Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
26 February 2025 – 12 March 2025

Virtual Hearing

Name of Registrant:	**Michael David Elphick**
NMC PIN:	01A0430E
Part(s) of the register:	Registered Nurse – Sub Part 1 Adult Nursing (Level 1) – 24 January 2004
Relevant Location:	Sunderland
Type of case:	Misconduct
Panel members:	Richard Weydert-Jacquard (Chair, Registrant member) Margaret Stoddart (Lay member) Matthew Wratten (Lay member)
Legal Assessor:	Justin Gau
Hearings Coordinator:	Jumu Ahmed
Nursing and Midwifery Council:	Represented by Fiona Williams, Case Presenter
Mr Elphick:	Not present and not represented in the hearing
Facts proved:	Charges 1.1.2 - 1.1.4, 1.2.1 - 1.2.6 (in its entirety), 1.3.1 - 1.3.4, 1.4.1 - 1.4.2, 1.5, 2, 3.1.1, 3.1.3, 3.2.1 - 3.2.5 (in its entirety), 3.3.1 - 3.3.3, 3.4, 4, 5.1.1 - 5.1.2, 5.2.1 - 5.2.10 (in its entirety), 5.3.1 – 5.3.35 (in its entirety), 5.4.1 - 5.4.14, 5.4.16 - 5.4.24, 5.5, 5.6.1 – 5.6.3, 5.7, 5.8, 5.9 [excluding 5.4.15 as this charge was found not proved], 6.1.2 – 6.1.5, 6.2.1 – 6.2.20 (in its entirety), 6.3.1 – 6.3.4 (in its entirety), 6.4.1 – 6.4.3, 6.5

Facts not proved:	Charges 1.1.1, 1.3.5, 3.1.2, 5.4.15, 6.1.1, 6.1.6
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 Mr Elphick was not in attendance and that the Notice of Hearing letter had been sent to Mr Elphick's registered email address by secure email on 9 January 2025.

Ms Williams, 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 Mr Elphick's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Elphick

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

Ms Williams submitted that there had been no engagement at all by Mr Elphick with the NMC in relation to these proceedings and, as a consequence, there was no reason to believe that an adjournment would secure his attendance on some future occasion.

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'*.

The panel has decided to proceed in the absence of Mr Elphick. In reaching this decision, the panel has considered the submissions of Ms Williams and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5 and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Elphick;
- Mr Elphick has not engaged with the NMC and has not responded to any of the emails sent to him about this hearing;
- There is no reason to suppose that adjourning would secure Mr Elphick's attendance at some future date;
- 1 witness is due to give live evidence;
- Not proceeding may inconvenience the witness and their employer;
- The charges relate to events that occurred in 2022;
- Further delay may have an adverse effect on the ability of the witness accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Mr Elphick in proceeding in his absence. Although the evidence upon which the NMC relies will have been sent to him at his registered email

address, he has made no response to the allegations. He will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Elphick's decisions to absent himself from the hearing, waive his rights to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf.

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

Decision and reasons on application to amend the charge

The panel heard an application made by Ms Williams to amend the wording of charge 4.

Ms Williams submitted that the proposed amendment would amend the typographical error, provide clarity and more accurately reflect the evidence.

> 4) Your actions in one or more of the above charges 3 .3.1, 3.3.2, & 3.3.3 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient ~~A~~ **B**, when you had not.

The panel accepted the advice of the legal assessor and had regard to Rule 28 of 'the Rules.

The panel was of the view that such an amendment, as applied for, was in the interest of justice. The panel was satisfied that there would be no prejudice to Mr Elphick 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.

Details of charge (as amended)

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.1) Did not discuss the following, during the consultation with Patient A;

1.1.1) Surgical date; **[NOT PROVED]**
1.1.2) Surgical procedure; **[PROVED]**
1.1.3) Length of stay; **[PROVED]**
1.1.4) Dose/frequency of medication; **[PROVED]**

1.2) Did not complete;

1.2.1) The discharge page of the Electronic POA; **[PROVED]**
1.2.2) The general wellbeing page; **[PROVED]**
1.2.3) The patient information page; **[PROVED]**
1.2.4) The audit C risk assessment; **[PROVED]**
1.2.5) The VTE risk assessment; **[PROVED]**
1.2.6) The multifactorial intervention plan for falls management pathway. **[PROVED]**

1.3) Inaccurately recorded information on Patient A's POA, without asking these questions/discussing this information with Patient A, namely;

1.3.1) The consent process was documented as discussed/'yes'; **[PROVED]**

1.3.2) Correct site surgery was documented as discussed/'yes'; **[PROVED]**

1.3.3) Suppression Therapy was documented as discussed/'yes'; **[PROVED]**

1.3.4) Patient A's neck size being less than 40cm on the STOPBANG risk assessment was documented as 'no'. **[PROVED]**

1.3.5) You ticked 'yes' to advise Patient A to bring in their medication on admission. **[NOT PROVED]**

1.4) Inaccurately recorded that you had provided the following information to patient A, when this had not been discussed;

1.4.1) Name; **[PROVED]**

1.4.2) Telephone Number. **[PROVED]**

1.5) Did not fully complete the Waterlow Score. **[PROVED]**

2) Your actions in one or more of the above charges 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.4.1 & 1.4.2. were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient A, when you had not. **[PROVED]**

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.1) Did not discuss the following areas during the consultation with Patient B;

3.1.1) Surgical date; **[PROVED]**

3.1.2) Surgical procedure; **[NOT PROVED]**

3.1.3) Length of stay; **[PROVED]**

3.2) Did not complete the;

3.2.1) Discharge plan; **[PROVED]**

3.2.2) General wellbeing page; **[PROVED]**

3.2.3) Patient information page; **[PROVED]**

3.2.4) VTE risk assessment; **[PROVED]**

3.2.5) The Multifactorial intervention plan. **[PROVED]**

3.3) Inaccurately recorded information on Patient B's POA, without asking these questions/discussing this information with Patient B, namely;

3.3.1) The consent process was documented as discussed/'yes'; **[PROVED]**

3.3.2) Correct site surgery was documented as discussed/'yes'; **[PROVED]**

3.3.3) Patient B's neck size being less that 40cm on the STOPBANG risk assessment was documented as 'no'. **[PROVED]**

3.4) Did not fully/correctly complete the Waterlow Score. **[PROVED]**

4) Your actions in one or more of the above charges 3 .3.1, 3.3.2, & 3.3.3 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient B, when you had not. **[PROVED]**

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.1) Did not discuss the following areas, during the consultation with Patient C;

5.1.1) Surgical date; **[PROVED]**

5.1.2) Surgical procedure; **[PROVED]**

5.2) Inaccurately recorded information on Patient C's POA, without asking these questions/discussing this information with Patient C, namely;

5.2.1) Recent/planned travel was documented as ‘no’; **[PROVED]**

5.2.2) The journey time home being greater than 1 hour was documented as ‘no’; **[PROVED]**

5.2.3) Attendance at short notice was documented as ‘no’; **[PROVED]**

5.2.4) Experience of chest pains/heart problems/angina was documented as ‘no’; **[PROVED]**

5.2.5) Recent change of symptoms relating to chest pains/angina was documented as ‘no’; **[PROVED]**

5.2.6) Medication alterations relating to angina was documented as ‘no’; **[PROVED]**

5.2.7) The consent process; **[PROVED]**

5.2.8) The correct site surgery; **[PROVED]**

5.2.9) Patient C’s neck size being less that 40cm on the STOPBANG risk; assessment; **[PROVED]**

5.2.10) Audit C questions. **[PROVED]**

5.3) Inaccurately recorded ‘none of the above’ to one or more questions relating to health conditions/past medical history, without discussing these in full with Patient C, namely;

5.3.1) Irregular heart beat; **[PROVED]**

5.3.2) Hear murmur; **[PROVED]**

5.3.3) Palpitations; **[PROVED]**

5.3.4) Stroke; **[PROVED]**

5.3.5) Mini stroke; **[PROVED]**

5.3.6) Atrial Fibrillation; **[PROVED]**

5.3.7) Current or previous aneurysm; **[PROVED]**

5.3.8) Any other cardiac/circulatory problems; **[PROVED]**

5.3.9) Asthma; **[PROVED]**

5.3.10) Breathlessness/difficulty breathing; **[PROVED]**

5.3.11) Inability to lie flat without shortness of breath; **[PROVED]**

5.3.12) Currently smoke or have you ever smoked; **[PROVED]**

5.3.13) Obstructive sleep apnoea; **[PROVED]**

5.3.14) Stop breathing when you sleep; **[PROVED]**

5.3.15) Snore loudly through a closed door; **[PROVED]**

5.3.16) Feel tired during the day/fall asleep; **[PROVED]**

5.3.17) Respiratory problems/pleurisy/persistent cough/coughing up blood/wheezing; **[PROVED]**

5.3.18) Bleeding disorder/excessive bruising; **[PROVED]**

5.3.19) Family history of bleeding/blood disorders; **[PROVED]**

5.3.20) Deep vein thrombosis/Pulmonary embolism; **[PROVED]**

5.3.21) Sickle cell disease; **[PROVED]**

5.3.22) Anaemia; **[PROVED]**

5.3.23) Hepatitis; **[PROVED]**

5.3.24) Jaundice; **[PROVED]**

5.3.25) Acid reflux; **[PROVED]**

5.3.26) Hiatus Hernia; **[PROVED]**

5.3.27) Stomach Ulcer; **[PROVED]**

5.3.28) Colostomy/ileostomy; **[PROVED]**

5.3.29) Neurological problems; **[PROVED]**

5.3.30) Dementia/memory problems; **[PROVED]**

5.3.31) Back problems; **[PROVED]**

5.3.32) Neck problems; **[PROVED]**

5.3.33) Jaw problems; **[PROVED]**

5.3.34) Tracheostomy; **[PROVED]**

5.3.35) Previous head/neck/maxillofacial surgery; **[PROVED]**

5.4) Recorded information in Patient C's POA, without discussing this information fully with Patient C, namely information relating to;

5.4.1) Digestion; **[PROVED]**

5.4.2) Diabetes; **[PROVED]**

5.4.3) Mental health; **[PROVED]**

5.4.4) Family history/adverse reaction to anaesthesia; **[PROVED]**

5.4.5) Previous admissions to hospital/intensive care/high dependency unit; **[PROVED]**

5.4.6) Medication; **[PROVED]**

5.4.7) Recreational drugs; **[PROVED]**

5.4.8) Infection prevention; **[PROVED]**

5.4.9) Symptoms of diarrhoea; **[PROVED]**

5.4.10) Invasive devices; **[PROVED]**

5.4.11) Cancer treatment; **[PROVED]**

5.4.12) Residence; **[PROVED]**

5.4.13) Employment in a health/social care setting/Ministry of Defence; **[PROVED]**

5.4.14) Involvement in a close contact sport; **[PROVED]**

5.4.15) Surgery; **[NOT PROVED]**

5.4.16) Growth hormone/gonadotrophin treatment; **[PROVED]**

5.4.17) Blood transfusions; **[PROVED]**

5.4.18) Dietary requirements; **[PROVED]**

5.4.19) Dependents; **[PROVED]**

5.4.20) Mobility/access requirements/wheelchair/walking aids; **[PROVED]**

5.4.21) History of falls; **[PROVED]**

5.4.22) People living in the same residence; **[PROVED]**

5.4.22) Learning difficulties; **[PROVED]**

5.4.23) Autism; **[PROVED]**

5.4.24) Daily living activities. **[PROVED]**

5.5) Did not record a full list of medications for Patient C. **[PROVED]**

5.6) Did not complete the following pages;

5.6.1) Discharge page; **[PROVED]**

5.6.2) General wellbeing page; **[PROVED]**

5.6.3) Patient information page. **[PROVED]**

5.7) Did not complete the Waterlow score fully/correctly. **[PROVED]**

5.8) Did not complete the multifactorial intervention plan fully/correctly. **[PROVED]**

5.9) Your actions in one or more of the above charges 5.2.1, 5.2.2, 5.2.3, 5.2.4, 5.2.5, 5.2.6, 5.2.7, 5.2.8, 5.2.9, 5.2.10, 5.3.1, 5.3.2, 5.3.3, 5.3.4, 5.3.5, 5.3.6, 5.3.7, 5.3.8, 5.3.9, 5.3.10, 5.3.11, 5.3.12, 5.3.13, 5.3.14, 5.3.15, 5.3.16, 5.3.17, 5.3.18, 5.3.19, 5.3.20, 5.3.21, 5.3.22, 5.3.24, 5.3.25, 5.3.26, 5.3.27, 5.3.28, 5.3.29, 5.3.30, 5.3.31, 5.3.32, 5.3.33, 5.3.34, 5.3.45, 5.4.1, 5.4.2, 5.4.3, 5.4.4, 5.4.5, 5.4.6, 5.4.7, 5.4.8, 5.4.9, 5.4.10, 5.4.11, 5.4.12, 5.4.13, 5.4.14, 5.4.15, 5.4.16, 5.4.17, 5.4.18, 5.4.19, 5.4.20, 5.4.21, 5.4.22, 5.4.23 & 5.4.24 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient C, when you had not. **[PROVED for all except 5.4.15]**

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.1) Did not confirm/discuss the following areas, during the consultation with Patient D;

6.1.1) Surgical date; **[NOT PROVED]**
6.1.2) Surgical procedure; **[PROVED]**
6.1.3) Length of stay; **[PROVED]**
6.1.4) Post operative care; **[PROVED]**
6.1.5) Patient D's activity level; **[PROVED]**
6.1.6) Patient D's medication; **[NOT PROVED]**

6.2) Did not fully complete/discuss;

6.2.1) The Covid 19 section; **[PROVED]**
6.2.2) The heart & circulation section; **[PROVED]**
6.2.3) The lungs & breathing section; **[PROVED]**

6.2.4) The blood section; **[PROVED]**

6.2.5) The liver section; **[PROVED]**

6.2.6) The hormones section; **[PROVED]**

6.2.7) The kidney section; **[PROVED]**

6.2.8) The bones and joint section; **[PROVED]**

6.2.9) The neurology section; **[PROVED]**

6.2.10) The mental health section; **[PROVED]**

6.2.11) The anaesthetic history section; **[PROVED]**

6.2.12) Patient D's activity level; **[PROVED]**

6.2.13) The infection prevention section; **[PROVED]**

6.2.14) The daily living section; **[PROVED]**

6.2.15) The discharge page; **[PROVED]**

6.2.16) The general well being section; **[PROVED]**

6.2.17) The patient information page; **[PROVED]**

6.2.18) The Waterlow score; **[PROVED]**

6.2.19) The multifactorial intervention place for falls management pathway; **[PROVED]**

6.2.20) The audit C risk assessment. **[PROVED]**

6.3) Inaccurately recorded information on Patient D's POA, without asking these questions/discussing this information with Patient D, namely;

6.3.1) The consent process was documented as discussed/'yes'; **[PROVED]**

6.3.2) Correct site surgery was documented as discussed/'yes'; **[PROVED]**

6.3.3) Advice to Patient D about bringing in their medication was documented as discussed/'yes; **[PROVED]**

6.3.4) Patient D's neck size being less that 40cm on the STOPBANG risk assessment. **[PROVED]**

6.4) Inaccurately recorded that you had provided information in Patient D's POA, without providing this information to Patient D, namely;

6.4.1) Name; **[PROVED]**

6.4.2) Telephone number; **[PROVED]**

6.4.3) Suppression therapy as per Spire policy. **[PROVED]**

6.5) Your actions in one or more of the above charges 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.4.1, 6.4.2 & 6.4.3 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient D, when you had not. **[PROVED]**

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

Background

Mr Elphick was referred to the NMC on 23 March 2023 from Spire Healthcare (Spire). The charges arose whilst Mr Elphick was employed as a registered nurse, working in the pre-operative assessment ('POA') department as a team leader at Spire. Concerns were raised about Mr Elphick's POA following a patient complaint.

All of Mr Elphick's competencies were signed off and subsequent training was performed with support from the pre-operative team.

All patients require POA to determine whether they are safe to proceed with either a local or general anaesthetic and their surgical procedure. POA's are completed over the telephone or face to face.

Patients are sent an electronic questionnaire before the assessment. The telephone consultation time set for a patient for a local anaesthetic would be 30 minutes and general anaesthetic would be 45 - 60 minutes.

If a patient had not completed the online questionnaire and they were due to go under general anaesthetic the time slot would be 60 minutes, if the questionnaire had been completed it would be 45 minutes. General anaesthetic pre-operative assessment is more in depth due to the extra risk involved.

All calls at Spire were recorded, so all of the registrant's calls/assessments were accessible. The medical records were then accessed including the pre-operative print off summary, risk assessment booklet, online questionnaire and full assessment.

Spire raised concerns that Mr Elphick, on multiple occasions, failed to discuss and complete several areas of the assessment and he had dishonestly documented answers where the questions had not in fact been discussed with patients.

Multiple samples of Mr Elphick's assessments between April to November 2022 were audited by Spire. The four in particular are:

- Exhibit AD-5 Audio recording 11 April 2022, 15 minutes and 10 seconds
- Exhibit AD-10 Audio recording 17 May 2022, 12 minutes and 48 seconds
- Exhibit AD-15 Audio recording 08 November 2022, 10 minutes and 56 seconds
- Exhibit AD-20 Audio recording 09 November 2022, 4 minutes and 3 seconds

As a result, concerns were raised by Spire in relation to:

- The quality of POA performed
- The safety risk to patients due to POA not being carried out correctly
- Falsification of medical records

Mr Elphick resigned from Spire prior to disciplinary proceedings.

The regulatory concerns are:

1. Failure in patient assessment – in that Mr Elphick did not conduct an adequate preoperative assessment on one or more occasions
2. Poor record keeping – in that Mr Elphick made inaccurate records of preoperative assessments on one or more occasions
3. Dishonesty – in that Mr Elphick intended to create a misleading impression that he had undertaken complete preoperative assessments when he had not.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral, documentary and audio evidence in this case together with the submissions made by Ms Williams.

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

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 witness called on behalf of the NMC:

- Witness 1: National Clinical Specialist for pre-operative assessment at Spire.

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

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

Charge 1.1.1

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.1) Did not discuss the following, during the consultation with Patient A;

1.1.1) Surgical date;

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence and the audio recording 'Exhibit AD-5 Audio recording 11 April 2022'.

In the audio recording 'Exhibit AD-5 Audio recording 11 April 2022', the panel noted that at 7 minutes and 46 seconds, Mr Elphick says to Patient A:

Mr Elphick: *'when is it that you are coming in, the 18th?'*
Patient A: *'no, 16th'*
Mr Elphick: *'16th, oh alright'*

Additionally, at 13 minutes and 36 seconds, Mr Elphick confirmed to Patient A that their surgery was due to take place on 16th.

Accordingly, the panel was satisfied that Mr Elphick did discuss the surgical date with Patient A. It, therefore, found this charge not proved.

Charge 1.1.2 and 1.1.3

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.1) Did not discuss the following, during the consultation with Patient A;

1.1.2) Surgical procedure;
1.1.3) Length of stay;

These sub-charges are found proved.

In reaching this decision, the panel took into account the documentary evidence and the audio recording 'Exhibit AD-5 Audio recording 11 April 2022'.

There was no evidence within the written evidence nor the audio recordings of Mr Elphick talking to Patient A about the surgical procedure or length of stay in the hospital.

The panel accordingly found these sub-charges proved.

Charge 1.1.4

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.1) Did not discuss the following, during the consultation with Patient A;

1.1.4) Dose/frequency of medication;

This sub-charge is found proved.

In reaching this decision, the panel took into account the documentary evidence and the audio recording 'Exhibit AD-5 Audio recording 11 April 2022'.

In the audio recording 'Exhibit AD-5 Audio recording 11 April 2022', the panel noted that at 7 minutes and 46 seconds, Mr Elphick says to Patient A:

> Mr Elphick: *'With your meds, stop your naproxen a week before your surgery* […] *stop it today, stop it today* […] *don't take the naproxen because … the reason being is because … it has thinning properties* […] *take your gabapentin and your paroxetine and your lansoprazole and leave out your naproxen* […] *and when you come in for your procedure, when you bring your meds in, bring it in their normal boxes* […]'

Whilst Mr Elphick confirmed with Patient A that he should not be taking naproxen, he did not discuss about the dose or frequency of any medication.

The panel found this sub-charge proved.

Charge 1.2.1 – 1.2.6

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.2) Did not complete;

1.2.1) The discharge page of the Electronic POA;
1.2.2) The general wellbeing page;

1.2.3) The patient information page;
1.2.4) The audit C risk assessment.
1.2.5) The VTE risk assessment.
1.2.6) The multifactorial intervention plan for falls management pathway.

These sub-charges are found proved.

In reaching this decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient A dated 11 April 2022.

The panel had sight of POA for Patient A. Mr Elphick did not complete the questions on the pages on: discharge, general wellbeing, the patient information, the audit C risk assessment, the VTE risk assessment or the multifactorial intervention plan for falls management pathway.

The panel, therefore, found these sub-charges proved.

Charge 1.3.1 – 1.3.4

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.3) Inaccurately recorded information on Patient A's POA, without asking these questions/discussing this information with Patient A, namely;

1.3.1) The consent process was documented as discussed/'yes';
1.3.2) Correct site surgery was documented as discussed/'yes';
1.3.3) Suppression Therapy was documented as discussed/'yes';

1.3.4) Patient A's neck size being less than 40cm on the STOPBANG risk assessment was documented as 'no'.

These sub-charges are found proved.

In reaching this decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient A dated 11 April 2022.

Within the POA for Patient A, Mr Elphick recorded that he had discussed with Patient A about the consent process, the surgical site, details of suppression therapy and also that Patient A's neck size was less than 40cm on the STOPBANG risk assessment. However, within 'Exhibit AD-5 Audio recording 11 April 2022', Mr Elphick did not have these discussions with Patient A.

The panel, therefore, found these sub-charges proved.

Charge 1.3.5

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.3) Inaccurately recorded information on Patient A's POA, without asking these questions/discussing this information with Patient A, namely;

1.3.5) You ticked 'yes' to advise Patient A to bring in their medication on admission.

This sub-charge is found NOT proved.

In reaching this decision, the panel took into account the documentary evidence which included Witness 1's witness statement and the audio recording 'Exhibit AD-5 Audio recording 11 April 2022'.

In the audio recording 'Exhibit AD-5 Audio recording 11 April 2022', the panel noted that at 8 minutes and 25 seconds, Mr Elphick says to Patient A:

> Mr Elphick: *'and when you come in for your procedure, when you bring your meds in, bring it in their normal boxes* […]'
>
> Patient A: '*right'*

Additionally, this was confirmed in Witness 1's statement at paragraph 21.

Mr Elphick confirmed with Patient A that he should be bringing in his medications in the boxes on the day he is admitted into his surgery.

Accordingly, the panel was satisfied that Mr Elphick did ask Patient A to bring in their medication on admission and did correctly tick 'yes' in their POA. It, therefore, found this sub-charge not proved.

Charge 1.4

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.4) Inaccurately recorded that you had provided the following information to patient A, when this had not been discussed;

1.4.1) Name;
1.4.2) Telephone Number.

These sub-charges are found proved.

In reaching this decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient A dated 11 April 2022 and the audio recording 'Exhibit AD-5 Audio recording 11 April 2022'.

Within the POA for Patient A, Mr Elphick recorded that he had provided Patient A with a name or telephone number. However, within the audio recording 'Exhibit AD-5 Audio recording 11 April 2022', Mr Elphick did not provide a name or telephone number of the pre-operative team.

The panel, therefore, found these sub-charges proved.

Charge 1.5

That you, a registered nurse whilst working at Spire Washington Hospital (the Hospital);

1) On 11 April 2022 carried out an inadequate pre-operative assessment ('POA') of Patient A, in that you;

1.5) Did not fully complete the Waterlow Score.

This charge is found proved.

In reaching this decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient A dated 11 April 2022.

The panel had sight of Patient A's POA in which Patient A's Waterlow Score was not completed by Mr Elphick.

The panel, therefore, found this sub-charge proved.

Charge 2

2) Your actions in one or more of the above charges 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.4.1 & 1.4.2. were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient A, when you had not.

This charge is found proved.

In reaching its decision, the panel took into account the documentary evidence which included Witness 1's witness statement, Ms 2's email dated 15 December 2022, Ms 2's investigation meeting notes dated 14 December 2022 with Mr Elphick and Mr Elphick's response bundle. The panel also had regard to Witness 1's live evidence and the audio recording 'Exhibit AD-5 Audio recording 11 April 2022'.

In considering whether Mr Elphick's actions were dishonest, the panel had regard to the test as set out in the case of *Ivey v Genting Casinos* [2017] UKSC 67:

- *What was the person's actual state of knowledge or belief as to the facts; and*
- *Was that conduct dishonest by the standards of ordinary decent people?*

The panel also took into account the NMC Guidance document 'Making decisions on dishonesty charges and the professional duty of candour' (Reference: DMA-8) (Last Updated 27/02/2024).

The panel took into account Witness 1's witness statement and her live evidence to the panel. It was of the view that Witness 1's evidence was clear and consistent. Witness 1 told the panel that Mr Elphick had been trained and signed off as competent.

In the email dated 15 December 2022 provided by Ms 2, it stated:

> *'Michael never discussed with me any requirement for training as a POA nurse*
> *He received his initial two day zoom training from [the POA lead from the central team]. Michael then sat in* […] *who were currently working on PIA until he felt confident and signed off to perform POA*
> *Michael is a very proficient PIA nurse and he has excellent IT skills and a very professional telephone manner [sic] He picked up the processes ie, making diagnostic appointments etc very quickly and regularly completed his clinics ahead of time requesting to* […]
> *He was appointed to the team lead role and was trained in triage and notes check which he performed as required.'*

Ms 2 confirmed that Mr Elphick was trained and signed off as competent in undertaking pre-operative assessments.

The panel took into account the audio recording 'Exhibit AD-5 Audio recording 11 April 2022' which confirmed that Mr Elphick did not have the required discussions with Patient A. The panel noted that in Mr Elphick's response bundle he does not comment on why he had inaccurately recorded information on Patient A's POA without asking the required questions or discussing the information with Patient A.

The panel took into account Ms 2's investigation meeting notes dated 14 December 2022:

> [Mr Elphick] – *'I don't like to go in like a novice and also you're dealing with different people in different societies in private health care, so you've got your directors, very intellectual people but you've also got people that need more time. That's what*

enables you to do, those that are direct, no problems you move straight on. Those that need more time especially the elderly.'

The panel considered the questions posed in *Ivey* namely what Mr Elphick's knowledge was at the time and then whether his conduct would be regarded as dishonest by the standards of 'ordinary decent people.' The panel noted that Mr Elphick was inducted and trained to ask all the mandatory questions to patients for their pre-operative assessments and would understand why the questions and discussions were required, and the risks to patient safety if they were not asked. Therefore, the panel was of the view that on 11 April 2022, during the telephone call with Patient A, Mr Elphick knew that he had failed to ask multiple mandatory questions and furthermore did not complete or record all the data items on Patient A's POA accurately.

The panel determined that Mr Elphick's conduct would be considered dishonest by ordinary decent people. The panel was therefore of the view that when completing and recording certain data items inaccurately within the POA in the way he did, Mr Elphick must have known that he was being dishonest.

For these reasons, the panel found this charge proved.

Charge 3.1.1

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.1) Did not discuss the following areas during the consultation with Patient B;

3.1.1) Surgical date;

This sub-charge is found proved.

In reaching this decision, the panel took into account the audio recording 'Exhibit AD-10 Audio recording 17 May 2022'.

In the audio recording 'Exhibit AD-10 Audio recording 17 May 2022', the panel noted that within 40 seconds of the recording, Mr Elphick refers to a hospital letter and about Patient B's fasting instructions before their surgery. Patient B confirms that their fasting instructions are written in the letter. Mr Elphick tells Patient B:

> '*You can eat and drink normal until 2:30 in the morning and then you can have clear fluids up until 6:30 and then you're with us at 7:30.*'

In the entirety of the 12 minutes and 48 seconds of the audio recording, Mr Elphick does not discuss with Patient B about their surgical date.

For these reasons, the panel found this sub-charge proved.

Charge 3.1.2

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.1) Did not discuss the following areas during the consultation with Patient B;

3.1.2) Surgical procedure;

This charge is found NOT proved.

In reaching this decision, the panel took into account Witness 1's witness statement and the audio recording 'Exhibit AD-10 Audio recording 17 May 2022'.

In Witness 1's witness statement, she stated:

'I noted several areas that were not discussed by Michael with the patient. First was that the surgical date, procedure, and length of stay was not discussed with the patient during the consultation. As discussed during the previous call, we need to be confirming with the patient that they know what they are coming in for, what they are having done and how long they are planning on staying with us. This ensures they turn up on the right date, receive the procedure they are expecting and the length of stay, this sets their expectations and helps to plan the discharge. This was not discussed by Michael but is part of the standard pre-operative assessment.'

Within the 4 minutes and 5 seconds of the audio recording, Mr Elphick asked Patient B:

'*In your own words, what is it that you're coming in for to be done?*'

Patient B said:

'*It is classed as breast enlargement*'

Mr Elphick responded:

'*Mhmm, perfect*.'

The panel noted within the audio recording that the reason for the surgery was a sensitive conversation for Patient B. Nevertheless, Mr Elphick should have used clinical terminology as a registered nurse.

The panel was of the view that Mr Elphick did briefly discuss their surgical procedure with Patient B.

The panel therefore did not find this sub-charge proved.

Charge 3.1.3

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.1) Did not discuss the following areas during the consultation with Patient B;

3.1.3) Length of stay;

This sub-charge is found proved.

In reaching this decision, the panel took into account the audio recording 'Exhibit AD-10 Audio recording 17 May 2022'.

In the entirety of the 12 minutes and 48 seconds of the audio recording, Mr Elphick did not discuss Patient B's length of stay in the hospital following their surgery.

For these reasons, the panel found this sub-charge proved.

Charge 3.2

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.2) Did not complete the;

3.2.1) Discharge plan;
3.2.2) General wellbeing page;
3.2.3) Patient information page;
3.2.4) VTE risk assessment;
3.2.5) The Multifactorial intervention plan.

These sub-charges are found proved.

In reaching this decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient B dated 17 May 2022.

Within the POA for Patient B, Mr Elphick did not complete the questions on the pages on: discharge plan, general wellbeing, the patient information, the VTE risk assessment or the multifactorial intervention plan for falls management pathway.

The panel, therefore, found these sub-charges proved.

Charge 3.3

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.3) Inaccurately recorded information on Patient B's POA, without asking these questions/discussing this information with Patient B, namely;

3.3.1) The consent process was documented as discussed/'yes';
3.3.2) Correct site surgery was documented as discussed/'yes';
3.3.3) Patient B's neck size being less that 40cm on the STOPBANG risk assessment was documented as 'no'.

These sub-charges are found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient B dated On 17 May 2022 and the audio recording 'Exhibit AD-10 Audio recording 17 May 2022'.

Within the POA for Patient B, Mr Elphick recorded that he had discussed with Patient B about the consent process, the surgical site and also that Patient B's neck size was less than 40cm on the STOPBANG risk assessment. However, within the audio recording 'Exhibit AD-10 Audio recording 17 May 2022', Mr Elphick did not have these discussions with Patient B.

The panel, therefore, found these sub-charges proved.

Charge 3.4

3) On 17 May 2022 carried out an inadequate pre-operative assessment ('POA') of Patient B, in that you;

3.4) Did not fully/correctly complete the Waterlow Score.

This sub-charge is found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient B dated On 17 May 2022.

The panel had sight of Patient A's POA in which Patient B's Waterlow Score was not completed.

The panel, therefore, found this sub-charge proved.

Charge 4

4) Your actions in one or more of the above charges 3.3.1, 3.3.2, & 3.3.3 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient B, when you had not.

This charge is found proved.

In reaching its decision, the panel took into account the documentary evidence which included Witness 1's witness statement, Ms 2's investigation meeting notes dated 14 December 2022 with Mr Elphick and Mr Elphick's response bundle. The panel also had regard to Witness 1's live evidence and the audio recording 'Exhibit AD-10 Audio recording 17 May 2022'.

In considering whether Mr Elphick's actions were dishonest, the panel had regard to the test as set out in the case of *Ivey* and the NMC Guidance document 'Making decisions on dishonesty charges and the professional duty of candour'.

The panel took into account all of the evidence listed in charge 2.

The panel considered the questions posed in *Ivey* namely what Mr Elphick's knowledge was at the time and then whether his conduct would be regarded as dishonest by the standards of 'ordinary decent people.' The panel noted that Mr Elphick was inducted and trained to ask all the mandatory questions to patients for their pre-operative assessments and would understand why the questions and discussions were required, and the risks to patient safety if they were not asked. Therefore, the panel was of the view that on 17 May 2022, during the telephone call with Patient B, Mr Elphick knew that he had failed to ask multiple mandatory questions and furthermore did not complete or record all the data items on Patient B's POA accurately.

The panel determined that Mr Elphick's conduct would be considered dishonest by ordinary decent people. The panel was therefore of the view that when completing and recording certain data items inaccurately within the POA in the way he did, Mr Elphick must have known that he was being dishonest.

For these reasons, the panel found this charge proved.

Charge 5.1

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.1) Did not discuss the following areas, during the consultation with Patient C;

5.1.1) Surgical date;
5.1.2) Surgical procedure;

These sub-charge are found proved.

In reaching its decision, the panel took into account the audio recording 'Exhibit AD-15 Audio recording 08 November 2022'.

With regard to the surgical date, in the audio recording 'Exhibit AD-15 Audio recording 08 November 2022', within 1 minute and 5 seconds, Mr Elphick confirmed with Patient C that they were due a blood test on 11 November 2022 at 11:00am and 22 November at 09:30am. Mr Elphick at 1:09 in the recording then said to Patient C:

'*And then you're with us the next day for your operation*.'

The panel acknowledged that Mr Elphick stated the dates of Patient C's blood test but was of the view that Mr Elphick did not specifically mention the surgical date for Patient C.

Further, in relation to the surgical procedure, the panel noted that Mr Elphick mentioned to Patient C at 7 minutes and 3 seconds of the audio recording:

'*I know you got spinal stenosis and that's why you need the operation'*

Mr Elphick did not discuss with Patient C the correct surgical procedure that they were attending for.

In light of the above, the panel found these sub-charges proved.

Charge 5.2

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.2) Inaccurately recorded information on Patient C's POA, without asking these questions/discussing this information with Patient C, namely;

5.2.1) Recent/planned travel was documented as 'no';
5.2.2) The journey time home being greater than 1 hour was documented as 'no';
5.2.3) Attendance at short notice was documented as 'no';
5.2.4) Experience of chest pains/heart problems/angina was documented as 'no';
5.2.5) Recent change of symptoms relating to chest pains/angina was documented as 'no';
5.2.6) Medication alterations relating to angina was documented as 'no';
5.2.7) The consent process;
5.2.8) The correct site surgery;
5.2.9) Patient C's neck size being less that 40cm on the STOPBANG risk assessment;
5.2.10) Audit C questions

These sub-charges are found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient C dated 8 November 2022 and the audio recording 'Exhibit AD-15 Audio recording 08 November 2022'.

The panel had sight of Mr Elphick's POA of Patient C dated 8 November 2022. The panel noted from the audio recording 'Exhibit AD-15 Audio recording 08 November 2022', Mr Elphick did not have these discussions with Patient C.

The panel, therefore, found these sub-charges proved.

Charge 5.3

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.3) Inaccurately recorded 'none of the above' to one or more questions relating to health conditions/past medical history, without discussing these in full with Patient C, namely;

5.3.1) Irregular heart beat;
5.3.2) Hear murmur;
5.3.3) Palpitations;
5.3.4) Stroke;
5.3.5) Mini stroke;
5.3.6) Atrial Fibrillation;
5.3.7) Current or previous aneurysm;
5.3.8) Any other cardiac/circulatory problems;
5.3.9) Asthma;
5.3.10) Breathlessness/difficulty breathing;
5.3.11) Inability to lie flat without shortness of breath;
5.3.12) Currently smoke or have you ever smoked;
5.3.13) Obstructive sleep apnoea;
5.3.14) Stop breathing when you sleep;
5.3.15) Snore loudly through a closed door;
5.3.16) Feel tired during the day/fall asleep;
5.3.17) Respiratory problems/pleurisy/persistent cough/coughing up blood/wheezing;

5.3.18) Bleeding disorder/excessive bruising;
5.3.19) Family history of bleeding/blood disorders;
5.3.20) Deep vein thrombosis/Pulmonary embolism;
5.3.21) Sickle cell disease;
5.3.22) Anaemia;
5.3.23) Hepatitis;
5.3.24) Jaundice;
5.3.25) Acid reflux;
5.3.26) Hiatus Hernia;
5.3.27) Stomach Ulcer;
5.3.28) Colostomy/ileostomy;
5.3.29) Neurological problems;
5.3.30) Dementia/memory problems;
5.3.31) Back problems;
5.3.32) Neck problems;
5.3.33) Jaw problems;
5.3.34) Tracheostomy;
5.3.35) Previous head/neck/maxillofacial surgery;

These sub-charges are found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA of Patient C dated 8 November 2022 and the audio recording 'Exhibit AD-15 Audio recording 08 November 2022'.

The panel had sight of Mr Elphick's POA of Patient C dated 8 November 2022. The panel noted from the audio recording 'Exhibit AD-15 Audio recording 08 November 2022', Mr Elphick did not have full discussions with Patient C about their health.

The panel, therefore, found these sub-charges proved.

Charge 5.4.1 – 5.4.14 and 5.4.16 – 5.4.24

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.4) Recorded information in Patient C's POA, without discussing this information fully with Patient C, namely information relating to;

5.4.1) Digestion;
5.4.2) Diabetes;
5.4.3) Mental health;
5.4.4) Family history/adverse reaction to anaesthesia;
5.4.5) Previous admissions to hospital/intensive care/high dependency unit;
5.4.6) Medication;
5.4.7) Recreational drugs;
5.4.8) Infection prevention;
5.4.9) Symptoms of diarrhoea;
5.4.10) Invasive devices;
5.4.11) Cancer treatment;
5.4.12) Residence;
5.4.13) Employment in a health/social care setting/Ministry of Defence;
5.4.14) Involvement in a close contact sport;

[…]

5.4.16) Growth hormone/gonadotrophin treatment;
5.4.17) Blood transfusions;
5.4.18) Dietary requirements;
5.4.19) Dependents;
5.4.20) Mobility/access requirements/wheelchair/walking aids;
5.4.21) History of falls;

5.4.22) People living in the same residence;
5.4.22) Learning difficulties;
5.4.23) Autism;
5.4.24) Daily living activities.

These sub-charges are found proved.

In reaching its decision, the panel took into account Patient C's POA dated 8 November 2022 and audio recording 'Exhibit AD-15 Audio recording 08 November 2022'.

The panel had sight of Mr Elphick's POA of Patient C dated 8 November 2022. The panel noted from the audio recording 'Exhibit AD-15 Audio recording 08 November 2022', Mr Elphick did not have full discussions with Patient C about the above sub-charges.

The panel, therefore, found these sub-charges proved.

Charge 5.4.15

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.4) Recorded information in Patient C's POA, without discussing this information fully with Patient C, namely information relating to;

5.4.15) Surgery;

This sub-charge is found NOT proved.

In reaching its decision, the panel took into account Patient C's POA dated 8 November 2022.

Within the POA, there was no reference made on the form to ‘surgery’.

Consequently, the panel did not find this sub-charge proved.

Charge 5.5

5) On 8 November 2022 carried out an inadequate pre-operative assessment (‘POA’) of Patient C, in that you;

5.5) Did not record a full list of medications for Patient C.

This sub-charge is found proved.

In reaching its decision, the panel took into account Patient C’s POA dated 8 November 2022.

Mr Elphick did not record a full list of Patient C’s medications. It therefore found this sub-charge proved.

Charge 5.6

5) On 8 November 2022 carried out an inadequate pre-operative assessment (‘POA’) of Patient C, in that you;

5.6) Did not complete the following pages;

5.6.1) Discharge page;
5.6.2) General wellbeing page;
5.6.3) Patient information page.

These sub-charge are found proved.

In reaching its decision, the panel took into account Patient C's POA dated 8 November 2022.

Mr Elphick did not complete the pages on the form relating to discharge, Patient 's general wellbeing and patient information. It therefore found these sub-charges proved.

Charge 5.6

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.7) Did not complete the Waterlow score fully/correctly.

This charge is found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA for Patient C dated 8 November 2022.

The panel had sight of the 'Waterlow assessment and chart' on Patient C's POA in which the page was not completed by Mr Elphick.

The panel, therefore, found this sub-charge proved.

Charge 5.8

5) On 8 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient C, in that you;

5.8) Did not complete the multifactorial intervention plan fully/correctly.

This charge is found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA for Patient C dated 8 November 2022.

The panel had sight of the 'multifactorial Intervention Plan for Falls Management Pathway' on Patient C's POA in which the page was not completed at all by Mr Elphick.

The panel, therefore, found this sub-charge proved.

Charge 5.9

5.9) Your actions in one or more of the above charges 5.2.1, 5.2.2, 5.2.3, 5.2.4, 5.2.5, 5.2.6, 5.2.7, 5.2.8, 5.2.9, 5.2.10, 5.3.1, 5.3.2, 5.3.3, 5.3.4, 5.3.5, 5.3.6, 5.3.7, 5.3.8, 5.3.9, 5.3.10, 5.3.11, 5.3.12, 5.3.13, 5.3.14, 5.3.15, 5.3.16, 5.3.17, 5.3.18, 5.3.19, 5.3.20, 5.3.21, 5.3.22, 5.3.24, 5.3.25, 5.3.26, 5.3.27, 5.3.28, 5.3.29, 5.3.30, 5.3.31, 5.3.32, 5.3.33, 5.3.34, 5.3.45, 5.4.1, 5.4.2, 5.4.3, 5.4.4, 5.4.5, 5.4.6, 5.4.7, 5.4.8, 5.4.9, 5.4.10, 5.4.11, 5.4.12, 5.4.13, 5.4.14, 5.4.15, 5.4.16, 5.4.17, 5.4.18, 5.4.19, 5.4.20, 5.4.21, 5.4.22, 5.4.23 & 5.4.24 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient C, when you had not.

This charge is found proved [excluding 5.4.15 as this charge was found not proved].

In reaching its decision, the panel took into account the documentary evidence which included Witness 1's witness statement, Ms 2's investigation meeting notes dated 14 December 2022 with Mr Elphick and Mr Elphick's response bundle. The panel also had regard to Witness 1's live evidence and the audio recording 'Exhibit AD-15 Audio recording 08 November 2022'.

In considering whether Mr Elphick's actions were dishonest in relation to his POA for Patient C, the panel had regard to the test as set out in the case of *Ivey* and the NMC's guidance.

The panel considered the questions posed in *Ivey* namely what Mr Elphick's knowledge was at the time and then whether his conduct would be regarded as dishonest by the standards of 'ordinary decent people.' The panel noted that Mr Elphick was inducted and trained to ask all the mandatory questions to patients for their pre-operative assessments and would understand why the questions and discussions were required, and the risks to patient safety if they were not asked. Therefore, the panel was of the view that on 8 November 2022, during the telephone call with Patient C, Mr Elphick knew that he had failed to ask multiple mandatory questions and furthermore did not complete or record all the data items on Patient C's POA accurately.

The panel determined that Mr Elphick's conduct would be considered dishonest by ordinary decent people. The panel was therefore of the view that when completing and recording certain data items inaccurately within the POA in the way he did, Mr Elphick must have known that he was being dishonest.

For these reasons, the panel found this charge proved.

Charge 6.1.1

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.1) Did not confirm/discuss the following areas, during the consultation with Patient D;

6.1.1) Surgical date;

This sub-charge is found NOT proved.

In reaching its decision, the panel took into account the audio recording 'Exhibit AD-20 Audio recording 09 November 2022'.

In the audio recording at around 3 minutes and 12 seconds:

> [Mr Elphick]: *'Do you know what time you're coming in for your surgery?'*
> [Patient D]: *'no'*
> [Mr Elphick]: *'7:30 in the morning on the 24th* […]'

The panel was of the view that Mr Elphick did discuss and confirm with Patient D of their surgery date. It therefore did not find this sub-charge proved.

Charge 6.1.2 – 6.1.5

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.1) Did not confirm/discuss the following areas, during the consultation with Patient D;

6.1.2) Surgical procedure;
6.1.3) Length of stay;
6.1.4) Post operative care;
6.1.5) Patient D's activity level;

These sub-charges are found proved.

In reaching its decision, the panel took into account Patient D's POA dated 9 November 2022 and audio recording 'Exhibit AD-20 Audio recording 09 November 2022'.

Mr Elphick did not have full discussions with Patient D about the surgical procedure, the length of stay for Patient D, the post operative care and Patient D's activity level.

The panel, therefore, found these sub-charges proved.

Charge 6.1.6

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.1) Did not confirm/discuss the following areas, during the consultation with Patient D;

6.1.6) Patient D's medication;

This sub-charge is found NOT proved.

In reaching its decision, the panel took into account the audio recording 'Exhibit AD-20 Audio recording 09 November 2022'.

In the audio recording at around 1 minute and 45 seconds:

> [Mr Elphick]: *'There's a couple of medications I need you not to take, your clopidogrel. Stop that a week before.*
> [Patient D]: *'Yup'*
> [Mr Elphick]: *'And you know your Lisinopril*
> [Patient D]: *'Do I really need to stop that?'*
> [Mr Elphick*]: 'Just on the morning of your surgery.'*
> [Patient D]: *'Oh, that's no problem.'*
> […]
> [Mr Elphick]: *'your Lisinopril is for your blood pressure medication*
> [Patient D]: *'Right'*

[Mr Elphick]: *'You can take all the rest as normal.'*
[Patient D]: *'So I don't take the clopi …'*
[Mr Elphick]: *'Clopidogrel, stop that a week before'*
[Patient D]: *'Yeah'*
[Mr Elphick]: *'And the Lisinopril you just don't take that on the morning of your surgery.'*
[Patient D]: *'Right, that's great.'*

The panel was of the view that Mr Elphick did discuss Patient D's medication with them, and what should be taken and what medication needs to be stopped before their surgery. It therefore did not find this sub-charge proved.

Charge 6.2

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.2) Did not fully complete/discuss;

6.2.1) The Covid 19 section;
6.2.2) The heart & circulation section;
6.2.3) The lungs & breathing section;
6.2.4) The blood section;
6.2.5) The liver section;
6.2.6) The hormones section;
6.2.7) The kidney section;
6.2.8) The bones and joint section;
6.2.9) The neurology section;
6.2.10) The mental health section;
6.2.11) The anaesthetic history section.
6.2.12) Patient D's activity level;

6.2.13) The infection prevention section;
6.2.14) The daily living section;
6.2.15) The discharge page;
6.2.16) The general well being section;
6.2.17) The patient information page.
6.2.18) The Waterlow score;
6.2.19) The multifactorial intervention place for falls management pathway.
6.2.20) The audit C risk assessment.

These sub-charges are found proved.

In reaching its decision, the panel took into account Patient D's POA dated 9 November 2022 and audio recording 'Exhibit AD-20 Audio recording 09 November 2022'. The panel noted that the conversation was 4 minutes and 3 seconds long.

Mr Elphick did not have full discussions with Patient D or complete Patient D's POA on the sections within the sub-charges.

The panel, therefore, found these sub-charges proved.

Charge 6.3

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.3) Inaccurately recorded information on Patient D's POA, without asking these questions/discussing this information with Patient D, namely;

6.3.1) The consent process was documented as discussed/'yes';
6.3.2) Correct site surgery was documented as discussed/'yes'.

6.3.3) Advice to Patient D about bringing in their medication was documented as discussed/'yes;

6.3.4) Patient D's neck size being less that 40cm on the STOPBANG risk assessment

These sub-charges are found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA for Patient D dated 9 November 2022 and audio recording 'Exhibit AD-20 Audio recording 09 November 2022'.

Mr Elphick did not discuss the consent process, the surgical site or Patient D's neck size being less that 40cm on the STOPBANG risk assessment with Patient D. Further, the panel noted that Mr Elphick did talk to Patient D about their medication. However, Mr Elphick did not ask Patient D to bring in their medication on the day of their surgery. Therefore, in ticking 'yes' to represent that these discussions took place, the information was inaccurately recorded.

The panel found these sub-charges proved.

Charge 6.4

6) On 9 November 2022 carried out an inadequate pre-operative assessment ('POA') of Patient D, in that you;

6.4) Inaccurately recorded that you had provided information in Patient D's POA, without providing this information to Patient D, namely;

6.4.1) Name;
6.4.2) Telephone number;
6.4.3) Suppression therapy as per Spire policy.

These sub-charge are found proved.

In reaching its decision, the panel took into account the documentary evidence which included Mr Elphick's POA for Patient D dated 9 November 2022 and audio recording 'Exhibit AD-20 Audio recording 09 November 2022'. The panel noted that the conversation was 4 minutes and 3 seconds long.

Mr Elphick did not provide Patient D with the name, telephone number of the pre-operative assessment team or details of suppression therapy as per Spire policy. Therefore, Mr Elphick had inaccurately recorded this information on Patient D's POA.

The panel found these sub-charges proved.

Charge 6.5

6.5) Your actions in one or more of the above charges 6.3.1, 6.3.2, 6.3.3, 6.3.4, 6.4.1, 6.4.2 & 6.4.3 were dishonest, in that you sought to misrepresent that you had undertaken a complete pre-operative assessment of Patient D, when you had not.

This charge is found proved.

In reaching its decision, the panel took into account the documentary evidence which included Witness 1's witness statement, Ms 2's investigation meeting notes dated 14 December 2022 with Mr Elphick and Mr Elphick's response bundle. The panel also had regard to Witness 1's live evidence and the audio recording 'Exhibit AD-20 Audio recording 09 November 2022'.

The panel had regard to the test as set out in the case of *Ivey* and the NMC's guidance.

The panel considered the questions posed in *Ivey* namely what Mr Elphick's knowledge was at the time and then whether his conduct would be regarded as dishonest by the standards of 'ordinary decent people.' The panel noted that Mr Elphick was inducted and trained to ask all the mandatory questions to patients for their pre-operative assessments and would understand why the questions and discussions were required, and the risks to patient safety if they were not asked. Therefore, the panel was of the view that on 9 November 2022, during the telephone call with Patient D, Mr Elphick knew that he had failed to ask multiple mandatory questions and furthermore did not complete or record all the data items on Patient D's POA accurately.

The panel determined that Mr Elphick's conduct would be considered dishonest by ordinary decent people. The panel was therefore of the view that when completing and recording certain data items inaccurately within the POA in the way he did, Mr Elphick must have known that he was being dishonest.

For these reasons, the panel found this charge 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 his fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise kindly, safely and professionally.

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

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

Submissions on misconduct

Ms William referred to the case of *Remedy UK Ltd, R (on the application of) v The General Medical Council* [2010] EWHC 1245 (Admin) and the NMC's guidance on: 'Misconduct (Reference: FTP-2a, Last Updated 02/12/2024); 'How we determine seriousness' (Reference: FTP-3, Last Updated 27/02/2024) and 'Serious concerns which are more difficult to put right' (Reference: FTP-3a, Last Updated 27/02/2024).

Ms Williams said that multiple charges were found proved where Mr Elphick, knowingly and despite his training, went through the POA without asking patients the required questions. She submitted that Mr Elphick was not open or honest with patients about each stage of the questionnaire that he had to fill in, which was a serious concern that is difficult to put right. She further submitted that Mr Elphick's conduct was not upholding professional standards. Ms Williams said that the panel heard the four audited phone calls and submitted that the quality of service given to the patients deteriorated over time with the 'Exhibit AD-20 Audio recording 09 November 2022' only being approximately 4 minutes. She said that Mr Elphick's POA did not improve with learning or training, and that his conduct was far below the standard that is expected of a registered nurse. She submitted that as there is a pattern to Mr Elphick's misconduct as there are four incidents of misconduct. She said that the guidance states a pattern of misconduct is more likely to cause harm to patients. Ms Williams submitted that there is no evidence of actual harm to patients caused by Mr Elphick's misconduct. However, there was a risk of significant harm being caused to patients.

Ms Williams referred the panel to the NMC's guidance on 'How we determine seriousness' and submitted that Mr Elphick's misconduct demonstrates an attitudinal concern which amounts to a serious concern. She further submitted that Mr Elphick's misconduct would have a negative impact on the public's confidence in the nursing profession.

Ms Williams identified the specific, relevant standards where Mr Elphick's actions amounted to misconduct. She submitted that standards 20 and 20.2 applied from **'**The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code).

Ms Williams submitted that Mr Elphick has not engaged with the NMC proceedings and so there is little or no evidence of Mr Elphick taking steps to remediate the concerns or to reflect on the misconduct.

Ms Williams invited the panel to take the view that the facts found proved amount to misconduct.

Submissions on impairment

Ms Williams 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 case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant* [2011] EWHC 927 (Admin)*.*

Ms Williams submitted that Mr Elphick's misconduct had put patients at risk of harm and given the absence of remediation or further training, there remains a risk in the future as well. She further submitted that the concerns are serious which has, and in the future will, bring the nursing profession into disrepute. Ms Williams also submitted that as the code of conduct is engaged, Mr Elphick's misconduct has breached the fundamental tenets of the

nursing profession and was dishonest. She therefore submitted that all four limbs of *Grant* were engaged.

Ms Williams also submitted that there is a risk to colleagues as they are treating patients without them being properly assessed.

Ms Williams submitted that Mr Elphick's practice is impaired as a result of his misconduct. She submitted that he occupies a position of trust in society and is expected at all times to act professionally to ensure patients can trust nurses, particularly in the context of undergoing surgery.

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, *Ashton v General Medical Council* [2013] EWHC 943, *General Medical Council v Meadow* [2007] QB 462 (Admin)*, Preiss v GDC* [2001] 1 WLR 1296*, Calhaem v GMC* [2007] EWHC 2606, and *Grant*.

Decision and reasons on misconduct

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

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of **'**The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision. The panel also had regard to the NMC's guidance: 'Misconduct' (Reference: FTP-2a) and 'Making decisions on dishonesty charges and the professional duty of candour' (Reference: DMA-8).

The panel was satisfied that charge 5.1.1 did not represent misconduct as Mr Elphick's had said the words '*And then you're with us the next day for your operation*'. The panel was of the view that this was more of a technical breach, and did not meet the required standard of seriousness.

With that exception, the panel was satisfied that Mr Elphick's actions as represented by the charges found proved did fall significantly short of the standards expected of a registered nurse, and amounted to a breach of the Code. The panel considered that had Mr Elphick's actions been isolated and limited to infrequent omissions on the POA's, then that may not have met the threshold for professional misconduct. Alternatively, had there been evidence of training issues, then there would be no misconduct. However, the number of Mr Elphick's omissions on multiple POA's indicated a pattern of behaviour which presented significant risks to patient safety. The panel bore in mind its conclusions on the facts that these omissions and crucially his falsification of patient records were deliberate and dishonest.

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

The panel was satisfied that there had been a breach of the following specific sections of the Code:

> *'**Prioritise people***
> *You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.*
>
> ***1 Treat people as individuals and uphold their dignity***

To achieve this, you must:

1.2 make sure you deliver the fundamentals of care effectively

4 Act in the best interests of people at all times

8 Work co-operatively

To achieve this, you must:

8.2 maintain effective communication with colleagues

8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff

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

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

To achieve this, you must:

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

10.6 collect, treat and store all data and research findings appropriately

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 …'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was satisfied that Mr Elphick's actions in the charges found proved represented a serious falling-short of the standards expected of a registered nurse and did amount to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Elphick'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 was satisfied that limb a) of the test in *Grant* is satisfied as to past conduct. Whilst there was no evidence of actual harm being caused to patients as a result of Mr Elphick not conducting adequate POA’s and dishonestly entering inaccurate information on patients records, the panel was satisfied that it had the potential to put patients at high risk of significant harm. Witness 1 told the panel in her live evidence:

> *‘So it's really important that we pre assess patients ahead of their surgery, want to make sure that they are suitable for surgery and suitable for the anaesthetic type. We obviously want to make sure as well that the patients are pre optimised ahead of surgery, so we want to make sure that they are in their fittest state possible.*

Ahead of surgery and ahead of an anaesthetic because obviously any anaesthetic comes at a risk to a patient.

And it's really important that we get the information correct at POA because it's all about safeguarding the patient before they come into a hospital. Our hospitals are obviously a private health group so not all of our hospitals have critical cares [sic] *and so we have to make sure that we've got the right patients coming in to the right hospitals for the right level of care. So it could be that a patient is actually too complex to come to us at Spire and that they would be safer in the NHS, where they've got all the support systems around them in terms of critical care.*

It's really, really important that we extract all of the information required regarding the patient's past medical history, because that then would trigger any kind of escalation route. So we have a need to assess that support, our pre-op department. So for example, say if a patient has had a stroke within the last six months and we won't be able to admit them for surgery because that would be unsafe. It would dramatically increase our risk of having another stroke. So it's really, really important that we extract the correct information about the history about their medications, because it could be that they're on a medication that we actually need to stop ahead of surgery. Say for example, a blood thinning medication.'

The panel noted from Witness 1's live evidence the accurate competition of POA's were important to filter out patients who required complex care and who might require Intensive Therapy Unit (ITU) as Spire did not always have this facility in their hospitals. If these patients were not filtered out by their POA, which was part of Spire's fail safe procedure to ensure that this happened at an early stage, it could lead to patients being in a clinically inappropriate setting which could be extremely dangerous or it could result in them having their procedure cancelled at the last minute.

The panel was satisfied that limb b) of the test in *Grant* is satisfied as to past conduct. The panel was satisfied that Mr Elphick's misconduct and dishonesty had brought the nursing

profession into disrepute, and that members of the public would be shocked that a registered nurse had behaved in that way.

The panel was satisfied that limb c) of the test in *Grant* is satisfied as to past conduct. Nurses are expected to be honest and demonstrate integrity and to prioritise patient safety and act in their best interests at all times. The panel was satisfied that Mr Elphick's misconduct had breached the fundamental tenets of the nursing profession. Specifically, a nurses ever present regard for and prioritisation of patient safety, as well as the expectation that nurses remain honest, demonstrate integrity at all times and as such act within the best interests of their patients.

The panel was satisfied that limb d) of the test in *Grant* is satisfied as to past conduct. Mr Elphick had dishonestly entered inaccurate information on all four patients' records.

The panel then considered whether the *Grant* test could be satisfied in respect of the risk of future misconduct. In doing so, it considered the guidance in the case of *Cohen.*

The panel had regard to the NMC's guidance on 'How we determine seriousness', 'Serious concerns which are more difficult to put right'. It noted:

> *'breaching the professional duty of candour to be open and honest when things go wrong, including covering up, falsifying records …'*

It also noted from the guidance on 'Serious concerns which could result in harm if not put right' (Reference: FTP-3b):

> *'Promote professionalism and trust*
> *The evidence shows that the nurse, midwife or nursing associate has:*
> - *failed to uphold the reputation of the profession, by not acting with honesty and integrity, treating people fairly …*
> - *failed to maintain the level of health needed for safe and effective practice.'*

With regards to whether Mr Elphick's conduct is easily remediable, the panel found that the misconduct in this case is difficult, but not impossible, to remediate. The panel was of the view that Mr Elphick's misconduct was a progressive pattern across multiple patients over a sustained period of time for at least 7 months. The panel considered that Mr Elphick's misconduct is at the higher end of misconduct and that there are attitudinal concerns with regard to Mr Elphick's honesty, integrity, prioritisation of patient safety and to act in the best interests of patients at all times.

With regards to whether Mr Elphick's misconduct has been remedied, the panel did not have any evidence of any steps he has taken to strengthen his practice or to address the concerns. The panel had sight of Mr Elphick wishing to no longer be a nurse and his application for agreed removal. Mr Elphick did not provide any evidence of reflections or insight as to why he acted in the way he did and why he acted dishonestly. The panel determined that the misconduct has not been remedied.

As a result of the absence of any evidence demonstrating that Mr Elphick has taken steps to address the concerns or to engage with the NMC, as well as his deep seated attitudinal concerns with regards to honesty, integrity and acting in the best interest for patients at all times, the panel also determined that it is highly likely that Mr Elphick's misconduct will reoccur.

In coming to its decision, the panel had regard to the Fitness to Practise Library, updated on 27 March 2023, which states:

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

The panel was of the view that ‘not acting kindly’ was not a feature in this case. In fact, when Mr Elphick spoke to his patients, he had a pleasant manner. However, the concerns are that he was not practising safely nor professionally as he was not undertaking patients POA’s adequately and was recording information incorrectly on patient records.

Accordingly, the panel determined that there was a potential future risk of misconduct under the test in *Grant* in respect of limbs a, b, c and d.

The panel has therefore decided that a finding of current impairment of fitness to practise is necessary on the grounds of public protection.

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. It also took into account the NMC’s guidance on ‘Serious concerns based on public confidence or professional standards’ (Reference: FTP-3c)

The panel determined that a finding of impairment on public interest grounds is required because the public and profession would expect that the gravity of the charges found proved would be marked by a finding of current impairment of fitness to practise. The panel is satisfied that public confidence in the profession and the NMC’s ability to declare and uphold proper professional standards would be undermined if a finding of impairment were not made in this case. It therefore finds Mr Elphick’s fitness to practise also impaired on the grounds of public interest.

Sanction

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

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

Submissions on sanction

Ms Williams submitted that the aggravating features include abuse of trust, conduct which placed patients at risk of harm, and a pattern of misconduct over a period of time which was directly linked to Mr Elphick's practice. She also submitted that there are deep seated attitudinal concerns and no evidence of any steps Mr Elphick has taken to strengthen his practice, or to develop insight, and there is no evidence of remorse. In terms of any mitigating features, Ms Williams submitted that there is no evidence that actual harm was caused to any patients.

Ms Williams invited the panel to impose a striking-off order. She submitted that taking no action or a caution order would be wholly inappropriate and not proportionate, particularly as the panel had determined that Mr Elphick's misconduct was at the higher end of the spectrum. With regards to a condition of practice order, Ms Williams submitted that there are no workable conditions that could be formulated to address the concerns.

With regards to suspension order, Ms Williams submitted that the seriousness of the regulatory concerns do warrant a temporary removal from the register and therefore it could be appropriate. However, as there are multiple incidents, a pattern of deep seated attitudinal concerns, four serious dishonesty charges, as well as absence of any evidence of strengthening of practice or insight, it would not protect the public or meet the wider public interest.

Accordingly, Ms Williams submitted that a striking-off order would be the appropriate and proportionate order. She referred the panel to the NMC's guidance on Striking-off order (Reference: SAN-3e, Last Updated 30/08/2024). She submitted that the regulatory concerns do raise fundamental questions about Mr Elphick's professionalism and that public confidence would not be maintained if he is not removed from the register. She further submitted that a striking-off order would protect the public, meet the wider public interest and uphold professional standards. She submitted that the regulatory concerns go to such fundamental issues around Mr Elphick's professionalism and his trustworthiness as a registered nurse. She referred the panel to the guidance on 'Considering sanctions for serious cases' (Reference: SAN-2) and submitted that findings of dishonesty would always be serious and therefore Mr Elphick's actions are incompatible with continued registration.

Decision and reasons on sanction

Having found Mr Elphick'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 decision on sanction is a matter for the panel independently exercising its own judgement.

The panel had careful regard to the guidance 'Considering sanctions for serious cases' (Reference: SAN-2).

The panel took into account the following aggravating features:

- Abuse of a position of trust
- Pattern of behaviour several instances over 7 months
- Lack of remorse, reflection, insight or strengthened practice
- Direct risk to people receiving care, in particular in not assessing whether critical care might be required

- Systematic or longstanding deception
- Involved vulnerable victims
- Undermining clinical governance
- A deep seated attitudinal concern with no clear motive for his dishonesty

The panel noted that within his preliminary interview with Spire, Mr Elphick denied any issues. Furthermore, during Spire's disciplinary process, Mr Elphick resigned. He has also failed to engage with this hearing. Consequently, the panel is unable to determine what motivated his dishonest behaviour.

The panel determined that there are no mitigating features in this case.

The panel noted from the NMC guidance 'Considering sanctions for serious cases' (Reference: SAN-2):

> *'Honesty is of central importance to a nurse, midwife or nursing associate's practice. Therefore allegations of dishonesty will always be serious and a nurse, midwife or nursing associate who has acted dishonestly will always be at some risk of being removed from the register.'*

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case and the public protection issues identified. The panel decided that it would be neither proportionate nor in the public interest to take no further action. Furthermore, it would not protect the public.

The panel then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Elphick's practice would not be appropriate in the circumstances. The SG states that a caution order may be appropriate where 'the case is at the lower end of the spectrum of impaired fitness to practise and the panel wishes to mark that the behaviour was unacceptable and must not happen again.' The panel considered that Mr

Elphick'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. Furthermore, it would not protect the public.

The panel next considered whether placing conditions of practice on Mr Elphick's registration would be a sufficient and appropriate response. The panel took into account the NMC's guidance on 'Conditions of practice order' (Reference: SAN-3c). The panel is of the view that given the nature of the charges in this case which includes dishonesty as well as given Mr Elphick's lack of any remorse, reflection or insight into his misconduct, there are no practical or workable conditions that could be formulated. The misconduct identified in this case was not something that can be addressed through retraining. The panel also took into account that Mr Elphick demonstrated very disturbing deep seated attitudinal behaviour and his unwillingness to engage with the NMC. Furthermore, the panel concluded that the placing of conditions on Mr Elphick's registration would not adequately address the seriousness of this case, protect the public or meet the public interest.

The panel then went on to consider whether a suspension order would be an appropriate sanction. The panel took into account the NMC guidance on 'Suspension order' (Reference: SAN-3d). The panel determined that 'this was not a single instance of misconduct but where a lesser sanction is not sufficient'. Further, there is evidence of deep seated attitudinal concerns and the panel was not satisfied that Mr Elphick has any insight into the regulatory concerns and determined accordingly that he does pose a significant risk of repeating the misconduct. The panel was still mindful of the fact that an imposition of a suspension order with a review may protect the public. However, given the absence of any evidence of remorse, insight or steps he has taken to strengthen his practice, the panel was not persuaded that a suspension order with a review would achieve any useful purpose 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 looking at the guidance on 'Striking-off order' (Reference: SAN-3e), the panel took note of the following:

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

The panel concluded that the regulatory concerns do raise fundamental questions about Mr Elphick's professionalism as his actions had breached the fundamental tenets of the nursing profession. In addition, the misconduct was at the higher end of the spectrum. It was of the view that Mr Elphick's actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with him remaining on the register. The panel determined that the findings in this particular case demonstrate that Mr Elphick's actions were serious and to allow him to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body. Furthermore, the panel determined that a striking-off order would be the only sanction which will be sufficient to protect patients, members of the public, and maintain professional standards.

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 Mr Elphick's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct himself, the panel has concluded that nothing short of this would be sufficient in this case.

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

This will be confirmed to Mr Elphick in writing.

Interim order

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

Submissions on interim order

Ms Williams submitted that an interim order should be imposed for a period of 18 months to cover the 28-day appeal period and the subsequent period, should an appeal be lodged. She submitted that this is necessary for the protection of members of the public and otherwise in the public interest. With regard to the type of order, she said that this was a matter for the panel.

Ms Williams told the panel that an interim conditions of practice order was imposed on Mr Elphick's practice.

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

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. The panel therefore imposed an interim suspension order for a period of 18 months which would cover the likely time for an appeal to be heard, should one be lodged.

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

That concludes this determination.