# Nursing and Midwifery Council
# Fitness to Practise Committee

## Substantive Order Review Hearing
## Tuesday 16 January 2024

Virtual Hearing

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| **Name of Registrant:** | Francis Dike |
| **NMC PIN:** | 06H2816E |
| **Part(s) of the register:** | Registered Mental Health Nurse (2006) |
| **Relevant Location:** | Bedfordshire |
| **Type of case:** | Misconduct |
| **Panel members:** | Nicola Jackson (Chair, lay member)<br>Frances Clarke (Registrant member)<br>Keith Murray (Lay member) |
| **Legal Assessor:** | Laura McGill |
| **Hearings Coordinator:** | Rene Aktar |
| **Nursing and Midwifery Council:** | Represented by Suren Agarwala, Case Presenter |
| **Mr Dike:** | Present and unrepresented at the hearing |
| **Order being reviewed:** | Suspension order (8 months) |
| **Fitness to practise:** | Impaired |
| **Outcome:** | **Conditions of practice order (9 months)** |

**Decision and reasons on review of the substantive order**

The panel decided to replace the current suspension order with a conditions of practice order.

This order will come into effect at the end of 22 February 2024 in accordance with Article 30(1) of the 'Nursing and Midwifery Order 2001' (the Order).

This is the first review of a substantive suspension order originally imposed for a period of 8 months by a Fitness to Practise Committee panel on 25 May 2023.

The current order is due to expire at the end of 22 February 2024.

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:

> *'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 what the symptoms of Service User 1's sores were or might be*

*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 following a physiotherapy appointment, guidance or directions to be followed for staff to ensure that care was provided safely*

*2. In relation to Service User 1, failed to ensure that they received:*

*2.1 one or more calls at the time and/or the frequency required and/or appropriate to the Service User's needs*

*2.2 on one or more occasions between 1 October 2018 and 25 October 2018, a call of the length required*

*2.3 between 1 October and 25 October 2018, calls totalling the number of hours required*

*3. In relation to Service User 2, failed to ensure as of 25 October 2018 that their care plan:*

*3.1 included guidance from a physiotherapist or exercise professional setting out:*

*3.1.1 what exercise Service User 2 should complete*

*3.1.2 for how long that exercise should be carried out*

*3.1.3 how often that exercise should be carried out 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. In relation to Service User 4, failed to ensure that they received:*

*6.1 on 20 October 2018 and/or 21 October 2018, any required calls*

*6.2 on one or more occasions between 1 October 2018 and 25 October 2018, other than at 6.1 above, a call of the length required*

*6.3 between 1 October and 25 October 2018, calls totalling the number of hours required*

*7. In relation to Service User 5, failed to ensure that between 1 October 2018 and 25 October 2018 they received calls totalling the number of hours required*

*8. In relation to Service User 6, failed to ensure that between 1 October 2018 and 25 October 2018 they received calls totalling the number of hours required*

*9. In relation to Service User 7, failed to ensure that between 1 October 2018 and 25 October 2018 they received calls totalling the number of hours required*

*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 monitor when calls were missed, and/or late, and/or shorter than the required length*

*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 [PRIVATE], failed to contact their GP or advise their family to do so*

*15. In relation to the recruitment of staff:*

*15.1 failed to ensure that one or more gaps in staff members' employment records had been explored adequately or at all, or such exploration had been recorded in their employment files*

*15.2 failed to ensure that an enhanced DBS check of one or more staff members:*

*15.2.1 was carried out or if carried out was recorded as having been carried out*

*15.2.2 where recorded as carried out, included the date of issue in the record*

*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. Caused or permitted the Service to carry out annual mental capacity assessments without regard to whether there were grounds for concern as to Service Users' capacity*

*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. Failed to have in place any or an adequate system for effective deployment of staff so as to assist meeting patients' needs and/or assist visits being of the required length*

*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 original panel determined the following with regard to impairment:

***'Decision and reasons on impairment***

*The panel next went on to decide if as a result of the misconduct, Mr Dike'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. 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 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) ...'*

*The panel was of the view that limbs a, b and c of the Grant test were engaged. It was of the view that service users were put at risk by Mr Dike's managerial actions and omissions. It was also satisfied that Mr Dike had brought the profession into disrepute as he was a nurse manager inadequately running a service regulated by the CQC and had failed to implement and reach the standards required for the service. The panel was of the view that the matters found proved were serious breaches of several areas of the Code by Mr Dike.*

*The panel was satisfied that the misconduct in this case is capable of remediation. It therefore gave careful consideration to the evidence before it in determining whether or not Mr Dike had sufficient insight into his failings and whether any steps had been taken to strengthen his practice. In considering these aspects, the panel noted that Mr Dike had not provided any written reflections, mitigation, evidence of training, or his current practice, save a letter from his employer of 15 April 2021.*

*Regarding insight, the only information available to the panel was Mr Dike's comments made at the time of the inspections. The panel was of the view that Mr Dike's comment highlighted an issue with regard to his attitude as it did not demonstrate any concern as to whether appropriate care was being provided to the vulnerable service users. The panel was of the view that Mr Dike had failed to demonstrate an understanding of how and why these*

*problems had arisen, and why it was that he had not addressed them when they did. The panel found that Mr Dike had not demonstrated any insight into his failings, or their possible consequences for vulnerable service users.*

*With regard to whether Mr Dike has addressed any of the regulatory concerns the panel had regard to the letter from [PRIVATE] dated 15 April 2021 and noted that Human Resources comment that there were 'no concerns regarding Mr D and his work practises (sic)'. However, the letter did not make clear that [PRIVATE] was aware of the detail of the regulatory concerns. It is also a letter written some time ago. The panel was not reassured by this letter that Mr Dike had addressed the regulatory concerns. Further, it noted that it had no information regarding Mr Dike's practice since this date. The panel was of the view that there was insufficient evidence before it to demonstrate that Mr Dike had addressed the regulatory concerns or strengthened his practice.*

*In light of Mr Dike's lack of insight and lack of evidence of remediation, the panel concluded that there is a risk of repetition and determined that a finding of impairment 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. The panel determined that a finding of impairment on public interest grounds is required due to the risk of harm to vulnerable service users who relied upon the service to provide their care, for which Mr Dike was responsible. It concluded that public confidence in the profession would be undermined if a finding of impairment was not made in this case.*

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

The original panel determined the following with regard to sanction:

***'Decision and reasons on sanction***

*Having found your fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had careful regard to the SG. The decision on sanction is a matter for the panel independently exercising its own judgement.*

*The panel took into account the following aggravating features:*

*• A lack of insight into your misconduct*
*• Your misconduct occurred whilst you were in a position of trust and you had a high level of responsibility.*
*• You demonstrated a pattern of misconduct over a period of time which involved wide ranging concerns.*
*• Your conduct put patients at risk of harm.*

*The panel also took into account the following mitigating features:*

*• Since registration you have practised as a nurse without concern and have practised as a nurse since the charges arose without concern.*
*• [PRIVATE]*

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

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

*The panel next considered whether placing conditions of practice on your registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel noted that you had worked for a period of 6 months under an interim conditions of practice order without concern, and for a further period of 18 months afterwards, again without incident as the interim conditions of practice order had been revoked. However, the panel is of the view that there are no practical or workable conditions that could be formulated, given the wide-ranging nature of the charges found proved in this case and your lack of insight into the effects of your misconduct on patient care and the impact on the nursing profession. Furthermore, the panel concluded that because of your lack of insight the placing of conditions on your registration would not adequately address the seriousness of this case nor protect the public interest.*

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

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

*The panel considered that this was not a single instance of misconduct but had occurred during a single period in an otherwise longstanding and unblemished nursing career. The panel took into account that you have demonstrated a significant period of good practice without incident as a nurse since these events occurred. It noted that there was no evidence of attitudinal problems and that you had apologised to the panel and shown remorse for what happened. The panel was satisfied that what could have been interpreted as attitudinal problems were rather a lack of insight into your failings. The panel was satisfied that in this case, the misconduct was not fundamentally incompatible with you remaining on the register.*

*The panel went on to consider whether a striking-off order would be proportionate but, taking account of all the information before it, and of the mitigation provided, it concluded that it would be disproportionate. Whilst the panel acknowledges that a suspension may have a punitive effect, it would be unduly punitive in your case to impose a striking-off order.*

*Balancing all these factors the panel has concluded that a suspension order would be the appropriate and proportionate sanction.*

*The panel noted the hardship such an order will inevitably cause you. However, this is outweighed by the public interest in this case. The panel noted that you have chosen, for the present, not to work as a nurse and have other employment. This order may delay but will not prevent you returning to nursing.*

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

*In making this decision, the panel carefully considered the submissions of Mr Hoskins in relation to the sanction that the NMC was seeking in this case. However, the panel considered that you have demonstrated a significant period of good practice since these incidents and, given you indicated you would like to return to nursing, a suspension order would give you the opportunity to develop your insight*

*and demonstrate that to a reviewing panel, and to provide evidence of how you have addressed your misconduct, such as training and a reflective piece.*

*The panel determined that a suspension order for a period of 8 months was appropriate in this case to mark the seriousness of the misconduct, and to give you the opportunity to prepare for a review towards the end of that period.*

*At the end of the period of suspension, another panel will review the order. At the review hearing the panel may revoke the order, or it may confirm the order, or it may replace the order with another order.*

*Any future panel reviewing this case would be assisted by:*

*• your attendance at any future hearing;*
*• a reflective statement using a model such as Gibbs model;*
*• reports or appraisals from managers with whom you now work (even if not in a nursing capacity);*
*• if possible, a reference from [PRIVATE] covering the period after 15 April 2021 until you left in December 2022;*
*• evidence of any training courses undertaken.*

*This decision will be confirmed to you in writing.'*

**Decision and reasons on current impairment**

The panel has considered carefully whether your fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as a registrant's ability to practise safely kindly and professionally. 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, your bundle, and responses from you under affirmation. It has taken account of the submissions made by the case presenter on behalf of the NMC.

Mr Agarwala submitted that you have a managerial qualification and are involved in project work that is something that is not easily undertaken. He submitted that you also paid homage to your mother by taking up nursing.

Mr Agarwala submitted that you do not seek to go back to managerial roles in the nursing profession, [PRIVATE]. He submitted that your heart is set on being a nurse.

Mr Agarwala submitted that if the panel were to decide that the impairment has been addressed or could be addressed with conditions to allow you to go back to nursing, then it would the panel's prerogative and privilege to do so.

[PRIVATE]. You said that you made a lot of mistakes and that you have reflected on your errors. You said that you have used a lot of time to do your reflections properly on what had happened. You said that you have looked at what you need to improve on which includes being able to communicate properly.

You said that you looked into a course on diabetes at university but that you could not undertake this due to not being a practising nurse. You said that you are currently training in computers and project management. You said that you intend to add on to your skills and that you are currently working. You said that you have been supervised on numerous occasions and that you have had positive references.

When answering the panel's questions, you said that you regret not supervising your staff properly and that in your reflective piece, you have expressed that there was a shortage of staff. You said this was part of the problem that led to the difficulties outlined in the charges. You informed the panel that you realised that patients could have been harmed as a result of your failures.

You said that you are currently doing a leadership and management course and Microsoft and computer training. You said that you are waiting to resume your nursing practise and if you are able to, to undertake a diabetic care course which you are very interested in. You said that you have not done any recent training in relation to care plans but that you have been trained on care planning for many years. You said that you have been working in a care home for a long time and that you would like to return. You said that you expressed regret at what had happened. You said that you do not want to go back to managing a business and that nursing is something that you would like to go back to.

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 your fitness to practise remains currently impaired.

The panel had sight of two testimonials and a reflective statement provided by you. The panel took into account the evidence which you provided but considered that it did not fully address the clinical issues in this case. The panel noted that the reflection was relatively brief. Although you attempted to complete a recognised model of reflection, it did not address the core issues and was lacking in detail. The panel considered that the reflection focused on you as a business owner and did not address the concerns about public protection and public interest. The panel therefore decided 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. The panel determined that, in this case, a finding of continuing impairment on public interest grounds is also required.

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

**Decision and reasons on sanction**

Having found your 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 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 your 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 your 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 considered substituting the current suspension order with a conditions of practice order. Despite the seriousness of your misconduct, there has been evidence produced to show that your insight has begun to develop, you have demonstrated remorse, and there was no evidence of underlying attitudinal issues. You have indicated that you wish to return to nursing.

The panel was satisfied that it would be possible to formulate practicable and workable conditions that would allow you to return to unrestricted practice and would serve to protect the public and the reputation of the profession in the meantime.

The panel decided that the public would be suitably protected as would the reputation of the profession by the implementation of the following conditions of practice:

‘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.

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, a Band 6 nurse or equivalent.

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

4. You must work with your supervisor to create a Personal Development Plan (PDP). Your PDP must address the clinical concerns raised by the allegations found proved to include care planning and risk assessment. This should include training to be undertaken to address the concerns underlying your failings. You should send your case officer a record of your PDP before your next review hearing.

5. You must keep a reflective practice profile. The profile will detail a sample of a cases of where you have undertaken care planning/risk assessments. The profile must:
    - Set out the nature of the care given;
    - Be signed by your supervisor at each fortnightly meeting;
    - Contain feedback from your supervisor.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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 9 months.

This conditions of practice order will take effect upon the expiry of the current suspension order, namely the end of 22 February 2024 in accordance with Article 30(1).

Before the end of the period of the order, a panel will hold a review hearing to see how well you have complied with the order. At the review hearing the panel may revoke the order or any condition of it, it may confirm the order or vary any condition of it, or it may replace the order for another order.

This will be confirmed to you in writing.

That concludes this determination.