Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Meeting
Monday, 6 July 2026

Virtual Meeting

Name of Registrant:	**Francis Dike**
NMC PIN:	06H2816E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nursing (21 September 2006)
Relevant Location:	Bedfordshire
Type of case:	Misconduct
Panel members:	Dave Lancaster (Chair, lay member) Sophie Agolini (Registrant member) Emma Foxall (Lay member)
Legal Assessor:	Graeme Henderson
Hearings Coordinator:	Fionnuala Contier-Lawrie
Order being reviewed:	Conditions of practice order (12 months)
Fitness to practise:	Impaired
Outcome:	**Striking-Off order to come into effect on 22 August 2026 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Meeting

The panel noted at the start of this meeting that the Notice of Meeting had been sent to Mr Dike's registered email address by secure email on 28 May 2026.

The panel took into account that the Notice of Meeting provided details of the review that the review meeting would be held no sooner than 29 June 2026 and inviting Mr Dike to provide any written evidence seven days before this date.

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The panel accepted the advice of the legal assessor.

In the light of all of the information available, the panel was satisfied that Mr Dike has been served with notice of this meeting in accordance with the requirements of Rules 11A and 34 of the *'Nursing and Midwifery Council (Fitness to Practise) Rules 2004'* (as amended) (the Rules).

Decision and reasons on review of the current order

The panel decided to impose a striking off order. This order will come into effect at the end of 22 August 2026 in accordance with Article 30(1) of the *'Nursing and Midwifery Order 2001'* (as amended) (the Order).

This is the fourth review of a substantive order originally imposed by a Fitness to Practise Committee panel on 25 May 2023. The first order was a suspension order for a period of eight months. This was reviewed on 16 January 2024 and a conditions of practice order was imposed for nine months. This was reviewed on 15 October 2024 and a conditions of practice order was continued for a further nine months. This was reviewed on 11 July 2025 and a conditions of practice order was continued for a further 12 months.

The current order is due to expire at the end of 22 August 2026.

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

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

'That you, a registered nurse:-

1. In relation to Service User 1, failed to ensure as of 25 October 2018 that their care plan set out clearly and/or at all:

1.1 with respect to the use of a Hoist:

1.1.1 what sort of hoist should be used

1.1.2 what sort of sling should be used

1.1.3 how many members of staff should operate the hoist

1.2 with respect to meal preparation:

1.2.1 what the risks were

1.2.2 what level of support Service User 1 required

1.2.3 what their preferences were

1.3 with respect to pressure sores:

1.3.1 …

1.3.2 how staff could prevent pressure areas developing

1.3.3 whether Service User 1 could reposition themselves

1.3.4 how Service User 1 needed support

1.3.5 what action to take should their skin start to break down.

1.3.6 …

2. …

3.1 …

3.2 set out adequately and/or at all how catheter and/or stoma care should be provided safely

4. In relation to Service User 2, failed to ensure that staff had any or adequate specialist training in catheter and/or stoma care

5. In relation to Service User 3, failed to ensure as of 25 October 2018 that the section of their Care Plan entitled 'Functional Electronic System' set out clearly and/or at all:

5.1 what FES equipment does

5.2 how FES equipment should be used

5.3 how long FES equipment should be used for

5.4 the risk of incorrect use or overuse

6…

7. ...

8. ...

9…

10. In relation to Service User 9, between 24 May 2018 and 5 June 2018, failed to ensure that they received any and/or adequate care in relation to food shopping and/or food preparation

11. As of 18 September 2018, in respect of one or more Service Users, failed to ensure that the service had, or had available, accurate and complete incident and accident records

12. In respect of recording of care calls:

12.1 failed to ensure that staff had been fully trained in the use of the CM2000 call system prior to its introduction

12.2 as of 18 September 2018, failed to ensure that at least one of CM2000 and paper records, or the two combined, provided a complete record of calls.

12.3 as of 18 September 2018, failed to ensure that there was evidence of all calls which had taken place since the introduction of the CM2000 call system

13. As of 25 October 2018 Failed adequately or at all to:

13.1 …

13.2 have in place tools to monitor the standard of care provided during calls

13.3 have in place a system to record health or wellbeing information from calls

13.4 in respect of calls other than those at 2.1 & 6.1 above, ensure that calls took place at times required and/or appropriate to the needs of Service Users

13.5 in respect of calls other than those at 2.2 & 6.2 above, ensure calls were of the required length

13.6 ensure that care during calls was of a proper standard

13.7 identify and/or act upon occasions when the standard of care provided in calls was poor

14. On an unknown date prior to 25 October 2018, with regard to a Service User's suspected UTI, failed to contact their GP or advise their family to do so

15. ...

16. In relation to the training of staff:

16.1 on one or more occasions prior to 25 October 2018 personally provided training to staff in one or more of the following areas when you had no relevant training specific qualification:

16.1.1 moving and handling

16.1.2 safeguarding of adults and children

16.1.3 food hygiene

16.1.4 equality and diversity

16.1.5 pressure care

16.1.6 medicines administration

16.1.7 health and safety

16.1.8 first aid

16.1.9 the Mental Capacity Act 2005

16.2 in respect of one or more of the areas at

16.1.1 - 16.1.9 above on one or more occasions provided training which was inadequate.

16.3 failed to ensure that spot checks of staff competency:

16.3.1 were adequate in number

16.3.2 addressed safeguarding

16.3.3 addressed medication administration

16.3.4 assessed the performance of individual staff

16.4 with regard to moving and handling training:

16.4.1 failed to provide any or adequate practical training

16.4.2 failed to have in place effective monitoring to ensure that training was being followed and/or staff were competent

17…

18. With respect to complaints, failed to have in place and/or make use of:

18.1 a written policy for dealing with complaints

18.2 an effective system to:

18.2.1 monitor complaints

18.2.2 ensure complaints were acted upon

18.2.3 improve the Service in light of complaints

19. ...

20. In respect of reportable concerns:

20.1 on or about 22 December 2016 you became aware of a reportable concern but failed to report it until 20 February 2018

20.2 on or about 09 September 2017 you became aware of a reportable concern but failed to report it until 20 February 2018

20.3 on or about 04 October 2017 you became aware of a reportable concern but failed to report it until 20 February 2018

20.4 on or about 21 December 2017 you became aware of a reportable concern but failed to report it until 01 May 2018

20.5 on or about 08 June 2018 you became aware of a reportable concern but failed to report it until 30 August 2018

20.6 on or about 06 June 2018 you became aware of a reportable concern but failed to report it until 30 August 2018

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

The third reviewing panel determined the following with regard to impairment:

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

The panel considered whether Mr Dike’s fitness to practise remains impaired.

The panel noted that the last reviewing panel commented that Mr Dike had slightly improved his insight. At this hearing the panel had regard to the recommendations of the last reviewing panel suggesting that today’s panel would be assisted by Mr Dike’s:

- *‘Attendance at any future hearing*
- *If you are not working in a nursing capacity and unable to comply with the conditions set out above, then to provide the panel with reflective statements relating to nursing practice, and evidence of relevant training including training regarding risk assessment and care planning’*

Today’s panel noted that it did not have any new information before it to confirm that he had complied with the conditions imposed, demonstrated any further insight into his misconduct, or take an effective steps to maintain his knowledge or skills.

The panel therefore found that there has been no change in circumstances since the previous hearing in October 2024. The panel therefore determined that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. Given the nature of the wide ranging failings concerning vulnerable service users being cared for in the community, where there is

no evidence that they have been remediated to date, the panel found that Mr Dike was also impaired on the grounds of public interest.

For these reasons, the panel finds that your fitness to practise remains impaired.

The third reviewing panel determined the following with regard to sanction:

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

The panel next considered whether imposing a further conditions of practice order on Mr Dike's registration would be sufficient to protect patients and address concerns about public confidence or proper professional standards and conduct. The panel is mindful that any conditions imposed must be proportionate, measurable, workable and relevant.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the misconduct found proved.

The panel was of the view that a further conditions of practice order would be sufficient to protect patients and the wider public interest, reaffirming that there was: no evidence of deep seated attitudinal problems; there were identifiable areas of Mr Dike's practice in need of assessment and or

retraining; and conditions could be created that could be monitored and assessed. In this case, there are conditions which could be formulated which would protect patients during the period they are in force. The panel considered that the conditions were not too onerous allowing Mr Dike to work in an environment alongside nursing colleagues whilst gathering evidence to support a return to practice without restrictions. The panel considered whether varying the conditions would assist Mr Dike's return to practice, however without his attendance and engagement at this hearing, it could not address this.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate and would not be a reasonable response in the circumstances of Mr Dike's case.

Accordingly, the panel determined, pursuant to Article 30(1)(a) to make a conditions of practice order for a period of 12 months, which will come into effect on the expiry of the current order, namely at the end of 22 August 2025. The panel imposed a 12 months order to give Mr Dike the opportunity to comply with the conditions, strengthen his insight into his past misconduct and to take further steps to maintain his skills and knowledge. It decided to impose the following conditions which it considered are appropriate and proportionate in this case:

> *'For the purposes of these conditions, 'employment' and 'work' mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, 'course of study' and 'course' mean any course of educational study connected to nursing, midwifery or nursing associates.*
>
> 1. *You must only work with one employer, which must not be an agency or a temporary staffing organisation.*

2. *You should not work as the nurse in charge of a shift. You should work at all times on the same shift as, but not always be directly supervised by, another registered nurse.*

3. *You should have supervision meetings monthly to discuss your clinical practice.*

4. *You should undertake relevant training courses agreed by your manager/ supervisor which include care planning and risk assessment with regard to patients. A record of your training should be sent to your NMC Case Officer before your next review hearing.*

5. *You should write a reflective piece monthly and discuss this with your supervisor during your monthly meeting. This reflective piece should include:*
   - *a sample of a cases of where you have undertaken care planning/risk assessments;*
   - *the nature of care given*

This should be submitted to your NMC Case Officer before your next review hearing.

6. *You must provide a document from your supervisor which:*
   - *Confirms that monthly meetings have taken place*
   - *Details your progress and practice*

   This should be submitted to your NMC Case Officer before your next review hearing.

7. *You must keep us informed about anywhere you are working by:*
   a) *Telling your case officer within seven days of accepting or leaving any employment.*
   b) *Giving your case officer your employer's contact details.*

8. *You must keep us informed about anywhere you are studying by:*

a) *Telling your case officer within seven days of accepting any course of study.*
b) *Giving your case officer the name and contact details of the organisation offering that course of study.*

9. *You must immediately give a copy of these conditions to:*
   a) *Any organisation or person you work for.*
   b) *Any employers you apply to for work (at the time of application).*
   c) *Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.*

10. *You must tell your case officer, within seven days of your becoming aware of:*
    a) *Any clinical incident you are involved in.*
    b) *Any investigation started against you.*
    c) *Any disciplinary proceedings taken against you.*

11. *You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:*
    a) *Any current or future employer.*
    b) *Any educational establishment.*
    c) *Any other person(s) involved in your retraining and/or supervision required by these conditions*

The period of this order is for 12 months.'

Decision and reasons on current impairment

The panel has considered carefully whether Mr Dike's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the

panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it, including the NMC bundle.

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

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

At this hearing, the panel had regard to the recommendations of the last reviewing panel, suggesting that today's panel would be assisted by Mr Dike's:

- *'Attendance at any future hearing*
- *Evidence of compliance with the conditions.*
- *If Mr Dike is not working in a nursing capacity and unable to comply with the conditions set out above, then he is to provide the panel with reflective statements relating to nursing practice, and evidence of relevant training including training regarding risk assessment and care planning*
- *Any references and testimonials from any work role whether in nursing or not.'*

Today's panel noted that it did not have any new information before it to show that Mr Dike has complied with the conditions which were imposed, no evidence of insight or steps taken to maintain his knowledge or skills.

The panel therefore found that there has been no change in circumstances since the hearing in October 2024. The panel therefore determined that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest, which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. Given the nature of the wide-ranging failings concerning vulnerable service users being cared for in the community, where there is no evidence that they have been remediated, the panel found that Mr Dike was also impaired on the grounds of public interest.

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

Decision and reasons on sanction

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

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case.

The panel noted that Mr Dike's NMC registration had expired on 30 September 2023. He only remained on the NMC Register because he was the subject of these disciplinary proceedings. The panel was aware that in certain circumstances it would be possible to allow his registration to lapse having made a finding of impairment.

The panel had careful regard to the NMC guidance *'Removal from the register when there is a substantive order in place'* (REV-2h, last updated 13 May 2026).

The panel did not consider that the central factors were engaged. In particular, there has been no recent engagement with the NMC, let alone recent evidence demonstrating that they have retired and do not intend to return to practice.

The panel decided that it would be neither proportionate nor in the public interest to take no further action.

It then considered the imposition of a caution order but again determined that, due to the seriousness of the case, and the public protection issues identified, an order that does not restrict Mr Dike'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, but the Committee wants to mark that what happened was unacceptable and must not happen again.'* The panel considered that Mr Dike's misconduct was not at the lower end of the spectrum and that a caution order would be inappropriate in view of the issues identified. The panel decided that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether a conditions of practice order would remain a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel noted that Mr Dike has not engaged with the NMC since October 2024, and it has no evidence before it today to show that he has adhered to the conditions.

In view of Mr Dike's clear lack of engagement and lack of evidence that he has complied to the current conditions in place, the panel considered that any conditions of practice order would not be workable and would serve no useful purpose.

The panel next considered imposing a suspension order. The panel noted that Mr Dike has not provided any evidence to show he has taken any steps to strengthen his practice or provided any evidence of further insight into his failings. In these circumstances, the panel determined that a period of suspension would not serve any useful purpose.

The panel also had regard to the NMC SG *'Deciding between suspension and strike off'* (SAN-3, last updated 28 January 2026), which states

> '*Professionals are under an obligation to cooperate with their regulator. Where professionals have failed to engage with the fitness to practise process, it won't usually be appropriate to use a suspension order as a means of giving them a 'last chance' to engage, reflect or show insight'*

The panel noted that this revision to the sanctions guidance took place in January 2026. The guidance made it clear that where a professional has failed to engage in the regulatory process, it would not be usually appropriate to provide that professional with a last chance.

The panel considered that, as Mr Dike had been absent from the previous review, the last reviewing panel had effectively provided Mr Dike with a last chance. As such, this panel could see no purpose in providing Mr Dike with a further last chance.

The panel therefore determined that it was necessary to take action to prevent Mr Dike from practising in the future and concluded that the only sanction that would adequately protect the public and serve the public interest was a striking-off order. The panel therefore directs the registrar to strike Mr Dike's name off the register.

This striking-off order will take effect upon the expiry of the current conditions of practice order, namely the end of 22 August 2026 in accordance with Article 30(1).

This will be confirmed to Mr Dike in writing.

That concludes this determination.