursing profession and in the NMC as the regulator would be undermined if a finding of current impairment were not made in the circumstances of this case.

Having regard to all the above, the panel was satisfied that Mr Brennan's fitness to practise is currently impaired on the grounds of both public protection and in the wider public interest."

The original panel determined the following with regard to sanction:

'Having found Mr Brennan'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:

- *Abuse of a position of trust;*
- *Abusive behaviour towards colleagues;*
- *Mr Brennan's lack of insight and remorse into his failings; and*
- *Lack of engagement with the substantive hearing.*

The panel did not identify any mitigating features.

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, the public protection and the public interest issues identified, an order that does not restrict Mr Brennan'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 Brennan's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Mr Brennan's registration would be a sufficient and appropriate response. The panel was mindful that any conditions imposed must be proportionate, measurable, and workable.

The panel was of the view that there are no practical or workable conditions that could be formulated, given the nature of all the charges in this case. The panel determined that there are some charges that can be addressed with a conditions of practice order. However, there are others that demonstrate attitudinal concerns and these cannot be addressed with a conditions of practice order.

Additionally, the panel had no information before it about Mr Brennan's current circumstances due to his lack of engagement with this hearing and there is no evidence of insight into his misconduct. In light of this, the panel considered that, even if appropriate conditions of practice could be formulated, it could not be satisfied that Mr Brennan would comply with any such conditions of practice.

Furthermore, the panel concluded that the placing of conditions on Mr Brennan's registration would not adequately address the seriousness of this case and would not mark the public interest identified by the panel.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG indicates that the seriousness of the case may require a temporary removal from the register. The panel noted that it had to consider the least restrictive order that would provide the necessary level of protection. The panel carefully considered the SG and decided that a period of suspension would be sufficient to protect patients and maintain public confidence in the profession and uphold professional standards. The panel determined that this was the most proportionate sanction.

The panel did go on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, the panel concluded that it would be disproportionate. Whilst the panel acknowledged that a suspension may have a punitive effect, it would be unduly punitive in Mr Brennan's case to impose a striking-off order. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with remaining on the register.

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

The panel noted the hardship such an order may well cause Mr Brennan. However, this is outweighed by the public interest in this case.

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

The panel determined that a suspension order for a period of 12 months was appropriate in this case to mark the seriousness of the misconduct. This period of

suspension may allow Mr Brennan to re-engage with the NMC and to take steps to strengthen his practice following the findings of this panel.

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

Any future panel reviewing this case may be assisted by:

- *A reflective piece which properly addresses the misconduct identified by this panel in its determination;*
- *Evidence of any training which Mr Brennan may have undertaken which addresses the misconduct identified by this panel;*
- *Mr Brennan's engagement with the NMC, including his attendance at a review of this order; and*
- *Testimonials from any role, paid or unpaid, which Mr Brennan may have undertaken during his period of suspension.*

It is open to Mr Brennan to request an early review of this order, under Article 30(2) of the Nursing and Midwifery Order 2001 if he considers that there is new information about his fitness to practise which should be heard by a panel at a review hearing.'

Decision and reasons on current impairment

The panel has considered whether Mr Brennan's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's suitability to remain on the register without restriction and their ability to practise kindly, safely and professionally. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle. It has taken account of the submissions made by Mr Choudhury on behalf of the NMC. He

submitted that Mr Brennan remains impaired on public interest and public protection grounds.

Mr Choudhury outlined the background of the case. He noted that the panel had the power to extend the current order or to impose a new one upon the expiry of the current suspension order. Mr Choudhury submitted that the charges found proved by the original panel were serious in nature and had several aggravating factors.

Mr Choudhury submitted that the risk of repetition remains. He submitted that Mr Brennan has provided no further evidence of insight into his actions or steps taken to strengthen his practice. He submitted that, in the absence of any new evidence, Mr Brennan's fitness to practise remains impaired. He submitted that he had not received specific instructions from the NMC as to the appropriate sanction and noted that it was at the discretion of the panel to decide a proportionate and fair sanction upon a finding of impairment but suggested that it may be appropriate for the panel to extend Mr Brennan's current period of suspension for a period of 12 months.

The panel accepted the advice of the legal assessor.

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel considered whether Mr Brennan's fitness to practise remains impaired.

The panel noted the findings of the previous panel and that the charges it found proved were serious and wide-ranging, across several areas of practice and occurred in two locations over a two-year period. The panel bore in mind the previous findings of attitudinal problems. They noted that the previous panel found Mr Brennan had a lack of insight and remorse.

The panel today had no new evidence before it. It could not therefore determine whether Mr Brennan had developed any insight, shown any remorse, or taken any steps to strengthen his practice. It further noted Mr Brennan's apparent lack of engagement with

the suggestions made by the previous panel. It could not therefore determine that the risk of harm had reduced.

The original panel determined that Mr Brennan was liable to repeat matters of the kind found proved but considered that his misconduct was capable of remediation. This panel was disappointed that no such evidence had been presented to it and that Mr Brennan had not acted on the original panel’s recommendations. In light of this, this panel determined that Mr Brennan remains liable to repeat matters of the kind found proved. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, the public interest concerns have not been addressed and a finding of continuing impairment on public interest grounds is also required.

For these reasons, the panel finds that Mr Brennan’s fitness to practise remains impaired.

Decision and reasons on sanction

Having found Mr Brennan’s fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also considered the ‘NMC’s Sanctions Guidance’ (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

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

The panel next considered whether imposing conditions of practice on Mr Brennan's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable, and workable. The panel bore in mind the seriousness of the facts found proved at the original hearing, the attitudinal concerns identified by the original panel, and Mr Brennan's non-attendance and limited engagement with the NMC. It concluded that a conditions of practice order would not therefore be workable and would not adequately protect the public or satisfy the public interest.

The panel considered it necessary to impose a further period of suspension in light of the previous panel's findings on the severity of the misconduct and Mr Brennan's lack of engagement and remediation to date. The panel also concluded that, given the seriousness of Mr Brennan's misconduct and the absence of further evidence, a further12-month period of suspension would be the most appropriate duration and the shortest period necessary to address its concerns. It was of the view that a 12-month suspension order would also allow Mr Brennan sufficient further time to fully reflect on the severity of his previous misconduct and to develop his insight and take steps to strengthen his practice.

The panel considered that a striking-off order at this stage would be disproportionate at this time but that the option would remain for a future panel if no action were taken by Mr Brennan to demonstrate insight and remediation.

The panel determined therefore that a suspension order is the appropriate and proportionate sanction which would continue to both protect the public and satisfy the wider public interest. Accordingly, the panel determined to impose a further suspension

order for the period of 12 months which would provide Mr Brennan with an opportunity to engage with the NMC and to provide evidence of insight and strengthening of his practice.

The panel noted the hardship such an order may well cause Mr Brennan. However, the panel considered that the need to protect the public and uphold the public interest outweighed Mr Brennan's interests in this regard.

This suspension order will take effect upon the expiry of the current suspension order, namely the end of 4 October 2024 in accordance with Article 30(1).

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

Any future panel reviewing this case would be assisted by:

- A reflective piece which properly addresses the misconduct identified by the substantive hearing panel in its determination;
- Evidence of any training which Mr Brennan may have undertaken which addresses the misconduct identified;
- Mr Brennan's full engagement with the NMC, including his attendance at a review of this order; and
- Testimonials from any role, paid or unpaid, which Mr Brennan may have undertaken during his period of suspension.

The panel noted that it is open to Mr Brennan to request an early review of this order, under Article 30(2) of the Nursing and Midwifery Order 2001 if he considers that there is new information about his fitness to practise which should be heard by a panel at a review hearing

This will be confirmed to Mr Brennan in writing.

That concludes this determination.