Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Monday, 25 November 2024 – Tuesday, 26 November 2024

Virtual Meeting

Name of registrant:	Daniel Jibu
NMC PIN:	15I0272C
Part(s) of the register:	RN1: Registered Nurse – (sub part 1) Adult – Level 1 10 September 2015
Relevant Location:	South Lanarkshire
Type of case:	Misconduct
Panel members:	Michelle Lee (Chair, Registrant member) Vanessa Bailey (Registrant member) Lynne Vernon (Lay member)
Legal Assessor:	Alain Gogarty
Hearings Coordinator:	Petra Bernard
Facts proved:	Charges 1, 2a, 2c, 2d
Facts not proved:	Charges 2b
Fitness to practise:	Impaired
Sanction:	**Conditions of practice order (12 months with review)**
Interim order:	**Interim conditions of practice order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Mr Jibu's registered email address by secure email on 21 October 2024.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, the time, date and the fact that this meeting was to be heard virtually.

In the light of all of the information available, the panel was satisfied that Mr Jibu 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).

Details of charge

That you, a registered nurse:

1) On 6 January 2022 administered medication to Resident A when it was not prescribed to them, as set out in schedule 1.

2) On discovering the medication error in charge 1:

(a) Failed to undertake any or sufficient physical observations of Resident A.

(b) Failed to record the medication error in Resident A's care plan.

(c) Failed to seek medical advice.

(d) Breached your professional duty of candour by failing to inform the Home Manager and/or Resident A's family of the medication error.

Schedule 1

Diazepam 2mg

Zolpidem 10mg

Quetiapine 100mg

Peptec liquid 10ml

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

Background

The NMC received a referral about your fitness to practise on 24 January 2022 by the Nurse Manager, at Staffscanner ('the Agency'). At the time of the alleged concerns in the referral, you were working as an agency nurse for Victoria House Care Home ('the Home'). This referral resulted in an investigation by the NMC, which identified the regulatory concerns set out below. A regulatory concern is an issue that the NMC sees as being a possible risk to the public, to professional standards or to the public's confidence in nurses, midwives and nursing associates.

The alleged facts are as follows:

On 6 January 2022, you administered the wrong medications to the wrong resident. You were meant to administer the medication to Resident B, but you administered them to Resident A. The medication you administered incorrectly was Diazepam 2mg (sedative), Zolpidem 10mg (sleeping tablet), Quetiapine 100mg (antipsychotic) and Peptac Liquid 10mls for indigestion.

You realised that you had given the medication to the wrong resident. However, you failed to:

- accurately record the medication error in Resident A's notes

- take observations to ensure the Resident A was well and Resident A was not prescribed any of these medications

- escalate to the GP or other medical professional for advice and how best to treat Resident A

- inform the Home manager, Resident A and their family that you had made the error.

You handed over to a colleague in the morning that you had made a medication error. Mr Jibu's colleague completed all of the actions you should have taken. The medication caused Resident A no obvious harm apart from making them more drowsy than usual. Your error was escalated to the Agency and a local investigation was completed.

You were suspended from undertaking shifts with the Agency for a number of weeks.

Due to [PRIVATE], Mr Jibu moved from the area and is not currently working as a registered nurse.

On 1 December 2022, the Case Examiners (CE) considered that there was a case to answer.

Undertakings were agreed between Mr Jibu and the NMC to commence on 13 January 2023 but Mr Jibu failed to complete the undertakings as stipulated due to [PRIVATE]. The matter was therefore referred back to the CE's on 29 May 2024 where they decided to refer the matter to the Fitness to Practise Committee for final adjudication.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the documentary evidence in this case together with the representations made by the NMC.

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 had regard to the written statements of the following witnesses on behalf of the NMC:

- Witness 1: Registered nurse at the Home, at the material time
- Witness 2: General manager at the Home, at the material time
- Witness 3: Referrer; local internal investigator; nurse manager at the Agency, at the material time

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

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

Charge 1

That you, a registered nurse:

1) On 6 January 2022 administered medication to Resident A when it was not prescribed to them, as set out in schedule 1.

This charge is found proved.

In reaching this decision, the panel had regard to: the witness statements of Witnesses 1, 2 and 3; Mr Jibu's own admission and the Medication Administration Charts (MAR) of Resident A and Resident B.

The panel took into account the witness statement of Witness 1, which states:

> *'Daniel provided me with a handover where he informed me that he made a drug error and had given medication to the wrong person. My memory is not clear; but I think I left him for a short period of time when I returned, he had gone off duty.'*

The panel had sight of the MAR charts exhibited by Witness 3. The MAR charts show that Mr Jibu should have administered Resident A with the following medications: donepezil; mirtazapine and theiCal-d3; and Resident B's MAR with: Diazepam; Zolpidem; Quetiapine and Peptec.

The panel determined that the evidence establishes that Resident A's and Resident B's medication were mixed up and that Resident B should have been administered the medication administered to Resident A, as described in the charge.

The panel noted that the MAR chart front sheet includes a photograph of Resident A, as well as other details to identify her. It was of the view that Mr Jibu ought to have properly identify Resident A before administering medication to her. The panel also noted that Mr Jibu had signed that he had administered Diazepam, Zolpidem, Quetiapine 100mg and Peptac Liquid to Resident A, which were the drugs prescribed for Resident B.

The panel took into account the Witness statement of Witness 2, which states:

> *'Daniel stated that he asked carer [Mr 1], who is res b and it was [Mr 1], that pointed out Res A; Res B has full mental capacity and she would be able to say her name...part of normal caring is to speak to the residents. Because Daniel had not completed an incident report, [Witness 1] completed it with him present and he signed the report. If he was in any doubt there is always a manager on call to advise'.*

On the basis of the evidence before it, the panel was satisfied that Mr Jibu had administered the medication in Schedule 1 of this charge to Resident A when it was not prescribed to them.

The panel therefore finds this charge proved.

Charge 2a

2) On discovering the medication error in charge 1:
(a) Failed to undertake any or sufficient physical observations of Resident A.

This charge is found proved.

In reaching this decision, the panel took into account Witness 3's internal investigation letter dated 21 January 2022. The panel noted the Mr Jibu's responses to the assertions below:

> ***'You did not contact medical services for advice due to giving highly sedative medications to an individual***
> *I checked the resident after midnight (after medication round) and she was sleeping and I considered I couldn't do anything till morning'*
>
> ***'You failed to do observations with the resident following the error to monitor vital signs***
> *The resident was already sleeping and I left her to rest'*

The panel was of the view that Mr Jibu's observation of Resident A *'sleeping'* was not a sufficient physical observation. The panel determined that in the event of a drugs error, a different set of observations, specifically vital signs, should have been undertaken by Mr Jibu and concluded that the visual observations he made were insufficient in the circumstances.

The panel therefore finds this charge proved on the basis that Mr Jibu did not undertake sufficient physical observations of Resident A.

Charge 2b

(b) Failed to record the medication error in Resident A's care plan.

This charge is found NOT proved.

In reaching this decision, the panel took into account that it had not been provided with a copy of the care plan. As such, and in the absence of any evidence to show any record of a medication error in Resident A's care plan, the panel finds this charge not proved.

Charge 2c

(c) Failed to seek medical advice.

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1 Witness 2 and Witness 3.

Witness 1's witness statement includes:

'I went to check through the documents and to see if an incident form had been completed. A report had been completed but there was no follow up, very little detail, the form showed that none of the normal steps had been taken, the family had not been informed, the GP or our manager'

The panel also had regard to the Incident/Accident Report provided and noted that key actions in relation to medical advice sought were not undertaken by Mr Jibu.

The panel determined that the evidence establishes that Mr Jibu did not seek medical advice. The panel therefore finds this charge proved.

Charge 2d

> (d) Breached your professional duty of candour by failing to inform the Home Manager and/or Resident A's family of the medication error

This charge is found proved.

In reaching this decision, the panel took into account the witness statements of Witness 1, Witness 2 and Witness 3.

Witness 1's witness statement includes:

> *'As a result of this I and put into action what should be done. I informed the residents GP and family...'*

The panel had regard to the Incident/Accident Form which indicated that Resident A's next of kin was not informed, neither were the Deputy or the Director of the Home, nor anyone in authority.

The panel therefore finds 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 Mr Jibu's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to 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 Jibu's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In coming to its decision, the panel had regard to the case of *Roylance v GMC (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.'

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives and nursing associates (2015' ("the Code") in making its decision.

The NMC identified the following specific, relevant standards of the Code where Mr Jibu's actions amounted to misconduct: 1.1; 1.2; 4.2; 8.5; 10.1; 10.2; 14.2; 14.3; 19.1; 19.2; and 20.1.

The NMC requires the panel to bear in mind its overarching objective to protect 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. The panel has referred to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin).

The NMC invited the panel to find Mr Jibu's fitness to practise impaired on public protection and public interest grounds.

The panel accepted the advice of the legal assessor which included reference to *Roylance v General Medical Council* (No 2) [2000] 1 A.C. 311.

Decision and reasons on misconduct

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

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

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

1.1 Treat people with kindness, respect and compassion.

1.2 Make sure you deliver the fundamentals of care effectively.

3 Make sure that people's physical, social and psychological needs are assessed and responded

To achieve this, you must:

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it

4 Act in the best interests of people at all times

To achieve this, you must

4.2 make sure that you get properly informed consent and document it before carrying out any action.

6 Always practise in line with the best available evidence

To achieve this, you must:

6.2 maintain the knowledge and skills you need for safe and effective

practice

8 Work cooperatively

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

To achieve this, you must:

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

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

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

[PRIVATE]

13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence

14. Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this you must:

14.2 explain fully and promptly what has happened, including the

likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers.

14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly.

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

19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures

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

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel was of the view that Mr Jibu did not deliver the fundamentals of nursing care. The panel found that Mr Jibu's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Mr Jibu'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, 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 *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin) 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/their fitness to practise is impaired in the sense that S/He/They:*
>
> 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 determined that limbs *a) b)* and *c)* are engaged.

The panel determined that Mr Jibu breached numerous sections of the Code. The panel was of the view that Mr Jibu demonstrated no understanding of the risk in the error he had caused and as such, it would be remiss in its duty if it were not to find Mr Jibu's fitness to practise impaired.

The panel finds that Mr Jibu placed Resident A at risk of harm by giving medication to Resident A when it was not prescribed to them. The panel was of the view that the risk of harm was made worse by Mr Jibu not undertaking a physical observation of Resident A.

The panel determined that as a result of Mr Jibu's misconduct, he has breached the fundamental tenets of the nursing profession and therefore brought its reputation into disrepute.

Regarding insight, the panel were concerned that Mr Jibu has provided no evidence of insight, nor has he demonstrated an understanding of how his actions put Resident A at risk and how this impacted negatively on the reputation of the nursing profession. The panel noted that Mr Jibu had admitted his error however the panel determined that he had not sufficiently demonstrated how he would handle the situation differently in the future.

However, the panel is of the view that there is a risk of repetition due to Mr Jibu's lack of reflection into his misconduct. The panel therefore decided 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 also required because of the seriousness of the charges found proved. The panel concluded that public confidence in the profession would be undermined if a finding of impairment were not made in this case and therefore finds Mr Jibu's fitness to practise impaired on the grounds of public interest.

The panel concluded that the misconduct is remediable but it has not been remediated.

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

Sanction

The panel has considered this case very carefully and has decided to make a conditions of practice order for a period of 12 months with a review. The effect of this order is that Mr Jibu's name on the NMC register will show that he is subject to a conditions of practice order and anyone who enquires about his registration will be informed of this order.

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) published by the NMC. The panel accepted the advice of the legal assessor.

Representations on sanction

The panel noted that in the Statement of Case, the NMC had advised Mr Jibu that it would seek the imposition of a conditions of practice order for a period of 12 months with review, if it found his fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mr Jibu's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose in this case. The panel has borne in

mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The panel had 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:

- Mr Jibu's lack of insight into his failings
- Mr Jibu's conduct which put patients at risk of suffering harm.

The panel took into account the following mitigating features:

- Mr Jibu's [PRIVATE]
- Mr Jibu's early admission to the facts

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 Mr Jibu'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 Jibu'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 placing conditions of practice on Mr Jibu's registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable. The panel took into account the SG, in particular:

- *No evidence of harmful deep-seated personality or attitudinal problems;*
- *Identifiable areas of the nurse or midwife's practice in need of assessment and/or retraining;*
- *No evidence of general incompetence;*
- *Potential and willingness to respond positively to retraining;*
- *The nurse or midwife has insight into any health problems and is prepared to agree to abide by conditions on medical condition, treatment and supervision;*
- *Patients will not be put in danger either directly or indirectly as a result of the conditions;*
- *The conditions will protect patients during the period they are in force; and*
- *Conditions can be created that can be monitored and assessed.*

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case.

The panel had regard to the fact that Mr Jibu admitted his failings at the first opportunity and did not try to cover it up. The panel was of the view that it was in the public interest that, with a course of updating his clinical knowledge in the areas of deficit identified and appropriate safeguards, Mr Jibu should be able to return to practise as a nurse.

Balancing all of these factors, the panel determined that the appropriate and proportionate sanction is that of a conditions of practice order.

The panel was of the view that to impose a suspension order or a striking-off order would be disproportionate, too severe and would not be a reasonable response at this stage in the circumstances of Mr Jibu's case. The panel was of the view that, while the charges found proved are serious, the risk of repetition and harm can be mitigated by putting appropriate conditions in place. The panel determined that Mr Jibu's behaviour was not fundamentally incompatible with remaining on the register.

Having regard to the matters it has identified, the panel has concluded that a conditions of practice order would protect the public and mark the importance of maintaining public confidence in the profession, and will send to the public and the profession a clear message about the standards of practice required of a registered nurse.

The panel determined that the following conditions 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 restrict your practice to a single employer which can be an agency. If the employer is an agency, your agency placements must be with a single provider to ensure continuity and support.

2. You must not be the nurse in charge or the sole nurse on duty on any ward, unit or any other working environment.

3. You must not administer medication until you are assessed and declared competent to do so by another registered nurse.

4. You must ensure that you are supervised by another registered nurse any time you are working. Your supervision must consist of working at all times on the same shift as, but not always directly observed by a registered nurse.

5. You must have regular meetings with your line manager, mentor, or supervisor once a month to discuss your practice in relation to:

a) Medication administration and management
b) Record keeping
c) Escalation of concerns
d) Monitoring and observations of patients

e) Communication with colleagues

6. Prior to any review hearing, you must provide a report to the NMC from your line manager, mentor, or supervisor regarding your practice in relation to:

a) Medication administration and management

b) Record keeping

c) Escalation of concerns

d) Monitoring and observations of patients

e) Communication with colleagues

7. You must keep the NMC informed about anywhere you are working by:

a) Telling your case officer within seven days of accepting or leaving any employment.

b) Giving your NMC case officer your employer's contact details.

8. You must keep the NMC informed about anywhere you are studying by:

a) Telling your NMC case officer within seven days of accepting any course of
study.

b) Giving your NMC 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 agency you apply to or are registered with for work.

c) Any employer you apply to for work (at the time of application).

d) 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 allow your NMC case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

a) Your line manager, mentor or supervisor

b) Any current or future employer

c) Any educational establishment

d) Any other person(s) involved in your retraining and/or supervision required by these conditions

11.You must tell your NMC 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.

The duration of this order is for a period of 12 months with review.

Before the end of the period of the order, a panel will hold a review hearing to see how well Mr Jibu has 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.

Any future panel reviewing this case would be assisted by:

- Evidence that Mr Jibu has completed courses in the following:
  - Medication administration and management
  - Record keeping

- Evidence of Mr Jibu's compliance with the conditions of practice, including:
  - Reflective piece showing insight into his failings and what he would do differently in the future

This will be confirmed to Mr Jibu in writing.

Interim order

As the conditions of practice 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 Jibu's own interest until the conditions of practice sanction takes effect.

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

Representations on interim order

The panel took account of the written representations made by the NMC that:

> *'If a finding is made that the registrant's fitness to practise is impaired on a public protection basis is made and a restrictive sanction imposed we consider an interim order in the same terms as the substantive order should be imposed on the basis that it is necessary for the protection of the public and otherwise in the public interest.*

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 the only suitable interim order would be that of a conditions of practice order, as to do otherwise would be incompatible with its earlier findings. The conditions for the interim order will be the same as those detailed in the substantive order for a period of 18 months, to allow for the possibility of an appeal to be made and determined.

If no appeal is made, then the interim conditions of practice order will be replaced by the substantive conditions of practice order 28 days after Mr Jibu is sent the decision of this hearing in writing.

That concludes this determination.