Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 14 October – Friday 1 November 2024

Virtual Hearing

Name of Registrant:	**Joanne Davenport**
NMC PIN:	97C0566E
Part(s) of the register:	Registered Nurse – RNMH Mental Health Nurse – February 2000
Relevant Location:	Nottingham
Type of case:	Misconduct
Panel members:	John Kelly (Chair, lay member) Allwin Mercer (Registrant member) Caroline Taylor (Lay member)
Legal Assessor:	Nigel Pascoe (14 October – 18 October 2024) Sean Hammond (21 October – 1 November 2024)
Hearings Coordinator:	Rene Aktar
Nursing and Midwifery Council:	Represented by Beverley Da Costa, Case Presenter
Ms Davenport:	Not present and unrepresented
No case to answer:	Charge 2.4.2
Facts proved:	Charges 1.1, 1.2, 2.1, 2.3, 2.4.1, 2.4.3, 2.6, 2.7, 3
Facts not proved:	Charges 2.2, 2.5, 4 & 5
Fitness to practise:	Impaired

Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Davenport was not in attendance and that the Notice of Hearing letter had been sent to Ms Davenport's personal email address by secure email on 12 September 2024.

Further, the panel noted that the Notice of Hearing was also sent to Ms Davenport's representative on 12 September 2024.

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

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, dates and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Davenport's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence. The panel noted that the email address used was not the registered email address. However, it also noted evidence of recent communication from Ms Davenport to the NMC using the personal email address.

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

Decision and reasons on proceeding in the absence of Ms Davenport

The panel next considered whether it should proceed in the absence of Ms Davenport. It had regard to Rule 21 and heard the submissions of Ms Da Costa who invited the panel to

continue in the absence of Ms Davenport. She submitted that Ms Davenport has voluntarily absented herself.

Ms Da Costa referred the panel to an email dated 14 October 2024 at 13:58 received from Ms Davenport which stated:

> *"Afternoon*
>
> *I will not be in attendance today or at any point during the hearing."*

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 the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel decided to proceed in the absence of Ms Davenport. In reaching this decision, the panel considered the submissions of Ms Da Costa and the advice of the legal assessor. It had 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:

- No application for an adjournment has been made by Ms Davenport;
- Ms Davenport has engaged with the NMC and has responded stating that she would not be in attendance at the hearing;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- Four witnesses are due to attend to give live evidence;

- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2019;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case due to the serious allegations involved and the potential impact on public confidence in the nursing profession.

There is some disadvantage to Ms Davenport in proceeding in her absence. Although the evidence upon which the NMC relies has been sent to her, Ms Davenport has not responded to the allegations. Ms Davenport will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on her own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Davenport's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

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

Details of charge (as amended during the hearing)

'That you, a registered nurse, while acting as a community psychiatric nurse for the Nottinghamshire Healthcare NHS Trust:

1. Did not preserve patient safety in that you:

1.1. Did not visit Patient A between 18 November 2019 and 29 December 2019, on a weekly basis as set out in his care plan of 18 November 2019, or at all. **[PROVED]**

1.2. Did not visit Patient B between November 2019 and April 2020 on a monthly basis, or at all. **[PROVED]**

2. Did not maintain appropriate patient records in that you:

2.1. Did not make a contemporary record of any visits or attempted visits to Patient A between 18 November 2019 and 29 December 2019. **[PROVED]**

2.2. Did not create and/or record an updated care plan for Patient A between 18 November 2019 and 29 December 2019. **[NOT PROVED]**

2.3. Did not create and/or record an updated risk assessment for Patient A between 18 November 2019 and 29 December 2019. **[PROVED]**

2.4. ~~On or around 10 April 2020~~ Updated Patient A's records in respect of the following dates without making clear these entries had been added retrospectively:

2.4.1. 26 November 2019. **[PROVED]**

2.4.2. 28 November 2019. **[NO CASE TO ANSWER]**

2.4.3. 2 December 2019. **[PROVED]**

2.5. Did not make a contemporary record any visits or attempted visits to Patient B between November 2019 and April 2020. **[NOT PROVED]**

2.6. Did not create and/or record a care plan for Patient B. **[PROVED]**

2.7. In 2019 and/or 2020 did not maintain an up-to-date risk assessments and/or care plans and/or core assessments for one or all of the patients outlined in Schedule 1. **[PROVED]**

3. Your conduct as outlined in charge 2.4 was dishonest in that you added entries retrospectively to Patient A's record in order to hide that fact that you did not make contemporaneous entries at the time and/or that you did not visit or attempt to visit Patient A between 18 November 2019 and 29 December 2019. **[PROVED]**

4. You informed the Nottinghamshire Healthcare NHS Trust that the reason you did not visit Patient A between 2 December 2019- 27 December 2019 was that you were on annual leave/[PRIVATE] leave at the time when this was not the case. **[NOT PROVED]**

5. Your conduct as outlined in charge 4 was dishonest in that you gave a false explanation for the reasons you did not visit Patient A between 2 December 2019 and 28 December 2019. **[NOT PROVED]**

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

Background

Ms Davenport was referred to the NMC on 11 June 2021 by Witness 2, an Operational Manager at Nottinghamshire Healthcare NHS Trust (the Trust). In addition, Ms Davenport referred her own fitness to practise to the NMC in a letter dated 29 June 2021. These referrals resulted in an investigation by the NMC, which identified the regulatory concerns including:

1. Failure to preserve patient safety – in that you didn't visit patients
2. Record keeping – Failing to/not keeping appropriate up-to-date records/risk assessments
3. Dishonesty – in that you created records in an attempt to mislead your employer that your records were up to date.

Two caseload reviews were carried out in March 2019 and June 2020 by the Clinical Lead for the team. Issues were found with Ms Davenport's record keeping along with indications of failures to visit patients regularly.

Ms Davenport was appointed as Care Coordinator (CCO) for Patient A in July 2019.

On 18 November 2019, a Consultant Psychiatrist, Dr 1, reviewed Patient A in the presence of Ms Davenport. [PRIVATE]. It was agreed that Patient A would be subject to structured clinical management for six weeks, including a requirement that he be visited on a weekly basis by Ms Davenport as his CCO.

[PRIVATE].

In line with Trust policy, a serious untoward incident (SUI) investigation was carried out by two doctors, Dr 2, a Clinical Psychologist and Dr 3, a Consultant Psychiatrist. This investigation reported in June 2020.

A second investigation (the Trust investigation) into Ms Davenport's work was instigated by the Trust into allegations that Ms Davenport had departed from patient care plans. This investigation was carried out by Witness 1, a retired registered nurse employed by the Trust to investigate incidents that occurred at the Trust. The investigation report was submitted on 22 November 2020.

In June 2020, Patient B complained that they had not been receiving consistent care from the Trust and that Ms Davenport had not visited them regularly or as required.

Decision and reasons on application to admit hearsay into evidence

After hearing the oral evidence of Witness 2, the panel invited Ms Da Costa to address them in relation to the admissibility of the hearsay evidence contained within the documentary exhibit bundle, in particular, the exhibits produced by Witness 1 and Witness 2 in their written statements.

Ms Da Costa acknowledged that the NMC's exhibits bundle contained hearsay evidence, including:

- A report by Dr 1 to H.M. Coroner for Nottinghamshire (the Coroner) which was signed and dated by Dr 1 and included a statement of truth.
- Notes of interviews conducted with three colleagues of Ms Davenport as part of the Trust investigation.

However, Ms Da Costa submitted that this was an agreed exhibits bundle. She explained that prior to the hearing, the documents had been served upon Ms Davenport and Thompson's Solicitors who were representing her at the time. There was an opportunity for Ms Davenport to object to the content of the exhibits bundle, and some redactions were agreed. There was no objection to the hearsay evidence. Ms Da Costa submitted that in the absence of any objection from Ms Davenport, it was the NMC's position that this hearsay evidence was admissible and included in the hearing bundle by agreement because it provides important context for the panel.

The panel expressed concern that the agreement was reached by Ms Davenport's former representative, and that Ms Davenport was not present at the hearing.

Ms Da Costa submitted that in the circumstances, the NMC would no longer seek to rely on the interview notes.

Ms Da Costa submitted however, that the NMC did intend to rely upon the content of the witness statement of Dr 1 and therefore made an application under Rule 31 to admit this evidence as hearsay on the basis that it was fair and relevant.

Ms Da Costa submitted that Dr 1's evidence is relevant [PRIVATE] and also establishes the requirement that Patient A be visited on a weekly basis.

Ms Da Costa submitted that Dr 1 is not present as his evidence is not contentious in that it is factual evidence.

Ms Da Costa submitted that Dr 1's evidence is not the sole or decisive evidence due to the number of documents produced [PRIVATE]. She submitted that Dr 1's evidence is supported by contemporaneous documents.

Ms Da Costa therefore submitted that it would be fair and relevant to admit the hearsay evidence of Dr 1 into evidence and invited the panel to take this view.

The panel heard and accepted the legal assessor's advice on the issues it should take into consideration in respect of this application. This included that Rule 31 provides that, so far as it is '*fair and relevant*', a panel may accept evidence in a range of forms and circumstances, whether or not it is admissible in civil proceedings. He referred the panel to the Guidance in the case of *Thorneycroft v Nursing and Midwifery Council* [2014] EWHC 1565 (Admin).

The panel considered the submissions, legal advice, and relevant case law. The panel first considered whether the evidence was relevant to the matters in issue in the case and then considered whether it would be fair to admit the evidence applying the principles in *Thorneycroft*.

The panel was satisfied that the evidence contained in Dr 1's Coroner's report was relevant to the disputed charges [PRIVATE] and the requirement that he be visited weekly by Ms Davenport in her role as CCO as part of a six-week structured clinical management plan.

The panel next considered whether it would be fair to admit Dr 1's Coroner's report as hearsay evidence. In reaching this decision, the panel applied the principles established in the case of *Thorneycroft*. The panel considered each of the factors identified by the Court as relevant to the panel's decision.

1. The panel determined that the evidence of Dr 1, whilst relevant to the charges, is not the sole or decisive evidence in respect of any charge.

2. The panel noted that that Dr 1's evidence is historical, given that Dr 1 only saw Patient A once. The panel noted that in terms of the nature and extent of Ms Davenport's challenge to Dr 1's evidence, it appears to the panel that this is very limited. The panel took into account that Ms Davenport would have had the opportunity to correct the care plans and would have raised any objections in her interviews. The panel further took into account that this is documented on Patient A's care notes.
3. The panel noted that Ms Davenport has not provided any reason as to why Dr 1 might fabricate their account. There is no information before the panel to suggest that this is the case.
4. The panel was mindful that the charges against Ms Davenport are serious and that an adverse finding by the panel may have a significant impact upon her career.
5. The panel noted that it has not been provided with a reason for the non-attendance of Dr 1 at the hearing, other than a decision having been taken by the NMC to seek to rely upon his witness statement.
6. The panel acknowledged that there have not been any attempts to secure the attendance of Dr 1.
7. The panel noted that Ms Davenport was provided with a copy of Dr 1's coroner's report as part of the evidence bundle prior to the hearing and that she raised no objection to the admissibility.

Having regard to the above factors, the panel came to the view that the hearsay evidence is relevant to the issues in the case, and it would be fair to accept it into evidence. At the conclusion of the fact-finding stage, the panel will give what weight it deems appropriate to Dr 1's hearsay evidence once it has heard and evaluated all the evidence before it.

Decision and reasons on application to amend Charge 2.4

Having heard all of the oral evidence from the NMC witnesses, the panel was concerned that Charge 2.4 as currently worded did not reflect the evidence, in particular, the oral evidence of Witness 2.

The panel noted that the stem of Charge 2.4 alleges that Ms Davenport *"On or around 10 April 2020"* made three entries in Patient A's patient records relating to 26 November 2019, 28 November 2019 and 2 December 2019 without making clear that those entries were added retrospectively.

The panel further noted the oral evidence of Witness 2 is that Ms Davenport actually made those entries on 9 January 2020, 29 November 2019, and 27 December 2019 respectively. Any amendments to these records on or around 10 April 2020 were done at the request of management in order to mark them as retrospective.

The panel was mindful of its responsibility to be proactive and to ensure that a fair and reasoned decision is reached on the evidence in relation to the charge and that it should not fail simply because of a drafting error. The panel therefore invited Ms Da Costa to consider whether the NMC wished to make an application to amend Charge 2.4.

Having taking instructions, Ms Da Costa applied to amend the stem of Charge 2.4 by deleting *"On or around 10 April 2020."* She submitted that the deletion of these words would cause no unfairness to Ms Davenport and would allow the panel to reach a decision in respect of Charge 2.4 taking into account the specific dates referred to by Witness 2 in her oral evidence. Ms Da Costa submitted that should the amendment be approved, the NMC would offer no evidence in respect of Charge 2.4.2.

The panel accepted the advice of the legal assessor.

The panel decided to allow the amendment. In reaching this decision, the panel had regard to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules). The panel was of the view that the amendment is in the interests of

justice because it focuses on the evidence and the mischief that the charge was drafted to address. The panel was satisfied that the amendment would avoid a serious charge failing due to a drafting error. Further, the panel was satisfied that there would be no prejudice to Ms Davenport and no injustice would be caused to either party by the proposed amendment being allowed. It was therefore appropriate to allow the amendment, as applied for, to ensure clarity and accuracy.

Decision and reasons in relation to whether there is a case to answer on Charge 2.4.2

The panel, of its own volition, considered whether in light of the NMC's decision to offer no evidence on Charge 2.4.2, there remained a case to answer on this charge.

The panel heard and accepted the advice of the legal assessor who referred the panel to Rule 24(7) of the Rules.

The panel heard evidence from Witness 2 about the exact date the entry was made in Patient A's patient records, and the expected time scale for such entries to be made. The entry detailed in Charge 2.4.2 dated 28 November 2019, was entered on 29 November 2019 which was within the 24 hours specified by the Trust. The panel agreed it was appropriate for the NMC to offer no evidence and therefore there was no case to answer.

The panel's request for further evidence

Ms Da Costa closed the NMC's case and made final submissions on the facts. The panel accepted the advice of the legal assessor and retired in camera to consider its decision on facts.

The panel identified that there may be further important evidence available in relation to Charges 4 and 5. The panel therefore paused its deliberations and resumed the hearing in order to request that Ms Da Costa make enquiries in relation to the availability of further

evidence. The panel informed Ms Da Costa that it appears that Charge 4 is premised on what Ms Davenport allegedly said about her annual leave to the investigators who interviewed her during the course of the SUI Investigation.

The SUI investigation report is produced as an exhibit by Witness 2 who gave live evidence but was not a party to the SUI investigation nor any of the interviews conducted as part of it. The panel noted that in the SUI investigation report, whilst there is reference to Ms Davenport be interviewed by telephone, the record of that interview is not included.

The panel took into account that there is an assertion in the text of the SUI report that Ms Davenport was *"On planned leave between 2 December and 27 December 2019".* The panel considered that in order to properly consider Charge 4, it needed to see what record was available of the telephone interview and possibly hear evidence from the authors of the SUI investigation report. Given the serious nature of the allegation, including the background of the case and the dishonesty elements, the panel was mindful of its duty to be proactive in order to reach a fair and reasoned decision on these charges. The panel therefore considered that it was proportionate and appropriate to make this request for further evidence from the NMC.

Ms Da Costa acknowledged on behalf of the NMC that it would be appropriate for enquiries to be made to ascertain whether the further evidence requested by the panel is available.

The panel accepted the advice of the legal assessor. The legal assessor provided advice in relation to the panel's responsibility to be proactive where it considers that further evidence is required to enable the panel to reach its decisions. In particular, he referred the panel to the section of the NMC Guidance DMA-6, in relation to 'further evidence' and to the cases CHRE v GMC and Ruscillo [2004] EWCA Civ 1356 and PSA v NMC and Jozi [2015] EWHC 764 (Admin).

The panel decided to formally make the request for this further evidence.

Application to re-open the NMC's case on the facts

Ms Da Costa informed the panel that a witness statement from Dr 2 is now available. In the circumstances, she applied to re-open the NMC's case in order to adduce and rely upon the witness statement of Dr 2.

The panel accepted the advice of the legal assessor that under Rule 24(1), the panel has a discretion to depart from the order of proceedings in a hearing if in the panel's view, it would be fair and in the interests of justice to do so.

The panel was mindful that the reason for Ms Da Costa's application to re-open the NMC's case at the fact finding stage was a direct result of the panel's request that enquiries be as to whether further evidence was available. In the circumstances, the panel determined that it was in the interests of justice for the NMC to be permitted to re-open its case in order to provide clarity to the available evidence. The panel was satisfied that it would cause no unfairness to Ms Davenport. The panel therefore allowed Ms Da Costa's application.

Application to adduce Dr 2's witness statement as hearsay evidence

Ms Da Costa informed the panel that the NMC does not require Dr 2's attendance at the hearing to give oral evidence, however, if the panel requires Dr 2's attendance, she is available to give evidence. She submitted that, if the panel does not require Dr 2's attendance at the hearing, then Dr 2's witness statement should be admitted as hearsay evidence pursuant to Rule 31 of the Rules. She submitted that the evidence is relevant to charges 4 and 5 and that it would be fair to admit it as it provides clarity to the circumstances in which the SUI investigation report was produced. She further submitted that, should the panel have no questions for her it would be unreasonable to require the attendance of Dr 2 at the hearing when Ms Davenport is not present and the NMC have no questions for her.

The panel accepted the advice of the legal assessor.

The panel decided to admit the witness statement of Dr 2 dated 26 October 2024 as hearsay evidence. In reaching this decision, the panel is satisfied that Dr 2's witness statement contains evidence relevant to Charges 4 and 5. The panel is further satisfied that in the circumstances, it is fair to admit Dr 2's witness statement. The panel noted that it is not the sole and decisive evidence in relation to charges 4 and 5. The panel was of the view that there is no evidence before it to suggest that Dr 2 may have a motive to fabricate her evidence and was of the view that she provided a fair and balanced witness statement. The panel noted that the NMC took steps to arrange for the attendance of Dr 2 to give evidence if so required and accepts that there are no questions or challenge to Dr 2's evidence and therefore provides a good reason for not calling her as a witness. The panel also noted the content of the witness statement and that it assists Ms Davenport's case. For all the above reasons, the panel decided to admit Dr 2's witness statement as hearsay evidence. It would be a matter for the panel to determine what, if any, weight was to be attached to it.

Having received this evidence, the panel again retired in camera to continue its deliberations on its decisions on the facts.

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 Da Costa on behalf of the NMC.

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

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Witness 1: Retired registered nurse employed by the Trust to investigate incidents
- Witness 2: Operational Manager at Nottinghamshire Healthcare NHS Foundation Trust
- Witness 3: Team Manager at Nottinghamshire Healthcare NHS Foundation Trust
- Witness 4: Band 7 Community Clinical Team Lead/Community Mental Health Nurse at Nottinghamshire Healthcare NHS Foundation Trust

The panel had sight of documentary evidence from:

- Dr 1: Consultant Psychiatrist employed by the Trust
- Dr 2: Clinical Psychologist employed by the Trust

Charge 1.1

That you, a registered nurse, while acting as a community psychiatric nurse for the Nottinghamshire Healthcare NHS Trust:

1. Did not preserve patient safety in that you:

1.1 Did not visit Patient A between 18 November 2019 and 29 December 2019, on a weekly basis as set out in his care plan of 18 November 2019, or at all.

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's written and oral evidence, Dr 1's Coroner's report and the documentary evidence before it.

The panel was mindful that Dr 1's Coroner's report was admitted as hearsay evidence. The panel decided to place significant weight upon it because it considered the report to be essentially factual and consistent with the contemporaneous record made of his consultation with Patient A that took place on 18 November 2019.

The panel accepted the evidence in Dr 1's Coroner's report which included the requirement for Ms Davenport to conduct weekly visits following his meeting with Patient A and Ms Davenport on 18 November 2019. Dr 1's Coroner's report stated:

> *"The plan that was agreed on the day was no change in medication, to commence structured clinical management for six weeks, CCO to visit weekly and Outpatient appointment in 2 months, and support worker to provide regular input."*

The panel had sight of Ms Davenport's Coroner's report dated 20 May 2020 in which, with reference to the meeting with Patient A on 18 November 2019, she stated:

"Although it was agreed that there would be weekly visits this was flexible depending on the commitments of my caseload and availability."

The note in Patient A's patient record by Dr 1 clearly states that the visits were to be weekly. The panel heard evidence from Witness 2 that weekly visits were unusual, and this would have demonstrated that Patient A had a very high level of need and support required. There was no indication that these visits were flexible depending on Ms Davenport's availability in the contemporaneous note written by Dr 1. The panel therefore preferred the evidence from Dr 1.

The panel had sight of Patient A's patient records covering the period of 18 November 2019 to 29 December 2019. The notes detailed attempted phone calls from Ms Davenport to Patient A on 28 November 2019 and 2 December 2019 as well as a failed cold call visit on 26 November 2019. There were no records of any successful weekly visits being conducted by Ms Davenport.

The panel took into account the Trust Investigation report and its record of an interview conducted by Witness 1 on 28 October 2020 with Ms Davenport.

During the interview, Witness 1 questioned Ms Davenport:

"When did you see the patient before the last appointment?"

Witness 1 detailed Ms Davenport's response to the question:

"JD [Ms Davenport] *stated she saw the patient over the Christmas period at some point, but the care plan stated she should have seen the patient weekly, and she didn't. JD stated if she was on annual leave, she should have allocated someone else to see the patient. JD stated that engagement with the patient was difficult."*

The panel noted that with regard to Ms Davenport's claim of Patient A being difficult to engage with, other health professionals had been in contact with him between 18 November and 29 December 2019. Ms Davenport had a duty as his care coordinator to visit Patient A weekly and there are no records of any successful visits conducted by her during this period.

The panel noted that in the Trust investigation interview, Ms Davenport confirmed herself that she did not conduct weekly visits.

The panel found that there was sufficient evidence to prove that Ms Davenport did not visit Patient A between 18 November 2019 and 29 December 2019, on a weekly basis as set out in his care plan on 19 November 2019, or at all.

The panel therefore found this charge proved.

Charge 1.2

> 1.2 Did not visit Patient B between November 2019 and April 2020 on a monthly basis, or at all.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's and Witness 4's written and oral evidence and the documentary evidence before it.

In her witness statement, Witness 2 said that:

> *"In June 2020 the Trust received a complaint from a patient about the care they were receiving from Joanne. The patient complained that they were not receiving consistent care and not being visited according to the care plan."*

In her witness statement, Witness 4 said:

> *"As a Care Coordinator (CCO) the registrant was expected to have contact with patients at least once a month and ideally face to face. However, as a Band 6 I would have expected the registrant to have more frequent contact with patients due to the complexities in presentations that Band 6 practitioners usually hold. Rio Progress notes* [patient records] *should be completed within 24hrs of a clinician seeing or having contact with a patient."*

In her supplementary witness statement, Witness 2 stated:

> *"Joanne was the care coordinator for Patient B from 14 August 2019. Joanne was required to see the patient every month.*
>
> *[PRIVATE]. He had had a number of admissions to the Hospital. [PRIVATE]. [Patient B] was taking a variety of medications that had to be overseen by the care coordinator as part of a holistic care plan."*

The panel noted and accepted the evidence of Witnesses 2 and 4 that Ms Davenport was expected to visit Patient B on a monthly basis.

The panel took into account the patient records for Patient B for the period 6 November 2019 to 9 April 2020 and Witness 2's supplementary statement, commenting on the patient records for Patient B in which she said:

> *"The RiO* [patient records] *notes show that there was no entries made by Joanne between 6 November 2019 to 9 April 2020. This indicates that Joanne either did not visit the patient for nearly 6 months or made no records in relation to this patient's care…On her return to work Joanne was asked about the complaint and said that the patient had been difficult to work with. She gave no further explanation as to why there had been no records made."*

The panel noted the evidence of Witness 4 and the caseload reviews carried out by her as an audit tool. Witness 4 told the panel that she carried out two case load reviews in respect of Ms Davenport in March 2019 and June 2020. These audits were reported in the form of matrices exhibited by Witness 4. The panel noted that in relation to Patient B, the matrix for June 2020 shows the following:

> *"last contact prior to 09/04/2020 6/11/2020.?* [sic] *What is the role of a CCO is"? Previous review for Core Doc to be completed."*

Witness 4 gave oral evidence confirming that her finding from her audit of Patient B's patient records was that Ms Davenport had not recorded any contact between herself and Patient B between 6 November 2019 and 9 April 2020. She confirmed that reference to the date *"6/11/2020"* above was a typographical error on her part. The panel accepted this explanation having itself examined the dates contained in the patient records for Patient B.

The panel found the evidence of Witnesses 2 and 4 to be cogent and supported by contemporaneous documents and consequently gave this evidence significant weight. Witness 2's witness statement notes that Ms Davenport was not able to take part in responding to the complaint by Patient B [PRIVATE], when asked about the complaint, she said that the patient had been difficult to work with and gave no further explanation as to why there had been no record made.

The panel determined on balance, it was likely that Ms Davenport did not visit Patient B on a monthly basis between the relevant dates as required.

The panel therefore found this charge proved.

Charge 2.1

2. Did not maintain appropriate patient records in that you:

2.1 Did not make a contemporary record of any visits or attempted visits to Patient A between 18 November 2019 and 29 December 2019

This charge is found proved.

In reaching this decision, the panel took into account Witness 2's written and oral evidence, alongside all of the documentary evidence before it.

The panel had regard to patient record entries for Patient A during the relevant period. It noted an entry dated 26 November 2019 which indicates that Ms Davenport made a cold call attempted visit to Patient A's home address that day, without success. It heard evidence from Witness 2 that this record was created on 9 January 2020. This evidence was based on contemporaneous patient record information and the panel accepted it.

Patient record entries show that Patient A made a telephone call [PRIVATE] on 27 December 2019 and this prompted Ms Davenport to call him back on the same day, with a patient record made reflecting that.

A patient record entry dated 30 December 2019 gives details of a visit made by the registrant to Patient A on that day.

In Ms Davenport's Coroner's report, she states:

> *"41. **26.11.19** – (Retrospective entry) I went to Patient A's home address as I was passing and I thought I would call in and check on his well-being, there was no answer upon knocking, I waited for a few minutes and there was no reply. I would normally post a note through the door to say I had called but I did not on this occasion."*

When interviewed during the Trust investigation on 28 October 2020, Ms Davenport was asked why she was unable to record on [patient records] at the time she saw Patient A. In

response, Ms Davenport stated that she often called in to see the patient on her way home from work and didn't know why she didn't outcome [make a record] on [patient records], stating that perhaps she forgot.

The panel noted that records for Patient A and her own Coroner's report suggest that Ms Davenport made only one attempted visit to Patient A on 26 November 2019. This is significantly inconsistent with her claim, when interviewed as part of the Trust investigation to have often made attempted visits to Patient A's home on her way home from work, and consequently the panel gave her explanations little weight.

The panel took into account that weekly visits to Patient A were not made to Ms Davenport as required. The panel decided that the one attempted visit entered into the patient records, was not contemporaneous and that when Ms Davenport was interviewed as part of the Trust investigation as to why she did not record this at the time she saw the patient, she did not provide an adequate answer.

The panel concluded that Ms Davenport did not make a contemporary record of any visits or attempted visits to Patient A between 18 November 2019 and December 2019.

The panel therefore found this charge proved.

Charge 2.2

> 2.2 Did not create and/or record an updated care plan for Patient A between 18 November 2019 and 29 December 2019.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's written and oral evidence, alongside all of the documentary evidence before it.

The panel took into account Witness 2's written statement which stated:

> *"…Weekly visits are also contained within the care plan which Joanne updated on 27 December 2019."*

The panel took into account Patient A's 'Summary & Care Plan' dated 17 June 2019. This document was produced before Ms Davenport assumed the role of Patient A's CCO.

The panel noted that this care plan included on its final page the following information:

> *"**Updated by** Joanne Davenport*
> ***Updated on** 27th December 2019 11:10"*

The panel relied on this contemporaneous document and the evidence of Witness 2 and concluded that Ms Davenport updated Patient A's care plan on 27 December 2019 and therefore found this charge not proved.

This charge is found NOT proved.

Charge 2.3

> 2.3 Did not create and/or record an updated risk assessment for Patient A between 18 November 2019 and 29 December 2019.

This charge is found proved.

In reaching this decision, the panel took into account Witness 2 and Witness 4's written and oral evidence, Ms Davenport's acceptance when interviewed, alongside all of the documentary evidence before it.

The panel heard from Witness 4 that risk assessments should be updated at least every six months. As risks change frequently with patients, the assessment should also be updated whenever there is an increase or decrease in the risks for that patient. The panel took into account that after the consultation with Dr 1 on 18 November 2019, it was clearly identified that Patient A's risk profile had changed.

The panel took into account the SUI investigation report which states:

> *"According to* [Patient A's] *electronic records, his risk assessment was last updated by his care coordinator JD on 8 January 2020 at 9.40. Prior to this it had been completed on 15 April 2019…"*

The panel took into account Witness 2's written statement which said:

> *"This risk is documented in* [Patient A's] *risk assessment which had been updated by Joanne on 8 January 2020."*

The panel also had regard to the record of interview as part of the Trust investigation that took place between Witness 1 and Ms Davenport. Witness 1 asked Ms Davenport:

> *"I understand that Issues became apparent again following a SI* [sic] *investigation in relation to a patient on your caseload where it transpired that the patient had no up to date care plan or risk assessment, had not been seen for some time despite having a care plan which indicated he should be seen on a weekly basis. Is this correct?".*

In response, Ms Davenport is recorded as stating:

> *"JD stated she did see the patient a* [PRIVATE] *and there was a care plan in place, but it hadn't been updated. JD stated the patient was a complex individual, but she*

hadn't updated the care plan and she should have reviewed the risks and the care plan."

The panel found no evidence that Patient A's risk assessment was updated following the consultation with Dr 1 on 18 November 2019 and it noted Ms Davenport's own comments that she should have reviewed the risks associated with Patient A. On this basis, the panel found that Ms Davenport did not create and/or record an updated risk assessment for Patient A between 18 November 2019 and 29 December 2019 and therefore found this charge proved.

Charges 2.4.1 and 2.4.3

2. Updated Patient A's records in respect of the following dates without making clear these entries had been added retrospectively:
   2.4.1 26 November 2019.
   2.4.3 2 December 2019.

These charges are found proved.

In reaching this decision, the panel took into account Witness 2 and Witness 3's written and oral evidence, alongside all of the documentary evidence before it. The panel had regard of these charges individually and collectively.

In her written statement, Witness 3 stated that:

"Initially the entries that Joanne had written were not written in retrospect but written as though they were at the time. After a conversation with myself and [PRIVATE], *she agreed to delete the previous entries that were documented in retrospect.*

Joanne's notes should have been clearly documented that the entries were written in retrospect. I don't believe this was a mistake, although its possible. An

experienced nurse would ensure that the RiO [patient record] *entries were written within a timely manner..."*

In her written statement, Witness 2 stated:

"… Joanne wrote retrospective entries on the RiO [patient record] *system about her contacts with Patient A after he was admitted to the hospital. Joanne did not state that they were written in retrospect but gave the impression that they were written at the time of her visits/calls. The entries had to be removed."*

Witness 2 took the panel to Patient A's patient records and explained that the strike through entries shown in grey are deleted entries. These entries were deleted on 10 April 2020, as per Witness 3's instruction, but remained on the records as an audit trail. The panel heard oral evidence from Witness 2 that the entry for 26 November 2019 was created on 9 January 2020 [PRIVATE]. The entry for 2 December 2019 was created on 27 December 2019. Neither entry was marked as retrospective.

The panel found that there was sufficient evidence to prove that Ms Davenport updated Patient A's records for 26 November 2019 and 2 December 2019 without making clear these entries had been added retrospectively.

The panel therefore found these charges proved.

Charge 2.5

2.5 Did not make a contemporary record any visits or attempted visits to Patient B between November 2019 and April 2020.

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 2's written and oral evidence, alongside all of the documentary evidence before it.

The panel had sight of Patient B's patient records and also two matrices showing the outcomes of two caseload reviews of Ms Davenport's work carried out by Witness 4 in March 2019 and June 2020.

The panel took into account Witness 2's written statement in which she stated:

> *"In June 2020 the Trust received a complaint from a patient about the care they were receiving from Joanne. The patient complained that they were not receiving consistent care and not being visited according to the care plan.*
> *…*
> *The RiO* [patient record] *notes show that there were no entries made by Joanne between 6 November 2019 to 9 April 2019. This indicates that Joanne either did not visit the patient for nearly 6 months or made no records in relation to this patient's care."*

The panel noted its earlier decision in relation to charge 1.2 in which it determined that Ms Davenport did not visit Patient B on a monthly basis between November 2019 and April 2020.

Having regard to this and the absence of any reference in Patient B's patient records to the effect that, aside of actual visits, Ms Davenport made no attempted visits during the relevant period, the panel relied on the contemporaneous records and concluded that Ms Davenport did not make any attempted visits to Patient B.

On the basis that there were no visits or attempted visits by Ms Davenport to Patient B during the relevant period. As such, no records were needed and therefore the panel found this charge not proved.

Charge 2.6

2.6 Did not create and/or record a care plan for Patient B

This charge is found proved.

In reaching this decision, the panel took into account Witness 4's written and oral evidence, alongside all of the documentary evidence before it.

The panel took into account email correspondence on 7 June 2020 from Witness 4 to Witness 3 which stated:

> *"Patient B - still not sure what our role is in his care. I questioned this last time she went* [PRIVATE] *for a long period of time. NO Core Ax / Care Plan. Risk Ax 2yrs out of date. When she returned last time it was agreed she would complete these core docs in her graded return. Of the 9 she has had regular contact with him - ? role though??"*

The panel took into account the case load reviews completed by Witness 4 in March 2019 and again in June 2020. Against Patient B's name in 2019, Witness 4 records:

> *"no core no plan out of date risk* [assessment]*."*

In the 2020 review, Witness 4 reports that there is still no care plan for Patient B. The panel relied on these contemporaneous documents and accepted the evidence of Witness 4. It concluded that a care plan for Patient B was not in place during March 2019 and that this was still outstanding in June 2020.

The panel found that there was sufficient evidence to prove that Ms Davenport did not create and/or record a care plan for Patient B.

The panel therefore found this charge proved.

Charge 2.7

> 2.7 In 2019 and/or 2020 did not maintain an up-to-date risk assessments and/or care plans and/or core assessments for one or all of the patients outlined in Schedule 1

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's, Witness 3's and Witness 4's written and oral evidence, alongside all of the documentary evidence before it.

The panel heard evidence from Witness 4 that there is an expectation that core assessments should be reviewed/updated annually. Risk assessments and care plans should be updated between six to twelve months. Witness 1 explained that mental health needs change all the time, and these documents should be updated regularly to reflect this.

The panel had sight of two matrices reporting the outcomes of two case load reviews of the work of Ms Davenport carried out by Witness 4 in March 2019 and June 2020.

The matrices detail the status of core assessments, care plans and risk assessments amongst other information for all of the patients listed in Schedule 1. The panel noted that for each patient listed on the matrix, one or more of these documents were either out of date or not present.

When Witness 1 was questioned by the panel, she confirmed that she had conducted an independent case load review of the same patients and concurred with the findings of Witness 4.

The panel took into account all of the evidence in relation to each patient in Schedule 1, in particular the contemporaneous record of the reviews carried out by Witness 4. The panel acknowledged that the core assessments, risk assessments and care plans were either not present or out of date. The panel noted that this evidence was supported by Witness 1 when she confirmed that she went through the assessment and compared the documents against the records.

The panel found that there was sufficient evidence to prove that in 2019 and/or 2020, Ms Davenport did not maintain an up-to-date risk assessment and/or care plan and/or core assessments for one or all of the patients outlined in Schedule 1.

The panel therefore found this charge proved.

Charge 3

3. Your conduct as outlined in charge 2.4 was dishonest in that you added entries retrospectively to Patient A's record in order to hide that fact that you did not make contemporaneous entries at the time and/or that you did not visit or attempt to visit Patient A between 18 November 2019 and 29 December 2019

This charge is found proved.

In reaching this decision, the panel took into account Witness 1's, Witness 3's and Witness 4's written and oral evidence, Dr 1's statement, Ms Davenport's acceptance when interviewed, alongside all of the documentary evidence before it.

The panel took into account Dr 1's entry in Patient A's patient records dated 18 November 2019 which stated:

> *"I reviewed Patient A today for the first time, in attendance was Joe* [sic] *Davenport his care coordinator…*

no change in medication
to commence structed clinical management for 6 weeks
cco to visit weekly."

Ms Davenport's Coroner's report reflects Dr 1's entry in Patient A's patient records and states:

"The plan from this review was no change in medication, to commence the CSM programme to have Care Coordinator visits weekly and regular support worker input. and a further outpatient appointment in two months…"

The panel noted the contemporaneous records and accepted the evidence of Dr 1 based on them. The panel also accepted Ms Davenport's comments above and concluded that she knew of the requirement to visit Patient A on a weekly basis.

Another entry in Patient A's patient records from the duty log on 27 December 2019 states:

"Hi
Please note a call has come in from the above client. This client normally sees Jo Davenport who is off leave until 27/12. He told me he does not feel very good. Please can somebody call him…"

Ms Davenport subsequently phoned Patient A on the same day and updated patient records with the outcome of this call and created the record of the phone call that allegedly was made by Ms Davenport on 2 December 2019.

The panel first considered Ms Davenport's subjective state of mind and knowledge at the time that she made the patient record entries referenced in charges 2.4.1 and 2.4.3.

In respect of Charge 2.4.1, the panel noted that this refers to an entry in patient records of an attempted visit allegedly made on 26 November 2019 but not created until 9 January 2020, [PRIVATE]. The panel previously found that Ms Davenport did not visit Patient A as required on a weekly basis during the relevant period and concluded that, when she made the record on 9 January, she would have known of the requirement and of her failure to make the required visits.

The panel went on to consider Ms Davenport's subjective knowledge and belief in terms of whether the attempted visit she claimed to have made on 26 November 2019 actually took place. The panel noted that there are no records of any other visits or attempted visits to Patient A during the relevant period. In addition, the entry for 26 November 2019 was made on 9 January 2020. However, the telephone call to Patient A on 2 December 2019 and subject to charge 2.4.3, was recorded in patient records on 27 December 2019.

The panel considered it likely that had the attempted visit taken place on 26 November 2019, then it would have been in Ms Davenport's contemplation when she made entries to Patient A's patient records on 27 December 2019. This combined with the absence of any other visits and the time of the entry [PRIVATE], leads the panel to conclude that on the balance of probabilities, the attempted visit did not take place, and that Ms Davenport knew that to be the case.

[PRIVATE]. The panel heard evidence that as an experienced Band 6 nurse, Ms Davenport would have been fully aware of the importance of marking patient records as retrospective when not written contemporaneously and the panel accepted this evidence.

The panel next considered whether Ms Davenport's conduct was honest or dishonest by applying the objective standards of ordinary decent people. The panel was satisfied that it was more likely than not that Ms Davenport's conduct was an attempt to hide the fact that she had not visited or attempted to visit Patient A weekly as she should have done. The panel was further satisfied that this was dishonest applying the objective standards of ordinary decent people.

In respect of Charge 2.4.3, the panel noted that the entry of 2 December 2019 was created on 27 December 2019 and was not marked as retrospective. Again, the panel was satisfied that Ms Davenport would have known as an experienced nurse of the need to make patient records contemporaneously and if not, to clearly mark them as having been made as retrospectively. The panel took the view when she created the record for 2 December 2019, Ms Davenport knew she had not marked it as retrospective, and she knew she should have done so.

The panel was satisfied on the balance of probabilities, that by the objective standards of ordinary decent people, Ms Davenport's conduct was dishonest, and that Ms Davenport was attempting to hide the fact that she was not recording her patient records contemporaneously as per the Trust practice.

The panel therefore found this charge proved in respect of both charges 2.4.1 and 2.4.3.

Charge 4

4. You informed the Nottinghamshire Healthcare NHS Trust that the reason you did not visit Patient A between 2 December 2019- 27 December 2019 was that you were on annual leave/[PRIVATE] leave at the time when this was not the case.

This charge is found NOT proved.

The panel had regard to Ms Davenport's annual leave record which shows that she was on leave from 23 December to 24 December 2019 and was aware that she also had the public holidays on 25 and 26 December 2019 off. The panel saw no evidence in relation to any other annual [PRIVATE] leave for Ms Davenport during this period. The panel noted that in various places in the documentation provided to it and during oral evidence, references were made to Ms Davenport being on annual leave or claiming to be on annual leave from 2 December to 27 December 2019.

Having considered those references, the panel was of the view that they are repetitions of an assertion which appears in the SUI investigation report, completed in June 2020 [PRIVATE]. The SUI investigation report states:

"CCO JD subsequently went on planned leave from 2.12.2019 to 27.12.2019…"

The panel noted that this comment is in the form of an assertion that Ms Davenport was on annual leave between those dates and does not appear to be information emanating from questions being asked of and answers being provided by Ms Davenport. None of the witnesses were able to confirm what Ms Davenport was asked, what her reply was, or how this assertion came to be captured.

The panel is satisfied that this assertion is the source of other references of Ms Davenport being on annual leave during this period.

Ms Davenport was interviewed by telephone during the course of the Level 2 investigation. Despite raising questions, the panel was unable gain access to the interview notes to assess whether Ms Davenport informed the Trust via the interviewer that she was on annual leave between 2 December 2019 and 27 December 2019.

Following further enquiries at the behest of the panel, both authors of the report, Dr 2 and Dr 3, were spoken to by the NMC. Dr 3 provided information that he had not carried out the interview with Ms Davenport and that this had been done by his colleague, Dr 2. Dr 2 could not recall if she had interviewed to Ms Davenport and the panel had regard to a statement provided by Dr 2 dated 26 October 2024 which states:

"I may have been part of this interview, but I do not remember.

…

The information regarding the Registrant planned annual leave between 02 – 27 December 2019 came to be included in the report as I believe it was mentioned by either her or her manager in response to a question during the interview...

Unfortunately, I am unable to remember anything beyond what I have outlined about the interview due to the time that has passed since the report was produced."

When Ms Davenport was later interviewed as part of the Trust investigation which took place on 28 October 2020, Witness 1 asked:

"I understand that during the SI investigation some discrepancy was revealed regarding your potential absence from work 2nd-27th Dec in that you told the investigating panel that you were on annual leave during this period. Is this correct?"

It was documented that Ms Davenport responded in the following terms:

"JD stated she could not recall saying that, [PRIVATE] *and that the interview was over the phone, but she wouldn't have said she was off on annual leave for that length of time, as it is unlikely this would have been authorised."*

The panel found this to be a plausible assertion by Ms Davenport.

Having regard to all of the evidence and information, the panel did not find any reliable evidence that Ms Davenport informed the Trust that she was on annual/[PRIVATE] leave for the whole period of 2 December 2019 to 27 December 2019.

The panel therefore found this charge NOT proved.

Charge 5

5. Your conduct as outlined in charge 4 was dishonest in that you gave a false explanation for the reasons you did not visit Patient A between 2 December 2019 and 28 December 2019.

This charge is found NOT proved.

In light of its findings on charge 4, the panel found charge 5 not proved.

Fitness to practise

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

Submissions on misconduct

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

Ms Da Costa invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2018' (the Code) in making its decision.

Ms Da Costa identified the specific, relevant standards where Ms Davenport's actions amounted to misconduct. She submitted that the charges found proved amount to misconduct in this case. Ms Da Costa referred to *Roylance v General Medical Council.*

Ms Da Costa submitted that the conduct found proved by the panel fell short of what would have been expected of a registered nurse. She submitted that Ms Davenport was a registered nurse who was responsible for a number of patients who were vulnerable due to their personal circumstances and medical conditions.

Ms Da Costa submitted that the following sections of the NMC professional standards of practice and behaviour for nurses, midwives and nursing associates (the Code) are engaged:

> ***'1 Treat people as individuals and uphold their dignity***
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
>
> ***4 Act in the best interests of people at all times***
>
> ***10 Keep clear and accurate records relevant to your practice***
>
> ***16 Act without delay if you believe that there is a risk to patient safety or public protection***
> *16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practice*
> *16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can*
>
> ***19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice***
>
> ***20 Uphold the reputation of your profession at all times'***

Ms Da Costa said that Ms Davenport's actions in failing to provide care can be said to have brought the profession into disrepute.

Submissions on impairment

Ms Da Costa moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

Ms Da Costa submitted that Ms Davenport's failings involve a serious departure from the standards expected of a registered nurse. She submitted that the patients involved were vulnerable.

Ms Da Costa submitted that Patient B, had to take it upon themselves to complain to the Trust and to seek help as a result of having no contact from Ms Davenport as their care coordinator.

Ms Da Costa submitted that Patient A required weekly visits from their care coordinator, Ms Davenport. [PRIVATE].

Ms Da Costa submitted that there was a risk of harm to patients. She submitted that Ms Davenport failed to provide adequate care which placed them at risk of very serious harm.

Ms Da Costa submitted that Ms Davenport is likely to cause harm to patients in the future. She submitted that there is nothing before the panel to indicate insight and remediation into these failings.

Ms Da Costa submitted that there was information through the Trust investigation [PRIVATE]. However, there has been nothing further in terms of any work to address insight or any work undertaken to address her failings.

Ms Da Costa submitted that there is nothing before the panel in relation to addressing Ms Davenport's dishonesty and said that conduct relating to dishonesty is not always easy to remediate.

Ms Da Costa submitted that these failings were repeated over a lengthy period of time. She submitted that they were repeated in relation to different vulnerable patients.

Ms Da Costa submitted that the misconduct in this case is so serious that Ms Davenport has brought the nursing profession into disrepute. She submitted that Ms Davenport has breached the fundamental tenets of her profession.

Ms Da Costa submitted that Ms Davenport is impaired on both public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *Calhaem, v General Medical Council* [2007] EWHC 2606, *General Medical Council v Meadow* [2007] QB 462 (Admin), *Cohen v General Medical Council* [2008] EWHC 581 (Admin) and *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin).

The panel had regard to the NMC Guidance DMA-1 in relation to impairment.

Decision and reasons on misconduct

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

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

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Ms Davenport's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Davenport's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *To achieve this, you must:*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively*
>
> ***3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *To achieve this, you must:*

3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.5 work with colleagues to preserve the safety of those receiving care

8.6 share information to identify and reduce risk

10 Keep clear and accurate records relevant to your practice

To achieve this, you must:

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

10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need

10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements

10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation

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

To achieve this, you must:

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

16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

20 Uphold the reputation of your profession at all times

To achieve this, you must:

20.1 keep to and uphold the standards and values set out in the Code

20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct.

In respect of the charges found proved, the panel identified three core issues:

1. Not visiting patients as required
2. Not maintaining appropriate patient records by:
    a. Not making contemporary records of visits
    b. Not creating/updating care plans, core and risk assessments
    c. Not marking entries as retrospective
3. Dishonesty in an attempt to hide that visit were not made and patient records were not up to date.

In respect of charges 1.1 and 1.2, the panel found that Ms Davenport did not visit vulnerable patients as required. The panel noted that Ms Davenport consistently did not

visit patients over an extended period of time. The panel took into account that Ms Davenport had a duty to follow the care plans and visit the patients. The panel determined that Ms Davenport's conduct in charges 1.1 and 1.2 put patients at significant risk of harm and fell far below the standards expected of a registered nurse and in the panel's view, amounts to misconduct.

In respect of charge 2, Ms Davenport held responsibility for coordinating and maintaining appropriate patient records. The panel was of the view that it was imperative for all services and healthcare professionals responsible for caring for each patient to have access to accurate and up-to-date records in relation to vulnerable patients. Ms Davenport failed to maintain the patient records of 27 patients over an extended period of time. The panel considered that record keeping is a fundamental aspect of nursing and that Ms Davenport's sustained failure to maintain adequate records for 27 patients fell far below the standards expected of a registered nurse and amount to misconduct.

Ms Davenport's conduct in relation to charge 3 was dishonest. Although serious in itself, the panel noted that her dishonesty, in failing to identify a patient record as retrospectively made and later making a false record of an attempted visit to Patient A was all the more serious. The dishonesty took place in a clinical setting and was aimed at covering up Ms Davenport's earlier misconduct. The panel is of the view that fellow practitioners would find her conduct deplorable and concluded that this amounts to misconduct.

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

Decision and reasons on impairment

The panel next went on to decide if as a result of her misconduct, Ms Davenport's fitness to practise is currently impaired.

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. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

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

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

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

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

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel concluded that all four limbs of this test are engaged in this case.

In relation to limb *a*, the panel noted that vulnerable patients with complex mental health needs were under Ms Davenport's care and as such were more reliant on effective care. Ms Davenport did not complete or maintain appropriate patient records thereby placing them at unwarranted risk of harm. Furthermore, in relation to Patient A and B, by not visiting them in accordance with their care plans, the panel was satisfied that Ms Davenport exposed these vulnerable patients to the risk of harm.

In relation to limb *b*, the panel is of the view that Ms Davenport brought the profession into disrepute by reason of her misconduct involving 27 patients over an extended period of time. Patient B resorted to making a formal complaint in order to access services which should have been provided regularly. The Trust had to conduct an investigation as a result of this complaint. In the panel's view, Ms Davenport's misconduct, which involved clinical failings and subsequent dishonest acts in an attempt to hide those failings, is so serious that it would undermine public confidence in the nursing profession and therefore bring it into disrepute.

In relation to limb *c*, Ms Davenport breached the fundamental tenets of the nursing profession. The panel is of the view that accurate record keeping and visiting patients as per their care plans are fundamental practices in nursing. The panel also considered that honesty, integrity and a duty of candour underpin what is expected of a registered nurse. In relation to limb *d*, the panel found in charge 3, Ms Davenport's actions were dishonest in that she deliberately did not mark entries in patient records as retrospective and made a false entry in patient records in order to cover up her earlier misconduct.

The panel noted that in addition to considering Ms Davenport's past conduct, Dame Janet Smiths 'test' also requires it to consider what Ms Davenport may be liable to do in the future. The panel therefore considered the three questions posed in the case of Cohen; whether Ms Davenport's conduct is capable of remediation, whether it has been remediated, and whether it is highly unlikely to be repeated.

In relation to the first of these questions, the panel considered that the record keeping, and case load aspects of Ms Davenport's misconduct are potentially remediable with appropriate commitment from her and training support. In relation to the dishonesty aspect, the panel takes the view that although ultimately capable of remediation, this area of her dishonesty will be much more difficult to remediate because it relates to clinical practice and attempts to cover up clinical failings.

Turning to the second question, the panel saw no current evidence of any strengthened practice, reflection, or developed insight. The panel noted that following her interview as part of the Trust investigation during 2020, Ms Davenport provided the following reflective comments:

> *"I take full responsibility for the errors I have made and of the importance of making my manager/supervisor know if I am struggling and in need of help/support. I hope that the outcome of this investigation will be that I can return to my role as a band 6 CPN and to continue to work within a team. I have worked for the NHS for 18 years and have been a qualified nurse for 20 years. I have always worked very hard and demonstrated empathy, care and kindness towards patients, carer's and colleagues. I have excellent communication skills and formed therapeutic relationships over the years and have received a lot of positive feedback as nurse. Overall, I think that I am an excellent nurse and I want to continue to work in this profession. I have always looked forward to coming to work in the mornings and enjoy the challenges that the day brings*

I know there were concerns raised leading up to and during the coroner's hearing, [PRIVATE], *I have never been summoned to a coroner's hearing before.*

I know I have recently had difficulties with case management, and I hope I have proved I can complete work particularly assessments to a high standard and therefore will be able to transfer this high standard towards a working caseload. This investigation has helped me to regain my focus, and I hope I get the chance to prove that I will never allow myself to lose this focus in the future."

The panel acknowledges that during the Trust investigation, Ms Davenport took some responsibility for her actions and describes some of the context within which she was working during 2019/2020. However, the panel considered her insight to be limited because the above account was provided in 2020, and the panel has not had the benefit of seeing any updated reflections or evidence in practice from Ms Davenport.

The panel acknowledged that Ms Davenport had sickness absence between March and July 2019. [PRIVATE]. Staff members who were struggling with the changes to working practices were offered support by the Trust. Ms Davenport was offered assessment training but did not book herself on to this and did not regularly attend her supervision sessions.

Given the above, the panel was of the view that Ms Davenport has not remediated her misconduct.

The panel next considered the third question in Cohen. Given the lack of evidence of strengthened practice, and remediation and in the absence of any up-to-date information on insight, the panel concluded that Ms Davenport's conduct is not highly unlikely to be repeated. Indeed, it considers the risk of repetition in the circumstances to be high.

Having regard to these matters, the panel was of the view that all four limbs of Dame Janet Smith's 'test' are engaged as to the future.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

Having regard to the scope of Ms Davenport's misconduct and the risk of repetition identified, the panel determined that a finding of impairment on public protection grounds is necessary in this case.

The panel also determined that a finding of impairment on public interest grounds is required. Ms Davenport's misconduct has the potential to divert those who are in need of mental health services away from the support network. In addition, the panel is of the view that such is the seriousness of the misconduct in this case that the public and fellow professionals would be appalled if a finding of impairment were not made. The panel also considered that a finding of impairment on public interest grounds is needed to send a message to the profession and to declare and uphold proper standards.

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

Sanction

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

In reaching this decision, the panel had regard to all the evidence that has been adduced in this case and had regard to the Sanctions Guidance (SG) published by the NMC. The panel accepted the advice of the legal assessor.

Submissions on sanction

Ms Da Costa informed the panel that the NMC would be seeking a striking-off as the only appropriate sanction in this case. She submitted that this is in consideration to the Sanctions Guidance surround the imposition of striking off orders.

Ms Da Costa submitted that the aggravating factors in this case include:

- Repeated misconduct over a prolonged period of time in respect of multiple patients;
- Dishonesty;
- Harm caused to a vulnerable patient;
- Lack of insight into the misconduct; and
- The impact of misconduct on patients and colleagues.

In answer to a question by the panel as to what harm was actually caused to patients as opposed to the risk of harm, Ms Da Costa submitted that there is a link between the lack of care that Patient A was receiving from Ms Davenport [PRIVATE].

Ms Da Costa submitted that a mitigating factor is that Ms Davenport previously engaged with the proceedings and provided responses in relation [PRIVATE].

Ms Da Costa submitted that the dishonesty in this case is very serious.

Ms Da Costa submitted that a striking-off order is the only sanction sufficient to protect patients, members of the public and to maintain the professional standards of the profession.

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

Decision and reasons on sanction

Having found Ms Davenport'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 regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.

[PRIVATE].

The panel identified the following aggravating features:

- Ms Davenport's repeated misconduct over a prolonged period of time involving 27 vulnerable patients
- Lack of insight into her failings
- Ms Davenport's dishonesty and the fact that it was aimed at covering up her earlier misconduct
- The impact of Ms Davenport's colleagues in having to pick up her patients and rectify her caseload
- Vulnerable patients were placed at risk of harm

The panel also took into account the following mitigating features:

- Ms Davenport provided some albeit limited reflections and insight
- [PRIVATE]
- The change to working conditions at the Trust

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

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Ms Davenport'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 Ms Davenport's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the seriousness of the case. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether placing conditions of practice on Ms Davenport's registration would be a sufficient and appropriate response. The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the charges in this case. Although there are some charges that could be remediated through conditions, the dishonesty identified in this case would be extremely difficult to remediate through conditions. The panel considered conditions to be unworkable in this case because of Ms Davenport's lack of engagement and the absence of any information as to her current practice. The panel concluded that the placing of conditions on Ms Davenport's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The SG states that suspension order may be appropriate where some of the following factors are apparent:

- *A single instance of misconduct but where a lesser sanction is not sufficient;*
- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *No evidence of repetition of behaviour since the incident;*
- *The Committee is satisfied that the nurse or midwife has insight and does not pose a significant risk of repeating behaviour;*

- …
- ...

The panel decided that of the four relevant factors to consider which may indicate that a suspension order is appropriate in this case, none of the factors are engaged in this case. Ms Davenport's misconduct was not a single incident protracted and involving multiple patients. The panel's findings of dishonest indicates attitudinal problems and whilst there is no evidence of repetition, the panel does not have any information about Ms Davenport's practice since 2019/2020. The panel identified in its determination on impairment that there is a serious risk of repetition in this case.

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

Finally, in considering whether a striking-off order is the appropriate and proportionate sanction in this case, the panel took note of the following paragraphs of the SG which identify key considerations that the panel should take into account:

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

Ms Davenport's actions were significant departures from the standards expected of a registered nurse and do raise fundamental questions about her professionalism. In the circumstances, the panel was of the view that public confidence in the profession cannot be maintained if Ms Davenport were to remain on the register. In the absence of any information about strengthened practice or insight, the panel has concluded that there is a

serious risk of repetition and therefore concluded that striking-off is the only sanction which addresses the overarching objectives. The panel concluded that the misconduct in this case is such that it is fundamentally incompatible with continued registration.

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

Having regard to the effect of Ms Davenport's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Ms Davenport in writing.

Interim order

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

Submissions on interim order

Ms Da Costa invited the panel to impose an interim suspension order for a period of 18 months. She submitted that this interim order is necessary on the grounds of public protection, and it is also in the public interest, having regard to the panel's findings.

Decision and reasons on interim order

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

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. In the panel's judgment, public confidence in the regulatory process would be damaged if Ms Davenport were to be permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.
The panel therefore imposed an interim suspension order for a period of 18 months.

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

That concludes this determination.