Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 3 April - Thursday 6 April 2023
Tuesday 11 April – Friday 14 April 2023
Monday 17 April – Friday 21 April 2023

Tuesday 20 June – Wednesday 21 June 2023 (in camera)
Thursday 22 June 2023

Monday 4 September - Wednesday 6 September 2023 (virtual)

2 Stratford Place, Montfichet Road, London, E20 1EJ

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:	Anthony Griffin (Chair, Lay member) Paul Leighton (Lay member) Shorai Dzirambe (Registrant member)
Legal Assessor:	Charles Conway (Day 1-15) Michael Levy (Day 16) Marian Killen (Days 17-19)
Hearings Coordinator:	Philip Austin (Days 1 – 8) Sharmilla Nanan (Days 9, 11-16) Roshani Wanigasinghe (Day 10) Monsur Ali (Days 17-19)
Nursing and Midwifery Council:	Represented by Amy Hazlewood, Case Presenter (Days 1-13) Represented by Ben Edwards, Case Presenter

	(Day 16) Represented by Alastair Kennedy, Case Presenter (Days 17-19)
Mr Brennan:	Not present and not represented in his absence
Facts proved:	Charges 1, 2, 3, 4, 8a, 8b, 9a, 9b, 9c, 10a, 10b, 10c, 11a, 11b, 11c, 12, 13, 14, 15g, 18a, 18b, 18c, 18d(i), 18d(ii),18d(iii), 18d(iv), 19a, 21a, 21b, 21c(i), 21c(ii), 21d, 22b, 22c, 23a, 23b, 23c, 23d, 24, 25a, 25b, 26a, 26b, 26c, 26d, 26e, 26f, 27a, 27b, 27c(i), 27c(ii), 27c(iii), 29a and 29b
Facts not proved:	Charges 5, 6, 7, 15a, 15b, 15c, 15d, 15e, 15f, 16, 17, 19b, 19c, 20a, 20b, 20c, 22a, 28, 30a, 30b, 30c, 30d, 30e, 30f, 30g, 30h, 30i, 30j, 30k, 30l, 31 and 32
Fitness to practise:	Impaired
Sanction:	Suspension order (12 months)
Interim order:	Interim suspension order (18 months)

Decision and reasons on service of Notice of Hearing

At the start of this hearing, the panel noted that Mr Brennan was not in attendance, nor was he represented in his absence.

The panel was informed that notice of this hearing was sent by email to the address that the Nursing and Midwifery Council ("NMC") had on the NMC Register for Mr Brennan on 2 March 2023. The panel noted that Rule 34(1)(c) of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004' allows for electronic service of the notice of hearing. The panel further noted that the Notice of Hearing was also sent to Mr Brennan's representative at Burton Copeland LLP by email on the same date.

Ms Hazlewood, on behalf of the NMC, submitted that the service by email 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 time, date and venue of the hearing 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 light of the information available, the panel was satisfied that the notice of hearing had been served in compliance and in accordance with Rules 11 and 34 of the Rules.

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. It had regard to Rule 21 of the Rules, and heard submissions from Ms Hazlewood who invited the panel to proceed in the absence of Mr Brennan.

Rule 21 (2) states:

> (2) Where the registrant fails to attend and is not represented at the hearing, the Committee—
>
> (a) shall require the presenter to adduce evidence that all reasonable efforts have been made, in accordance with these Rules, to serve the notice of hearing on the registrant;
>
> (b) may, where the Committee is satisfied that the notice of hearing has been duly served, direct that the allegation should be heard and determined notwithstanding the absence of the registrant; or
>
> (c) may adjourn the hearing and issue directions.

Ms Hazlewood referred the panel to the NMC document titled 'Proceeding in Absence Summary'. She submitted that there has been engagement from Mr Brennan in relation to this matter, both through his representative at Burton Copeland LLP, and with himself directly.

Ms Hazlewood informed the panel that Mr Brennan's representative has indicated that neither he, nor Mr Brennan will be at this hearing. She submitted that Mr Brennan himself has confirmed that this hearing can proceed in his absence, and that he takes no issue with the witnesses or the entire case being heard virtually.

Ms Hazlewood submitted that Mr Brennan has not asked for an adjournment in this matter, nor would one be likely to secure his attendance at some point in the future. She submitted that Mr Brennan has voluntarily absented himself from this hearing.

Ms Hazlewood submitted that a number of witnesses have been warned to give evidence over the course of this hearing. She submitted that there is a strong public interest in hearing this matter and disposing of the case expeditiously.

Ms Hazlewood invited the panel to proceed in the absence of Mr Brennan as it is fair, appropriate and proportionate to do so in these circumstances.

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with great care'* as referred to in the case of *R v Jones (Anthony William) (No.2)* [2002] UKHL 5, and '*with the utmost caution*' in *R (Raheem) v NMC* [2010] EWHC 2549 (Admin).

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

- Mr Brennan has indicated that he does not intend to attend the hearing and he has consented to the hearing proceeding in his absence;
- Mr Brennan has provided a response to the regulatory concerns, along with a statement dated 5 October 2019, which the panel can take account of in considering this matter;
- Mr Brennan was offered the opportunity for this hearing to be heard virtually, which he agreed to, but made no further indication to suggest that this would secure his attendance;
- An application for adjournment has not been made by Mr Brennan;
- There is no reason to suppose that adjourning would secure Mr Brennan's attendance at some future date;
- Eleven witnesses have been warned to give oral evidence at this hearing;

- Not proceeding may inconvenience the witnesses, their employers and, should they be involved in clinical practice, the patients or those who need their professional services;
- Further delay may have an adverse effect on the ability of the witnesses to accurately recall events; and
- The earliest charge relates to an event that occurred as far back as 2017;
- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledged that there is some disadvantage to Mr Brennan in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him, he will not be able to challenge in person the evidence relied upon by the NMC and will not be able to give oral evidence on his own behalf. However, in the panel's judgement, this can be mitigated by the panel asking questions of the witnesses. It noted that it has received Mr Brennan's response to the charges, along with a statement dated 5 October 2019. The panel can make allowance for the fact that the NMC's evidence will be tested by cross-examination of the witnesses and can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Brennan's decision 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 decided that it is fair, appropriate and proportionate to proceed in the absence of Mr Brennan. The panel will draw no adverse inference from Mr Brennan's absence in its findings of fact.

Decision and reasons on application to amend the charge

Ms Hazlewood made an application to amend the wording of charge 30. The proposed amendment was to correct a typographical error, as the date referred to in the stem is incorrect. Ms Hazlewood proposed that the date in the stem of charge 30 should be amended from 10 November 2018 to 10 November 2019, as this would better reflect the evidence the panel had received.

The panel noted that the stem in charge 30 currently states that:

> *"30. On or around 10 November 2018, in relation to an incident where Patient D had ligatured"*

The panel accepted the advice of the legal assessor and had regard to Rule 28 of the Rules, which states:

> "*28 (1) At any stage before making its findings of fact, in accordance with rule 24(5) or (11), the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) or the Fitness to Practise Committee, may amend*
>
> *(a) the charge set out in the notice of hearing; or*
>
> *(b) the facts set out in the charge, on which the allegation is based,*
>
> *unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.*"

The panel was of the view that such an amendment, as applied for, was in the interests of justice.

The panel determined that amending the stem of charge 30 in the way proposed would not fundamentally alter the case against Mr Brennan. It considered it to be a typographical error which could easily be corrected for clarity and accuracy.

The panel was aware that Mr Brennan had been sent all of the paperwork relating to this case, as would his representative at Burton Copeland LLP. It was of the view that the

proposed amendment did not disadvantage Mr Brennan in any way. The mischief identified in the allegations remain the same.

Therefore, the panel decided to grant Ms Hazlewood's application to amend the stem of charge 30 to read as follows:

> *"30. On or around 10 November 2019, in relation to an incident where Patient D had ligatured"*

Details of charges (as amended)

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) Placed Patient A into seclusion, without any clinical justification.

6) Did not employ any de-escalation techniques prior to placing Patient A into seclusion.

7) Administered Olanzapine to Patient A without any clinical justification.

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) Patient A kicked and punched doors/windows prior to his seclusion.

b) Patient A approached you in a threatening manner prior to his seclusion.

c) You walked around with Patient A prior to his seclusion.

d) Patient A required more than one member of staff to assist him to the seclusion area.

e) That Patient came towards you in a threatening manner in the seclusion room.

f) That several interventions were used to minimise the time of seclusion/de-escalate Patient A's behaviour.

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

16) Your actions in one or more charges 15) a, 15) b, 15) c, 15) d, 15) e, & 15) f above were dishonest in that you sought to misrepresent Patient A's presentation/the necessity to seclude Patient A.

17) You actions in charge 15 g) above were dishonest in that you sought to misrepresent the period of Patient A's seclusion.

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) Without conducting a comprehensive risk assessment of Patient A.

c) Without discussing the change of decision/the risk of Patient A with any other member of staff.

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

a) Raised your voice/shouted at Colleague Y.

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

c) Challenged Colleague Y's risk assessment/decision to restrict Patient A's leave.

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) Grabbed Patient C by the feet/ankles.

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) Following an incident where Patient D had ligatured, used words to effect,'*I don't get why people self-harm if they aren't going to do it right'*

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) Instructed Colleague U, not to cut the ligature off.

b) Instructed Colleague U, that the ligature was not tight enough.

c) Instructed Colleague U, that you wanted to speak to Patient D before cutting the ligature off.

d) Instructed Colleague U, that she had made a mistake for helping Patient D.

e) Described Patient D, using words to the effect, '*she is an attention seeker'*

f) Spoke to Colleague U, using words to the effect, '*you are just a support worker*'

g) Spoke to Colleague U using words to the effect, '*You are not important*'

h) Did not escalate a formal complaint/statement made against Colleague N to management.

i) Did not record Patient D's physical presentation in the incident report.
j) Did not record how tight Patient D's ligature was in the incident report.
k) Instructed one or more staff members to lock Patient D in a room/the lounge.
l) Kept Patient D in secluded room for one or more hours.

31) Inaccurately recorded that you had prompted staff to remove the ligature from Patient D.

32) Your actions in charge 31 above were dishonest in that you sought to conceal the true nature of your instructions relating to Colleague D's ligature.

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

Background

Mr Brennan entered the NMC register in 2006 and was referred to the NMC on 25 March 2019 by St Andrew's Healthcare. The charges arose whilst Mr Brennan was employed as a registered nurse at St Andrews Hospital and later during his employment at Mill Lodge Hospital.

In October 2017, Mr Brennan allegedly falsified seclusion paperwork, in that he had completed a second seclusion pack after the original paperwork which had been misplaced and it is alleged that this was not recorded as being completed retrospectively. Mr Brennan received a first written warning as a consequence.

Mr Brennan was overseeing Pritchard Ward (the Ward) at St Andrew's Hospital as a Band 6 Nurse Lead/Deputy for the Ward in June 2018.

On 18 August 2018, Patient A was placed into seclusion as Mr Brennan had recorded on the Rio notes (case management system) that Patient A was behaving aggressively by kicking doors and punching windows. Ms 1, a nurse manager, viewed the CCTV footage

and stated that Patient A's behaviour did not warrant immediate seclusion. It is alleged that Mr Brennan did not attempt to de-escalate the situation and he allegedly also recorded that he had administered Olanzapine for severe agitation. Ms 1 could not see any evidence of severe agitation on the CCTV and reported this matter as she considered it a falsification of records to justify administration of antipsychotic medication (a chemical restraint).

Mr Brennan was subsequently suspended from duty and the matter was investigated by Ms 7, a Nurse Manager. Ms 7 states that Mr Brennan did not try to de-escalate the situation and that Patient A did not threaten Mr Brennan or approach him aggressively. It is also alleged that Mr Brennan also left Patient A in seclusion on several occasions without observation in breach of the seclusion policy. Mr Brennan allegedly entered the seclusion area on his own when two or more staff should have been present. It is alleged that Mr Brennan left the clinic door open, on several occasions, when the practice at St Andrew's hospital is to ensure the clinic room door is closed and locked at all times.

No CCTV footage has been provided in respect of these allegations.

Mr Brennan allegedly shouted at Colleague Z, a health care assistant, *'I will have you punished, I will tell [Ms 1] and have you punished'.*

It is alleged that Mr Brennan recorded that he took Patient A out of seclusion however Mr Brennan had allegedly taken Patient A to the de-escalation room and left Patient A locked in this area which indicated that the seclusion continued. Mr Brennan also allegedly gave Patient A medication and left to go to another area of the Ward to get water for Patient A whilst leaving the patient unattended with the medication. This was in breach of the medication policy.

Mr Brennan allegedly also walked around with the medication key in his hand when it should have been attached to his belt.

On 18 August 2018, Mr Brennan allegedly recorded a Rio entry that co-codamol and Olanzapine had been administered to Patient A. However, there was no record of time, dose or route of administration recorded on the medication system ('EMAS' or 'Electronic Medication Administration System').

Mr Brennan allegedly agreed to a plan of staff not taking Patient A for a walk in the hospital grounds, only to contradict the decision without any clinical justification. Mr Brennan approached Colleague Y and allegedly raised his voice at her, asking why her risk assessment meant Patient A could not go on leave in the grounds.

On 10 January 2019, Mr Brennan was dismissed following disciplinary proceedings into these concerns.

Mr Brennan started working at Mill Lodge in September 2019

On 2 October 2019, Patient C threatened staff with a butter knife and was restrained on the floor. Mr Brennan allegedly held Patient C's ankles and pushed them down. Another colleague told Mr Brennan that this was an incorrect hold but Mr Brennan did not change this.

On 3 October 2019, Patient C became agitated and picked up an hot water urn in the kitchen. Mr Brennan allegedly told staff to lock the doors to the lounge and kitchen and also told staff to evacuate the unit but left two patients inside. Police were called to deal with the situation.

Mr Brennan allegedly asked Colleague V why she thought she could be a nurse and said that she was not good enough. Mr Brennan would refer to Colleague U as 'only a support worker' and that she was 'not important'.

It is alleged that Mr Brennan would behave in a 'flirty' way with Patient E and tell her about his personal life and experiences. He is alleged to have unfairly dismissed the needs of other patients to spend time with Patient E.

On or around 10 November 2019, Patient D had placed a ligature around her neck and was unable to talk. Mr Brennan allegedly instructed Colleague U not to cut the ligature as it was not tight enough however Colleague U cut the ligature and Mr Brennan told Colleague U that she was wrong for helping an attention seeker like Patient D. Patient D became hostile after the ligature was removed and Mr Brennan allegedly ordered the staff to lock the room whilst Patient D was in restrictive holds. There was no seclusion policy and Patient D was allegedly kept in seclusion for hours.

Colleague U also states that Mr Brennan would make comments about patients who self-harmed and would say they were *'not doing it right.'* Colleague U noted a time when a patient ligatured, and Mr Brennan said words to the effect of *"I don't get why people self-harm if they aren't going to do it right".* Colleague U said Mr Brennan spoke about patients as if they were objects and would laugh at patients who had serious incidents.

Mr Brennan was suspended from Mill Lodge and subsequently resigned with immediate effect on 11 December 2019.

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 Ms Hazelwood on behalf of the NMC.

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

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: Employed by St Andrews Hospital as a nurse manager and is a registered nurse. Worked with Mr Brennan on Pritchard Ward as a ward manager. She had a professional relationship with Mr Brennan.

- Ms 2: Employed by St Andrews Hospital as a health care assistant and knew Mr Brennan from working in different wards at St Andrews including Pritchard Ward. She had a professional relationship with Mr Brennan.

- Colleague Z Employed by St Andrews Hospital as a staff nurse and at the material time was employed as a health care assistant. She knew Mr Brennan from working on Pritchard Ward. She had a professional relationship with Mr Brennan.

- Colleague Y Employed by St Andrews Hospital as a clinical placement lead and is a registered nurse. She knew Mr Brennan from working on Pritchard

	Ward and had a professional relationship with Mr Brennan.
• Dr 5	Employed by St Andrews Hospital as a associate specialist and is a psychiatrist and ward doctor. She knew Mr Brennan from working on Pritchard Ward and had a professional relationship with Mr Brennan.
• Colleague W	At the material time was employed by Mill Lodge on Amrik Ward as a mental health support worker. She had a professional relationship with Mr Brennan.
• Ms 7	Employed by St Andrews Hospital as nurse manager and is a registered nurse. She knew Mr Brennan through the investigation she completed. She had not met Mr Brennan prior to her investigation and had a professional relationship with him.
• Ms 8	At the material time was employed by Mill Lodge as a support worker. She sometimes worked with Mr Brennan on Amrik Ward. She had a professional relationship with Mr Brennan.

- Ms 9 — Employed by St Andrews Hospital in an non-clinical administrative capacity. At the material time reviewed the CCTV footage and made notes to form a timeline. She has not met Mr Brennan and only knows of him through the internal investigation conducted by St Andrews.

- Ms 10 — Employed by St Andrews Hospital and at the material time was a clinical lead and is a registered nurse. She had a professional relationship with Mr Brennan.

- Colleague U — Employed by Mill Lodge as bank staff. At the material time she was working as a support worker.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor. It considered the witness statements, documentary evidence provided by the NMC, the oral evidence from witnesses called by the NMC and the response to these allegations given by Mr Brennan during his employer's investigation proceedings and his written response to the NMC.

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

Charge 1

> "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"

This charge is found PROVED.

In reaching this decision, the panel took into account Ms 10's evidence.

In Ms 10's NMC witness statement, she stated *"…during the hearing on 21 December 2017 John explained that he had completed a seclusion pack at the original time of the seclusion and I have seen no evidence to refute that. This pack was lost or misplaced by the ward following the seclusion. It is stated in the investigation report … that John had admitted during the interview on 2 November 2017… that he had completed a seclusion document in October 2017 for the seclusion incident that he was involved in on the 18 September 2017."*

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 2 November 2017 at which Mr Brennan was in attendance. The panel noted that Mr Brennan said during this interview, *"I was asked to update a document I originally wrote. I was responsible and present at the time… I'm unaware if the Rio document was added in hindsight."*

The panel considered the Disciplinary Investigation Report dated 27 November 2017 which states:

> *"JB admitted during the interview, on the 2nd November 2017, that he had completed a seclusion document, in October, for the seclusion incident that*

he was involved in on the 18 September. He describes this as being at the request of his manager(…), who gave him a blank seclusion pack for completion, due to information being missing.

…

JB completed the seclusion paperwork retrospectively and back dated this to 18th September, using incorrect information form a seclusion on 19th September including the datix number."

The panel considered the evidence before it and found that Mr Brennan had retrospectively completed a seclusion pack for a seclusion that commenced on 18 September 2017. The panel therefore found this charge proved.

Charge 2

"That you, a registered nurse, whilst employed at St Andrew's Healthcare on Pritchard Ward around 10 October 2017;

2) Did not document that the seclusion pack had been recorded retrospectively."

This charge is found PROVED.

In reaching this decision, the panel took into account Ms 10's evidence.

The panel noted that Ms 10's NMC witness statement, states *"…nowhere on the … seclusion documentation had John recorded clearly that it had been completed retrospectively, and therefore I found that this was falsification of seclusion records in breach of St Andrew's policies and NMC Code of Practice around record keeping."*

The panel took into consideration the Disciplinary Investigation Report dated 27 November 2017 which states: *"JB completed the seclusion paperwork retrospectively and back dated this to 18th September, using incorrect information from a seclusion on 19th September including the datix number."*

In light of this, the panel found that Mr Brennan did not document that the seclusion pack had been recorded retrospectively and found this charge proved.

Charge 3

> "That you, a registered nurse, whilst employed at St Andrew's Healthcare on Pritchard Ward around 10 October 2017;
>
> 3) Recorded an incorrect Datix number in the seclusion pack."

This charge is found PROVED.

In reaching this decision, the panel took into account Ms 10's documentary evidence.

The panel considered the Formal Investigation Interview Meeting Notes dated 2 November 2017. The panel noted that Mr Brennan accepted during this interview that he completed and signed the seclusion pack dated 18 September and that the Datix number was "*A mistake*".

On this basis, the panel found that Mr Brennan had recorded an incorrect Datix number in the seclusion pack and found this charge proved.

Charge 4

> "That you, a registered nurse, whilst employed at St Andrew's Healthcare on Pritchard Ward around 10 October 2017;

4) Recorded an incorrect date for the seclusion."

This charge is found PROVED.

In reaching this decision, the panel took into account the documentary evidence of Ms 10.

The panel considered the Formal Investigation Interview Meeting Notes dated 2 November 2017. The panel bore in mind that Mr Brennan was "*shown the seclusion pack dated the 18th September*" and that he acknowledged during the interview *"This is the one I completed. I can see straight away I made an error – I can see I put the wrong dated. [Sic] This is the one I initiated and managed. That's my error with the wrong date."*

The panel concluded that Mr Brennan recorded an incorrect date for the seclusion and therefore found this charge proved.

Charge 5

"On or around 18 August 2018:

5) Placed Patient A into seclusion, without any clinical justification."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account documentary and oral evidence of Ms 9, Ms 1, Colleague Z, Dr 5, Ms 2 and Ms 7. The panel had regard to the responses from Mr Brennan.

The panel noted that it did not see the CCTV footage as it was not available. It was only able to consider the CCTV footage log compiled by Ms 9 and the various witness accounts of those who viewed the CCTV. It took into consideration that the CCTV footage totalled six hours across seven cameras and that Ms 9 said in her oral evidence she reviewed the

footage and typed up her notes in two hours. The panel took into consideration that the CCTV footage did not cover the patient's bedrooms or bathrooms, nor did it have any sound to accompany the footage. The CCTV also did not cover inside the seclusion room. The panel noted that Mr Brennan had been with Patient A since 7am and the CCTV footage log did not document from that time but from 07.42.22. The panel noted the entries on the CCTV footage log state at 10.11.33 *"JB goes to the door of … bedroom, patient… then approaches. JB goes into the room and patient follows"* and at 10.12.14 *"JB leaves patient … room."* The panel bore in mind the gaps in CCTV footage log. For example, it noted that the CCTV footage log had an approximately 15-minute unexplained gap between 10.14 and 10.31 where nothing has been documented. The panel was of the view that it could not tell what happened in this time. The panel also considered the quality of the CCTV footage which witnesses had described as grainy but that individuals could be identified.

The panel had regard to the Rio entry, entered by Mr Brennan on 18 August 2018 and updated on 19 August 2018. It stated *"… awoke this morning for medication and appeared slightly agitated although not to the degree that required further intervention. He later then became very psychotic and began to kick doors and punch windows. he requested staff to open the bathroom door. He came out with his head and hair wet which appeared unusual. He then approached me in a threatening manner and stated you better get me out now. I asked him to come to low stim with me which he refused. I then got the assistance of staff and walked around with him. Considering how he was presenting I asked him to sit on the mattress in the seclusion room… did not comply and came towards me again in a threatening manner. I then made the decision to seclude…"* The panel noted that this was a contemporaneous record.

Colleague Z stated in her evidence that she was working in the office at the time of incident described in the charge and was called on by Mr Brennan later on. In her NMC statement she stated, *"On or around 18 August 2018 I believe I was in the office when John told me to take Patient A to the low stimulation seclusion area…".* The panel bore in mind the evidence of Ms 1 and Ms 7 who had described the layout of the ward and it

acknowledged that Colleague Z may not have seen Patient A's presentation and any interaction between him and Mr Brennan, given Colleague Z's location on the ward.

The panel considered the evidence of Ms 1. In her NMC witness statement she stated *"[Colleague Z] told me that the registrant had secluded Patient A and that she had concerns about the registrant's handling of the patient and also the registrant's handling of her at the time. [Colleague Z] advised that the registrant was saying things about her questioning his decision and that's when she started telling me about the seclusion. Initially, it wasn't presented to me as someone raising concerns about the seclusion, her concern seemed to be more that the registrant had threatened [Colleague Z] with coming to me to report her for questioning his authority."*

The panel considered the evidence of Ms 2. In her NMC witness statement, she stated "*I was in the corridor when the patient, Patient A, was walking around and kicking doors. From the time we started the shift in the morning, Patient A was unsettled and was kicking walls he was in the bedroom corridor and I was in the bedroom corridor. Patient A was not an easy patient, he had attacked many staff before.*" The panel noted that in Ms 2's oral evidence she said Colleague Z could not see the corridor and did not see that Patient A was agitated.

The panel considered the evidence of Dr 5. In her NMC witness statement she stated, *"I was asked to review the CCTV footage regarding the incident on 18 August 2018…I will confirm that I was only asked to observe and didn't have the benefit of audio. The patient may have been threatening but I couldn't hear it… From the CCTV you could see, for example, the Patient A mouth move but I couldn't tell what he was saying. There was no extreme behaviour as it would be quite obvious physical behaviours that you could see on the camera footage (if it wasn't audio)… from what I observed he was quite amenable to being lead."* On the Formal Witness Interview Meeting Notes dated 28 September 2018, when asked if whether there was behaviour that warrants being put in seclusion, Dr 5 states, *"No, but I don't see the antecedents or what happened in the lounge. I don't know what happened in the lounge, and what was said. That looked very amicable to me…*

When psychotic, he appears to be perplexed, restless and pacing up and down, clutching head and sometimes displaying aggressive behaviour such as kicking and punching".

The panel had regard to the evidence of Ms 7. In her NMC witness statement, she stated *"The doctor noted that the patient had been aggressive to the registrant in the past and so a verbal indicator might have been sufficient for the registrant to think that seclusion was the required option."* In the Disciplinary Investigation report, dated 24 October 2018 and exhibited by Ms 7, it states *"[Dr 5] is an Associate Specialist Doctor who works on Prichard ward with Patient A and therefore has a good knowledge background of his mental state… Having reviewed the CCTV she confirmed she could see no visual evidence that warranted Patient A being secluded. She felt Patient A presented slight agitation, which at most would warrant pm medication to be offered as well as some time in the quiet room / low stim area. She didn't feel that seclusion was necessary from what she could see. She stated she couldn't comment on what comments or threats may have been made by Patient A or how they could have been interpreted by staff."*

The panel considered Mr Brennan's account of this incident as detailed in the Regulatory Concerns Response Form dated, 5 October 2019. He said *"Soon after and again I was standing at the top of the corridor the service user came out of the bathroom and approached me. He came close to me and said in an agitated "get me of this ward now" [sic] He appeared dishevelled and his head/hair was very wet. I could see that he was very psychotic and agitated so I decided to manage this. I discreetly walked away from the service user into the office and communicated with a [Colleague Z] who was on the computer. I stated to her that I needed her assistance now. I then returned to the service user."*

The panel considered the evidence regarding Mr Brennan's MAPA status at the material time. It noted that Ms 1 in her NMC witness statement stated, *"On 19 July 2018 there was an incident involving Patient A and the registrant. The registrant went on a period of absence after this as he had damaged his intercostal muscles causing him significant pain when breathing and moving. His GP had prescribed pain medication and advised recovery*

could take between four and six weeks… I met with the registrant on his return to work and he told me that he had been de-escalating and trying to administer inter-muscular medication… at which point Patient A became very resistive… I can't recall if we had the occupational health report back but if I recall correctly he was deemed to be non-MAPA…If someone is non-MAPA then they shouldn't be engaging in any physical elements of management of aggression…I can't remember exactly but I am pretty certain that, at the time of the August incident, the registrant was still non-MAPA because the incident occurred within 4-6 weeks of his return to work."

It noted that in Mr Brennan's written response to the NMC, he stated *"Due to my experience in general and my rapport with this service user I was able to utilise me[sic] skills to be able to manage this. On each occasion the service user would laugh and apologise. Once we arrived at the shop he was interacting with the person behind the counter making purchases. I assisted him with this meaning I was standing beside him. He then attempted to punch me in the side of the head. I gestured and motioned in order to avoid this. Again he smiled and apologised… On the morning of the event I was still on restricted duty."*

The panel was of the view that the NMC had not sufficiently discharged the burden of proof in respect of this charge. The panel took into consideration that the individuals who had reviewed the CCTV footage did not see anything which justified Patient A's seclusion however the panel bore in mind that the CCTV footage did not cover the bedroom or bathroom and did not have any sound. The panel also was aware that the witnesses did not view the CCTV in its entirety for example Dr 5 said that she only saw two brief clips of the CCTV footage. The panel noted that the CCTV footage log did capture one kick from the patient in the corridor. The panel also considered that Colleague Z was not in a position to see the incident as described in the charge as she was in the office, but that Ms 2 heard the patient banging and kicking.

The panel bore in mind that Mr Brennan's prior interactions with Patient A may have had an impact on Mr Brennan's decision to place Patient A in seclusion. However the panel

was of the view that despite the previous injury sustained by Mr Brennan due to Patient A's aggressive past behaviour towards him, this by itself did not justify placing Patient A into seclusion.

However, the panel noted the verbal indicator, *"you better get me out now",* from Patient A which Mr Brennan recorded in the Rio entry. Mr Brennan subsequently considered it appropriate to place Patient A in seclusion due to his threatening approach. Due to Patient A's verbal indicators and behaviour in the bedroom on this particular occasion the panel was of the view that Mr Brennan did have clinical justification to place Patient A into seclusion. The panel therefore found this charge not proved.

Charge 6

"On or around 18 August 2018:

6) Did not employ any de-escalation techniques prior to placing Patient A into seclusion."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the documentary evidence of Ms 1 and Mr Brennan's written responses to the NMC.

The panel had regard to the Rio entry completed by Mr Brennan on 18 August 2018, which states *"I asked him to come to low stim with me which he refused. I then got the assistance of staff and walked around with him. Considering how he was presenting I asked him to sit on the mattress in the seclusion room so I could assist him with his current issues that would make it safe for both him and the staff that were assisting him. [The patient] did not comply and came towards me again in a threatening manner. I then made the decision to seclude at 10;45am."*

The panel considered Mr Brennan's completed Regulatory Concerns Response Form dated 5 October 2019. He stated *"As I was walking around to the back I noticed that the staff member and service user were not following. I then returned and communicated the same instructions to the staff member. On this second occasion the service user to comply. I enter the area of safety and opened up the seclusion room door. As the patient entered the area he was walking towards me. He then walked by me and entered the seclusion room. the assisting member of staff was still protesting and questions my decisions although I continued to focus on the service user. The service user stood in the room and there was a mattress behind him. I communicated with the service user to take a seat on the mattress. He initially did not but with ongoing encouragement he eventually sat down. I thanked the service user for working with us. The service user then stood up and again I communicated with him to take a seat. He then turned and began to come towards me with agitated expression. I then made the decision to close the door."*

The panel had regard to the CCTV notes made by Ms 9. It bore in mind that the CCTV footage viewed by Ms 9 did not show the inside of the seclusion room and did not have any audio so she would not be able to discern what Mr Brennan and Patient A spoke about. The panel noted that there was a 17-minute gap on the CCTV notes which was not accounted for.

The panel considered all the evidence before it. It noted that Mr Brennan asked Patient A if he wanted to go to 'low stim', walked with Patient A to the seclusion room and asked Patient A to sit on the mattress in the seclusion room. The panel noted that Patient A appeared to reluctantly and momentarily comply when he reached the seclusion room but that this adherence to Mr Brennan's instructions did not continue and when Patient A approached him, he closed the door which started Patient A's seclusion. For all the above reasons the panel was of the view that Mr Brennan had employed some de-escalation techniques prior to placing Patient A into seclusion. The panel therefore did not find this charged proved on the balance of probabilities.

Charge 7

"On or around 18 August 2018:

7) Administered Olanzapine to Patient A without any clinical justification."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Witness 1 and Dr 5.

The panel took into consideration the NMC witness statement of Ms 1 where she stated, "*What concerned me about the medication was that, the patient already appeared to have been secluded without warrant and if you're tranquillising a patient that is already calm then that is essentially chemical restraint. Added to that, the patient might well be distressed because they are in unwarranted seclusion and that is totally legitimate. I believe the patient was given Olanzapine".*

The panel had regard to the Rio entry completed by Mr Brennan on 18 August 2018, which stated *"While in seclusion several interventions were used to minimise the length of time the seclusion would continue for. He was given co co-odmal [sic] and olanzapine followed by 2 cups of hot chocolate and a meal."*

The panel considered the Formal Witness Interview Meeting Notes dated 28 September 2018 conducted by St Andrews. During this interview, Dr 5 said *"If they have prn we go with the least strength. With [Patient A] when he is unwell and responding to psychotic symptoms we give the anti-psychotic medication. With [Patient A] even if he is desperate and not slept for many hours, he will insist that he has the Promethazine however he needs the anti-psychotic medication. If he is desperate he sometimes accepts Olanzapine sometime later."*

The panel considered Dr 5's NMC witness statement, which stated *"If you as a nurse see a patient becoming agitated and you see the warning signs then you might have a conversation and see if they might want to. It would be appropriate to offer PRN in this instance."*

The panel bore in mind that Mr Brennan stated that Patient A was asked to sit on the mattress but instead of complying, Patient A approached Mr Brennan appearing agitated and threatening. The panel noted that Patient A was in seclusion when he was offered Olanzapine as he did not appear to be settling. The panel noted that Patient A remained unsettled during his time in seclusion, and it was of the view that by administering Olanzapine to Patient A, this would minimise the time that Patient A spent in seclusion which it determined was a clinical judgement. The panel therefore found this charge not proved.

Charges 8a and 8b

"On or around 18 August 2018:

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."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1, the documentary evidence of Ms 7 and Ms 9.

The panel considered Ms 1's NMC witness statement. She stated *"I can't recall if we had the occupational health report back but if I recall correctly, he was deemed to be non-*

MAPA (management and prevention of aggression). MAPA is a course which all staff working for St Andrews have to do. It covers de-escalation and gives staff tools to use if physical intervention is required. If someone is non-MAPA then they shouldn't be engaging in any physical elements of management of aggression. We would usually advise that a member of staff who is non-MAPA is not directly involved in any situation which could escalate. Essentially the rule would be not to put yourself at any risk unless absolutely necessary. I can't remember exactly but I am pretty certain that, at the time of the August incident, the registrant was still non-MAPA because the incident occurred within 4-6 weeks of his return to work."

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance and was conducted by his employers at St Andrews. During this interview Mr Brennan accepted that he was non-MAPA as a result of an injury two weeks prior to this incident. He said *"Obviiuosly [sic] discussed with my manager and id say for the first week or whatever I had to stay in the office… And then I report that … I felt safe enough to be in the clincal area but obviously not get involved in restraining you know … but I could still obviously verbally de-escalate but certaintily not get involved in restraint."*

The panel next considered the CCTV Notes for 18 August 2018 complied by Ms 9. It noted the entry made at 12:19:00 states, *"JB opens the seclusion room door and appears to go inside. Another staff member waits by the door"* and the entry at 12:21:41, states *"JB returns and checks through the seclusion door window. JB opens the door and stands in the doorway. JB appears to the [sic] enter the room and at 12:21:57 another staff member then comes to stand by the door."* The entry at 12:23:06 states, *"JB leaves the seclusion room and closes the door. JB leaves the observation corridor."* It also noted that the entry at 12:43:24 states *"JB returned to the ward carrying food. JB carried the food to the observation corridor and to the room where [Patient A] is secluded. JB opens the door and appears to go inside whilst another member of staff waits by the door"*. Further the panel bore in mind the entry at 12.47.35, which states, *"JB leaves the office and goes to the*

room where [Patient A] is secluded. JB opens the door and appears to go inside. No other staff member is present."

The panel considered the evidence before it and it determined that Mr Brennan was non-MAPA on or around 18 August 2018.

In respect of Charge 8a, the panel was satisfied based on the evidence outlined above that Mr Brennan had on one or more occasion entered the seclusion area whilst being designated on a non-MAPA period. The panel therefore found this charge 8a proved.

In respect of charge 8b, the panel was satisfied based on the evidence outlined above that Mr Brennan had on one or more occasion entered the seclusion area alone or without another member of staff present. The panel therefore found this charge 8b proved.

Charges 9a, 9b and 9c

> "On or around 18 August 2018:
>
> 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."

These charges are found PROVED.

In reaching this decision, the panel took into account the documentary evidence of Ms 7.

The panel considered the Administration Record Co-Codamol dated between 17 August 2018 and 24 August 2018 for Patient A. It bore in mind that the record stated that *'2*

tablets oral When Required Up to every 4 Hours, Maximum 8 tablet in 24 hours'. It also noted the entry on 18 August 2018 at 12.20 was entered by a nurse with the initials *'SM'* which confirms the time, dosage and route of administration of Co-Codamol to Patient A on the EMAS system by another nurse. In light of this, the panel found charges 9a, 9b and 9c proved.

Charges 10a, 10b and 10c

> "On or around 18 August 2018:
>
> 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."

These charges are found PROVED.

In reaching this decision, the panel took into account the documentary evidence of Ms 7.

The panel considered the EMAS Administration Record for Olanzapine dated between 25 July 2018 and 11 September 2018 for Patient A. It bore in mind that the record stated *'Olanzapine PO/IM, 5mg -10mg, 6 hourly, Max 10mg/24hours'*, however it noted that there were no entries on or around 18 August 2018 to record the timing, dosage and route of administration for Olanzapine in the EMAS system. The panel therefore found charges 10a, 10b and 10c proved.

Charges 11a, 11b and 11c

> "On or around 18 August 2018:

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."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 7 and Ms 9.

The panel considered Ms 7's NMC witness statement. She stated *"Firstly with the keys. On the CCTV you could see the registrant clearly walking around with the medication keys in his hand. These keys should be attached to a belt by a piece of fabric which is not easily broken and there's a pocket on the belt which the keys can be put into so they aren't hanging down."*

The panel considered Ms 9's NMC witness statement. She stated *"I observed at around 10.08am that the medication keys weren't attached to Mr Brennan's belt. He was holding these in his hand."*

The panel also considered Ms 9's CCTV Notes for 18 August 2018. It noted the entry made at 10:08:13 that states, *"JB leaves the office and enters the clinic room; his medication keys are detached from his belt and the chain can be seen handing loosely."*

The panel noted that Mr Brennan did not make a response to this charge in his regulatory concerns response form. However, it noted that Ms 7 stated in her NMC statement that *"When the registrant watched the CCTV with us, he admitted that the keys weren't attached and should have been."*

The panel considered the evidence before it. The panel was satisfied that on or around 18 August 2018, Mr Brennan did not secure the clinic/medication keys by walking around with

the keys in his hand, he did not attach the keys to a designated belt or key ring and did not keep the keys in a designated pocket. The panel therefore found charges 11a, 11b and 11c proved.

Charge 12

> "On or around 18 August 2018:
>
> 12) After dispensing medication to Patient A, left Patient A alone with the medication/in possession of the medication"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 7 and Ms 9.

The panel considered Ms 9's CCTV Notes for 18 August 2018. It noted the entry made at 09:59:13 states, *"The same patient reappears with medication."* The next entry at 09:59:20 states, *"JB leaves the clinic carrying a water bottle and enters the office, leaving the patient in the corridor with the medication. The patient wanders into the day area then returns to the corridor to watch JB in the office."*

The panel also considered the NMC witness statement of Ms 7. She stated *"Also on the CCTV was where we saw that the registrant gave Patient A the medication and then went to another area of the ward to get Patient A a drink. The patient could have done anything with the medication in that time. The registrant didn't have sight of the patient, he was in a completely different room. The medication policy clearly states this isn't correct and the registrant would know this. Medication could have been given to another patient (medication can often be used as currency in these types of wards unfortunately) and it could have been contrary to the other patient's medication. Or Patient A could have just not taken medication he had been prescribed and we'd have had no idea."*

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance and was conducted by his employer St Andrews. During the interview, when asked if he would ever leave a patient with medication, Mr Brennan said *"… as I said that morning when, when I asked a question about the medication … that may have happened yeah."*

The panel considered the evidence before it. The panel determined that on or around 18 August 2018, after dispensing medication to Patient A, Mr Brennan left Patient A alone with the medication/in Patient A's possession of the medication. The panel therefore found this charge proved.

Charge 13

> "On or around 18 August 2018:
>
> 13) On one or more occasion left Patient A alone/unattended/unobserved, during Patient A's seclusion period."

This charge is found PROVED.

In reaching this decision, the panel took into account of the evidence from Ms 7, Ms 2 and Ms 1.

The panel considered Ms 7's NMC witness statement. She stated *"Whilst Patient A was in seclusion we noted that on the CCTV you could see that Patient A was left alone by the registrant on multiple occasions. The seclusion policy states that patients should <u>always</u> be observed."*

The panel had regard to St Andrews's Seclusion Policy, dated May 2018. It states:

"Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others [Code of Practice 26.103].

If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded [Code of Practice 26.104]."

The panel noted that between 10:45 until 12:45, appropriate observations were made by Ms 2 of Patient A. The panel noted that Patient A was in the observation corridor between 12:45 to 13.37pm and that there were no observations made of Patient A during this time. The panel had regard to Ms 7's oral evidence who stated that the observation corridor was secured by locked doors and that Patient A being in this area was considered to be continued seclusion. Ms 1 confirmed this in her oral evidence.

The panel bore in mind that Patient A was not left unattended the whole of the time that he was in seclusion however whilst Patient A was in the observation corridor there were times that he was not appropriately observed as outlined in the seclusion policy. The panel determined that Mr Brennan had on one or more occasion left Patient A alone/unattended/unobserved, during Patient A's seclusion period. It therefore found this charge proved.

Charge 14

"On or around 18 August 2018:

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 7 and Ms 9.

The panel considered the CCTV Notes for 18 August 2018 compiled and exhibited by Ms 9. It noted the entry made at 09:59:20 which states *"JB leaves the clinic carrying a water bottle and enters the office, leaving the patient in the corridor with the medication. The patient wanders into the day area then returns to the corridor to watch JB in the office."* Then at 10:00:01, it states *"JB leaves the office with a cup for a patient, which he passes to him. The patient can be seen tilting his head back with the cup in his hand. The cup is then passed back to JB who is standing with the patient, he then takes the cup away and goes back to the clinic room leaving the door open. The door to the day area is open at this point."* The next entry at 10:03:34 states *"JB leaves the clinic room, pushing the door closed and enters the day space".*

The panel took into account the Disciplinary Report dated 24 October 2018, completed by St Andrews, which states, *"The CCTV shows that at 1001a.m. JB opens the clinic door and then distributes medication to a patient with the clinic door open and the door to the main ward. JB then goes to get a drink for the patient, securing the clinic door, however leaves the patient with the medication untaken. The Medication Policy 5.4 states: Medicines must never be left in a patient or public area or transported around public patient areas unless in a suitable locked container. JB acknowledged in investigation meeting that the clinic door should be closed when administering medication."*

The panel noted that in Mr Brennan's Regulatory concerns response form, he stated that he *"cannot comment on this allegation at present".*

The panel acknowledged that the door was left open at around 10:01 a.m. and the clinic door was not secured at this time. The panel therefore found this charge proved.

Charge 15a

"On or around 18 August 2018:

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

a) Patient A kicked and punched doors/windows prior to his seclusion.

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1, Ms 2, Ms 7 and Colleague Z. It also noted Mr Brennan's written responses to the NMC.

The panel had regard to the Rio entry, entered by Mr Brennan on 18 August 2018 and updated on 19 August 2018. It stated, *"He later then became very psychotic and began to kick doors and punch windows."* The panel noted that this was a contemporaneous record.

The panel was informed by Ms 1 in her oral evidence that the CCTV does not cover the patient's bedrooms. The panel took into consideration that Mr Brennan could see things that were not captured by the CCTV footage and that Patient A may have kicked and punched doors/windows prior to his seclusion in his room.

The panel considered the Formal Witness Interview on 31 August 2018 between Ms 2 and Ms 7, conducted by St Andrews. It noted Ms 2 said in relation to her observations of Patient A that she made an entry *"Every 15 minutes. As soon as we put him inside I write it down straight away. Was upset from going into seclusion. He was walking around the room kicking the wall and floors. He was doing the same before he was in seclusion; he was walking around kicking and thumping the doors."*

The panel considered the local statement of Ms 1 dated 23 August 2018 which outlines a conversation she had with Colleague Z. Ms 1 indicates that Colleague Z read the Rio entry

entered by Mr Brennan dated 18 August 2018. Within Ms 1's local statement there is a comment from Colleague Z regarding the Rio entry stating that she *"wasn't aware of this happening"* in respect of *"[Patient A] awoke this morning for medication and appeared slightly agitated although not to the degree that required further intervention. He later then became very psychotic and began to kick doors and punch windows."* The panel took into consideration that Colleague Z was in the office prior to Patient A's seclusion when he had been kicking and punching doors/windows. The panel bore in mind that Colleague Z said in her oral evidence that she would have been able to hear the noise from this incident. The panel considered the topography of the ward and it was of the view that Colleague Z would have been unlikely to hear the activity from the office.

The panel considered the NMC witness statement of Ms 1. She stated, *"There had been a description in the RIO about the patient escalating prior to the seclusion and we were trying to see if that was what happened. The only thing I saw on the CCTV – we have radiators which are boxed in (because of the nature of the ward) – was the patient coming out of his room with some towels, walking to the top of the corridor, putting the towels on the floor and then kicking the radiator cover. There didn't seem to be any force involved in the kick."* The panel took into account that Ms 1 appeared to base her observations on the CCTV footage.

The panel considered its observations outlined at charge 5, in respect of the CCTV footage. The panel bore in mind that the witnesses who viewed or sampled the CCTV and referred to it in their evidence in respect of this charge did not have the benefit of the accompanying audio to go along with the CCTV footage.

The panel bore in mind Mr Brennan's response in respect of this charge. He stated *"At approximately 10:15 am I noticed the service user pacing the corridor and looking slightly agitated. He then went into the bathroom and appeared that he was attending to his self-care. Soon after and again I was standing at the top of the corridor the service user came out of the bathroom and approached me. He came close to me and said in an agitated "get me of this ward now" [sic] He appeared dishevelled and his head/hair was very wet."*

The panel considered the evidence before it and for all the above reasons the panel was of the view that the NMC failed to prove that this was an inaccurate record of what happened in the circumstances. The panel therefore found this charge not proved.

Charge 15b

"On or around 18 August 2018:

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

b) Patient A approached you in a threatening manner prior to his seclusion."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1 and the responses from Mr Brennan in respect of this charge.

The panel had regard to the Rio entry, entered by Mr Brennan on 18 August 2018 and updated on 19 August 2018. It stated, *"He then approached me in a threatening manner and stated you better get me out now."* The panel noted that this was a contemporaneous record.

The panel was informed by Ms 1 in her oral evidence that the CCTV does not cover the patient's bedrooms. The panel took into consideration that Mr Brennan could see things that were not captured by the CCTV footage as they were in Patient A's bedroom. The panel also took into consideration the gaps in the CCTV footage notes, and also that there was no audio recording on the CCTV footage.

The panel bore in mind Mr Brennan's response in respect of this charge. He stated *"At approximately 10:15 am I noticed the service user pacing the corridor and looking slightly*

agitated. He then went into the bathroom and appeared that he was attending to his self-care. Soon after and again I was standing at the top of the corridor the service user came out of the bathroom and approached me. He came close to me and said in an agitated "get me of this ward now" [sic] He appeared dishevelled and his head/hair was very wet."

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance and conducted by his employer, St Andrews. During the interview Mr Brennan said *"…when he came out of the bathroom his hair was wet and his face was wet and he looked again what I would say very psychotic in his presentation. So much so that he looked at me in a very threatening way and he said to me "get me off this ward now" and I thought well I'll have to obviously evaluate this and decide what to do with this. So I asked him to come around the back and he refused and most of the time when he's mildly or moderately psychotic he would come but in this case he was not coming he was refusing."*

The panel considered the evidence before it and noted that Mr Brennan had been consistent in his accounts. The panel determined that on the balance of probabilities Mr Brennan had not inaccurately recorded in Patient A's Rio notes that Patient A had approached him in a threatening manner prior to his seclusion. The panel therefore found this charge not proved.

Charge 15c

"On or around 18 August 2018:

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

c) You walked around with Patient A prior to his seclusion"

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1, Ms 9, and Mr Brennan's responses in respect of this charge.

The panel had regard to the Rio entry, entered by Mr Brennan on 18 August 2018 and updated on 19 August 2018. It stated, *"I asked him to come to low stim with me which he refused. I then got the assistance of staff and walked around with him."* The panel noted that this was a contemporaneous record which was made at the material time.

The panel bore in mind Mr Brennan's response in respect of this charge. He stated *"As I was walking around to the back I noticed that the staff member and service user were not following. I then returned and communicated the same instructions to the staff member. On this second occasion the service user to comply."*

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance and conducted by his employer, St Andrews. During the interview Mr Brennan said *"So I asked him to come around the back and he refused most of the time when he's mildly or moderately psychotic he would come but in this case he was not coming he was refusing. Again I initiated him to come round the back and I initiate the assistance of [Colleague Z]… To Assist me with this… so when I went round to low stim I opened both doors to give myself options as to what I might do. So when he walked around he was still looking at me and walking towards me…"*

The panel considered its observations outlined at charge 5, in respect of the CCTV footage. The panel bore in mind the gaps in the CCTV notes exhibited by Ms 9 and that the CCTV footage had no audio to make out what was being said. It noted that individuals could be recognised on the CCTV footage despite its grainy quality.

The panel was of the view that Mr Brennan was consistent in the various accounts he gave of this incident namely that he walked around with Patient A who demonstrated

threatening behaviour in his facial expressions and what he said to Mr Brennan. On this basis, the panel found this charge not proved.

Charge 15d

> "On or around 18 August 2018:
>
> 15) Inaccurately recorded in Patient A's Rio notes that;
>
> d) Patient A required more than one member of staff to assist him to the seclusion area."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1 and Ms 9.

The panel had regard to the Rio entry, entered by Mr Brennan on 18 August 2018 and updated on 19 August 2018. It stated, *"I asked him to come to low stim with me which he refused. I then got the assistance of staff and walked around with him."* The panel noted that this was a contemporaneous record.

The panel considered the local statement of Ms 1 dated 23 August 2018 which outlines a conversation she had with Colleague Z. Ms 1 indicates that Colleague Z read the Rio entry entered by Mr Brennan dated 18 August 2018. Within Ms 1's local statement there is a handwritten comment from Colleague Z regarding the Rio entry stating that she *"walked on my own. didn't need 2. No de-escalation going on. given instruction to sit"* in respect of *"I then got the assistance of staff and walked around with him"* on Mr Brennan's Rio entry.

The panel considered its observations outlined at charge 5, in respect of the CCTV footage and the CCTV Notes for 18 August 2018 complied by Ms 9. It noted the entries on the CCTV notes at 10.45.25 which states *"Patient enters the corridor. JB is close behind.*

JB then leaves the view of the CCTV and … walks down the bedroom corridor" and at 10.47.35, it states *"JB opens the door to the seclusion room in the observation corridor*". The panel noted that for a couple seconds Mr Brennan was the only staff member present with Patient A and at times, he was in the vicinity of Patient A and Colleague Z rather than being alongside them. The panel considered the wording used in the CCTV notes of *"close behind"* and noted that from the topography of the ward, that Mr Brennan would need to get in front of Patient A to open the door to the seclusion room which he did.

The panel considered the evidence before it and accepted that Mr Brennan sought help from another colleague to take Patient A to the seclusion area. It noted that Mr Brennan was non-MAPA (as outlined in charge 5) and was in the vicinity / close proximity to Patient A and his colleague as they walked around to the seclusion room. The panel therefore found this charge not proved.

Charge 15e

> "On or around 18 August 2018:
>
> 15) Inaccurately recorded in Patient A's Rio notes that;
>
> e) That Patient came towards you in a threatening manner in the seclusion room."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1 and it considered the evidence outlined at charge 5 in respect of Mr Brennan's MAPA status and its observations of the CCTV footage.

It also considered the Rio entry, made by Mr Brennan on 18 August 2018 and updated on 19 August 2018. It stated, *"[Patient A] did not comply and came towards me again in a*

threatening manner. I then made the decision to seclude at 10.45am." The panel noted that this was a contemporaneous record.

The panel had regard to evidence outlined at charge 15c in respect of Ms 1's local statement dated 23 August 2018 which outlines a conversation she had with Colleague Z and the handwritten comments from Colleague Z regarding Mr Brennan's Rio entry.

The panel bore in mind the gaps in the CCTV notes exhibited by Ms 9 and that the CCTV footage in the seclusion room was not recordable. The panel accepted the evidence of Mr Brennan and found that Mr Brennan did not inaccurately record that Patient A came towards him in a threatening manner in the seclusion room on the Rio entry. The panel therefore found this charge not proved.

Charge 15f

> "On or around 18 August 2018:
>
> 15) Inaccurately recorded in Patient A's Rio notes that;
>
> f) That several interventions were used to minimise the time of seclusion/de-escalate Patient A's behaviour."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 9, Ms 2, and the documentary evidence of Ms 7. The panel also considered Mr Brennan's responses to the NMC.

The panel considered its observations outlined at charge 5, in respect of the CCTV notes exhibited by Ms 9. It bore in mind that the CCTV in the seclusion room is not recorded and that it was not part of the footage reviewed by Ms 9. The panel considered the entry on Ms

9's CCTV notes at 11.00.56 that *"JB enters the observation corridor and checks through seclusion room window. JB along with another member of staff appear to have a conversation with [redacted] through the door".* At the entry of 11.35.04 the CCTV notes state *"JB enters the observation corridor and goes into a room"*. It noted the entry at 11.46.22 states *"JB enters the observation corridor with item from [redacted] room and enters the seclusion room. JB leaves the item and closes the seclusion room door. JB then leaves the observation corridor."* It noted at 12.09.24, the CCTV notes state *"JB opens the seclusion room door and stands in the doorway."* The panel also considered entry 12.43.24 of the CCTV notes which state *"JB returned to the ward carrying food. JB carried the food to the observation corridor and to the room where [redacted] is secluded. JB opens the door and appears to go inside whilst another member of staff waits by the door".*

The panel considered the evidence of Ms 2. In her NMC witness statement, she stated *"I do recall the registrant giving Patient A medication. I was stood with the registrant when he gave the patient medication. I do not know what the medication was. I recall the registrant asking the patient whether he had taken the tablets I did not see the patient taking them."* In her documentary evidence, she exhibited the Seclusion Observation Record for Patient A with entries dated *'18/08/18'*. The panel noted the entry at 12.45 which states *"having food and walking around".* Ms 2 also exhibited the Food and Fluid Intake Chart for Patient A with entries dated *'18/08/18'*. The panel noted the entry at 11.15, states *'cup of water - taken'*, the entry at 12.15 states *'hot chocolate - taken'* and the entry at 12.30 states *'lunch and drink, blackcurrant - taken'*.

The panel had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance. During this interview Mr Brennan stated, *"And that's where I left it that … over the next 2 hours then I follow up … my care and attention to the patient who's in seclusion in regards to going out of the door speaking to the patient seeing that he was okay, did he need anything. He did say he requested 8 sachets of hot chocolate in a cup obviously I didn't give him 8 because it would be a bit impractical… so he was given a hot chocolate in regards to accessing the*

seclusion by myself, the other member of staff [Ms 2] she was there as well doing observations … to clinically justify why I'm, opening the door and speaking to this patient…" The panel noted that this interview took place approximately two weeks after the original entry was made.

The panel considered Mr Brennan's response to the regulatory concerns which he provided in 2019. He stated, *"I then proceeded with the business of addressing the service user who was in seclusion. The duty doctor arrived and communicated with me and we both communicated with the patient. Throughout the time that the service user was in seclusion I came and gave them Hot chocolate and some medication. At approximately 12.45pm I terminated the seclusion. The service user stated that he would prefer to remain in the area and not return to his bedroom at this time. I agreed with them and reiterated that if he needs me then to knock the office door."*

The panel considered the evidence before it and determined that on 18 August 2018 Mr Brennan had accurately recorded in Patient A's Rio that several interventions were used to minimise the time of seclusion/de-escalate Patient A's behaviour. The panel therefore found this charge not proved.

Charge 15g

"On or around 18 August 2018:

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

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 7 and Ms 9. It also had regard to the responses of Mr Brennan to the NMC.

The panel had regard to St Andrew's Seclusion policy, date of issue May 2018, which states:

> *"Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others [Code of Practice 26.103].*
>
> *If a patient is confined in any way that meets the definition above, even if they have agreed to or requested such confinement, they have been secluded [Code of Practice 26.104]."*

The panel had regard to Ms 9's NMC witness statement which stated *"After leaving the seclusion room, Patient A paced around the observation corridors until 1.37pm, when Mr Brennan came back to escort A to the day area. I believe that Mr Brennan had closed the door, leaving A in the observation corridor until 1.37pm, meaning that A still appeared to be de facto secluded during this time."*

The panel considered the evidence of Ms 7. In her NMC witness statement she said *"The registrant's reports on both RIO and Datix … reported that seclusion was ended at 12.45pm and it appears that the registrant (on the CCTV footage) appears to allow Patient A out of the seclusion room at 12.45 but then the registrant took Patient A o [sic] the de-escalation room to talk to him and then left the patient locked in the de-escalation/seclusion area which is locked and separate from the ward… In respect of leaving the patient, the registrant didn't agree that he had left the patient in any area by himself at any point. The registrant didn't agree that Patient A was still in seclusion, it was clear that the registrant didn't understand the policy around that. The registrant had very clearly been in other areas when the patient was still in seclusion because I had seen that on the CCTV, but he denied that that [sic] was what had happened."*

Further, the panel noted that in Ms 7's oral evidence she said that Patient A was still in seclusion when he was in the observation corridor as that was a locked area, and she denied that Patient A's seclusion was terminated when he was no longer being observed.

The panel considered Mr Brennan's response to the regulatory concerns which he provided in 2019. He stated, *"At approximately 12.45pm I terminated the seclusion. The service user stated that he would prefer to remain in the area and not return to his bedroom at this time. I agreed with them and reiterated that if he needs me then to knock the office door. From memory I believe that the service user returned to their bedroom at 13:45 and a significant part of the rest of my day on the ward was devoted to him."*

The panel considered the evidence before it. It noted that Mr Brennan indicated that Patient A's seclusion ended at *'approximately 12.45pm'*. The panel took into consideration that Patient A was in the observation corridor and had to knock for assistance, that meant that he was in a secure area which he was not able to leave without the support of staff and that he was isolated from others. The panel took into account that Mr Brennan did not acknowledge or address the second part of Patient A's seclusion, when the patient was in the observation corridor which was locked. The panel determined that Mr Brennan had inaccurately recorded in Patient A's Rio notes that Patient A's seclusion ended at 12.45p.m. The panel therefore found this charge proved.

Charge 16

> "16) Your actions in one or more charges 15) a, 15) b, 15) c, 15) d, 15) e, & 15) f above were dishonest in that you sought to misrepresent Patient A's presentation/the necessity to seclude Patient A."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence and not proved findings reached at charges 15) a, 15) b, 15) c, 15) d, 15) e and 15) f. In light of the panel's findings, it determined that it was not necessary to go on to consider whether Mr Brennan's actions were dishonest. It therefore found this charge not proved.

Charge 17

> "17) You actions in charge 15 g) above were dishonest in that you sought to misrepresent the period of Patient A's seclusion."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account its decision and reasons outlined at charge 15g. The panel had regard to the judgment and principles set out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords* [2017] UKSC 67.

The panel considered the Datix dated 23 July 2018, completed by Mr Brennan, which states *"Seclusion terminated at 12.45. Spent some time in the LSE and although he stated that the pain was still present I suggested that he come to Townsend as this has stabilised him in the past."*

The panel took into consideration that Mr Brennan had a genuine belief that he had ended Patient A's seclusion at approximately 12.45pm, as outlined in his regulatory concerns response form provided in 2019.

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance. During this interview Mr Brennan stated, in respect of ending Patient A's seclusion that, *"… again its based on clinical judgement and the exact time I think was 12:45… and for my past experiences he had got to a stage where he appeared stable and settled and ready to come out".*

The panel considered the evidence before it and accepted that there was no evidence to contradict that Mr Brennan did not understand that Patient A was still in seclusion when he was in the observation corridor. As a consequence, the panel was of the view that Mr Brennan did not override the seclusion policy and had not sought to dishonestly misrepresent the period of Patient A's seclusion. The panel was of the view that a reasonable person would not consider Mr Brennan's entry in relation to this charge was dishonest given his understanding of the seclusion policy. The panel therefore found this charge not proved.

Charge 18a

"18) After calling Colleague Z into the office;

a) Raised your voice/shouted at Colleague Z."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1 and Colleague Z and the documentary evidence of Ms 7.

The panel considered Ms 1's local statement made on 23 August 2018 which stated *"[Colleague Z] then stated that JB called her into the manager's office on the ward, once sat down she described how JB "lost it" – raised his voice…"* The panel considered this to be a contemporaneous note of the events that took place.

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance. During this interview Mr Brennan stated, in respect of his interaction with Colleague Z, *"I think my tone changed… Because I started telling her how dangerous the situation was she was challenging… I tried to get I made four attempts to explain and four attempts she still wasn't getting it."*

The panel considered Colleague Z's NMC witness statement. She stated, *"In his office he was shouting and pointing his finger at me."*

The panel was satisfied that on the balance of probabilities that Mr Brennan had at least raised his voice when addressing Colleague Z in the office. It therefore found this charge proved.

Charge 18b

"18)After calling Colleague Z into the office;

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1 and Colleague Z and the documentary evidence of Ms 7.

The panel considered Ms 1's local statement made on 23 August 2018 which stated *"[Colleague Z] then stated that JB called her into the manager's office on the ward, once sat down she described how JB "lost it" –… pointed his finger in her face"* The panel considered this to be a contemporaneous note of the events that took place.

The panel considered Colleague Z's NMC witness statement. She stated, *"In his office he was … pointing his finger at me."*

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance. During this interview, when Mr Brennan was asked if he gesticulated toward Colleague Z in anyway shape or form, including pointing, he said that *"I cannot remember that".* He added, *"I would have been expressive but not pointing no".*

The panel considered the Formal Witness Interview Meeting Notes dated 23 August 2018 between Colleague Z and Ms 1. In this meeting Colleague Z said, *"He was sat really close to me and pointing his finger in my face…"*. The panel noted that this interview took place soon after the incident.

The panel was of the view that Colleague Z had been specific and consistent in all of her accounts of this incident that Mr Brennan had pointed his finger in her face when she was in the office with him. The panel was satisfied on the balance of probabilities that after calling Colleague Z into the office Mr Brennan pointed his finger in Colleague Z's face. The panel therefore found this charge proved.

Charge 18c

"18) After calling Colleague Z into the office;

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1 and Colleague Z and the documentary evidence of Ms 7.

The panel considered the Formal Witness Interview Meeting Notes dated 23 August 2018 between Colleague Z and Ms 1. In this meeting Colleague Z said, *"He was sat really close to me and pointing his finger in my face and said 'don't you ever question my word ever again. We sort this out now' he said 'don't roll your eyes at me'. John was sat knee to knee with me, not touching, but uncomfortably close."* The panel noted that this interview took place soon after the incident.

The panel considered Colleague Z's NMC witness statement. She stated, *"His body language was also intimidating as he stood opposite me quite close. John was interrupting me when I tried to speak to him. At that point I felt I had to speak to someone, so I walked away, went to see [Ms 1] and reported this to her."*

The panel also had regard to the Formal Investigation Interview Meeting Notes dated 4 September 2018 at which Mr Brennan was in attendance. During the interview, Mr Brennan confirmed that he and Colleague Z were both seated when they spoke in the office. He also appeared to demonstrate the distance apart that he was sat from Colleague Z during the interview.

The panel bore in mind that Colleague Z's account had been broadly consistent in that Mr Brennan had been intimidating when he addressed her in the office. The panel was of the view that it was immaterial as to whether Mr Brennan and Colleague Z were seated or standing during this interaction. The panel determined that on the balance of probabilities after calling Colleague Z into the office, Mr Brennan sat/stood in front of Colleague Z in an intimidating manner. The panel therefore found this charge proved.

Charge 18d

"18) After calling Colleague Z into the office;

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.'*"

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Ms 1, Colleague Z and Ms 2. The panel also considered Mr Brennan's responses to the NMC.

The panel considered Ms 1's local statement made on 23 August 2018. It stated *"[Colleague Z] then stated that JB called her into the manager's office on the ward, once sat down she described how JB "lost it" –….saying "don't you ever question my authority again, if you do I will tell [Ms 1] and I will have you punished" – She stated that she had said to him "I haven't done anything" and he said "you have been talking to [Ms 2], shes told me"".* The panel considered this to be a contemporaneous note of the events that took place.

The panel considered the Formal Witness Interview Meeting Notes dated 23 August 2018 between Colleague Z and Ms 1. In this meeting Colleague Z said, *"He was sat really close to me and pointing his finger in my face and said 'don't you ever question my word ever again. We sort this out now' he said 'don't roll your eyes at me'. John was sat knee to knee with me, not touching, but uncomfortably close. I leaned away and recoiled, I was not rolling my eyes. He said 'if we don't sort this out now, I am telling [Ms 1] and I will have you punished'".* The panel noted that this interview took place five days after the incident.

The panel also considered the Formal Witness Interview Meeting Notes dated 4 October 2018. During this interview, Colleague Z said *"I came out and John said to me, "in my office now". I said "I'm coming" and he said now. He expressed this forcibly. I thought I was being told off. I sat down. That's why I went to see [Ms 1]. He said don't you ever, almost shouting, question my word again. He was so close to me and said to me, don't pull those faces, don't ever question that again… I thought he was a man out of control."*

The panel had regard to Colleague Z's NMC witness statement which stated, *"In his office he was shouting and pointing finger at me. John shouted at me: "Do not question my authority!' He also threatened me: "I will punish you!' while he spoke to me with raised voice."*

The panel considered Mr Brennan's completed Regulatory Concerns Response Form dated 5 October 2019. He stated *"The accusation made regarding speaking to a junior member of staff in an inappropriate and threatening manner is completely untrue. … I attempted on several occasion to highlight to the member of staff the gravity of how dangerous and the possibility of serious consequences that could have occurred due to her presentation during the event. As I wasn't successful in getting her to understand I chose to inform her of the option that I would pursue namely reporting her to her manager. It is contained within her statement that I said the following to her. "I will have her punished" Let me categorically state that this was at no time ever said to her. I have never uttered this words [sic] in my life time either in a professional or personal capacity."*

The panel considered the evidence before it and preferred the evidence of Colleague Z, to that of Mr Brennan's account which was not given on oath or in a signed witness statement. It noted Colleague Z had been consistent in her responses to St Andrews. On this basis, the panel determined that Mr Brennan had, after calling Colleague Z into the office, used words to the effect of *'Don't you ever question my word again', 'We sort this out now', 'Don't roll your eyes at me'* and *'I will have you punished.'* The panel therefore found charges 18d(i), 18d(ii), 18d(iii) and 18d(iv) proved.

Charge 19a

> "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."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague Y.

The panel considered the evidence of Colleague Y. In her NMC witness statement she stated *"I spoke to the registrant prior to approaching A about his leave. I told the registrant that we weren't planning on allowing A to leave the ward because of his behaviour, I explained we had concerns and no one felt comfortable taking him out. The registrant agreed with the plan, as I recall. I had a conversation with the patient and I told him that he wasn't settled so wouldn't be able to use his leave. A Senior Staff Nurse … was present for this conversation. I remember John walked into the middle of the conversation and tells [Patient A] to get ready to leave."*

The panel considered Colleague Y's oral evidence. She stated that Mr Brennan was narrow minded and dismissive of others' opinions. She said that Mr Brennan had agreed Patient A's leave with other staff but then changed his mind. The panel was of the view that Colleague Y's description of this incident was factual.

The panel considered the evidence before it and determined that on the balance of probabilities between June 2018 and September 2018 on an unknown date, Mr Brennan decided that Patient A would utilise his period of leave after agreeing with other staff members that Patient A would not be granted leave. The panel therefore found this charge proved.

Charge 19b

> "19) Between June 2018 and September 2018 on an unknown date, decided that Patient A would utilise his period of leave;
>
> b) Without conducting a comprehensive risk assessment of Patient A. After agreeing with other staff members that Patient A would not be granted leave."

This charge is found NOT PROVED.

In reaching this decision, the panel took into consideration that it did not have the risk assessment for Patient A and that it did not have any evidence to indicate that Mr Brennan needed to complete a risk assessment at all. It also noted that it had no information as to what makes a comprehensive risk assessment or what it should look like.

The panel determined that it had insufficient evidence to consider this charge and therefore found this charge not proved.

Charge 19c

> "19) Between June 2018 and September 2018 on an unknown date, decided that Patient A would utilise his period of leave;
>
> c) Without discussing the change of decision/the risk of Patient A with any other member of staff."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Colleague Y.

It noted in her NMC witness statement she said, *"I recall there being an incident with Patient A who was extremely high risk… At the time, [Patient A] was being nursed out on the ward. [Patient A] would have been allowed to go out on leave at times and it was coming up to him being scheduled to have some leave. St Andrew's has quite large grounds so leave for [Patient A] would usually be going out of the building and having a walk around the grounds. His section 17 required that he have two staff with him when he was on leave. I spoke to the registrant prior to approaching [Patient A] about his leave. I told the registrant that we weren't planning on allowing A to leave the ward because of his behaviour, I explained we had concerns and no one felt comfortable taking him out. The registrant agreed with the plan, as I recall… I had a conversation with the patient and I told him that he wasn't settled so wouldn't be able to use his leave. A Senior Staff Nurse – (Ms*

12) – was present for this conversation. I remember John walked into the middle of the conversation and tells [Patient A] to get ready to leave".

The panel considered the evidence before it and noted that whilst it had the evidence from Colleague Y, it did not have any evidence from Ms 12 about this incident to consider. The panel bore in mind that there was no evidence that Mr Brennan had or had not discussed the change of decision/the risk of Patient A with any other member of staff. The panel therefore found this charge not proved.

Charge 20

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

a) Raised your voice/shouted at Colleague Y.
b) Behaved in an intimidating/threatening manner towards Colleague Y.
c) Challenged Colleague Y's risk assessment/decision to restrict Patient A's leave."

These charges are found NOT PROVED.

In reaching this decision, the panel took into account that Mr Brennan worked with Colleague Y for a maximum for a period of six months from June 2018 as outlined in Colleague Y's evidence.

The panel took into consideration that the NMC has not adduced evidence for any unknown date for the period between June and September 2018 that amounts to the conduct outlined in these charges Mr Brennan other than the evidence adduced for 4 August 2018 which is the subject of charge 21 below.

The panel was not satisfied that the NMC had discharged its burden of proof and had provided evidence that between June 2018 and September 2018 on an unknown date that

Mr Brennan raised his voice/shouted at Colleague Y, behaved in an intimidating/ threatening manner towards Colleague Y and challenged Colleague Y's risk assessment/decision to restrict Patient A's leave. The panel was not satisfied that these charges could be proved and therefore found charges 20a, 20b and 20c not proved.

Charge 21

"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."

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague Y and documentary evidence of Ms 1.

The panel considered the email from Colleague Y to Ms 1, dated 29 August 2018. It noted that the email stated *"On 04/08/18 when John returned to shift he informed me that he wanted to speak with me at some point during the shift. When the office was empty, leaving only myself and John in there, he began to raise his voice at me and said that to change his decision on B utilising leave on Tuesday (31/07/18) was "very dangerous" and that "OTs should not be involved in clinical decisions". He further stated that "you should not go over my head and change my decisions". I informed him of the discussion we had and that the discussion involved me, SSN DN and OT CN. Also, informing him that HCA SS was not willing to escort B escort. Throughout this John presented as threatening and*

intimidating, making me feel really uncomfortable. After the conversation I had to take myself out of the ward environment as I did not want to show my emotions to my colleagues and patients, however in private I broke down. It was not the fact he disagreed with a decision I had made, as I welcome constructive feedback and given advice on better approaches to take, it was the manner in which this was all given to solely me, especially as this was a team decision." The panel considered this email to be a contemporaneous record of Colleague Y's account of the incident. It bore in mind that Colleague Y was consistent in her oral evidence with the contents of the email to Ms 1.

In respect of charge 21a, the panel considered the evidence before it and determined that Mr Brennan on or around 04 August 2018 raised his voice at Colleague Y. The panel therefore found charge 21a proved.

In respect of charge 21b, the panel considered the evidence before it and determined that Mr Brennan on or around 04 August 2018 inappropriately challenged Colleague Y's decision to restrict Patient B from utilising their period of leave on 31 July 2018. The panel therefore found charge 21b proved.

In respect of charges 21c(i) and 21c(ii), the panel considered the evidence before it and determined that Mr Brennan had on or around 04 August 2018, used words to the effect '*OTs should not be involved in clinical decisions*' and '*You should not go over my head and change my decisions.'* The panel therefore found charges 21c(i) and 21c(ii) proved.

In respect of charges 21d, the panel considered the evidence before it and determined that Mr Brennan on or around 04 August 2018 behaved in an intimidating/threatening manner towards Colleague Y. The panel therefore found charge 21d proved.

Charge 22a

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

a) Grabbed Patient C by the feet/ankles."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W and Ms 8.

The panel considered the evidence of Colleague W. In Colleague W's NMC witness statement she states, *"[redacted] was then restrained to the floor (on his back) by multiple staff as there was no other way. I remember that John was part of the floor restraint – and I remember he was pushing [redacted] feet to the floor. John had hold of his ankles and was pushing them down.".* The panel noted that Colleague W was present at the material time of the incident.

The panel noted in Colleague W's oral evidence she said that the patient was restrained on his back and feet were being held.

The panel considered the evidence of Ms 8. In her NMC witness statement she stated, *"I wasn't present for the incidents that occurred on 2 & 3 October 2019, nor the incident on 10 November 2019… Holding a patient's ankles locked against the floor in this way could cause them to damage their knees if they tried to kick out."* The panel noted that Ms 8 did not mention 'grabbing of Patient C's feet/ankles' in her evidence. The panel bore in mind that it was not aware of who informed Ms 8 about this incident or how she came about this information and determined to attach little weight to Ms 8's evidence which appeared to be based on hearsay evidence from an unknown source.

The panel considered the evidence before it. It noted that the wording of the charge was that Mr Brennan 'grabbed' Patient C by the feet/ankles but Colleague W described that Mr Brennan was holding Patient C's feet/ankles. The panel was not satisfied that the NMC has presented sufficient evidence to find this charge proved. The panel determined that it could not find on the balance of probabilities on or around 2 October 2019 Mr Brennan

used an inappropriate restraint technique on Patient C, in that he grabbed Patient C by the feet/ankles. The panel therefore found this charge not proved.

Charge 22b

> "22) On or around 2 October 2019 used an inappropriate restraint technique on Patient C, in that you;
>
> b) Pushed Patient C's feet/ankles to the ground."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W.

In Colleague W's NMC witness statement she states *"[Redacted] was then restrained to the floor (on his back) by multiple staff as there was no other way. I remember that John was part of the floor restraint – and I remember he was pushing [redacted] feet to the floor. John had hold of his ankles and was pushing them down. At the time of the incident, I was MAPA trained and in the position [redacted] was in, that was definitely incorrect, you're supposed to lift the feet up."* The panel took into consideration that Colleague W was taking notes at the material time Mr Brennan was attending on Patient C.

The panel considered the evidence before it and determined that on the balance of probabilities on or around 2 October 2019 Mr Brennan used an inappropriate restraint technique on Patient C, in that he pushed Patient C's feet/ankles to the ground. Therefore this charge is found proved.

Charge 22c

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

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W.

The panel considered Colleague W's NMC witness statement which states *"One of my colleagues [Colleague X] corrected John. I remember him saying something like "John, your hands are wrong/ John, your hands are in the wrong place." John didn't respond or change the way he was holding [redacted] ankles.".*

The panel considered the evidence before it and determined that on the balance of probabilities on or around 2 October 2019, Mr Brennan used an inappropriate restraint technique on Patient C, in that he continued to grab/push Patient C ankles/feet to the grounds, despite being told by Colleague X that the restraint was incorrect. The panel therefore found this charge proved.

Charge 23a

"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."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W and documentary evidence of Ms 8.

The panel considered the evidence of Colleague W. In her NMC witness statement she stated, *"John then says "lock the doors to the lounge and kitchen" and I said "what, we're locking ourselves in?" and he said "don't question me in the middle of an incident yeah". The kitchen has two doors – one is to the corridor and the other is a hatch door (split in two to the lounge. [Ms 11] goes to lock the kitchen door (the one to the corridor) but [redacted] kicks it just as she's about to lock it and it nearly hits her. [Ms 11] then comes into the lounge and locks the door between the lounge and the kitchen."* The panel took into consideration that Colleague W's oral evidence was consistent with her NMC witness statement.

The panel took into consideration the 'Investigatory Meeting at Mill Lodge re: Incident on 3 October 2019'. It noted that the minutes state *"John stated that the following needs to be added; "When I came out of the clinic and locked the door, I found [Ms 11] in [Patient C]'s room with the lights off, I asked [Ms 11] to come out of the room and proceeded into the lounge where I asked staff for [Patient C]'s location. The staff were not aware of his current whereabouts. I proceeded to contact the police, following the phone call, I made the decision to lock the lounge – staff unsure of [Patient C]'s whereabouts at this point. Once the doors were locked, [redacted] was seen down the corridor facing the lounge window*".

The panel took into consideration the 'Incident Reporting' document for an incident which took place on 3 October 2019 completed by Mr Brennan and exhibited by Ms 8. It states *"Staff attempted to lock the doors to prevent him from coming towards them however the kitchen door beside the corridor would not lock. The patient came in to the kitchen and staff were only able to close the bottom half of the other door. I directed staff to the exit into the garden as this was the only safe area of the ward at that time. The patient then came through the door so staff exited into the garden and locked the door. Other supporting staff approached the outside windows of patients … and requested that they stay in their room."*

The panel considered the evidence before it and determined on the balance of probabilities that on 3 October 2019 during an incident where Patient C wielded a metal urn Mr Brennan instructed one or more colleagues to lock doors to the lounge/kitchen in an attempt to seclude Patient C. The panel therefore found this charge proved.

Charge 23b

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W and the documentary evidence of Ms 8.

The panel considered Colleague W's evidence. In her NMC witness statement she stated, *"John then says "lock the doors to the lounge and kitchen" and I said "what, we're locking ourselves in?" and he said "don't question me in the middle of an incident, yeah"."* The panel took into account Colleague W was consistent in her oral evidence with her NMC witness statement.

The panel took into consideration the 'Incident Reporting' document for an incident which took place on 3 October 2019 completed by Mr Brennan and exhibited by Ms 8. The panel noted that the document confirms that Colleague W was present at the incident which supports Colleague W's account that Mr Brennan instructed staff to lock the doors and told staff "*don't question me in the middle of an incident, yeah*".

The panel considered the ‘Timeline of incidents on Amrika Ward 2-3 October 2019’. It noted that within the document it states *“[Colleague W] support worker then questioned why the doors were being locked? John replied “don’t question me whilst we are in an incident””.*

The panel considered the evidence before it and determined that on 3 October 2019 during an incident where Patient C wielded a metal urn when Mr Brennan was questioned by Colleague W about locking the doors, he used words to the effect *“don’t question me in the middle of an incident, yeah*”. The panel therefore found this charge proved.

Charge 23c

> “23) On or around 3rd October 2019 during an incident where Patient C wielded a metal urn;
>
> c) Instructed one or more colleagues to evacuate the Ward.”

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W.

In Colleague W’s NMC witness statement she states *“I remember it was was [sic] really eery at this point because you can’t open the top half of the kitchen door from the kitchen side but you can open the bottom half and we heard the click of [redacted] unlocking the bottom half of the door. At that point John told us to get out so we all evacuated.”*

The panel considered the evidence before it and determined that on the balance of probabilities on 3 October 2019 during an incident where Patient C wielded a metal urn, Mr Brennan Instructed one or more colleagues to evacuate the Ward. The panel therefore found this charge proved.

Charge 23d

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

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

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W and the documentary evidence of Ms 8.

In Colleague W's NMC witness statement, she stated *"Myself, [Ms 11], John and … are in the lounge at this point and [redacted] is still in the kitchen with the urn. There are two other patients on the ward who are both in their rooms."* The panel took into account Colleague W was consistent in her oral evidence that patients were left inside whilst Patient C was walking around with the urn.

The panel took into consideration the 'Incident Reporting' document for an incident which took place on 3 October 2019 completed by Mr Brennan and exhibited by Ms 8. The panel noted that the document states *"The patient then came through the door so staff exited into the garden and locked the door. Other supporting staff approached the outside windows of patients … and requested that they stay in their room".*

The panel considered the evidence before it and determined that on or around 3 October 2019 during an incident where Patient C wielded a metal urn, Mr Brennan left one or more patients on the Ward locked in with Patient C. The panel therefore found this charge proved.

Charge 24

> "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'"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague W.

In her NMC witness statement she stated, *"I didn't personally get on with John. I found he was kind of "I know best" at all times. I remember the first shift that I met him – straight away he was talking about "patients don't decide when they go for a cigarette break, they can fit around our day", At the time we used to take patients out for a cigarette whenever they wanted which, in fairness, was starting to get a bit ridiculous with staff outside all the time but I feel like he just came straight in with that and just the way he approached it was a bit blunt."*

In Colleague W's oral evidence, she stated that this was Mr Brennan's first shift. The panel noted that she gave an overview of what was happening on the ward and how she saw it occur.

The panel considered the evidence before it and noted that it did not have any evidence to contradict Colleague W's account. The panel determined on the balance of probabilities that whilst Mr Brennan was speaking to Colleague W, he used words to the effect, '*Patients don't decide when they go for a cigarette break, they can fit around our day'*. The panel therefore found this charge proved.

Charge 25

> "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’”

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague U.

In her NMC witness statement, she said *“I remember seeing him ask one nurse, [Colleague V], why she thought she could be a nurse and telling her that she wasn’t good enough and wasn’t strong enough.”*

Although, there was no direct evidence from Colleague V, the panel was of the view that Colleague U was consistent in her oral evidence with her NMC witness statement.

The panel considered the evidence before it and determined on the balance of probabilities that Mr Brennan whilst speaking to Colleague V, used words to the effect that ‘*Colleague V wasn’t good enough to be a nurse’* and ‘*Colleague V wasn’t strong enough to be a nurse’*. The panel therefore found charges 25a and 25b proved.

Charge 26

“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’”

These charges are found PROVED.

In reaching this decision, the panel took into account Colleague U's evidence.

In her NMC witness statement she stated *"John would often put me down. He made me feel like I wasn't good enough at my job which wasn't true, other colleagues would tell me that I was very good and very proactive. He would tell me that I am "only" a support worker and that I wasn't important. He would say that you were only valid if you were a nurse. I think nearly every shift he would make passive comments about "just" being a support worker and telling me I should only listen to him. I remember John would question me at times about why I "didn't achieve anything" in life and how I was "only" a support worker. I also remember sometimes when I would go to the office and he would question why I was a support worker and he would tell me that was all I would ever be because I didn't have any potential."*

The panel bore in mind that Mr Brennan has not provided an alternative account to Colleague U.

The panel considered the evidence before it and determined on a balance of probabilities that Mr Brennan whilst speaking to Colleague U, had used words to the effect that '*You are only/just a support worker',* '*You should only listen to me',* '*You are not important'*, '*Why didn't you achieve anything in life'*, '*Why are you a support worker' and* '*You will only ever be a support worker because you don't have any potential'.* The panel therefore found charges 26a, 26b, 26c, 26d, 26e and 26f proved.

Charge 27a

> "27) On one or more occasion;
>
> a) Unfairly dismissed the needs of other patients to spend time with Patient E"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague U.

In her NMC witness statement, she stated *"From what I saw, John didn't really make time for any patients bar one patient in particular – [redacted] I found the relationship that John had with [redacted] weird however at the time I was also new to mental health having only been working in it for a few months. I also thought that John would dismiss other patients to spend most of his time with [redacted] This isn't appropriate. He should treat all patients fairly but instead he was spending all his time with [redacted] It was noticeable that he would do this because he wouldn't attend to other patients straight away when he was the nurse on the ward."*

In her oral evidence, Colleague U said that Patient E would ask for Mr Brennan's attention and that he would not have time for other patients as a result. It noted that Colleague U said that Mr Brennan had described Patient E as attention seeking. She said it was noticeable that Mr Brennan would not attend to other patients straightaway. The panel was of the view that Colleague U had viewed Mr Brennan's relationship with Patient E to be unprofessional.

The panel considered the evidence before it and determined that on the balance of probabilities Mr Brennan had unfairly dismissed the needs of other patients to spend time with Patient E. The panel therefore found this charge proved.

Charge 27b

"27) On one or more occasion;

b) Disclosed information about your personal life to Patient E."

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague U.

The panel considered Colleague U's NMC witness statement. She stated *"I also witnessed John telling [redacted] lots of things about his personal life, about his life growing up and his experiences. I found this inappropriate, he was sharing things that aren't necessary to share with patients. We shouldn't be telling patients about our private life and where we live and our family and friends etc. it's crossing boundaries."*

Colleague U repeated this account in her oral evidence and noted that Mr Brennan had provided Patient E with information about his mother passing away. The panel bore in mind that during Colleague U's oral evidence she recalled in her training with Mill Lodge that staff were told not to share personal information about their lives.

The panel considered the evidence before it and determined that Mr Brennan had disclosed information about his personal life to Patient E. The panel therefore found this charge proved.

Charge 27c

> "27) On one or more occasion;
>
> 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'*"

This charge is found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague U.

In Colleague U's NMC witness statement she stated, *"I found the way John was with [redacted] to be really manipulative as well because he would be so nice to her and almost treat her like a friend or a companion but then he would be really harsh about her behind closed doors. He'd call her a "typical PD" (personally disorder) and he'd call her clingy and attention seeking."*

The panel considered the evidence before it and was of the view that on the balance of probabilities, Mr Brennan had when describing Patient E to colleagues used words to the effect that *'Patient E was typical PD [personality disorder]', 'Patient E was clingy'* and that *'Patient E was attention seeking'*. The panel therefore found charges 27c(i), 27c(ii) and 27c(iii) proved.

Charge 28

> "28) Following an incident where Patient D had ligatured, used words to effect, '*I don't get why people self-harm if they aren't going to do it right*"'

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Colleague U.

The panel considered the evidence of Colleague U. In her NMC witness statement she stated, *"I remember one time when a patient ligatured and again he said something like "I don't get why people self-harm if they aren't going to do it right". He said this about patient [redacted] I don't remember her surname"*.

The panel noted that the wording of the charge was specific to Patient D. The only evidence before the panel was that of Colleague U and her evidence referred to an unidentified patient. The panel therefore had no evidence to identify the patient in this charge as Patient D. The panel therefore find this charge not proved.

Charge 29

> "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*'"

These charges are found PROVED.

In reaching this decision, the panel took into account the evidence of Colleague U.

The panel considered Colleague U's NMC witness statement which stated, *"It was quite common for John to make comments about patients who self-harmed and he would say things about them "not doing it right" and things like that… I remember once when John made a comment to me about how he has to tell patients to "do it properly" (as in self-harm)…".*

Colleague U stated in her oral evidence, that Mr Brennan would openly share ways of self-harming and that he believed patients should be taught ways to self-harm.

The panel determined that Mr Brennan had on one or more occasion, when referring to patients who self-harmed, used words to the effect of *'they are a not doing it right'* and that he would have to tell them to '*do it properly*'". The panel therefore found charges 29a and 29b proved.

Charge 30

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

a) Instructed Colleague U, not to cut the ligature off.

b) Instructed Colleague U, that the ligature was not tight enough.

c) Instructed Colleague U, that you wanted to speak to Patient D before cutting the ligature off.

d) Instructed Colleague U, that she had made a mistake for helping Patient D.

e) Described Patient D, using words to the effect, '*she is an attention seeker'*

f) Spoke to Colleague U, using words to the effect, '*you are just a support worker*'

g) Spoke to Colleague U using words to the effect, '*You are not important*'

h) Did not escalate a formal complaint/statement made against Colleague N to management.

i) Did not record Patient D's physical presentation in the incident report.

j) Did not record how tight Patient D's ligature was in the incident report.

k) Instructed one or more staff members to lock Patient D in a room/the lounge.

l) Kept Patient D in secluded room for one or more hours."

These charges are found NOT PROVED.

In reaching this decision, the panel took into account the evidence of Ms 8 and Colleague U.

The panel considered Ms 8's evidence. In her NMC witness statement she stated *"I wasn't present for the incidents that occurred on 2 & 3 October 2019, nor the incident on 10 November 2019. I was employed at Mill Lodge as a Support Worker at the time and wasn't MAPA trained… I'm aware that there was an incident on 10 November 2019, where D was in her room, ligating with an object around her neck. Staff escalated this to John, and he advised against cutting the ligature as it wasn't tight enough and said that he would speak to D instead to persuade her to take it off. Other staff have reported that D couldn't speak at this point due to the ligature, and that she was turning blue".*

The panel also considered the Positive Behaviour Support Plan, created on 23 October 2019 and updated on 10 December 2019, which was exhibited by Ms 8. The panel noted

that it was unable to establish what had been updated in the Positive Behaviour Support Plan and noted that this plan had been updated almost a month after the incident took place. Further, Ms 8 stated in her NMC witness statement that *"I produce as Exhibit CA/02 a copy of D Positive Behaviour Support Plan, which outlined appropriate ways of responding to her behaviours."*

The panel took into consideration the 'Incident Reporting' exhibited by Ms 8 but had originally been recorded by Mr Brennan. The report stated *"Pt D was lying underneath the covers with a ligature in situ. I JB was prompted by observing staff…Pt D refused to remove ligature and communicated this to staff. I then promoted assisting staff to help with removing the ligature. Pt D was continually resistive although staff did manage to remove what was her jumper."*. The panel noted that the patient's initials had not been redacted in this document and that the description of events states that this incident involves Patient D. The panel noted that Colleague U was not listed in the staff who were directly involved in the incident nor was she listed on duty in this document.

The panel next considered the evidence of Colleague U. In her NMC witness statement, she stated *"I recall an incident with [redacted] where it was me, John and some other support workers on shift, I don't recall who. My colleague N (whose last name I don't know) found [redacted] in the bathroom and she had ligatured. N pulled the non-emergency alarm and I attended... [Redacted] was distressed when I arrived. It's a little hazy now whether she was able to breathe or not but I remember that she definitely couldn't talk. She was sat on the bathroom floor fighting with staff not to help her."* The panel noted the details of this incident differed to that outlined in Ms 8's evidence.

The panel bore in mind that during Colleague U's oral evidence, when put to Colleague U stated that she did not recognise the staff names who were listed as the staff who were directly involved in the incident or that were listed as on duty for the incident outlined in this charge. The date of the incident, 10 November 2019, was also put to Colleague U during her oral evidence however she did not recall the date of the incident she was referring to. She also said in her oral evidence that the ligature used may have been a

bandage. The panel noted that Colleague U said that this was the first incident of where Patient D had ligatured.

The panel was of the view that Colleague U spoke to a similar but separate incident to that referred to in Ms 8's evidence however, the specific details of incident which Colleague U referred to were significantly different to that outlined in Ms 8's evidence and referred to in the charge. The panel was of the view that Colleague U was not present at the incident outlined in the charge and referred to a separate incident. The panel noted that Ms 8 was not present at either incident described.

The panel considered the evidence before it and determined that the evidence did not consistently correspond with the details outlined at charge 30 and its sub-charges. It noted that Colleague U spoke to a similar incident, but her presence was not recorded at the incident on 10 November 2019 as documented in the 'Incident Reporting' document. The panel therefore found charges 30a, 30b, 30c, 30d, 30e, 30f, 30g, 30h, 30i, 30j, 30k and 30l not proved.

Charge 31

> "31) Inaccurately recorded that you had prompted staff to remove the ligature from Patient D."

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the documentary evidence of Ms 8 and the evidence of Colleague U.

The panel considered the evidence of Colleague U. It was of the view that Colleague U was referring to a separate and other incident.

The panel took into consideration the ‘Incident Reporting’ document for an incident which took place on 10 November 2019 completed by Mr Brennan. The panel took into consideration that there is no evidence before it to suggest that this report is inaccurate and therefore could not determine that Mr Brennan had inaccurately reported that he had prompted staff to remove the ligature from Patient D.

The panel was of the view that the evidence presented by the NMC for this charge is based around a different event to that described in the charge. The panel determined that it had no information before it that Mr Brennan had inaccurately recorded that he had prompted staff to remove the ligature from Patient D. The panel therefore found this charge not proved.

Charge 32

> “32) Your actions in charge 31 above were dishonest in that you sought to conceal the true nature of your instructions relating to Colleague D’s ligature.”

This charge is found NOT PROVED.

In reaching this decision, the panel took into account the evidence and findings outlined at Charge 31. It concluded that it could not find that you sought to conceal the true nature of your instructions relating to Colleague D’s ligature.

Consequently, the panel determined that charge 32 is not proved.

Decision and reasons on service of Notice of Hearing

At the start of this resuming hearing, the panel noted that Mr Brennan was not in attendance, nor was he represented in his absence.

The panel was informed that the notice of this hearing was sent to Mr Brennan's registered email address on 18 May 2023. The panel noted that Rule 34(1)(c) of the Rules allows for electronic service of the Notice of Hearing. The panel further noted that the Notice of Hearing was also sent to Mr Brennan's representative at Burton Copeland LLP by email on the same date.

Mr Kennedy, on behalf of the NMC, submitted that the service by email had complied with the requirements of Rules 11 and 34 of 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 time, date and venue of the hearing 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 the information available, the panel was satisfied that the notice of this resuming hearing had been served in compliance and in accordance with Rules 11 and 34 of the Rules.

Decision and reasons on proceeding in the absence of Mr Brennan

The panel noted that the issue of proceeding in the absence of Mr Brennan was fully addressed when the case commenced on Monday 3 April 2023.

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 Brennan'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 suitability to remain on the register unrestricted.

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

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

Submissions on misconduct

Mr Kennedy reminded the panel that the question of impairment involved a two-stage test and the panel first had to be satisfied that the facts proved amounted to serious professional misconduct. Only if the panel was satisfied of that, could it then go on to consider whether Mr Brennan's fitness to practise is currently impaired.

With regard to the question of misconduct, Mr Kennedy reminded the panel of the decision of the High Court in *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.'* The judgment adds, *'It is not any professional misconduct which will qualify. The professional misconduct must be serious.'*

Mr Kennedy invited the panel to take the view that the facts found proved amounted to misconduct and asked the panel to have 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 Kennedy identified the specific, relevant standards where Mr Brennan's actions amounted to misconduct. He submitted that in this case there are a number of paragraphs of the Code that have been breached and these are as follows:

> *'1.1 treat people with kindness, respect and compassion*
> *1.2 make sure you deliver the fundamentals of care effectively*
> *Work in partnership with people to make sure you deliver care effectively*
>
> *2.6 recognise when people are anxious or in distress and respond compassionately and politely*
>
> *8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate*
> *8.2 maintain effective communication with colleagues*
>
> *9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times*
>
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after an event*
> *13.4 take account of your own personal safety as well as the safety of people in your care*

15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16.5 do not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

20.1 keep to and uphold the standards and values set out in the Code
20.3 be aware at all times how your behaviour can affect and influence the behaviour of other people'

Mr Kennedy submitted that there are a number of factors in play which take Mr Brennan's behaviour over the threshold of misconduct, which are:

- He was a highly experienced nurse;
- He was in a senior position;
- He was entrusted with caring for vulnerable residents;
- He abused that trust by the use of inappropriate restraint;
- He abused colleagues in 2 workplaces by intimidating them using a raised voice and making threatening and demeaning language;
- He crossed professional boundaries with Patient E;
- His record keeping in relation to medication administration was poor;
- He breached local policy on more than one occasion; and
- He made derogatory remarks about vulnerable residents.

Mr Kennedy submitted that Mr Brennan's behaviour fell well below the standards expected of a registered nurse and was sufficiently serious to amount to misconduct.

Submissions on impairment

Mr Kennedy moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and address the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the nursing profession and in the NMC as a regulatory body. It also 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 Kennedy submitted that the panel should consider Mr Brennan's practice as a whole and that includes looking at past and future risks. The panel should take into account Mr Brennan's past behaviour and decide on the basis of that behaviour and what he has done since and whether or not he is currently impaired. The panel needs to consider the issue of public protection and the wider public interest and for this, Mr Kennedy referred the panel to the case of *Cohen v General Medical Council* [2008] EWHC 581 (Admin). He further stated that the panel needs to take into consideration Mr Brennan's remediation and insight when deciding on whether his fitness to practise is currently impaired.

Mr Kennedy reminded the panel that Mr Brennan only responded to the concerns arising out of his time at St Andrews Hospital and he denied those charges as he was entitled to. However, the panel found some of them proved. Mr Brennan has not provided a response to the incidents at Mill Lodge Hospital and the panel has no information to determine that Mr Brennan understands that the type of behaviour found proved is unacceptable.

Further, Mr Kennedy asked the panel to consider if it can be satisfied that Mr Brennan fully understands how far the standards of his behaviour fell and the impact of it on the reputation of the profession, the patients and his colleagues.

Furthermore, Mr Kennedy submitted that there remains a risk of Mr Brennan repeating the misconduct because he is yet to develop insight into his actions.

Mr Kennedy submitted that a finding of impairment was also necessary in the wider public interest, to promote and maintain public confidence in the nursing profession and to promote and maintain proper professional standards and conduct for members of the profession. Mr Kennedy therefore submitted that given the lack of evidence to reassure the panel on insight and remediation, the risk of repetition remains and a finding of current impairment is required.

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel accepted the advice of the legal assessor and had regard to the terms of the Code.

The panel was of the view that Mr Brennan's actions did fall significantly short of the standards expected of a registered nurse, and that his 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

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

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

8 Work cooperatively

To achieve this, you must:

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate

8.2 maintain effective communication with colleagues

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

10.1 complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

13.4 take account of your own personal safety as well as the safety of people in your care

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

To achieve this, you must:

16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

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

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. It also took note of the NMC guidance on seriousness. The panel was of the view that Mr Brennan's actions were a serious departure from the standards expected of a registered nurse.

The panel, in determining whether its findings of facts constitute misconduct considered each charge individually. It determined that while some did not reach the threshold of serious professional misconduct, there are a number which do.

The panel noted that there was a pattern of behaviour which was wide ranging and occurred across two different hospitals over a period of about two years. The panel therefore decided that when considering the charges collectively, as it is required to do, they amounted to serious professional misconduct.

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

Decision and reasons on 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.

Sanction

The panel has considered this case very carefully and has decided to make a suspension order for a period of 12 months. The effect of this order is that the register will show that Mr Brennan's registration has been suspended.

In reaching this decision, the panel 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 Kennedy submitted that the NMC is inviting the panel to impose a striking-off order in this case because Mr Brennan's conduct fell so seriously below the standards expected of a registered nurse and that it is fundamentally incompatible with him remaining on the register. He said that at this stage the matter is left to the panel's experience and expertise. He reminded the panel that the SG makes it clear that it is vital for the panel to start by considering sanction with the least impact on the nurse's practice and work upwards to the next most serious sanction if it needs to.

Mr Kennedy said that Mr Brennan engaged with the NMC initially but has disengaged with the substantive hearing and this can be considered as an aggravating feature. He reminded the panel that Mr Brennan abused his position, was abusive towards his colleagues and demonstrated a deep-seated attitudinal issue. Mr Brennan also failed to demonstrate any insight or remorse for his actions.

Mr Kennedy submitted that there are concerns that can be addressed with a conditions of practice order but there are some which are nothing to do with his practice. Therefore, these cannot be addressed with a conditions of practice order. He further submitted that a suspension order would not protect the public and satisfy the wider public interest. Mr Kennedy said that there is nothing before the panel which demonstrates that Mr Brennan is willing to remediate the concerns about his behaviour, and this, combined with his lack of willingness to change, makes it incompatible for him to remain on the register.

Decision and reasons on 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.

This decision will be confirmed to Mr Brennan in writing.

Interim order

Mr Kennedy made an application for an interim order as the substantive suspension 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 is in Mr Brennan's own interests until the suspension sanction takes effect.

Submissions on interim order

The panel took account of the submissions made by Mr Kennedy. He submitted that an interim suspension order for the period of 18 months is necessary to cover the period of any potential appeal. He said that this order would fall away after 28 days if no appeal of the substantive suspension order is made.

The panel accepted the advice of the legal assessor.

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 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 to cover any potential appeal of this order that Mr Brennan may make.

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

That concludes this determination.