Fitness to Practise Committee
Substantive Hearing

23 April – 1 May 2019

Nursing and Midwifery Council
2 Stratford Place, Montfichet Rd, London E20 1EJ

Name of registrant:	Joyce Mak
NMC PIN:	13I8120E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing – July 2014
Area of registered address:	London
Type of case:	Misconduct
Panel members:	Melissa D'Mello (Chair, lay member) Terry Shipperley (Registrant member) Patience McNay (Registrant member)
Legal Assessor:	Gillian Hawken
Panel Secretary:	Anita Abell
Ms Mak:	Not present and not represented
Nursing and Midwifery Council:	Represented by Kim Elcoate May, Case Presenter
Facts found proved:	Charges 1-9 inclusive
Fitness to practise:	Impaired
Sanction:	Striking off order
Interim order:	Interim suspension order (18 months)

Decision on service of Notice of Hearing:

Ms Mak was not in attendance. Written notice of this hearing had been sent to her registered address by recorded delivery and by first class post on 22 March 2019. The notice contained details of the hearing including time, date and place. Notice was also sent to Ms Mak's named representative in these proceedings, whose address details Ms Mak had provided to the NMC on 4 January 2019.

The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Ms Mak has been served with notice of this hearing in accordance with the requirements of Rules 11 and 34 of 'The Nursing and Midwifery Council (Fitness to Practise) Rules Order of Council 2004' ("the Rules").

Decision on proceeding in the absence of Ms Mak:

The panel then considered continuing in the absence of Ms Mak.

Ms Elcoate May informed the panel that the notice sent to Ms Mak had been collected from the delivery office and signed for on 25 March 2019. She submitted that the panel should proceed in the absence of Ms Mak. She provided the panel with a number of documents in support of her application.

The first document, which was 136 pages in length, contained correspondence from January 2019 to the present day between the NMC and Ms Mak, and the NMC and the person Ms Mak has named as her representative, who is based in Hong Kong.

The person named as a representative has been sent emails on more than four occasions and correspondence by airmail (delivery confirmed on four occasions) but has never responded to the NMC to confirm that he represents Ms Mak, or otherwise.

The same document contains an email from Ms Mak, dated 13 April 2019, which states:

> "You must also have received court notice which is differently from the NMC. I will not attend the hearing held by the NMC on the 15th of April, and nor will I attend the other provisional hearings held at mid April that approximately last for a week. Both of the hearing must not take place without my agreement.
>
> This is because I believed that there is another hearing in the first week of May." [sic]

Ms Elcoate May informed the panel that the hearing in the first week of May was an application from Ms Mak to the High Court to discharge an interim order currently in place on her nursing practice. That hearing had been scheduled for 2 May 2019. In response to being notified of the hearing date (in relation to the interim order) by the High Court, the NMC sent written representations to the High Court, copied to Ms Mak. The content of the representations was that the NMC had not received any documentation from Ms Mak in support of her application, despite the NMC having requested papers from her. Further the NMC highlighted that "the case has been listed for final disposal at a substantive hearing from 23 April to 1 May 2019". During the course of the first morning of this NMC hearing, evidence was provided to the panel that the application to the High Court scheduled for 2 May 2019 had been vacated and no alternative date fixed for a hearing. This notification was sent to the NMC by the High Court on the first morning of the hearing at 11:39.

Ms Elcoate May submitted that the NMC had made copious efforts to ensure Ms Mak was aware of the distinction between the interim order proceedings and the substantive order proceedings. She referred the panel to a written proceeding in absence summary document which lists all the email and postal correspondence between the NMC and Ms Mak, and the NMC and the person Ms Mak has named as her representative. In particular she drew attention to an email dated 15 April 2019, and a letter of the same date, which was sent by the NMC in response to Ms Mak's email of 13 April 2019 (transcribed above). Both the email and the letter contain the sentence:

> "You should be aware that the NMC will not be agreeing to cancel the hearing…and we will be asking the panel to proceed in your absence if you do not attend."

The NMC had also tried to telephone Ms Mak on various occasions including on 15 and 18 April 2019. The NMC calls went straight to an automated message saying that Ms Mak was not currently able to accept calls and to please try again later.

Ms Elcoate May informed the panel that there are five witnesses scheduled to attend the hearing and an adjournment would inconvenience them.

The panel heard and accepted the advice of the legal assessor. She reminded the panel of the cases of *General Medical Council v Adeogba* [2016] EWCA Civ 162 and *R v Jones* [1972] 1 WLR 887 and outlined the factors that the panel should take into account when reaching its decision. She advised the panel to consider fairness to both the NMC and to Ms Mak in determining whether to proceed today and, in particular, to have regard to the nature and circumstances of Ms Mak's behaviour in absenting herself from the hearing and her stated intention for doing so in her email of 13 April 2019. The panel should consider whether the landscape had changed, in light of the High Court's indication this morning that the hearing listed for 2 May 2019 has now been vacated.

The panel considered that Ms Mak was aware of today's hearing and that the NMC intended to apply to proceed in her absence. The panel concluded that, nevertheless, Ms Mak has chosen not to attend. The panel concluded that the NMC had provided a considerable amount of information on multiple occasions to Ms Mak, and her named representative, about interim order and substantive hearings, the fact that they are different and separate processes, and that she had had ample opportunity to ask any questions of the NMC if she was unclear. The reason she gave for non-attendance, that she was intending to attend the High Court next week, was not relevant to this hearing and was not sufficient for the panel to agree an adjournment. In reaching its decision the panel also took into account that the charges relate to 2017 and are very serious, including charges of dishonesty and an alleged breach of an interim order and there is a public interest in proceeding with these matters as soon as possible. Further there are five witnesses who are attending this hearing and any adjournment would inconvenience them. For these reasons the panel has decided to proceed in the absence of Ms Mak.

The panel acknowledge that there would be some disadvantage to Ms Mak by her not being present but it can mitigate this by considering the written responses she has sent in to the NMC, which run to 29 pages.

Having weighed the interests of Ms Mak with those of the NMC and the public interest in an expeditious disposal of this hearing the panel determined to proceed in her absence.

The panel informed the case presenter of its decision and directed that Ms Mak and her named representative be informed as soon as possible by email of the panel's decision to proceed with the hearing. The panel will now adjourn until the morning of day two.

The panel also directed that when it has finalised its determination on proceeding in absence, that should be forwarded to Ms Mak, and her named representative, by email. This will give Ms Mak, and/or her named representative, an opportunity to reflect and consider whether she wishes to attend the hearing on day two.

The charges (including amended charge 5)

"That you, a registered nurse:

1. On 18 January 2017 whilst working a bank shift at Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust"):

    a. When discharging Patient A who was on an ambulatory care pathway, you failed to follow the instruction of the nurse in the charge, Colleague A, that the patient needed to be discharged with a cannula in place, in that you removed the cannula

    b. After Patient A was re-cannulated you continued to disregard the instruction of the nurse in charge to leave a cannula in place, in that you removed the cannula for a second time and/or refused to discharge the patient with the cannula left in

    c. You failed to obtain the ECG machine required to assess Patient B's heart rhythm when requested to do so by Colleague A

    d. Did not follow instructions to go and speak to Colleague A about the incidents referenced at 1a and/or b and/or c above

Found proved in its entirety.

2. On 3 June 2017:

a. Reported to work on the surgical ward of Cromwell Hospital ("the Hospital") as a new starter to do an orientation shift when you were not employed by the Hospital

b. Told Colleague B that you had worked for the Hospital on 30 May 2017 on the orthopaedic surgical ward

Found proved in its entirety.

3. Your conduct in respect of charge 2a above was dishonest in that:

    a. You knew that your conditional offer of employment had been withdrawn on 2 June 2017 due to an unsatisfactory reference

    b. You intended to give the impression that you were an employee of the Hospital

Found proved in its entirety.

4. Your conduct in respect of charge 2b above was dishonest in that you knew you had not worked at the Hospital on 30 May 2017 but sought to give the impression you were an employee who had worked for the Hospital on a previous occasion.

Found proved.

5. On or around 5 June 2017:

    a. Reported to work on the surgical ward of Cromwell Hospital ("the Hospital") when you had been told on 3 June 2017 that you should not report to work at the Hospital until your employment status had been confirmed with management and/or HR

b. Refused to confirm how you had acquired a BUPA hospital uniform

c. Refused to leave the premises when advised you were not a BUPA employee

Found proved in its entirety.

6. Your conduct in respect of charge 5a above was dishonest in that you intended to give the impression you were an employee of the Hospital when you knew you were not

Found proved.

7. Between 9 August 2017 and 3 September 2017 when your practice was restricted by an interim suspension order, in the knowledge that you had signed an employment contract with HCA International Limited ("HCA") on 29 July 2017 with a provisional start date of 21 August 2017, you failed to inform HCA that your practice was restricted

Found proved.

8. Between 4 September 2017 and 5 October 2017, when your practice was restricted by an interim conditions of practice order, you breached condition 9 of the order in that you failed to immediately inform HCA that your practice was restricted

Found proved.

9. Your conduct in respect of charge 7 and/or 8 above was dishonest in that you deliberately sought to conceal from HCA previous concerns that had arisen in respect of your practice.

Found proved.

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

Background

Chelsea and Westminster Hospital

Ms Mak's curriculum vitae (CV) states that she began working at the Chelsea and Westminster Hospital NHS Foundation Trust ("the Hospital") in September 2014.

On 18 January 2017 Ms Mak was working a day shift in the Acute Assessment Unit (AAU) at the Hospital. The unit has 54 beds and admits patients from Accident & Emergency (A&E) who will then be referred elsewhere in the hospital or discharged home. On this shift Ms Mak was allocated to Bay A which has six beds and one side-room. She was the only nurse on duty in Bay A. She was assisted by two health care assistants who were working in both Bay A and Bay B, when required. Patient A and Patient B were Ms Mak's patients as they were located in Bay A.

Colleague A was a band 6 junior sister who was the nurse in charge of the shift. She was responsible for allocating nurses and health care assistants on the ward and she accompanied the consultant on the morning and afternoon ward round. On the consultant's instructions, Patient A was due to be discharged on an ambulatory care pathway with a cannula in place to facilitate the administration of an intravenous antibiotic.

It is alleged that Colleague A informed Ms Mak that Patient A should be discharged with a cannula in place and that Ms Mak disregarded this information and removed Patient A's cannula. A doctor discovered that the cannula had been removed and re-cannulated Patient A. It is alleged that Ms Mak removed the cannula for a second time and that she refused to discharge Patient A. Colleague A then re-cannulated Patient A for the third time and discharged her. It is said that Patient A made an informal complaint to Colleague A.

Colleague A was concerned about Patient B and it is alleged that she asked Ms Mak to obtain an electrocardiograph (ECG) machine. Ms Mak did not do so and Colleague A asked another colleague to obtain the machine. Patient B was discharged from the AAU to elsewhere in the hospital for enhanced cardiac care.

It is alleged that Colleague A asked Ms Mak to speak with her after handover about her behaviour on the shift. It is alleged that Ms Mak left without doing so.

Colleague A was concerned about Ms Mak's behaviour during this shift and spoke to a matron about it. On the advice of the matron, Colleague A completed a Datix form which listed her concerns.

Cromwell Hospital

Ms Mak applied for a position at the Cromwell Hospital ("the Cromwell"). On 28 April 2017 she was sent an email stating that she had been offered "the position of Staff Nurse – Orthopaedics subject to two satisfactory professional references" and other documentation. Ms Mak was sent a detailed Offer of Employment in a letter dated 2 May 2017. Her provisional start date was 29 May 2017.

On 2 June 2017 Colleague C telephoned Ms Mak to inform her that the job offer was withdrawn as one of the references was unsatisfactory. She followed this telephone call up with an email to Ms Mak on the same date, which stated that “we cannot proceed with the job offer”, attaching a letter dated 2 June 2017 also containing a withdrawal of the offer of employment.

It is alleged that on Saturday 3 June 2017 Ms Mak reported for work at the Cromwell stating that she was a new starter doing an orientation shift. Ms Mak had a uniform and name badge. Colleague B was the nurse in charge of the shift and, although it was unusual for a new starter to complete an orientation shift on a Saturday, she accepted what Ms Mak said as correct. Colleague B booked a further shift for Ms Mak on 6 June 2017, which she then cancelled later in the day.

As the 3 June shift progressed, Colleague B became concerned about Ms Mak’s behaviour. When Ms Mak left at the end of her shift Colleague B telephoned Ms E, a matron, and Mr F, a manager, about Ms Mak. After speaking with Ms E and Mr F, Colleague B then spoke to Ms Mak on the telephone. She informed Ms Mak that her shift scheduled for 6 June was cancelled and that Ms Mak should telephone Ms E first thing on Monday 5 June 2017, and clarify her employment situation.

It is alleged that Ms Mak also told Colleague B on 3 June 2017 that she had worked a shift on 30 May 2017 on the orthopaedic surgical ward. It is alleged that this behaviour was dishonest as Ms Mak knew that her offer of employment had been withdrawn and was intended to give the impression that Ms Mak was an employee of the hospital. It is also alleged that Ms Mak’s behaviour in stating that she worked a shift on 30 May was dishonest as it sought to give the impression that she had worked for the hospital on a previous occasion.

It is also alleged that Ms Mak reported for work at the hospital on 5 or 6 June 2017 when she had been told not to do so, that she refused to confirm how she had acquired a uniform and she refused to leave the Cromwell premises until security was called.

It is further alleged that Ms Mak's behaviour on 5 or 6 June 2017 was dishonest in that she intended to give the impression that she was an employee of the Cromwell when she knew she was not.

HCA International – Princess Grace Hospital

Ms Mak was referred to the NMC. She was informed of the referral on 24 July 2017. Her case was heard by an Investigating Committee interim order panel on 9 August 2017 and an interim suspension order for a period of 18 months was imposed. Ms Mak attended the hearing. She applied for an early review. Ms Mak attended the review which took place on 4 September 2017, when an interim conditions of practice order was substituted for the interim suspension order. Condition 9 of the interim conditions of practice order states:

9. You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the conditions listed at (1) to (8) above, to them:

    a) Any organisation or person employing, contracting with, or using you to undertake nursing work;
    b) Any agency you are registered with or apply to be registered with (at the time of application) to provide nursing services;
    c) Any prospective employer (at the time of application) where you are applying for any nursing appointment; and

d) Any educational establishment at which you are undertaking a course of study connected with nursing or midwifery, or any such establishment to which you apply to take such a course (at the time of application).

Ms Mak had applied for a position with HCA International (HCA), working as a staff nurse at the Princess Grace Hospital. She had signed a contract on 29 July 2017 with a provisional start date of 21 August 2017. Not all of the documentation was complete by 21 August, so the start date was put back. On 5 October 2017 HCA discovered the interim conditions of practice order via the NMC. Ms Mak was contacted by HCA and suspended on 5 October 2017. Her contract was terminated on the basis that she did not inform HCA about her interim conditions of practice order.

It is alleged that Ms Mak did not inform HCA that she was subject to either an interim suspension order (9 August to 3 September 2017) or an interim conditions of practice order (4 September 2017 onwards). It is also alleged that Ms Mak breached condition 9 of the interim conditions of practice order by not informing HCA of the interim order. It is further alleged that her actions, in concealing the concerns about her practice which led to the interim order, was dishonest.

Application to hear telephone evidence

During the oral evidence of Ms D, the panel asked some questions of her about whether a security badge had been issued to Ms Mak by the Cromwell Hospital. Ms D was unable to answer whilst giving oral evidence but she offered to look into the matter for the panel and to report back.

Ms D sent an email with the result of her enquiries. Ms Elcote May applied for this further evidence from Ms D to be given by telephone as it concerned a discrete piece of evidence and was likely to be very short.

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

The panel took into account that Ms D had already given evidence in person and that recalling her would inconvenience her. The panel considered it already had an opportunity to asses her demeanour and credibility as a witness and concluded that there was no need for her to attend the hearing in person.

Determination on amending charge 5

During its deliberations in relation to charge 5, the panel noted a possible discrepancy within the bundle relating to the date of Miss Mak's next alleged attendance at the Cromwell Hospital, following her attendance on 3 June 2017. The panel noted that the charge as currently drafted referenced Miss Mak reporting to work at the Cromwell Hospital on 5 June 2017. The evidence of Colleague C was that Miss Mak attended on 5 June 2017, and that Colleague C remembered it to be a Monday.

However, the interim order determinations before the panel, in relation to interim order hearings on 9 August 2017 and 4 September 2017, both referenced Ms Mak's next alleged attendance as being on 6 June 2017: "You then attended the Cromwell for another shift on 6 June 2017 and allegedly had to be escorted from the building by hospital security officers." Ms Mak's written representations in relation to this matter, submitted during the interim order process, referenced her attendance on 6 June 2017, not on 5 June 2017. For example, Ms Mak stated, "Joyce got the voice

mail from Colleague B to ring Ms E on Monday (5/6/2017). Joyce rang, however Ms E was not available that time and was not able to speak to Ms E. Therefore Joyce turned up on the 6/6/2017 as instructed."

The panel considered making an amendment to the charge, of its own volition, to allow for both dates, 5 and 6 June 2017, to be encompassed. The panel accepted the advice of the legal assessor that Rule 28 of the Rules states:

> "**28**(1) At any stage before making its findings of fact, 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 sought the views of the NMC in relation to its proposal to amend the date of charge 5 to "On or around 5 June 2017", which would cover both 5 and 6 June 2017.

The NMC's position was stated to be as follows:

> "Our position is that the evidence presented by the NMC indicates that the incident occurred on the date alleged (5 June 2017), but if the panel consider it appropriate to amend the date to resolve any confusion, then

the NMC is neutral about such an amendment. An amendment to "On or around 5 June 2017…" would cover both 5 and 6 June 2017."

The panel was of the view that such an amendment did not alter the nature of the allegation in any way and was in the interest of justice. Although Miss Mak was not present to make any representations in relation to the proposed amendment, the panel was satisfied that Miss Mak would not be disadvantaged by the amendment and that there would be no prejudice to her. The panel bore in mind that Miss Mak's written representations referenced 6 June 2017 and so the amendment would not necessitate a different approach to her presenting her case. The panel determined that no injustice would be caused to either party by the proposed amendment and that it was appropriate to make the amendment to ensure accuracy and that the charge reflects the evidence that has been adduced.

Additional documents

During the course of the hearing the panel asked for a number of additional documents as follows:

- It was provided with a staff rota relating to 18 January 2017;
- The panel requested an unredacted Datix form from Chelsea and Westminster Hospital which was not available but the Hospital did provide Ms Mak's contemporaneous written account, dated 20 January, of events on 18 January 2017, and submitted by her during the Hospital's investigation;
- Ms D provided additional information relating to the issuing of a security pass at Cromwell hospital to Ms Mak;
- The panel requested the visitors' book for the Cromwell hospital which Ms Mak claims to have signed. The panel was informed that the book was destroyed after a year so was not available.

Determination on facts

The panel heard evidence from, and read the exhibits of, the following witness:

- Colleague A, who was the nurse in charge, a band 6 junior sister, on 18 January 2017 on the AAU,
- Colleague B, who was the nurse in charge, a senior staff nurse, on 3 June 2017 on the surgical ward
- Colleague C, who was involved in the recruitment process and who met Ms Mak on 5 or 6 June 2017 at the Cromwell hospital
- Ms D, Chief Nurse at the Cromwell hospital who undertook a review of the documentation relating to Ms Mak's recruitment
- Ms G, an Human Resources (HR) shared services manager, who recruited Ms Mak to HCA International
- Mr H, an investigation team manager at the NMC.

The panel also read, and paid particular attention to when it was considering each charge, a bundle of documents submitted to the NMC from Ms Mak. These were documents submitted for consideration at the interim order hearings. Ms Mak had not submitted any further written representations for this substantive hearing.

When considering the charges, the panel took into account the submissions of Ms Elcoate May, and all of the evidence, both documentary and oral, before it.

The panel found Colleague A to be a reliable and helpful witness. She had a good and clear knowledge of the working environment in the AAU. She accepted that there were some questions she could not answer and that she had not seen Ms Mak

remove the cannula so that it was possible that someone else could have removed it.

The panel found Colleague B to have a clear recollection of events. She gave full answers to the questions put to her and was able to back up statements made by her about Ms Mak's behaviour on 3 June 2017 with specific examples.

The panel found Colleague C to be professional, measured and consistent in her evidence. She had a very clear recollection of the events relating to Ms Mak in early June 2017.

The panel found Ms D to be helpful and cooperative when asked to provide further evidence. However she was not a direct witness to any of the events. Her role was to review the documentation.

The panel found Ms G gave clear evidence about the recruitment process, her role and the expectations she had of her team.

The panel found Mr H to be professional and straightforward.

The panel also bore in mind that Ms Mak is of previous good character and that there have been no previous regulatory concerns or findings regarding her fitness to practise as a nurse.

The panel heard and accepted the advice of the legal assessor. The legal assessor gave a good character direction and advised the panel that the absence of any

previous regulatory breaches is potentially relevant, both to credibility and propensity at the fact-finding stage. Judging the weight to be given to Ms Mak's good character and its relevance to fact-finding will be a matter for the panel, taking account of all the evidence. The legal assessor advised that where the word "failed" appears in a charge, the NMC must prove that a duty to act in a certain manner existed. In relation to the dishonesty charges, the legal assessor drew attention to the test outlined in *Ivey v Genting Casinos 2017 UKSC 6.*

The panel also paid regard to the NMC guidance "Making decisions on dishonesty charges", dated 12 October 2018, in relation to the charges alleging dishonesty. In particular it considered all the circumstances surrounding the charge, Ms Mak's explanations and whether there are other more likely explanations for the alleged dishonest behaviour.

The burden of proof rests upon the NMC and Ms Mak does not have to prove or disprove anything. The standard of proof is the civil standard, namely the balance of probabilities. This means that, for a fact to be found proved, the NMC must satisfy the panel that what is alleged to have happened is more likely than not to have occurred. In determining the facts, the panel is entitled to draw common-sense inferences but not to speculate.

The panel then considered the charges against Ms Mak which were:

1. On 18 January 2017 whilst working a bank shift at Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust"):

    a. When discharging Patient A who was on an ambulatory care pathway, you failed to follow the instruction of the nurse in the charge, Colleague A, that

the patient needed to be discharged with a cannula in place, in that you removed the cannula

Colleague A's evidence was that she informed Ms Mak that Patient A was to be discharged with a cannula in place. Colleague A accepted that it was unusual for a patient to leave hospital with a cannula in place. This patient was to receive intravenous antibiotics and that is why the cannula was to remain in place. The decision had been taken after discussion with the consultant. Ms Mak, however, removed the cannula.

In her evidence, Colleague A stated that she had explained the ambulatory care pathway and had given a clear instruction to Ms Mak. However, after the cannula was removed for the first time, Colleague A wondered whether she had not been clear enough in her instruction. Colleague A's evidence was documented contemporaneously in a Datix incident report form which she completed on 18 January 2017.

Colleague A accepted that she did not see Ms Mak remove the cannula. However, the panel noted that Ms Mak accepted responsibility for removing it both in her written representations to the NMC and in her response to the Datix dated 20 January 2017.

Ms Mak accepted that she removed the cannula, stating: "Joyce removed cannula from a patient due to be discharged" and that this was on the basis that "cannula needs to be removed when patient is leaving the hospital".

Weighing up all of the evidence the panel concluded that it was more likely than not that Ms Mak removed the cannula.

The panel therefore find this charge proved.

b. After Patient A was re-cannulated you continued to disregard the instruction of the nurse in charge to leave a cannula in place, in that you removed the cannula for a second time and/or refused to discharge the patient with the cannula left in

Colleague A states that after Patient A was re-cannulated she reiterated her original instruction: “I said to Joyce that I was the nurse in charge and I was telling her to leave the cannula in and I explained why again. Joyce removed the cannula again and refused to discharge the patient with the cannula in.”

Colleague A therefore re-cannulated Patient A and discharged her herself.

The panel noted Colleague A’s acceptance, in her oral evidence, that she did not see Ms Mak remove the cannula the second time. The panel took into account Ms Mak’s written representations. Ms Mak does not specifically refer to a second removal of the cannula, but states that she had no further contact with Patient A “because she [Ms Mak] was not the one looking after the patient. It was another nurse called Grace.” The panel has seen the rota for that shift and there is no registered nurse with the first-name initial G.

Weighing up all of the evidence the panel concluded that it was more likely than not that Ms Mak had removed the cannula for a second time. Ms Mak was the registered nurse on that shift with responsibility for Patient A. On the information before the panel there was no nurse on duty called Grace. Further, the panel accepted the evidence of Colleague A that health care assistants would not have removed the cannula without express instruction to do so from a registered nurse. The panel also accepted the evidence of Colleague A that she carried out the patient discharge, Ms Mak having refused to do so.

The panel therefore find this charge proved.

c. You failed to obtain the ECG machine required to assess Patient B's heart rhythm when requested to do so by Colleague A

Colleague A noticed that Patient B was grey and sweating. She was concerned about Patient B's heart rhythm. Colleague A's evidence was that she asked Ms Mak twice to fetch an ECG machine but Ms Mak did not do so: "She [Ms Mak] then said to me that the patient was fine and did not need it." Colleague A then asked another member of staff to get the machine. Patient B was later transferred to another unit at the Hospital for further cardiac monitoring.

The panel considered that Ms Mak's evidence in relation to this charge was contradictory. In her evidence during the interim order process Ms Mak states "ECG was already done by the nursing team at the trolley admission". She does not say whether or not she obtained the ECG machine. In an email of 20 January 2017, as part of the Trust's internal investigation, Ms Mak states, "As instructed, I grabbed the ECG machine…". She also describes Patient B as being "…skin pink, well prefused" *(sic)*.

The panel took account of the contemporaneous Datix report submitted by Colleague A. The panel did not accept Ms Mak's evidence that she grabbed the ECG machine. On balance, the panel prefer the evidence of Colleague A, including the evidence that the patient was discharged for further cardiac treatment elsewhere in the hospital, to that written email of Ms Mak. It bore in mind that in this instance Ms Mak had a duty to follow an instruction of a senior nurse in charge. The panel considered that, by not following the reasonable instruction of Colleague A, Ms Mak failed in her duty to obtain the ECG machine.

The panel therefore find this charge proved.

d. Did not follow instructions to go and speak to Colleague A about the incidents referenced at 1a and/or b and/or c above

Colleague A's evidence was that she was concerned about Ms Mak's behaviour throughout the shift and she gave a clear instruction to Ms Mak that she wanted to speak with her at the end of the shift. This is supported by the Datix report she completed on the day itself.

Colleague A told the panel in her oral evidence that she did not discuss the incidents with Ms Mak on the ward during the shift as she wanted to do so in private at the end of the shift.

Ms Mak stated that she spoke with Colleague A about Patient A and in her email of 20 January 2017 stated, " …nurse in charge Colleague A requested to speak to me in the office. I was near the note trolley area (near bay A)…Was not aware that Colleague A wants to speak to me at the end of shift, as this information was not brought to my attention. I was only aware that Colleague A wants to speak to me in her office at the time of incident (1), unable that she wants to speak to at the end of her shift".*(sic)*

While the panel accept that it is possible that Ms Mak did not understand the timing of when she was due to speak to Colleague A, the panel concluded that she did understand she was supposed to speak to Colleague A.

The panel prefer the evidence of Colleague A to that written email of Ms Mak.

The panel therefore find this charge proved.

2. On 3 June 2017:

a. Reported to work on the surgical ward of Cromwell Hospital ("the Hospital") as a new starter to do an orientation shift when you were not employed by the Hospital

On 28 April 2017 Ms Mak was notified by email that her application for employment was successful subject to the receipt of two satisfactory references. On 2 May 2017 Ms Mak was sent a letter by the Cromwell Hospital which stated that "This offer is conditional upon the receipt of two satisfactory written references." On 2 June 2017 she was informed by telephone, email and recorded delivery letter that one of her references was not satisfactory and that the offer of employment was withdrawn on that same day.

Colleague B told the panel that Ms Mak reported for work at 08:00 on 3 June stating that she was a new member of staff and was due to do an orientation shift that day. Ms Mak was wearing hospital uniform and had a hospital name badge on her uniform. Whilst it was unusual for new staff to attend for orientation on a Saturday and Colleague B was not expecting a new staff member, Colleague B took Ms Mak's word about the situation.

There were a number of issues during the shift which concerned Colleague B. Ms Mak questioned the way Colleague B was applying a dressing to a patient. She also questioned the hospital protocol relating to swabbing patients for MRSA. Colleague B told the panel that Ms Mak was very enthusiastic and that she was really insistent that she [Ms Mak] must go and pick up the patient from recovery by herself. Ms Mak was unhappy when she was advised this would be inappropriate on an induction shift. During the shift Colleague B booked Ms Mak for a further shift on Tuesday 6 June 2017.

Colleague B said that, despite Ms Mak having sufficient time to wash her uniform before her next shift on 6 June, Ms Mak was very anxious to obtain a second uniform. Colleague B informed Ms Mak that she could not obtain another dress on a

Saturday. She told the panel that Ms Mak was insistent that the dress was required immediately.

After Ms Mak had left, Colleague B telephoned Ms E, a matron, and Mr F, a senior manager and told them of her concerns. Colleague B was informed that Ms Mak should not be working in the hospital as her references were unsatisfactory.

Colleague B rang Ms Mak, who was not available, and left a message. Ms Mak then rang her back. Colleague B instructed Ms Mak to telephone Ms E first thing on Monday morning and clarify her working situation. Colleague B was clear in her evidence that she had told Ms Mak not to report for duty until she had spoken to Ms E.

The written representations of Ms Mak stated that she was not aware that one of the references was unsatisfactory. She gives that as her reason for turning up for her shift on 3 June 2017 despite there being no evidence before the panel that she was asked to do so.

The panel concluded that the documentary evidence before it is clear that, by 3 June 2017, Ms Mak was aware that the offer of employment had been withdrawn because of an unsatisfactory reference and that she was not an employee of the Cromwell hospital.

The evidence of Colleague B was clear and accepted by the panel that Ms Mak turned up for work, in uniform, presenting herself as a new member of staff, ready to do an orientation shift.

The panel therefore find this charge proved.

b. Told Colleague B that you had worked for the Hospital on 30 May 2017 on the orthopaedic surgical ward

Colleague B told the panel that during the course of her shift, Ms Mak said that she had worked in the orthopaedic ward at the Cromwell on 30 May 2017. Colleague B considered this to be entirely plausible as it was not unusual for new nurses to work on both wards. Further, if the number of patients reduced at weekends, the staffing of the orthopaedic ward was often merged with the surgical ward.

Ms Mak states in her written representations:
"Joyce went to Bupa as instructed by the manager on the ward on 30 May 2017. (1st visit) – Manager have briefly introduced to the team and she was aware of my employment and arrival"*(sic).*
"Turn up on 30th May 2016. With my uniform. I was prepared for my first day of work. (Over prepared). Sent home" *(sic).*

The panel took into account the evidence of Colleague B and Ms Mak's written representations and concluded that it was more likely than not that Ms Mak told Colleague B that she had worked for the Hospital on 30 May 2017 on the orthopaedic surgical ward.

The panel therefore find this charge proved.

3. Your conduct in respect of charge 2a above was dishonest in that:

    a. You knew that your conditional offer of employment had been withdrawn on 2 June 2017 due to an unsatisfactory reference

The evidence of Colleague C was that in early June she was told that one of Ms Mak's references was unsatisfactory and that HR had informed Ms Mak of this. Colleague C rang Ms Mak on 2 June to inform her that the offer of employment was withdrawn. She followed this up in the afternoon with an email which states:

“Following our conversation over the phone in relation to the job offer, please see the attached letter of withdrawal. Unfortunately one of the references was unsatisfactory and we cannot proceed with the job offer…”

The attached letter, dated 2 June 2017, includes the following phrase: “… your reference…is unsatisfactory….we have no alternative but to withdraw the offer of employment with effect from today, 2 June 2017.”

In her written representations Ms Mak states:

“I though since both references are available, I can start work. So I innocently turn up on sat 3/6/2017. Met [Colleague B] …(found out on the 6/6/2017 that one reference was not ok)”. *(sic)*

There is clear documentary and oral evidence before that panel that Ms Mak was fully aware that one of her references was unsatisfactory and the employment offer had been withdrawn. Nonetheless she turned up for work in a uniform, with a name badge, and worked a shift. The panel consider such behaviour to be dishonest.

The panel therefore find this charge proved.

b. You intended to give the impression that you were an employee of the Hospital

Ms Mak turned up at the start of a shift, in uniform and with a name badge and told the nurse in charge that she was a new starter working an orientation shift and that she had worked in the orthopaedic ward on 30 May 2017. Ms Mak knew that the employment offer had been withdrawn the previous day. Whilst it was unusual for a new starter to work a Saturday shift, Colleague B accepted Ms Mak’s word.

The panel considered Ms Mak's behaviour to be dishonest.

The panel therefore find this charge proved.

4. Your conduct in respect of charge 2b above was dishonest in that you knew you had not worked at the Hospital on 30 May 2017 but sought to give the impression you were an employee who had worked for the Hospital on a previous occasion

Colleague B gave evidence that Ms Mak told her that she had worked on the orthopaedic ward. She also informed the panel that new nurses often worked on both the orthopaedic and surgical wards. Further, if the number of patients reduced at weekends, the staffing of the orthopaedic ward was often merged with the surgical ward. Colleague B therefore accepted Ms Mak's word.

Colleague C, in both her oral and written evidence, confirmed that she was on duty on 30 May and that Ms Mak did not work a shift on 30 May 2017. She also confirmed that Ms Mak did not work as an agency nurse on the orthopaedic ward that day.

The panel determined that even if Ms Mak had visited the orthopaedic ward to meet her future manager on 30 May 2017, there was no evidence before it that she had worked a shift there on that day. The panel concluded that Ms Mak was dishonest in that she did not work a shift in the orthopaedic ward on 30 May 2017. The panel also concluded that by claiming to have worked the shift, Ms Mak was undoubtedly trying to create the impression that she was an employee who had worked for the Hospital on a previous occasion.

The panel therefore find this charge proved.

5. On or around 5 June 2017:

a. Reported to work on the surgical ward of Cromwell Hospital ("the Hospital") when you had been told on 3 June 2017 that you should not report to work at the Hospital until your employment status had been confirmed with management and/or HR

Colleague B's evidence was that on the afternoon of 3 June 2017, she was sufficiently concerned about Ms Mak's behaviour on shift that she telephoned a matron, Ms E. Another manager, Mr F also rang Colleague B about Ms Mak. Following these conversations she rang Ms Mak and left a message. Ms Mak rang back, there was a discussion about references and Colleague B told Ms Mak that she was to telephone Ms E on Monday morning to clarify her employment situation. Colleague B was clear in her evidence that she had told Ms Mak not to report for duty until she had spoken to Ms E.

Colleague C's evidence is that Ms Mak "showed up again with a BUPA uniform on saying she is reporting to work. I was surprised to see her as HR and I had spoken to her on 2nd June 2017 and sent a letter withdrawing our job offer. Joyce replied 'no I'm supposed to be working here' ".

Ms Mak states:
"…(5/6/2017) Joyce rang, however Ms E was not available that time and was not able to speak to Ms E. Therefore Joyce turned up on 6/6/2017 as instructed. Only found out on 6/6/2017 that one of the references is not satisfied" *(sic)*

The panel prefer the evidence of Colleagues B and C to the written representations of Ms Mak.

The panel therefore find this charge proved.

b. Refused to confirm how you had acquired a BUPA hospital uniform

Colleague C met with Ms Mak and asked her where she got the hospital uniform. Her oral and written evidence was that Ms Mak refused to tell her: "Joyce declined to confirm how she obtained Bupa staff nurse uniform".
The evidence of Ms D was that, although uniforms had been ordered for Ms Mak, they had not yet been delivered to the Hospital and therefore could not, yet, have been issued to her.

Ms Mak does not cover this issue in her written representations.

The panel accept the evidence of Colleague C.

The panel therefore find this charge proved.

c. Refused to leave the premises when advised you were not a BUPA employee

The oral and written evidence of Colleague C was that she, and other staff, including HR and clinical governance, took Ms Mak to a private room and tried to explain to her that she was not an employee and asked her to leave the building. Ms Mak kept repeating that she was supposed to be working at the Cromwell and that she raised her voice, becoming a little aggressive. Eventually the security team were called and Ms Mak was escorted from the building with an instruction not to return.

In Ms Mak's written representations she states:
"Joyce left the hospital as instructed. Never turn up in that hospital again."
She makes no mention of being escorted off the premises by the security team.

The panel accept the evidence of Colleague C.

The panel therefore find this charge proved.

6. Your conduct in respect of charge 5a above was dishonest in that you intended to give the impression you were an employee of the Hospital when you knew you were not.

The panel heard the evidence of Colleague C who telephoned Ms Mak on 2 June 2017, following up the call with an email with a letter attached. On 2 June 2017 the same letter was sent be recorded delivery from HR to Ms Mak. All three communications consistently referred to the fact that one of Ms Mak's references was unsatisfactory and therefore her offer of employment was withdrawn.

After working a shift on 3 June 2017 Colleague B telephoned Ms Mak with an instruction to telephone Ms E on Monday morning. Colleague B also told Ms Mak that the shift she had booked for her on 6 June 2017 was cancelled. Colleague B was clear in her evidence that she had told Ms Mak not to report for duty until she had spoken to Ms E.

Ms Mak turned up in uniform at the start of a shift. She knew that she was not an employee of the hospital and she knew that a shift booked for her had been cancelled.

The panel concluded that such behaviour was dishonest.

T**he panel therefore find this charge proved.**

7. Between 9 August 2017 and 3 September 2017 when your practice was restricted by an interim suspension order, in the knowledge that you had signed an employment contract with HCA International Limited ("HCA") on 29 July 2017 with a provisional start date of 21 August 2017, you failed to inform HCA that your practice was restricted

The bundle before the panel contains an outcome letter, dated 14 August 2017, of the interim order hearing held on 9 August 2017 which was attended by Ms Mak. The letter confirms that an interim suspension order for a period of 18 months was imposed on Ms Mak's registration.

The bundle contains an outcome letter, dated 7 September 2017, of the early review interim order hearing held on 4 September 2017 which was requested and attended by Ms Mak. The letter confirms that the interim suspension order for a period of 18 months was replaced with an interim conditions of practice order, to run for the remainder of the same period.

Mr H confirmed the existence of these orders in his evidence before the panel.

The bundle also contains the contract signed by Ms Mak on 29 July 2017, with a provisional start date of 21 August 2017. The contract was signed before the imposition of any interim order, but after Ms Mak would have received her notice of referral letter which was dated 24 July 2017. Ms Mak's representations make clear that she was aware of the referral: "NMC referral received from case officer on the 24/7/2017. Joyce aware of the referral on the 24/7/2017"

The evidence of Ms G was that the recruitment process can be quite lengthy because of the need to obtain a number of documents and obtain certain clearances, and it was not unusual for people to start at a later date than their provisional start date. She informed the panel that because the process can be lengthy and it is a competitive market, recruitment staff would telephone potential employees on a regular basis for updates and to keep them interested. She informed the panel that at no stage between 9 August 2017, when an interim suspension was imposed, and 5 October 2017 when HCA discovered the existence of a restriction of Ms Mak's registration, did Ms Mak inform HCA of the interim order. Ms G informed the panel that there would have been regular opportunities for her to do so when she was contacted.

The panel next considered whether Ms Mak had a duty to inform HCA of her interim suspension order. It took into account the NMC publication The Code: Professional standards of practice and behaviour for nurses and midwives. In particular:

> 23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

The interim suspension hearing outcome letter of 14 August 2017 to Ms Mak states: "The effect of this suspension order is that you must not work as a nurse or as a midwife for as long as this order remains in place."

The panel concluded that this provision placed an obligation on Ms Mak to inform HCA, with whom she had already signed a contract, albeit that she had not started work, of her interim suspension order.

The HCA contract signed by Ms Mak placed an obligation on her, at paragraph 18.3, it stated "…employees have a duty to be aware of and comply with the Code… as set out by the appropriate professional bodies".

The panel took into account Ms Mak's written representations. She states:
"Joyce did not tell the employer HCA between this period on the conditions of practice or the interim suspension order of 18 months because there is a chance that the order could be revoke". *(sic)*

The panel did not consider that this is a sufficient reason for Ms Mak not to inform her potential employer of the interim suspension order.

The panel has therefore concluded that there was an interim suspension order in place; that Ms Mak was aware of the order; that she had a duty to inform HCA and that she did not do so.

The panel therefore find this charge proved.

8. Between 4 September 2017 and 5 October 2017, when your practice was restricted by an interim conditions of practice order, you breached condition 9 of the order in that you failed to immediately inform HCA that your practice was restricted

As stated earlier, the exhibits bundle contains an outcome letter, dated 7 September 2017, of the early review interim order hearing held on 4 September 2017 which was attended by Ms Mak. The letter confirms that the interim suspension order for a period of 18 months was replaced with an interim conditions of practice order to run for the same period

Condition 9 of that conditions of practice order states:

9. You must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures, and disclose the conditions listed at (1) to (8) above, to them:

    a) Any organisation or person employing, contracting with, or using you to undertake nursing work;
    b) Any agency you are registered with or apply to be registered with (at the time of application) to provide nursing services;
    c) Any prospective employer (at the time of application) where you are applying for any nursing appointment; and
    d) Any educational establishment at which you are undertaking a course of study connected with nursing or midwifery, or any such establishment to which you apply to take such a course (at the time of application).

The panel considers this condition is very clear, in that Ms Mak:
"must immediately tell the following parties that you are subject to a conditions of practice order under the NMC's fitness to practise procedures….:

a) Any organisation or person employing, contracting with, or using you to undertake nursing work;

c) Any prospective employer (at the time of application) where you are applying for any nursing appointment;"

The panel considers that it is clear that Ms Mak was under an obligation to inform HCA of the interim conditions of practice order. She had signed a contract with them [(a) above] and the application process was on-going [(c) above].

Ms G's evidence was that there had been ample opportunity for Ms Mak to inform HCA about her practice restrictions but she did not do so, particularly as she was telephoned and/or emailed on a regular basis by staff in the HCA recruitment team. HCA discovered the existence of the interim conditions of practice order through its contact with the NMC.

Mr H provided documentary evidence in the form of emails. The case officer spoke with Mr I, in the HR team at HCA. She provided a summary of the conversation in an email dated 10 October which Mr I confirmed as accurate in an email dated 11 October. The summary states

"call on 5 October…
Mr I states that at no point during the application process did the registrant disclose her IO COP or NMC investigations. The recruitment process is – online application; telephone call with Resource Advisor; then face to face interview. The registrant went through all 3 stages. Applicants are specifically asked about any pending investigations. Mr I spoke with her and he was given the impression by the registrant that she did not feel there was any reason for her to have restrictions on her PIN.

Due to break in employment in the last year Mr I asked the registrant to submit a statement, she said she was travelling, at no time did she mention any pending NMC investigation or employment issues despite being asked at all stages of the process". *(sic)*

In her written documentation Ms Mak alleges that at the review hearing, she and the Chair of the panel discussed that she only needed to let the employer know about her interim conditions of practice order on employment. There is no further evidence on this alleged conversation.

The panel considers that condition 9 is very clear and places a specific duty on Ms Mak to inform HCA of the interim conditions of practice and she did not do so.

The panel therefore find this charge proved.

9. Your conduct in respect of charge 7 and/or 8 above was dishonest in that you deliberately sought to conceal from HCA previous concerns that had arisen in respect of your practice.

The panel took into account the NMC guidance on dishonesty, referenced above.

The panel concluded that Ms Mak was aware of the referral as early as 24 July 2017. Further, she attended both hearings and would have known that she had an obligation to disclose the existence of an interim order from 9 August 2017, when the interim suspension order was imposed. That order was replaced with an interim conditions of practice order and condition 9 is very clear about the need to inform an employer of the existence of the order.

The panel considered Ms Mak's explanation. She relies on her hope that the order would be revoked ("because there is **a chance** that the order could be revoke" *(sic)*) and a suggestion that she discussed the matter with the Chair of the interim order

panel who it is alleged told her that she only need inform her employer “on employment”.

However, elsewhere in the documentation she appears to admit this charge. In a letter addressed to the interim order hearing on 3 November Ms Mak states:

“Attended HCA twice to speak to manager about the conditions of practice…was told by receptionist to come back second day…Joyce have tried an informed the new employed about the conditions and was not her intention to not let the employer know.”(*sic)*

On 3 October 2017 Ms Mak emailed her case officer stating “ …they [HCA] have found on the NMC site that my pin said suspended…my pin is not suspended. Do you mind kindly explain to them” (sic). A later email of the same date states “…I have recently employed by HCA…started my induction on Monday 2 October. Will be in general surgery ward next Monday….my fitness to practice is currently not impaired”*(sic)*

Ms G informed the panel in her evidence that on 5 October when Ms Mak was contacted by HCA and asked about the interim order her initial response was that this was an error on the part of the NMC.

The panel concluded that the alternative explanations offered by Ms Mak for her behaviour in charges 8 and 9 are inconsistent and not credible.

The panel concluded that Ms Mak had many opportunities to inform HCA of the interim suspension and interim conditions of practice, that she knew she was obliged to do so and that she knowingly chose not to do so. The panel concluded that such behaviour is dishonest.

The panel therefore find this charge proved.

Determination on misconduct and impairment

The panel went on to consider, on the basis of the facts found proved, whether Ms Mak's fitness to practise is impaired under Rule 24 (12) of the Nursing and Midwifery Council Fitness to Practise Rules 2004.

The panel approached its deliberations as a two stage process. It considered firstly whether as a matter of its professional judgment, there has been misconduct, and secondly, if so, whether, in the light of all the material before it, Ms Mak's fitness to practise is currently impaired by that misconduct.

Determination on misconduct

The panel first considered whether the facts proved amount to misconduct. It bore in mind the case of *Roylance v General Medical Council (No 2) [2000] 1 A.C. 311*, where misconduct was defined by Lord Clyde as:

> "…a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances."

The panel took into account the submissions of Ms Elcoate May and all of the evidence before it. Ms Elcoate May submitted a further bundle of documents for the

panel to consider at this stage. The bundle contained two [PRIVATE] medical reports (dated 27 November 2017 and 16 May 2018), and a number of positive testimonials relating to Ms Mak's practice prior to the time of the incidents specified in the charges.

The panel heard and accepted the advice of the legal assessor who referred to relevant case law and reminded it of the case of *General Medical Council v Chaudhary [2017] EWHC 2561 (Admin)*, which highlights that a finding of impairment does not inevitably flow from a finding of dishonesty, with the tribunal being fully entitled to look at the dishonesty in context.

The panel also had regard to the Nursing and Midwifery Council publication The Code: Professional standards of practice and behaviour for nurses and midwives (effective from 31 March 2015) (the Code). The panel considered the charges cumulatively and then considered each charge separately.

The panel reminded itself that, under The Code, registrants are personally accountable for acts and omissions in their practice. The panel concluded that Ms Mak had breached the following provisions of the Code:

1.2 make sure you deliver the fundamentals of care effectively (Charge 1)

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

(Charge 1)

5 Respect people's right to privacy and confidentiality (Charges 2-6)

8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate (Charge 1)

8.2 maintain effective communication with colleagues (Charge 1)

13.1 accurately assess signs of normal or worsening physical and mental health in the person receiving care (Charge 1)

20.1 keep to and uphold the standards and values set out in the Code (Charges 2-9)

20.2 act with honesty and integrity at all times… (Charges 2-9)

20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people (Charges 1-9)

20.5 treat people in a way that does not … cause them upset or distress (Charge 1)

23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body (Charges 7-9)

23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional healthcare environment (Charges 7-9).

The panel is aware that not all breaches of the Code are necessarily sufficiently serious to reach the threshold for a finding of misconduct.

In relation to charge 1, the panel took into account that Ms Mak was working as a bank nurse, was given specific instructions by the senior nurse in charge of the assessment unit and she repeatedly did not follow those instructions. The panel concluded that individually charges 1a) and 1 d) might not amount to misconduct. However, when taken in the context of the sequence of events and environment in which Ms Mak was working, as a bank nurse in a busy acute assessment unit, they are sufficiently serious to amount to misconduct. Charge 1b) caused distress to the patient who had to cannulated three times within a short period and charge 1c) involved Ms Mak refusing to provide appropriate equipment for a patient whose condition was deteriorating. These charges amount to misconduct both individually and cumulatively.

The panel next considered charges 2 to 6, all of which relate to the Cromwell Hospital. The panel paid particular attention to the evidence of Ms D who describes the potential risks associated with Ms Mak "working" at the Hospital when she was not an employee as

" The implications of Joyce working when she was not employed by us is that we could not be sure that she was safe to practice. New staff are supposed to undergo training and induction shift for two weeks when they start. We would not have known what her ability was in an emergency, for example she would not have had fire safety training or training in resuscitation. Joyce would also have had access to medication even though she had not passed the recruitment vetting process. When Joyce was on the ward she was being supervised all of the time, however Joyce may have been allowed to do moving and handling, but she would not be covered by insurance as she was not employed by us so this would have had implications there had been an accident. Also Joyce would have had access to personal information that she was not entitled to. We reviewed all patients and there was no harm and she was not alone with any patients and Joyce did not have access to patient information."

The panel concluded that the behaviour outlined in charges 2 to 6 placed patients at an unwarranted risk of harm and potentially had very serious consequences. Ms Mak had embarked on a deliberate course of dishonesty relating to her nursing practice, seeking to give the impression that she was employed at the Cromwell when she was not. The panel concluded that the behaviour displayed in every charge fell well below the standards expected of a registered nurse and amounts to misconduct.

The panel next considered charges 7 to 9. The panel concluded that this was another deliberate course of dishonesty relating to Ms Mak's nursing practice and an attempt by her to deceive her new employer. It also showed a disregard for the NMC regulatory process and was dishonest. The panel noted that two of the testimonials submitted at this stage of the hearing related to revalidation and were obtained during the period when Ms Mak was subject to an interim order. The testimonial authors make no mention of their awareness of the restrictions on Ms

Mak's practice nor her referral to the NMC. Further, the testimonials were not on headed paper nor was it clear whether any of the individuals had been Ms Mak's manager or supervisor. As such the panel placed little weight on these.

The panel determined that the behaviour displayed in charges 7-9, which shows dishonesty and a disregard for her regulator, is well below the standard expected of a registered nurse and amounts to misconduct. By failing to disclose the interim suspension order and the interim conditions of practice order on her practice, imposed by her regulator Ms Mak denied HCA the opportunity to conduct a proper assessment of her suitability for the position.

The panel concluded that Ms Mak's conduct demonstrated a pattern of dishonesty which was a serious departure from the standards which the public is entitled to expect of a registered nurse. The panel considered that honesty, candour and trustworthiness are the bedrock of any nurse's practice. In total the panel has found six instances of dishonesty. In the panel's judgment, Ms Mak's behaviour in relation to each charge individually and also cumulatively, and the numerous breaches of the Code, would be considered deplorable by fellow nurses. As such the panel concluded that Ms Mak's behaviour amounted to misconduct.

Determination on impairment

Having found that Ms Mak's behaviour amounted to misconduct, the panel went on to consider whether her fitness to practise is currently impaired by reason of that misconduct.

The panel was mindful that a registrant's impairment should be judged by reference to her suitability to remain on the register without restriction.

In deciding this matter the panel has exercised its independent professional judgement.

The panel took into account the submissions of Ms Elcoate May and all of the evidence before it.

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

The panel considered the case of *CHRE v NMC and Grant [2011] EWHC 97* and took into account the guidance provided by Dame Janet Smith and approved by Cox J. When deciding whether fitness to practise is impaired, it should be aware of the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession.

The panel reminded itself of the guidance formulated by Dame Janet Smith in her Fifth Shipman Report, as cited in *Grant*, regarding the proper approach to be taken when considering impairment:

a) Whether the registrant 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;
b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;
c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.
d) Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.

The panel concluded that in the past Ms Mak's behaviour had engaged limbs (a) to (d) above.

In relation to limb a) Patient A had to be cannulated three times, with an increased risk of infection, and this caused her distress. Patient B was also put at an unwarranted risk of harm as Ms Mak did not recognise his deteriorating condition and failed to obtain the appropriate equipment when asked to do so by the nurse in charge of the shift. There was also the potential for patient harm when Ms Mak worked a shift at Cromwell Hospital.

In relation to limb b) Ms Mak's behaviour has brought the profession into disrepute by: not following instructions from a senior colleague in charge of the shift; wearing a hospital uniform and name badge when these had not been issued to her; reporting for work knowing that she was not an employee; claiming that she had worked in a hospital ward on a previous date when she had not done so; refusing to leave the premises when asked to do so; her dishonesty and lack of candour in not disclosing the interim order to her new employer and her disregard for the NMC regulatory process.

In relation to limb c) Ms Mak breached fundamental tenets of the profession in that she breached several provisions of the Code.

Finally in relation to limb d), there are a number of charges of dishonesty found proved against her.

The panel next considered whether Ms Mak's fitness to practise is currently impaired and considered her likely future behaviour. In doing so, it took into account the

guidance in the case of *Cohen v General Medical Council [2008] EWHC 581 (Admin):*

> "… It must be highly relevant in determining if a [nurse's] fitness to practise is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

The panel concluded that the clinical failings were potentially remediable. The panel noted in particular that the testimonials submitted which cover the period prior to these events all attest to her skills as a nurse, describing her as "passionate", "caring" and "excellent". For the reasons given above the panel placed little weight on these testimonials.

The panel took into account the two [PRIVATE] reports before it:

[PRIVATE]

The reports date from after the events in the charges. Both reports indicated that, at the times of examination, there were no concerns about Ms Mak's health. [PRIVATE]. There is no information available to the panel that explains this possible change in attitude.

The panel next considered the dishonesty charges of which there were a substantial number, and which relate to the two separate employers, approximately two to three months apart. The panel considered that dishonesty is an attitudinal failing which is generally difficult to remediate. The panel took into account the NMC Guidance on "Serious concerns which are more difficult to put right" which states:

"A small number of concerns are so serious that it may be less easy for the nurse or midwife to put right the conduct, the problems in their practice, or the aspect of their attitude which led to the incidents happening."

It identifies the type of concerns as including:

- deliberately …not telling employers that their right to practise has been restricted or suspended, practising or trying to practise in breach of restrictions or suspension imposed by us.

The panel concluded that charges 7 to 9 inclusive relate to these concerns.

The panel next considered whether Ms Mak has shown any insight which could indicate that she has remediated these concerns. The panel took into account the NMC Guidance on remediation and insight. It noted in particular:

“A nurse or midwife who shows insight will usually be able to:

- step back from the situation and look at it objectively
- recognise what went wrong
- accept their role and responsibilities and how they are relevant to what happened
- appreciate what could and should have been done differently
- understand how to act differently in the future to avoid similar problems happening.

The panel concluded that while Ms Mak has engaged throughout the regulatory process, she has done none of the above. The panel considered the representations submitted by Ms Mak demonstrate that she has no insight into the seriousness of her conduct. Examples include:

In an email to her case officer dated 12 October 2017 she stated:

“”I am writing to you because fitness of practice is not impaired. Why do I have to practice with conditions? This has cause significant reputation to my new employer. When I am competent to be a registered nurse.

With all the informations I have provided to you previously. That shows I can be a nurse with no conditions at all. Can you please kindly remove the conditions of practice order? And so amended the website so i can actually be employed?” *(sic)*

In an email to her case officer dated 3 November 2017 she stated:

“I apologies to you and to the NMC that I have not let the employer know about the conditions of practice immediately…As stated before fitness to practice is not impaired.” *(sic)*

The panel noted that this apology is qualified with her assertion that her fitness to practise is not impaired. She stated in other emails to the NMC that her fitness to practise is not impaired, ignoring the many concerns raised about her practice by three employers within less than a year, the fact that she had an interim order imposed and the case examiners referred her to a fitness to practise panel. While Ms Mak has not formally admitted the charges, in her representations she does appear to acknowledge carrying out some of actions specified in the charges.

The panel gave weight to the [PRIVATE] report of May 2018 [PRIVATE]. This report lends support to the panel’s assessment of Ms Mak’s insight and her lack of understanding of the gravity of her actions. The general tenor of Ms Mak’s evidence, in her written representations, appears to indicate that, for example, she felt that the non-disclosure of her interim order to her new employer may have been justified in the circumstances.

The panel concluded that as Ms Mak has no insight she has not remediated the concerns relating to her clinical practice nor to her honesty and integrity. The panel therefore concluded that there is a high risk of repetition of similar behaviour and a consequent risk to patients. The panel has concluded that Ms Mak’s fitness to practise is currently impaired on public protection grounds.

The panel also considered the public interest in upholding standards in the profession and in maintaining confidence in the NMC as regulator. The panel concluded that members of the public would expect nurses to follow the reasonable

instructions of the nurse in charge of the shift, act with honesty and integrity, and to pay proper regard to the proceedings of her professional regulator. The panel has concluded that Ms Mak's fitness to practise is currently impaired on public interest grounds to ensure that proper standards of conduct and behaviour are maintained and to preserve public confidence in the nursing profession and in the NMC as regulator.

Decision under Rule 19 for part of the hearing to be held in private

During her submissions on misconduct and impairment Ms Elcoate May produced two [PRIVATE] reports for the panel to consider.

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

The panel considered that any reference to the [PRIVATE] reports should be in private. The reports are referred to in the panel's determination on misconduct and impairment.

Determination on sanction

Having determined that Ms Mak's fitness to practise is impaired, the panel went on to consider what sanction, if any, it should impose on her registration. The panel heard the submissions made by Ms Elcoate May and took account of all the evidence before it.

Ms Elcoate May informed the panel that the NMC sanction bid in relation to the dishonesty was a striking off order. This was based on the premeditated and multiple instances of dishonesty in the case.

The panel accepted the advice of the legal assessor.

Under Article 29 of the Nursing and Midwifery Council Order 2001, the panel can take no further action or it can impose one of the following sanctions: make a caution order for one to five years; make a conditions of practice order for no more than three years; make a suspension order for a maximum of one year; or make a striking off order. The panel has borne in mind that the purpose of a sanction is not to be punitive, though it may have a punitive effect.

The panel has applied the principles of fairness, reasonableness and proportionality, weighing the interests of patients and the public with Ms Mak's own interests and taking into account the mitigating and aggravating factors in the case. The public interest includes the protection of patients, the maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour. The panel has also taken account of the current NMC Sanctions Guidance as published on its website.

The panel concluded that the aggravating features in this case included:

- there was a pattern of misconduct lasting for almost a year
- Ms Mak lacks insight and has not remediated her failings
- Ms Mak's behaviour abused the trustworthiness expected of her as a registered nurse and placed her colleagues and her employers in a compromising situation

- Ms Mak's actions put patients at unwarranted risk of harm
- Ms Mak showed a disregard for her regulator and the regulatory process by not complying with her interim order.

The panel concluded that there were no mitigating features in this case.

The panel considered the sanctions in ascending order of seriousness.

The panel first considered the NMC guidance on factors to take into account when considering cases of dishonesty. The panel concluded the more serious considerations relating to dishonesty include:

- Ms Mak was a direct risk to patients in that she worked as a nurse whilst she was not employed, thereby invalidating any employer insurance, and she did not declare her interim order to her new employer so there was no opportunity to risk assess her, and
- The two instances of dishonesty involved premeditation, in the case of the Cromwell hospital turning up for work in a uniform on two occasions, and was systematic, in that she did not inform her new employer (HCA) of her interim order despite there being multiple opportunities to do so over several months.

The panel considered taking no further action but determined that this would be inappropriate. It would not address the seriousness of the charges found proved, which include dishonesty relating to Ms Mak's employment as a registered nurse, and not complying with the interim order imposed by her regulator. In such circumstances, it would not be in the public interest to take no further action. To do so would not provide sufficient public protection nor would it uphold the standards of

behaviour expected of a registered nurse, or maintain the reputation of the profession and the regulator.

The panel then went on to consider whether a caution order would be appropriate. The panel concluded that a caution order was not appropriate. The misconduct was too serious and Ms Mak's behaviour could not be described as being at the lower end of the spectrum of impaired fitness to practise. A caution order would not address the issue of public protection as it would allow Ms Mak to practise without restriction when the panel has concluded she placed patients at unwarranted risk of harm, practised when she was not employed and that there is a risk of repetition in this case. Further, the panel concluded that a caution order would not be in the public interest given the dishonesty in this case which relates directly to her employment as a nurse.

The panel next considered a conditions of practice order. The panel noted that she did not comply with her interim conditions of practice order and there is no information before the panel to indicate that Ms Mak would now be willing to comply with any conditions imposed. Further, the panel concluded that it was not possible to address the dishonesty in this case through a conditions of practice order. The principal issue of concern in this case is that of Ms Mak's honesty and integrity and the panel considered that it could not formulate workable conditions to address this issue. The panel therefore determined that a conditions of practice order was not an appropriate or proportionate sanction to protect the public and would not be sufficient to protect the wider public interest.

The panel went on to consider whether a suspension order would be the appropriate and proportionate response in this matter. The panel concluded that this was not a single incident of dishonesty but was repeated involving two different hospitals. The panel has concluded that Ms Mak's behaviour indicates that she has an attitudinal issue in that, despite being subject to an interim suspension and interim

conditions of practice order, Ms Mak did not comply with the interim order. Ms Mak subsequently insisted that her fitness to practise is not impaired and requested that the NMC remove these restriction and update their register accordingly. Further, Ms Mak would not accept that she was not employed at the Cromwell Hospital and refused to leave until escorted by a security guard. Additionally, Ms Mak she did not respond appropriately to reasonable requests from senior staff, including instances with Patient A and Patient B.

There was no information before the panel in relation to Ms Mak's current employment situation. In the light of the interim suspension order there is also no evidence before the panel in regard to any repetition of this misconduct since 2017. Notwithstanding, the dishonesty was repeated with two employers during that year.

The panel has already concluded that Ms Mak has not demonstrated any insight or remediation in relation to her dishonesty and that there is a high risk of repetition of similar behaviour. Noting the seriousness of the charges found proved, the panel placed weight on the aggravating features in this case and have determined that Ms Mak has an attitudinal issue. Taking all of the evidence into account the panel determined that a suspension order would not be sufficient to satisfy the public protection issues nor the high public interest in this case.

The panel then went on to consider a striking-off order. The panel considered Ms Mak's premediated and systematic dishonesty to be a serious departure from the relevant professional standards. She is untrustworthy and her misconduct was such that it could potentially put patients at unwarranted risk of harm. The panel concluded that Ms Mak does not understand the importance of honesty and integrity in the nursing profession, nor does she respect her regulator or the regulatory process. She put her needs (to secure employment) above the needs of her patients. Such behaviour is indicative of a lack of professionalism.

Having considered the aggravating factors, and the absence of any mitigating factors, and taking into account all of the evidence in this case the panel concluded that public confidence could not be maintained if a nurse who behaved in the manner Ms Mak did was allowed to remain on the register. The panel was mindful of the impact that a striking off order may have on Ms Mak in terms of financial, personal and professional hardship. Although Ms Mak had not responded formally to the charges, she had submitted written representations in relation to the interim order proceedings and stated her desire to practise as a nurse unrestricted. Taking full account of the important principle of proportionality, the panel determined that the public interest outweighed Ms Mak's interest. The panel concluded that Ms Mak's misconduct represented such fundamental departures from the relevant standards that public confidence in the profession and the NMC would be undermined if a striking off order were not made. The panel was in no doubt that the misconduct in this case is fundamentally incompatible with ongoing registration.

The panel therefore directed the Registrar to strike Ms Mak's name from the Register. Ms Mak may apply for restoration after five years from the date that this decision takes effect.

Determination on interim order

Pursuant to Article 29 (11) of the Nursing and Midwifery Order 2001, this panel's decision will not come into effect until after the 28 day appeal period, which begins on the date that notice of the striking off order has been served. Article 31 of the Nursing and Midwifery Order 2001 outlines the criteria for the imposition of an interim order. The panel may only make an interim order if it is satisfied that it is necessary for the protection of the public, or is otherwise in the public interest or in Ms Mak's own interest. The panel may make an interim conditions of practice order or an interim suspension order for a maximum of 18 months.

Ms Elcoate May made an application that the panel impose an interim suspension order on the grounds of public protection and in the public interest for an 18 months period to cover the appeal period and any possible appeal.

The panel has accepted the advice of the legal assessor. It has also had regard to the NMC's guidance to panels in considering whether to make an interim order. The panel has taken into account the principle of proportionality, bearing in mind the interests of the public and Ms Mak's own interests.

The panel has taken into account its reasons for making a striking off order. For those same reasons, the panel is satisfied that for reasons of public protection and that it is in the public interest for Ms Mak's registration to be subject to an interim order. The panel considered whether an interim conditions of practice order would be appropriate and proportionate and determined that it would not be for the same reasons given in the substantive order. The panel therefore imposes an interim suspension order.

The period of this order is for 18 months to cover any potential appeal, but if at the end of a period of 28 days, Ms Mak has not lodged an appeal the interim order will lapse and be replaced by the substantive order. On the other hand, if Ms Mak does lodge an appeal, the interim order will continue until the appeal is concluded.

This will be confirmed to Ms Mak in writing.

That concludes this determination.