Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting

Thursday, 29 May 2025 – Monday, 2 June 2025

Virtual Meeting

Name of Registrant:	**Seth Sonachand Dharmanan Singh Jeebun**
NMC PIN:	83C2283E
Part(s) of the register:	Registered Nurse – Sub Part 1 Mental Health Nurse (Level 3) – 22 July 1986
Relevant Location:	Bracknell
Type of case:	Misconduct
Panel members:	Susan Ball (Chair, Registrant member) Vivienne Cooper-Thorne (Registrant member) Delecia Dixon (Lay member)
Legal Assessor:	Robin Hay
Hearings Coordinator:	Petra Bernard
Facts proved:	All charges
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Charges

That you, a registered nurse and a director of Aster Healthcare Limited, a company convicted of corporate manslaughter contrary to section 1(1) of the Corporate Manslaughter and Corporate Homicide Act 2007:

1) Through your management of Birdsgrove Nursing Home, a nursing home owned and operated by Aster Healthcare Limited:

a) placed the residents thereof at unwarranted risk of harm.
b) contributed to the death of Patient A.

2) Sought to mislead the parties responsible for investigating Patient A's death by:

a) attempting to have a new thermostatic mixer valve fitted to a bath where Patient A had suffered scalding injuries before the one in place when Patient A suffered her injuries could be seized as evidence.

b) instructing a junior colleague to fabricate water temperatures.

c) asking for a report from an external firm to be completed to inaccurately record that all recommendations made had been completed when they had not been.

d) instructing junior colleagues and/or fellow directors to delete material recorded electronically.

e) instructing a family member to obtain a backdated service contract which inaccurately suggested a service contract was in place prior to Patient A's death.

3) Your actions at charge 2a and/or b and/or c and/or d and/or e were dishonest in that you were attempting to minimise your and your company's liability for Patient A's death.

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

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 Jeebun's registered email address by secure email on 24 April 2025.

The panel accepted the advice of the legal assessor.

The panel noted that Mr Jeebun had been afforded ample opportunity to submit any documentation he wished the panel to consider in advance of the meeting. The panel took into account that the Notice of Meeting provided details of the allegations and date this meeting was to be held.

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

Background

Mr Jeebun came onto the Nursing and Midwifery Council (NMC) register on 22 August 1986 as a registered mental health nurse. From 30 March 2006 he was a director of Aster Healthcare Limited, the Parent Company of Birdsgrove Nursing Home (the Home), owned and operated by Southern Counties Care Limited (a wholly owned subsidiary of Aster Healthcare Limited). The Home provided nursing care in a residential setting for elderly people and had capacity for 78 residents.

The charges arose following a referral to the NMC by Thames Valley Police submitted on 7 January 2016 in connection with Patient A's death, raising concerns about Mr Jeebun's fitness to practise. Mr Jeebun was identified as a company director of the Home.

On 5 February 2015 Patient A was given a bath at the Home by carers. She suffered burns and scalding to her legs due to the temperature of the water. She died in hospital

three days later and a police investigation was commenced. Mr Jeebun was charged on 31 January 2020 with the following:

- Failure to discharge a duty, contrary to section 33(1)(a) of the Health and Safety at Work Act 1974 (in relation to the risk of injury from hot water);

- Doing acts tending and intended to pervert the course of public justice, contrary to common law (in relation to false records being provided to the police and other regulators).

- Aster Healthcare Limited (the Parent Company), of which Mr Jeebun is the Director, was charged with:
  - Corporate manslaughter, contrary to section 1(1) of the Corporate Manslaughter and Corporate Homicide Act 2007 (relating to the death or Patient A);
  - Failure to discharge a duty, contrary to section 33(1)(a) of the Health and Safety at Work Act 1974 (in relation to the risk of injury from hot water).

On 16 July 2021, the Police informed the NMC that Aster Healthcare Limited had decided to plead guilty to the corporate manslaughter charge. In the light of this the Crown Prosecution Service (CPS) discontinued the charges against Mr Jeebun.

Aster Healthcare Limited pleaded guilty to count 1 – corporate manslaughter, Aster Healthcare Limited were found guilty and ordered to pay a substantial fine.

Regulatory Concern 1: Poor leadership and/or management resulting in risk of harm to residents at the Home.

Regulatory Concern 2**:** Mr Jeebun's conduct in regulatory concern 1 contributed to Resident A's death.

Regulatory Concern 3: Dishonesty in that Mr Jeebun attempted to conceal your failure to make the required improvements at the Home.

Decision and reasons on facts

In reaching its decisions on the facts, the panel took into account all the documentary evidence provided, together with the representations made by the NMC. There were no representations from Mr Jeebun before the panel.

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 witness statements of the following on behalf of the NMC:

- Witness 1: Director of [PRIVATE], at the material time
- Witness 2: HM Inspector of Health and Safety, at the material time
- Witness 3: Managing director [PRIVATE], at the material time

Before making any findings on the facts, the panel accepted the advice of the legal assessor.

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

Charges

That you, a registered nurse and a director of Aster Healthcare Limited, a company convicted of corporate manslaughter contrary to section 1(1) of the Corporate Manslaughter and Corporate Homicide Act 2007:

Charge 1a)

1) Through your management of Birdsgrove Nursing Home, a nursing home owned and operated by Aster Healthcare Limited:

a) placed the residents thereof at unwarranted risk of harm.

This charge is found proved

In reaching this decision, the panel took into account the: NMC's Statement of Case; Certificate of Conviction; Prosecution's opening note for sentence; and Judge's sentencing remarks from the Crown Court trial.

The panel had regard to the fact that Mr Jeebun was aware that there was a long-standing problem with the Home's Thermostatic Mixing Valves (TMV). In December 2012 the Health and Safety Executive (HSE) had visited the Home and in January 2013 issued a notice of contravention on the basis that the Home fell far short of the expected standards with reference to Legionella.

The panel took into account that Mr Jeebun was the most senior person in the Home responsible for health and safety. He was heavily involved in the day-to-day running of the Home. Based on the evidence from the criminal trial, his management style was described as '*chaotic, demanding, unsupportive, and dangerous'* when it came to health and safety and the dangerous hot water problems. Mr Jeebun exercised significant control over health and safety in the Home. Mr Jeebun set a limit of £200 expenditure which could not be exceeded by staff without his approval. Consequently, when the TMV health and safety issues were brought to Mr Jeebun's attention these were not remedied by him.

The panel had regard to the Court's finding that the risk of scalding to residents was entirely foreseeable, aggravated by Mr Jeebun's cost-cutting at the expense of safety.

The TMV hot water problem was an historic issue, not just an isolated incident. There was no evidence of an actioned maintenance plan nor any ongoing replacement

programme. Several official organisations raised the TMV issues with the Home on more than one occasion. Further, Mr Jeebun placing a financial limit on expenditure, prevented the required improvements being authorised by staff within the Home without his approval.

The panel therefore determined that through Mr Jeebun's management of the Home, he placed residents at unwarranted risk of harm. It therefore finds this charge proved.

Charge 1b)

1) Through your management of Birdsgrove Nursing Home, a nursing home owned and operated by Aster Healthcare Limited:

b) contributed to the death of Patient A.

This charge is found proved

In reaching this decision, the panel took into account the relevant parts of the evidence as above in Charge 1a).

It was Mr Jeebun's responsibility to ensure that the baths in the Home had been fitted with the correct TMV, and that there were thermometers available in the bathrooms for staff to measure water temperature. The correct TMV were not fitted to the bath that was used for Patient A. This resulted in a failure to control the water temperature. The model of TMV that was fitted to the bath used to bathe Patient A was fourteen years old at the time of the incident. This TMV failed to isolate the hot water supply and prevent an increase in water temperature which resulted in Patient A's injuries that contributed to her death.

Patient A's lower legs and feet were scalded with dangerously hot water while she was being bathed by carers. Mr Jeebun, as the director of the Home with hands on day-to-day responsibility, failed to manage/monitor the competence level of staff who had not had any training on the need to check bath water temperature with a thermometer prior to bathing patients or had never bathed patients before.

The panel had sight of the conclusions from the post-mortem conducted on Patient A, which includes:

> *'...Patient A's [sic] scalding injuries were consistent with her being dipped into hot water...the pathologist was of the opinion that the major cause of the development of bronchopneumonia was the scald injuries to her legs...'.*

The panel determined that through Mr Jeebun's management of the Home he contributed to the death of Patient A. It therefore finds this charge proved.

Charge 2a)

2) Sought to mislead the parties responsible for investigating Patient A's death by:

> a) attempting to have a new thermostatic mixer valve fitted to a bath where Patient A had suffered scalding injuries before the one in place when Patient A suffered her injuries could be seized as evidence.

This charge is found proved

In reaching this decision, the panel took into account Prosecution's opening note and the relevant parts of the Extract from the criminal trial.

The panel considered the chronology of events: 6 February 2015 photographs of Patient A's bathroom were taken by the Police crime scene investigation team who attended the Home; 9 February 2015 a meeting took place at the local authority's offices and two HSE inspectors visited the Home.

The Inspectors found the pipe leading to the bathroom where Patient A had been injured to be too hot to touch but on testing the water temperature was 42°C, leading them to conclude that there was a functional TMV fitted. However, during the investigation the Police recovered messages from Mr Jeebun's phone sent to Mr 1, the Home's maintenance man, in the evening of 9 February 2015:

'[Mr 1]*. Do you know any plumber who can be there before 8am and fit a 22ml mixer valve in case it does not have a valve there? I can pick a 22ml valve from* [Mr 3] *before 8am if need be and be at birdsgrove [sic] for 8am with the valve. Or can you fit it at 8am if I get it for you.'*

...

'[Mr 1]*. Take this seriously. Let's get one before 8am and get it fitted and sealed and adjusted before they come. Just concentrate on this valve. Time is critical* [Mr 1]*. We need it fitted before Even 9am. Is. It possible??'*

The TMV that had been in place at the time of Patient A's injuries was seized as evidence when the Inspectors returned on 10 February 2015. Upon examination, it was found that the TMV had not been serviced and was not working properly.

Mr Jeebun's messages to Mr 1 demonstrate an attempt by him to implement steps to mislead parties responsible for investigating Patient A's death, by giving the impression that the correct TMV had been in place at the time of Patient A's injuries. The panel concluded that the text messages from Mr Jeebun clearly indicate what he was attempting to achieve and further they were his own words. The panel therefore finds this charge proved.

Charge 2b)

2) Sought to mislead the parties responsible for investigating Patient A's death by:

b) instructing a junior colleague to fabricate water temperatures.

This charge is found proved

In reaching this decision, the panel took into account the relevant parts of the Prosecution's opening note for Sentence and the respective Witness statements of Witness 1 and Witness 2.

The panel had regard to the text message exchange between Mr Jeebun and Mr 1 as above in Charge 2a).

On or around 7 February 2015 Mr Jeebun called Mr 1 to the Home and on arrival, in the presence of the Home's Registered Manager and Critical Care Manager, instructed him to create a year's worth of water temperature records showing that the water temperatures for outlets where there was no functional TMV fitted, were below 43°C. Mr 1 reportedly spent the afternoon writing new temperature records for the Home and shredding the original records on Mr Jeebun's instruction.

On 12 February 2015 Witness 1 and Ms 2 of a water treatment company namely [PRIVATE] visited the Home to carry out a review of the first hot water risk assessment that had been completed in 2013 by a company called [PRIVATE] and provide Legionella awareness training to staff.

The logbook which [PRIVATE] had recommended that the Home use to record results of in-service testing of the TMVs, was found to be blank. Mr 1 produced a single sheet on which he had recorded water temperatures of all the outlets in the Home as being between 39°C and 44°C. Witness 1 and Ms 2 found many rooms in the Home did have TMVs fitted, and confronted Mr 1 about the differences in the temperatures recorded in the single sheet and those they had found on testing. Mr 1 reportedly admitted that he had falsified the water temperatures on Mr Jeebun's instruction and under threat of losing his job.

Mr Jeebun's text messages and his instructing a junior colleague to fabricate water temperatures on the water temperature record sheet to show that all the temperatures were between 39° and 44° is incontrovertible evidence of his attempt to mislead the investigation. The panel therefore finds this charge proved.

Charge 2c)

2) Sought to mislead the parties responsible for investigating Patient A's death by:

c) asking for a report from an external firm to be completed to inaccurately record that all recommendations made had been completed when they had not been.

This charge is found proved

In reaching this decision, the panel took into account the Witness Statement of Witness 1.

The panel had regard to evidence concerning an email written on or around 21 February 2015 from Witness 1 to Mr Jeebun, which included a copy of [PRIVATE] Legionella report. The report acknowledged that remedial actions had been completed but some items retained a high risk. Following receipt of further information from Mr Jeebun, the report was updated and sent to Mr Jeebun on 25 February 2015. The report had three action points left blank because Witness 1 did not have information on them.

On or around 6 March 2015 during a telephone call to Witness 1 it is alleged that Mr Jeebun told Witness 1 that most of the recommendations had already been completed, that those outstanding would be completed over the next few days, and asked Witness 1 to update the report to show all the recommended tasks had been completed.

The panel had regard to Witness 1's Witness statement:

'I had a telephone conversation with Sam Jeebun following contact from Thames Valley Police on 6th March 2015. I can't remember the exact conversation, I just remember the feeling the conversation gave me. Sam assured me that most of the recommendations had already been completed and the few remaining would be done over the next few days. Consequently, he requested that we update our report to show all the tasks had been finished as he assured us they would be by the time he forwarded it onwards.

...

We wanted to come and verify that the things he was asking us to put in the report had actually been completed. Sam was very agitated and angry with me, I believe he was angry because we would not just sign the report off on his say so, we wanted confirmation that things had been completed before we did'.

The panel determined that Mr Jeebun knew that the report recommendations had not been completed, yet he asked Witness 1 to amend the report to show that they had. The panel considered that Witness 1 demonstrates a greater level of credibility, integrity, business integrity and professionalism as a witness compared to that of Mr Jeebun.

The panel determined that Mr Jeebun sought to mislead the investigation by asking Witness 1 to complete the report to inaccurately record that all recommendations made had been completed when they had not been. The panel therefore finds this charge proved.

Charge 2d)

2) Sought to mislead the parties responsible for investigating Patient A's death by:

d) instructing junior colleagues and/or fellow directors to delete material recorded electronically.

This charge is found proved

In reaching this decision, the panel took into account the Witness Statement of Witness 2 and the relevant extracts from the criminal trial.

Witness 2's Witness Statement includes:

'During the investigation I was present when [Mr 1]*, maintenance man at Birdsgrove and* [Registered Manager]*, Home Manager at Birdsgrove were interviewed under caution.* [Mr 1] *said that Sam Jeebun had ordered him to*

falsify water temperature checks following the scalding at the home. Sam Jeebun had also told [Registered Manager] *to wipe the hard drives from the computer following the incident. It was clear from the investigation that Sam Jeebun had little interest in assisting the investigation and made a number of attempts to falsify or destroy evidence.'*

The panel saw evidence of an email on or around August 2014, from the Home's Registered Manager to Mr Jeebun about a safeguarding issue. It outlined her concerns after the Home's 'Trouble Shooter' had reportedly told her not to falsify documents. It is alleged that on receiving the email Mr Jeebun emailed Aster Healthcare Limited's Co-Director [PRIVATE], the following:

'go into [Registered Manager] *email and delete this email from her email which was sent to me…Once done then delete it from bin as well.'*

The panel was satisfied that this evidence demonstrates that Mr Jeebun sought to mislead the investigation by instructing junior colleagues and/or fellow directors to delete material recorded electronically. The panel therefore finds this charge proved.

Charge 2e)

2) Sought to mislead the parties responsible for investigating Patient A's death by:

e) instructing a family member to obtain a backdated service contract which inaccurately suggested a service contract was in place prior to Patient A's death.

In reaching this decision, the panel took into account the Witness Statement of Witness 3.

This charge is found proved

In his Witness Statement, Witness 3 states that on 19 February 2015 he received a telephone call from Mr 2, Aster Healthcare Limited's accountant, [PRIVATE]. It is alleged that Mr 2 told Witness 3 that the Home's TMV contract was out of date, and

asked him for a backdated service contract for an upcoming Care Quality Commission (CQC) inspection. Witness 3 asked for the request to be put in writing and upon receipt he emailed a backdated contract dated 3 February 2015 to Aster Healthcare Limited stating that his company, [PRIVATE] attended the Home yearly to inspect the TMVs, which was untrue. Mr Jeebun then provided this contract to the CQC.

Witness 3 further states:

> *'I am very glad that I did ask* [Mr 2] *to put it in writing to me, as I later found out a resident at Birdsgrove had been scalded in the bath on 5th February 2015 and had subsequently died of her injuries. I could not believe that Sam Jeebun had been trying to cover up his failings as a director of Birdsgrove and in doing so could have implicated me and my company in the involvement of this negligence. If I had not asked* [Mr 2] *to put that request in writing to me, I dread to think what could have happened to me and my business, Sam was going to throw me under the bus. Sam clearly had no empathy for that resident or her family, he was only concerned with saving his own skin. I am very shocked to hear he is a registered nurse as he does not seem to care about anyone but himself, I believe it was all about money for him'*

The panel determined that Mr Jeebun retained the power to hire and fire staff as the Director and was heavily involved in the day-to-day running of the Home. He had instructed Mr 2 to obtain the backdated contract from Witness 3 to make it appear as though a service contract had been in place before Patient A's death.

By 19 February 2015 Mr Jeebun would have been aware that Patient A had died on 8 February 2015, yet still he requested that this contract be back-dated to 3 February 2015. The panel determined Mr Jeebun's actions to be demonstrative of the elements in charge 2 as a whole, indicating the great lengths he was prepared to go in order to conceal his/the company's culpability/liability for the death of Patient A.
The panel concluded that Mr Jeebun sought to mislead the parties responsible for investigating Patient A's death by instructing a family member to obtain a backdated service contract which inaccurately suggested a service contract was in place prior to Patient A's death. The panel therefore finds this charge proved.

Charge 3

3) Your actions at charge 2 a and/or b and/or c and/or d and/or e were dishonest in that you were attempting to minimise your and your company's liability for Patient A's death.

This charge is found proved

In reaching this decision, the panel bore in mind that dishonesty bears its ordinary meaning. It must first decide what Mr Jeebun did or failed to do, then why he did or failed to do this. Having reached those decisions it must decide whether ordinary and decent people would have regarded what he did or failed to do, was dishonest.

The panel had regard to the multiple attempts made by Mr Jeebun to falsify documents and cover-up evidence related to Patient A's death. The panel determined that his actions were as a result of his failure to address longstanding TMV hot water problems at the Home, which represented a sustained pattern of dishonesty over a significant period of time.

The panel determined that any ordinary decent person would regard Mr Jeebun's actions to be dishonest, by his failure to reduce the known significant risk to elderly residents in relation to the water temperature. Further, Patient A was an elderly resident at the Home suffering with dementia who did not have the ability to articulate the fact that the water was too hot and was scalding her. Furthermore, all of Mr Jeebun's actions to conceal evidence and mislead the investigations occurred after the death of Patient A. The panel determined that this demonstrated his desire for him/his company not to be seen to be culpable in the death of Patient A. The panel further determined that members of the public, knowing that all of Mr Jeebun's actions and incidents occurred after the death of the Patient A, would regard him to be dishonest.
The panel determined that all the charges in Charge 2 involve dishonesty. The panel determined that it follows on the basis that having found Charge 2 proved in its entirety, Mr Jeebun's actions at charge 2a) and/or b) and/or c) and/or d) and/or e) were dishonest in that he attempted to minimise his and the company's liability for Patient A's death. The panel therefore concluded that it finds this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel next considered, whether the facts found proved amount to misconduct and, if so, whether Mr Jeebun'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 Jeebun's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

The NMC referred to the panel's 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's submission was that the panel should find that the facts found proved amount to misconduct. It identified the specific, relevant standards where Mr Jeebun's actions amounted to misconduct and submitted that he had breached the following provisions of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code): 1.2, 2.1, 8.5, 16.4, 17.1, 19.1, 20.1, 20.2, 20.4, 20.8, 25.1 and 25.2.

The NMC referred to the NMC's guidance FTP-3 'How we determine seriousness'. which provides, amongst other things, that *'conduct or poor practice which indicates a dangerous attitude to the safety of people receiving care is particularly serious'.* The NMC submitted that this case meets with this description. The NMC submitted that over a period of at least three years preceding Patient A's death, Mr Jeebun failed to ensure the TMV were fitted across the Home and appropriately maintained. This was despite the [PRIVATE] and [PRIVATE] repeatedly raising concerns about the risks presented by the hot water problems in the Home.

The NMC referred the panel to its guidance FTP-3a on 'Serious concerns more difficult to put right'. It submitted that Mr Jeebun's misconduct falls within this category of serious concerns which could result in harm if not put right. The NMC submitted that as the Director of Aster Healthcare Limited, Mr Jeebun was directly responsible for the safety of residents and exposed them to risk of harm. Moreover, actual harm was suffered because he prioritised his and/or Aster Healthcare Limited's finances before his professional duty to ensure the residents' safety.

Further, Mr Jeebun also breached his professional duty of candour to be open and honest when things went wrong and abused his position as Director to minimise his and/or Aster Healthcare Limited's contribution to Patient A's death.

The NMC submitted that Mr Jeebun's actions placed the residents of the Home at significant unwarranted risk of harm and contributed to Patient A's death. His actions involve a serious departure from the standards set out in the NMC Code and demonstrate a deep-seated attitudinal issue that is difficult to address and remedy.

The NMC further referred to the guidance FTP-3c '*Serious concerns based on public confidence or professional standard*' and submitted that this case is subject to serious concerns based on public confidence or professional standard. The NMC submitted that registered practitioners occupy a position of privilege and trust in society and are expected at all times to be professional. It submitted that prioritising patient's health and acting with integrity is fundamental to the standards expected of a registered nurse and central to the Code.

The NMC submitted that Mr Jeebun's misconduct can be described as being highly likely to undermine the public's confidence in the profession because it fell significantly short of the standards expected of a registered nurse, and his actions raise fundamental questions about his ability to uphold the standards and values set out in the Code.

The NMC's submission was that Mr Jeebun's fitness to practise is impaired on the grounds of public protection and is also otherwise in the public interest.

Decision and reasons on misconduct

In reaching its decision, the panel considered all the documentary evidence together with the submissions of the NMC. It also accepted the advice of the legal assessor.

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the '*The Code: Professional standards of practice and behaviour for nurses, midwives* and nursing associates (2015)' (The Code).

The panel found that Mr Jeebun's actions did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the Code. The panel determined the following sections to be engaged:

> ***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*
> ***2 Listen to people and respond to their preferences and concerns***
> *To achieve this, you must:*
> *2.1 work in partnership with people to make sure you deliver care effectively*
> ***8 Work cooperatively***
> *To achieve this, you must:*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> ***16 Act without delay if you believe that there is a risk to patient safety or public protection***
> *To achieve this, you must:*

16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:
17.1 take all reasonable steps to protect people who are vulnerable or at risk from
harm, neglect or abuse

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, treating people fairly and without discrimination, bullying or harassment
20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
20.8 act as a role model of professional behaviour for students and newly qualified
nurses, midwives and nursing associates to aspire to

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:
25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and

understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel determined that Mr Jeebun's actions amounted to serious misconduct. His repeated failures to promote professionalism, trust and dereliction of his duty to honesty and integrity, represented a serious departure from the standards expected of a registered nurse.

The panel further determined that Mr Jeebun failed to preserve the safety of Patient A, who was an elderly, vulnerable patient suffering from dementia. Furthermore, the panel found Mr Jeebun's dishonest actions to be at the more serious end of the spectrum. These were deliberate acts to cover up some of the failings and he did not take responsibility for those failings or take remedial actions. The panel determined that it was significant that Mr Jeebun attempted to obstruct subsequent investigations by replacing the TMV prior to any inspection. Also by attempting to cover up his failings by instructing colleagues to falsify records and delete email correspondence.

The panel found that Mr Jeebun's actions fell seriously short of the conduct and standards expected of a nurse and therefore amounted to misconduct.

Decision and reasons on impairment

The panel next considered whether as a result of his misconduct, Mr Jeebun'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/their fitness to practise is impaired in the sense that S/He/They:

a) *has [the registrant] 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 [the registrant] in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*

c) *has [the registrant] 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 [the registrant] in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel found all four limbs of *Grant* to be engaged.

The panel determined that Mr Jeebun's conduct was indicative of underlying deep-seated attitudinal behaviours and not a one-off occurrence. The panel determined that Mr Jeebun's misconduct was a pattern of serious failings in his position as the director in charge of the Home in which Patient A was an extremely vulnerable patient.

The panel found that Mr Jeebun's misconduct placed Patient A, who was a highly vulnerable patient suffering from dementia and entirely reliant on nursing staff, at risk of harm. The panel concluded that Mr Jeebun's repeated failure to adequately maintain the TMV's in the Home, caused Patient A actual physical harm.

The panel determined that there is evidence which demonstrates that during the Police investigation into Patient A's' death, Mr Jeebun made attempts to mislead the investigation by making arrangements to replace the TMV ahead of the inspection. The panel had nothing before it to demonstrate that Mr Jeebun can practice kindly, safely and professionally.

The panel found that Mr Jeebun's misconduct breached fundamental tenets of the nursing profession, including the obligation to treat patients with dignity, compassion, and respect. It was in no doubt that members of the public and other professionals would be appalled by Mr Jeebun's misconduct. In the light of the evidence before it, the panel determined that Mr Jeebun's conduct displayed a serious and sustained failure to uphold the most basic expectations of the nursing profession. The panel concluded that Mr Jeebun's actions had brought the profession into disrepute.

The panel was satisfied that there remains a current risk to patient safety. It determined that the pattern of behaviour and lack of comprehensive insight meant that there was a significant likelihood of repetition of the misconduct. The panel therefore decided that a finding of impairment is necessary on the grounds of public protection.

The panel bore in mind 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 next considered if a finding of impairment on public interest grounds is also required.

The panel had sight of a letter from Mr Jeebun to the NMC dated 24 February 2020, requesting that his NMC registration be cancelled with immediate effect. In an email to the NMC dated 3 March 2020, he wrote:

> *'I have done nothing wrong and we are confident that the criminal proceedings against me will be dropped.*
>
> *The reason for my voluntary cancellation was that, should NMC take the decision to put any restrictions I would rather cancel my registration voluntarily.'*

This indicated additional concerns in relation to Mr Jeebun's lack of insight and absence of accountability. Consequently, the panel determined that remediation, though possible, would be very difficult. Full remediation would require evidence of high levels of remorse, evidence of fully developed insight demonstrated by detailed reflections and evidence of strengthened practice in the areas of misconduct identified. It appeared to the panel that Mr Jeebun had a long-term disregard for patient safety, underlined by a pattern of behaviour which factors into the risk of repetition. He has neither expressed any remorse nor concern over Patient A's death. The panel therefore determined the likelihood of repetition is high.

The panel concluded that members of the public would be appalled by Mr Jeebun's actions. The panel concluded that failing to mark such misconduct with a finding of impairment would undermine public confidence in the profession and the NMC as its regulator. The panel, therefore, concluded that a finding of impairment was also in the wider public interest.

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

Sanction

The panel next considered the question of sanction. It has decided to make a striking-off order. It directs the registrar to strike Mr Jeebun off the register. The effect of this order is that the NMC register will show that Mr Jeebun has been struck-off the register.

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

Representations on sanction

The panel was aware that in the Notice of Meeting, dated 24 April 2025, the NMC had advised Mr Jeebun that it would seek the imposition of a striking-off order if it found Mr Jeebun's fitness to practise currently impaired.

Decision and reasons on sanction

Having found Mr Jeebun's fitness to practise currently impaired, the panel next considered what sanction, if any, it should impose. 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 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:

- Abuse of position of trust as company Director.
- Premeditated and repeated dishonesty.
- Obstructing enquiries for the purpose of self-preservation.
- Lack of insight or evidence of remorse and/or meaningful engagement with the NMC's investigation.
- Mr Jeebun knowingly placed residents at unwarranted risk of harm or death in pursuit of profit.

Mitigating factors

The panel could not identify any mitigating factors.

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

The panel next considered whether placing conditions of practice on Mr Jeebun's registration would be a sufficient and appropriate response. The panel determined that it would not be appropriate, further the aggravating factors mean that they would be unworkable. Mr Jeebun is not engaging with the NMC, his current employment status is unknown and it appears to the panel that there are deep-seated attitudinal issues which cannot be addressed through retraining or be remediated. The panel is of the view that there are no practical or workable conditions that could be formulated, given the serious nature of the misconduct identified. Furthermore, the panel concluded that the placing of conditions on Mr Jeebun's registration would not adequately address the seriousness of this case and would not protect the public.

The panel then considered 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;*
- *Health...* (not relevant); and
- *Lack of competence...* (not relevant)

The serious misconduct found proved was a significant departure from the standards expected of a registered nurse. The serious breaches of fundamental tenets of the profession evidenced by Mr Jeebun's misconduct is wholly incompatible with his remaining on the register. The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

Finally, the panel had regard to the following sections of the SG:

- *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?*

And the written representation of the NMC:

> *'The NMC consider a striking-off order to be the only sanction that would protect patients, maintain public confidence in nurses, uphold professional standards and confidence in the NMC as a regulator, and send a clear message to the public and professions about the standard of behaviour required of a registrant.'*

Mr Jeebun's misconduct was so serious and is fundamentally incompatible with his remaining on the register. Indeed to allow him to remain in practice as a nurse would undermine public confidence in the profession and in the NMC as its regulatory body.

Balancing all these factors and having taken into account all the evidence before it, the panel determined that the only appropriate and proportionate sanction is that of a striking-off order. Having regard to the serious misconduct identified, in particular the effect of Mr Jeebun'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.

The panel considered this order 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.

Representations on interim order

The panel took account of the representations made by the NMC that if a finding is made that Mr Jeebun's fitness to practise is impaired on a public protection basis and a restrictive sanction imposed, there should be an interim order imposed. This order should be in the same terms as the substantive order. Such an order is necessary for the protection of the public and is otherwise in the public interest.

Decision and reasons on 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. 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 Jeebun's own interests until the striking-off sanction takes effect.

The panel had regard to the serious nature of the misconduct found proved and the reasons set out in its decision for the substantive 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 concluded that an interim conditions of practice order would not be appropriate or proportionate for the reasons already identified in its determination for imposing the substantive order. The panel therefore decided to impose an interim suspension order for a period of 18 months to allow the time required for any potential appeal process.

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

This will be confirmed to Mr Jeebun in writing.

That concludes this determination.