Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday 3 October 2022 – Tuesday 11 October 2022

Virtual Hearing

Name of registrant:	**Olakunle Thomas Kokumo**
NMC PIN:	20B0199O
Part(s) of the register:	Registered Nurse: Adult Nurse, Level 1 7 February 2020
Relevant Location:	Essex
Type of case:	Misconduct
Panel members:	Janet Fisher (Chair, lay member) Linda Pascall (Registrant member) Jocelyn Griffith (Lay member)
Legal Assessor:	Paul Housego
Hearings Coordinator:	Megan Winter
Nursing and Midwifery Council:	Represented by Alfred Underwood, Case Presenter
Mr Kukomo:	Not present and unrepresented
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 1f, 1g, 2a, 2b, 3a, 3b, 3c, 4b, 4c, 5, 6a, 6b, 6c, 7a (in full), 7b, 8a, 8b, 10 and 11
Facts not proved:	Charges 4a, 8c, 8d, 8e and 9
Fitness to practise:	Impaired by reason of misconduct
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order – 18 months**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mr Kokumo was not in attendance and not represented, and that the Notice of Hearing letter had been sent to Mr Kokumo's registered address by email on 1 September 2022.

Mr Underwood, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the Nursing and Midwifery Council (Fitness to Practise) Rules 2004, as amended ('the Rules').

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegations, the time, dates and link to the virtual hearing and, amongst other things, information about Mr Kokumo's right to attend, be represented and call evidence, as well as the panel's power to proceed in his absence.

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

Decision and reasons on proceeding in the absence of Mr Kokumo

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

Mr Underwood invited the panel to consider the registrant's response bundle before it and submitted that, Mr Kokumo has engaged with the NMC in relation to these proceedings and provided responses to the allegations. He referred to an email dated 30 September 2022 in which Mr Kokumo confirmed he will not be attending. In that email, Mr Kokumo stated:

'Thanks for the confirmation and Yes I can confirm that I am not represented and I am not planning to attend the hearing.'

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'* as referred to in the case of *R* v *Jones (Anthony William)* (No.2) [2002] UKHL 5.

The panel has decided to proceed in the absence of Mr Kokumo. In reaching this decision, the panel has considered the submissions of Mr Underwood, and the advice of the legal assessor. It has had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Mr Kokumo;
- Mr Kokumo has engaged with the NMC and confirmed that he will not be attending the hearing;
- There is no reason to suppose that adjourning would secure his attendance at some future date;
- Eight witnesses are due to attend to give live evidence in respect of this matter;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- The charges relate to events that occurred in 2021;
- Further delay may have an adverse effect on the ability of witnesses accurately to recall events; and
- There is a strong public interest in the expeditious disposal of the case.

There may be some disadvantage to Mr Kokumo in proceeding in his absence. He will not be able to challenge the evidence relied upon by the NMC in person and will not be able to give evidence on his own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Mr Kokumo's decision to absent himself from the hearing, waive his right to attend, and/or be represented, and to not provide evidence or make submissions on his own behalf in person.

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

Details of the charge (as amended)

That you, a registered nurse:

1. On the night shift of 17/18 February 2021 in relation to Resident A:
    a. Left her unattended after taking her to the bathroom.
    b. Did not phone 999 following her fall.
    c. Did not carry out 4 hourly observations following her fall.
    d. Amended the Nourish record to state that your call to 111 had taken place at 00:40 when it had not.
    e. Incorrectly stated in the Nourish record that you had assisted her to and from the toilet at 00:15.
    f. Recorded on the accident form that her fall had taken place at 00:20 when it had not.
    g. Informed Colleague 1 and/or Colleague 2 that you had found her on the floor after completing nearby room checks when it was not you that had found her.

2. Your actions at charges 1d and/or 1e and/or 1f and/or 1g were dishonest in that you were intending to create a false impression:
   a. that you had not left Resident A unattended and/or;
   b. that 111 was called shortly after Resident A had fallen.

3. On 26 February 2021:
   a. Did not update documentation for the room of the day resident before 16:00.
   b. Did not complete the new admission paperwork for Resident G when requested.
   c. Did not complete the new admission risk assessments on Resident H on her admission to the Home.

4. On 1 March 2021:
   a. Did not document Resident F's fall correctly.
   b. Called the GP in the afternoon as opposed to the morning.
   c. Did not update the documentation for the room of the day resident I before 16:00.

5. On 3 March 2021 did not complete separate wound care plans for each of Resident A's wounds.

6. On 4 March 2021, in relation to the administration of Resident B's proportionality assessment-Beneldopa medication

   a. Placed it in Colleague 3's pocket.
   b. Asked Colleague 3 to administer it to the resident.
   c. Left it on the table in the resident's room.

7. On 25 March 2021:
   a. Without a second checker present administered:
   i. A Fentanyl patch to Resident C.
   ii. A slow release morphine tablet to Resident D.
   b. Asked Colleague 4 to sign the controlled drugs book when she had not been present for the administration of the medication above.

8. On 31 March 2021:
    a. Recorded that Resident B's medication had been administered at 13:51 when it had not been.
    b. Did not administer eye drops to Resident E.
    c. Did not fully engage in or document the discussion with the occupational therapist in relation to Resident J.
    d. Refused to assist a colleague with the hoist.
    e. Signed to say that medication had been administered to Resident C when you had left it on the table.

9. Your actions at charge 8a and/or 8e above were dishonest in that you intended to give the impression that the medication had been administered when it had not been.

10. On or around 29 April 2021 provided details to Quad Recruitment Agency purporting to be those of Colleague 5

11. Your actions at charge 10 above were dishonest in that you intended a false reference from Bymead Nursing Home to be submitted to Quad Recruitment Agency

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

Decision and reasons on application to amend the charges

During the course of deliberating facts the panel, of its own volition, decided to amend the wording of charge 11.

Original charge

11. Your actions at charge 9 above were dishonest in that you intended a false reference from Bymead Nursing Home to be submitted to Quad Recruitment Agency.

Proposed amendment

11. Your actions at charge ~~9~~ **10** above were dishonest in that you intended a false reference from Bymead Nursing Home to be submitted to Quad Recruitment Agency.

The panel accepted the advice of the legal assessor who referred it to Rule 28 of 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules):'

> *'28. (1) At any stage before making its findings of fact, in accordance with [rule 24(5) or (11)], the Investigating Committee (where the allegation relates to a fraudulent or incorrect entry in the register) [or the Fitness to Practise] Committee, may amend-*
>
> *(a) the charge set out in the notice of hearing; or*
> *(b) the facts set out in the charge, on which the allegation is based, unless, having regard to the merits of the case and the fairness of the proceedings, the required amendment cannot be made without injustice.*
>
> *(2) Before making any amendment under paragraph (1), the Committee shall consider any representations from the parties on this issue.'*

The panel was of the view that the amendment was in the interests of justice. The amendment corrected what was plainly a typographical error. The panel was satisfied that there would be no prejudice caused to either party by the amendment because the charge alleged to be dishonest was described in charge 11 and could only be charge 10.

Therefore, the panel decided to amend charge 11.

Decision and reasons on application for hearing to be held in private

During the course of Colleague 1 giving evidence, Mr Underwood made a request that this case be held partly in private on the basis that proper exploration of this case involves reference to the health of other third parties. The application was made pursuant to Rule 19 of the Rules.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel determined to go into private session in connection with the health of other third parties as and when such issues are raised in order to protect their interests.

Decision and reasons on facts

The panel considered the responses of Mr Kokumo to the charges, as set out in the Case Management Form (CMF). It noted that Mr Kokumo had made some admissions to the following charges: 1a, 1b, 1d, 1e, 1f, 3a, 3b, 3c, 4c, 6b, 6c, 7a(i), 7a(ii), 7b, 8a, 8b and 10. The panel decided to consider those admissions when it had reviewed the evidence. If the evidence supported those admissions the panel decided that it would find those charges proved on the basis of both admissions and evidence.

The panel noted that Mr Kokumo disputed the following charges: 1c, 1g, 2a, 2b, 4a, 4b, 5, 6a, 8c, 8d, 8e, 9 and 11.

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Underwood and written representations from Mr Kokumo.

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

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.

Dishonesty was alleged in this case and the panel was reminded of the test in respect of dishonesty set out in the case of Ivey (Appellant) v Genting Casinos (UK) Ltd. t/a Crockfords (Respondent) [2017] UKSC 67, where Lord Hughes, giving judgment, stated as follows:

> *"…The fact finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest".*

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Colleague 1: Registered Nurse and Deputy Manager at the Home at the time of the incidents
- Colleague 2: Care Practitioner at the Home
- Colleague 3: Carer at the Home
- Colleague 5: Registered Manager of the Home
- Colleague 6: Senior Carer at the Home
- Colleague 7: Registered Nurse and Owner and Director of the Home
- Colleague 8: Senior Carer at the Home
- Witness: Head of Compliance for Quad Recruitment Agency Limited.

Background

The NMC received a referral on 12 May 2021 from Bymead House Limited (the Home), where Mr Kokumo had been employed as a Registered Staff Nurse from 19 October 2020 until he was dismissed on notice and left on 31 March 2021. The Home reported the following concerns:

- Dishonesty in relation to patient records on 18 February 2021.
- Leaving a patient unattended who subsequently fell and suffered serious injuries on 18 February 2021.
- Failing to escalate that patient's care, when necessary, on 18 February 2021.
- Failing to complete accurate records during the period of 22 February 2020 to 31 March 2021.
- Failing to safely administer medication during the period of 22 February 2020 to 31 March 2021.
- Dishonesty in relation to an employment reference on 30 April 2021.

Charge 1a

1. On the night shift of 17/18 February 2021 in relation to Resident A:
    a. Left her unattended after taking her to the bathroom.

This charge is found proved.

The panel heard evidence from Colleague 1 in relation to this charge. In her witness statement, she describes a handover meeting on 18 February 2021 whereby Mr Kokumo told her that he had left Resident A's room to do other checks. The panel also heard from Colleague 6 in relation to this charge, she found Resident A lying on the floor in the room and rang the emergency bell at 01:04. Colleague 6's evidence was that the registrant appeared shortly after this.

The panel had regard to the call bell record which shows that Resident A called to be taken to the toilet at 00:29 and that Colleague 6 pressed the emergency alarm at 01:04. Colleague 7 gave evidence that the management of the Home tested the call bell to verify that it was recording the correct times and it was. Therefore, the panel was of the view that there was a 20 – 35 minute period during which at some point Mr Kokumo left Resident A unattended.

In response to panel questions, Colleague 7 said that staff were aware that there was a risk Resident A might try to leave the toilet without ringing the bell. Colleague 8 said that it was known among staff that the resident was impatient and would not necessarily wait for staff to attend and assist her. Colleague 8 also said that she would not leave residents for any time over five minutes without being checked.

In light of all of the reasons outlined above and taking into account Mr Kokumo's own admission to the charge within his CMF, the panel was satisfied that Mr Kokumo did leave Resident A unattended after taking her to the bathroom.

Charge 1b

1. On the night shift of 17/18 February 2021 in relation to Resident A:
    b. Did not phone 999 following her fall.

This charge is found proved.

In reaching this decision, the panel took into account the relevant contemporaneous documentation which consisted of Mr Kokumo's own entry into the Nourish system at 01:45 on 18 February 2021. His entry stated *'NHS 111 informed… if symptoms get worse we should ring 999.'* It is not disputed by Mr Kokumo that he did not call 999.

The panel had regard to the witness evidence provided by Colleague 1 and Colleague 7. Both witnesses were taken to the *'Falls Policy'* and Colleague 1 explained why she took the view that, based on what she had been told by Colleague 6 and Colleague 8, it was clearly a head injury that Resident A had suffered and therefore the flow chart limb marked *'Major/Injury'* ought to have been followed rather than intermediate/minor,

Colleague 6 looked at the photographic evidence provided to the panel and described Resident A as having significantly more swelling, including swelling to the forehead but that the colour of the bruising had not developed. Colleague 8 was particularly detailed in her description of what she saw on attending to Resident A directly after the fall. She described the swelling around Resident A's eye as *"like a ball".* The panel also had regard to the photographic evidence provided which showed Resident A's bruising/swelling, which it considered to be extensive.

On the basis of the clear evidence before it, the panel was therefore of the view that Mr Kokumo should have called 999, however there is no evidence to suggest that he did. Further, he admits to this charge in his CMF.

Charge 1c

1. On the night shift of 17/18 February 2021 in relation to Resident A:
    c. Did not carry out 4 hourly observations following her fall.

This charge is found proved.

The panel had regard to Colleague 8's oral evidence, in which she suggested that Mr Kokumo had been with Resident A all night after the fall. However, when asked about this in more detail, she said that she said this was based on what he told her. The panel noted that Colleague 8 was primarily responsible for residents on the ground floor and that Resident A's room was on the upper floor. She had not seen Mr Kokumo take any observations, save the assessments he had carried out at the time Resident A had been discovered on the floor and put back in bed. Colleague 8 had accepted what Mr Kokumo had told her, but not witnessed any observations being taken.

When Colleague 1 was asked as to why she said that no observations were completed by Mr Kokumo, she said that there was no documentation to show that he had. In Colleague 7's witness statement she sets out what is meant by observations. She said that they should include readings as to blood pressure and pulse and notes of injuries. However, the only entries into Nourish by Mr Kokumo detailing vital signs are at 01:41, at around the time Resident A was found and at 07:41 on 18 February 2021, some 6 – 7 hours later. The panel was therefore satisfied that Mr Kokumo did not carry out 4 hourly observations (as none were done around 04:00) and that the observations he did take where not recorded in the place that they should have been.

Charge 1d

1. On the night shift of 17/18 February 2021 in relation to Resident A:
   d. Amended the Nourish record to state that your call to 111 had taken place at 00:40 when it had not.

This charge is found proved.

The panel heard from Colleague 5 in respect of this charge both in her written and oral testimony. She explained that their computer program "Nourish" was updated by entering notes. The entries were automatically timed. However, it was possible to click on the time shown and amend it. The original time the entry was made was not deleted and could be revealed as a previous version of the entry. This was not something that nurses were supposed to do, as all entries should show the time they were made. Colleague 5 told the panel that she clicked on the entry at 00:40 and it showed that there was a previous version of that interaction timed 01:48. She told the panel that the person who made and amended the entry was Mr Kokumo. Colleague 5 said that all staff have their own login details and password and that nurses generally used the computer to make entries, but also had their own handheld devices. She was sure that no-one else could have amended the entry.

Colleague 5 said that it was not possible to ascertain which type of device Mr Kokumo had used. Further, she explained to the panel that in ascertaining the accuracy of the Nourish system, she made an entry herself and then went back to amend it to check the times were correct and they were.

The panel considered Colleague 5's evidence to be clear, credible and consistent in relation to this charge. There was no evidence before the panel to refute her account. Colleague 5's evidence was also supported by the call bell log and the entries which show Mr Kokumo's recording of the events at 01:45 and 01:47, these support Colleague 5's evidence that the 00:40 timing on Nourish had been amended from 01:48.

In light of the reasons as set out above and taking into account Mr Kokumo's own admission to the charge, the panel was of the view that Mr Kokumo amended the Nourish record to state that his call made to 111 had taken place at 00:40 when it had not.

Charge 1e

1. On the night shift of 17/18 February 2021 in relation to Resident A:
   e. Incorrectly stated in the Nourish record that you had assisted her to and from the toilet at 00:15.

This charge is found proved.

The panel had regard to the contemporaneous evidence which consisted of the call bell log. This log clearly displays that the original call for the resident to be taken to the toilet was at 00:29:20. As set out above, this call bell system was tested by the staff after the incident to ensure that it was recording accurately. The Nourish entry is timed at 00:15. This was in relation to Resident A being assisted to the toilet. The panel also took into account that this charge was admitted by Mr Kokumo in his response to the charges.

In these circumstances, the panel is of the view that on the balance of probabilities it is more likely than not that Mr Kokumo incorrectly stated in the Nourish record that he had assisted Resident A to and from the toilet at 00:15.

Charge 1f

1. On the night shift of 17/18 February 2021 in relation to Resident A:
   f. Recorded on the accident form that her fall had taken place at 00:20 when it had not.

This charge is found proved.

The panel had regard to the call bell log which shows the emergency bell having been activated by Colleague 6 at 01:04:09. However, the documentation provided shows that Mr Kokumo recorded a time of 00:20. The panel also took into account Mr Kokumo's own admission to this charge. For these reasons, the panel found this charge proved.

Charge 1g

1. On the night shift of 17/18 February 2021 in relation to Resident A:
   g. Informed Colleague 1 and/or Colleague 2 that you had found her on the floor after completing nearby room checks when it was not you that had found her.

This charge is found proved.

During the handover to the day shift following the evening incident involving Resident A, Mr Kokumo informed Colleague 1 and Colleague 2 that the resident had fallen over trying to get off the toilet and that she had fallen on top of her frame and onto her face outside heproportionality assessmenten-suite bathroom. Colleague 2 says in her statement that Mr Kokumo said that he was hovering outside her room and close to nearby rooms when he heard the crash. He then said he went to Resident A's bedroom and assisted her up.

The panel heard a conflicting account of the incident from Colleague 6 who said that, when she attended and found Resident A on the floor, she activated the emergency call bell and Mr Kokumo then attended. It also heard the corroborating evidence of Colleague 8 who told the panel that Colleague 6 was first on the scene. However, the panel noted a slight discrepancy in that Colleague 8 recalled arriving after Mr Kokumo. If so, she would not have known whether Mr Kokumo arrived before or after Colleague 6. The panel accepted the evidence of Colleague 6, who it found to be a credible witness.

The panel heard that Resident A told staff that she had been tapping at the door trying to get help for some time before Colleague 6 found her. Colleague 6 said that it was the noise Resident A was making which alerted her to Resident A's distress when Colleague 6 was in the corridor passing Resident A's room. The panel was of the view that, if Mr Kokumo had been outside/close to her room as he stated, he would have heard Resident A as did Colleague 6.

In Colleague 2's witness statement, she recalled that when the nurse (whom she told the panel was Colleague 1) informed the staff during handover on 18 February 2021 that Mr Kokumo had found Resident A, Colleague 6 spoke up and said that in fact it was her who had found the resident. The panel therefore considered that, on the balance of probabilities, it is more likely than not that Mr Kokumo informed Colleague 1 and/or 2 that he had found Resident A on the floor after completing nearby checks when he did not.

Charge 2

2. Your actions at charges 1d and/or 1e and/or 1f and/or 1g were dishonest in that you were intending to create a false impression:
    a. that you had not left Resident A unattended and/or;
    b. that 111 was called shortly after Resident A had fallen.

This charge is found proved in its entirety.

The panel took into account that some discrepancies may occur when recording an emergency because of human errors when handling a difficult and/or stressful situation. It was of the view that the discrepancies set out in sub-charges 1e and 1f could, in isolation, be put down to simple mistakes.

The panel went on to consider the other discrepancies, along with the clear evidence provided by Colleague 5 that the 00:40 entry had been amended and was originally made at 01:48. It considered these discrepancies, when looked at as a whole, to be more than simple mistakes. Therefore, it was of the view that Mr Kokumo deliberately attempted to mislead the home as to the timing of events and his role in them.

The panel took into account that Mr Kokumo would have known that Resident A was impatient, often did not wait for staff to assist her and that normal practice was to wait outside her room in case she did not use the call bell. This was referred to by more than one witness. It was also commented on by more than one witness that Mr Kokumo would have known that Resident A was at risk of falls. This was well known in the home. The panel accepted the evidence of Colleague 8 that her practice was to check on this particular resident after about five minutes, and that while she would leave Resident A in the bathroom alone for privacy while using the toilet she would stay outside the door, in the bedroom. She said that Resident A did not take long on the toilet. However, Mr Kokumo did not do this despite being aware of the circumstances and normal procedure.

Mr Kokumo left Resident A unattended for up to thirty minutes, until she was found injured on the floor in Room 21 by Colleague 6. Although Mr Kokumo attended the emergency very quickly, arriving possibly before Colleague 8, if he had been as close by as he suggests, he would have heard the noises which attracted Colleague 6’s attention.

The panel determined that Mr Kokumo's actions from that point were clearly intended to cover up his failure and deflect criticism from himself. In these circumstances and in the absence of any credible evidence from Mr Kokumo himself to the contrary, all his actions point towards an intent to mislead the Home's investigation. The panel was of the view that such behaviour is clearly dishonest by the standards of ordinary people. For all these reasons, the panel found this charge proved in its entirety.

Charge 3

3. On 26 February 2021:

a. Did not update documentation for the room of the day resident before 16:00.

b. Did not complete the new admission paperwork for Resident G when requested.

c. Did not complete the new admission risk assessments on Resident H on her admission to the Home.

This charge is found proved in its entirety.

When considering this charge, the panel had particular regard to the witness statement provided by Colleague 1. She stated:

> *'On February 2021, both [Colleague 5] and I had a reflective discussion with the Registrant about his practice […] During the conversation we spoke about his daily tasks such as calling the GP, dressings and updating the documentation of the resident in the room of the day. Each day every month there is a different room of the day where the particular resident's care plans and documentation should be updated. This should usually be done before 16:00 so that the nurses can do their 17:00 medication round until 20:00 when their shift ends. The Registrant had not yet updated the documentation for the resident who was in the room of the day.*

There was also a new admission from 25 February 2021 called [Resident G] and I had left a list of tasks for the Registrant to do such as complete observations, risk assessments, oral assessment and a food assessment. The Registrant had not completed these tasks.

There was also another new admission [Resident H] On admission or within 48 hours of admission several risk assessments need to be completed including an oral risk assessment, food assessment, manual handling assessment and a tissue viability care plan. These documents had not been completed on admission or when the resident was [sic] *the room of the day.'*

The pal considered Colleague 1 to be a clear and credible witness. Her witness statement was corroborated by her contemporaneous notes of the incident dated 26 February 2021, and by Mr Kokumo's response to the charges. Therefore, the panel found this charge proved in its entirety.

Charge 4a

4. On 1 March 2021:

a. Did not document Resident F's fall correctly.

This charge is found NOT proved.

Mr Kokumo denied this allegation. The panel had regard to the evidence provided by Colleague 1 stating that Mr Kokumo had failed to properly document this fall *'the registrant did not include what had happened but instead documented what he thought had happened.'* However, Colleague 7 said in her statement *'the registrant completed the incorrect accident documentation for Resident F.'* The panel further had sight of the Accident Report completed by Mr Kokumo on 26 February 2021 documenting Resident F's fall and which set out an account given to him by an eye witness. Looking at the evidence the panel was therefore unclear as to what error had been purported to have been made by Mr Kokumo.

Due to the different accounts provided by the witnesses and the confusion over the date, the panel was of the view that there was insufficient evidence to establish what way Mr Kokumo had failed to document Resident F's fall correctly. The panel therefore found this charge not proved.

Charge 4b

4. On 1 March 2021:

b. Called the GP in the afternoon as opposed to the morning.

This charge is found proved.

Colleague 1 provided a first-hand account of this incident in her witness statement. She said:

> *'The Registrant did not call the GP until the afternoon. The Registrant was aware that calls to the GP needed to be made in the morning so that if a resident needed a visit from the GP or needed medication the GP would have all day to deal with the request. When I spoke to the Registrant about calling the GP he said he would make the call after lunch knowing that this would be too late.'*

The panel noted that Mr Kokumo did not admit this charge. However, it also noted that Colleague 1's evidence was not challenged. There was no evidence provided to refute it. Therefore, on the balance of probabilities, the panel was of the view that Mr Kokumo called the GP in the afternoon as opposed to the morning.

Charge 4c

4. On 1 March 2021:

c. Did not update the documentation for the room of the day Resident I before 16:00.

This charge is found proved.

Colleague 1 provided a first-hand account in relation to this incident within her witness statement. She said:

> *'I found that at 16:00 the documentation and care plans had not been reviewed for the resident of the day who was [Resident I]. The room of the day documentation should be updated by 16:00 each day as nurses begin their medication round at 17:00 until 20:00.'*

The panel also took into account that Mr Kokumo has indicated in his responses to the charges that he does not dispute this account. The panel therefore found this charge proved on the balance on probabilities.

Charge 5

5. On 3 March 2021 did not complete separate wound care plans for each of Resident A's wounds.

This charge is found proved.

The panel had regard to Colleague 1's first-hand account and her contemporaneous notes of this incident. In her witness statement, she said:

> *'On 3 March 2021, whilst supervising the Registrant, I found that the wound care plans for Resident A were incorrect. As resident A had several wounds including a facial injury and skin tears on her arms and legs from her fall she needed separate wound care plans for each of her wounds. When the Registrant did the dressings on each wound on 3 March 2021 he documented wound care of certain wounds on the incorrect wound care plan. Three hours later this had not been rectified so I corrected the documentation myself.'*

The panel noted that Mr Kokumo did not admit this charge, however, it also noted Colleague 1's evidence has not been challenged and no evidence has been provided to refute it. Therefore, on the balance of probabilities, the panel was of the view that Mr Kokumo did not complete separate wound care plans for each of Resident A's wounds.

Charge 6a

6. On 4 March 2021, in relation to the administration of Resident B's proportionality assessment Co-Beneldopa medication:
a. Placed it in Colleague 3's pocket.

The panel found this charge proved.

The panel heard live evidence from Colleague 3 on this incident. The panel considered Colleague 3's evidence to be clear, credible and comprehensive. She reiterated what she had set out in her witness statement and her account was also corroborated by the second-hand accounts of Colleague 1, Colleague 7 and Colleague 5 in their statements. Colleague 3 also provided a local statement at the time which the panel considered to be contemporaneous evidence.

The panel noted that Mr Kokumo did not admit this charge. However, no evidence was provided to refute Colleague 3's account and therefore the panel found this charge proved on the balance of probabilities.

Charge 6b

6. On 4 March 2021, in relation to the administration of Residproportionality assessmentt B's Co-Beneldopa medication:
b. Asked Colleague 3 to administer it to the resident.

This charge is found proved.

The panel again had regard to the evidence provided by Colleague 3 in relation to this incident. The panel considered her account to be cogent and consistent in both her live evidence and written testimonial. The panel also took into account Mr Kokumo's own admission in relation to this incident in his response to the charges. The panel therefore found this charge proved.

Charge 6c

6. On 4 March 2021, in relation to the administration of Resproportionality assessmentent B's Co-Beneldopa medication:
c. Left it on the table in the resident's room.

The panel found this charge proved.

For the same reasons as set out in respect of charge 6b above, the panel also found this charge proved.

Charges 7a (i) and (ii)

7. On 25 March 2021:
a. Without a second checker present administered:
i. A Fentanyl patch to Resident C.
ii. A slow release morphine tablet to Resident D.

The panel found these charges proved.

The panel had regard to Colleague 1's account of this incident which she witnessed first-hand whilst supervising Mr Kokumo. Colleague 1 describes how Mr Kokumo apologised for his actions. This indicates his acceptance at the time both that he had done this and that it was incorrect. Colleague 1 said in her statement:

'Whilst I was getting the medication I needed, the Registrant asked [senior carer] to sign the controlled drugs book. I turned around and said that she was not to sign anything as nothing needed to be checked. The Registrant had administered a Fentanyl Patch to [Resident C] and a slow release Morphine tablet to [Resident D] without a second checker. The Registrant had filled out the controlled drugs book and had not got another member of staff to witness the administration or countersign his entries in the controlled drug book. It was 10:45 when I was in the medicine room and the medication had been administered two hours beforehand. This went against the Home's medication policy.'

Colleague 5 recalls in her witness statement that he said in her presence that he was going to get a '*second checker*' but by this point the drug had already been administered.

The panel finds from Mr Kokumo's apology and later admission to these charges in his responses within the CMF that they are found proved.

Charge 7b

7. On 25 March 2021:
b. Asked Colleague 4 to sign the controlled drugs book when she had not been present for the administration of the medication above.

This charge is found proved.

This incident was covered by Colleague 1 in her witness statement. She witnessed Mr Kokumo asking Colleague 4, a senior carer, to sign the controlled drugs book when she had not been present for the administration of the medication. Further, Colleague 1 said that she witnessed Mr Kokumo asking Colleague 4 to sign the controlled drugs book two hours after the drugs had been administered.

The panel also had regard to the Home's medication policy which Mr Kokumo breached by administering medication in this way. For the reasons as set out above and in light of Mr Kokumo's own admissions to the charge, the panel therefore found this charge proved.

Charge 8a

8. On 31 March 2021:

a. Recorded that Resident B's medication had been administered at 13:51 when it had not been.

This charge is found proved.

The panel had regard to the witness statements provided by Colleague 1 and Colleague 7. Colleague 1 provided a detailed account about her conversations with Mr Kokumo and Colleague 7. Colleague 7 exhibited the medication chart for Resident B which shows that medication was administered at 13:51. When Colleague 1 spoke to Mr Kokumo at around 15:00 and asked him if he had administered the medication, he said he had not because he could not find her. His failure to do so was against the medication policy, to which the panel had regard. Furthermore, Mr Kokumo indicated that he admitted this charge in his responses to the charges. For these reasons, the panel found this charge proved.

Charge 8b

8. On 31 March 2021:

b. Did not administer eye drops to Resident E.

This charge is found proved.

Colleague 1 refers to this incident in her witness statement. She recounts speaking to Mr Kokumo about the failure to administer the eyedrops to Resident E. She said that he told her that the resident was too sleepy and nauseous to administer them. Colleague 7 also refers to this incident in her witness statement, but her account is based upon the account of Colleague 1 and therefore the panel considered her evidence in relation to this incident to be hearsay. This charge is admitted by Mr Kokumo in his response to the charges. For these reasons, the panel find this charge proved.

Charges 8c and 8d

8. On 31 March 2021:
c. Did not fully engage in or document the discussion with the occupational therapist in relation to Resident J.
d. Refused to assist a colleague with the hoist.

These charges are found NOT proved.

The panel considered the only evidence available to it in relation to this charge to be hearsay. The witness statement of Colleague 1 is unclear. It can be read as an eyewitness report but it can also be read as relaying a report given to her by another. It is the only evidence in support of this charge. It states that Mr Kokumo leaned against the doorway and instructed the carer to speak to the occupational therapist when, in her view, it should have been a conversation between Mr Kokumo and the occupational therapist. The panel noted that Mr Kokumo does not admit this charge. The panel did not consider that the charge could be found proved solely on what may be hearsay evidence provided by Colleague 1.

For the reasons as set out above, the panel was of the view that the NMC has not discharged its burden of proof in relation to this charge and therefore the panel found this charge not proved.

Charge 8e

8. On 31 March 2021:

e. Signed to say that medication had been administered to Resident C when you had left it on the table.

This charge is found NOT proved.

The panel considered the evidence available to it in relation to this charge to be solely hearsay. Colleague 1 refers to the incident in her statement, she said that Colleague 3 informed her that she had taken Resident C back to her bedroom and found medication left on the table. Colleague 1 said that Mr Kokumo signed to say that Resident C had been given their medication on the EMEDs system when Resident C had not taken the medication as it had been left on her table.

Colleague 3 did not refer to this incident in her statement, nor did she refer to it in her live evidence. Therefore, the only evidence available to the panel is the hearsay evidence provided by Colleague 1. Mr Kokumo does not make any admissions in relation to this charge. Therefore, the panel was of the view that the NMC has not discharged its burden of proof in relation to this charge and therefore the panel found this charge not proved.

Charge 9

9. Your actions at charge 8a and/or 8e above were dishonest in that you intended to give the impression that the medication had been administered when it had not been.

This charge is found NOT proved.

The panel considered there to be insufficient evidence to suggest that Mr Kokumo was dishonest in respect of his false entries onto the record. The panel took into account that, when Mr Kokumo was challenged about his actions, he admitted to his mistakes straight away and fully accepted his wrongdoing. Mr Kokumo's actions in these charges relate to record keeping, and whilst his professional practice in these instances was unacceptable, the panel did not find any deliberate attempt at falsification with the intention of giving a misleading impression that the medication had been administered when it had not been. The panel therefore found this charge not proved.

Charge 10

10. On or around 29 April 2021 provided details to Quad Recruitment Agency purporting to be those of Colleague 5.

This charge is found proved.

The panel heard live evidence from the Head of Compliance at Quad Recruitment Agency Limited who investigated this purported employment reference for Mr Kokumo after it was submitted with an email address *"[firstname.homename]@outlook.com".* She found this to be unusual and contacted the Home, speaking with Colleague 7. Colleague 5 confirmed in her statement and live evidence that she never provided a reference for Mr Kokumo and that she had never had that email address. The telephone number given was not hers, nor was it similar to any number connected to her or the Home.

The Head of Compliance dealt with IP address matters in her witness statement. The panel noted that, although she is not an expert witness, she clearly recalls that she entered the IP address used to submit the reference purportedly from Colleague 5 into a website to locate it and it came up with an approximate location of Ipswich. The Home is on the Dorset coast. Mr Kokumo lived in Suffolk.

The panel considered all of the witnesses' evidence in relation to this charge to be corroborative and credible. Although Mr Kokumo does not admit this charge, there is no evidence available to the panel to refute the witnesses accounts. For these reasons, the panel found this charge proved.

Charge 11

11. Your actions at charge 10 above were dishonest in that you intended a false reference from Bymead Nursing Home to be submitted to Quad Recruitment Agency.

This charge is found proved.

The panel took into account that it has not heard from Mr Kokumo and therefore it is difficult to assess his thoughts at the time. However, it was of the view that the evidence referred to in charge 10 above is sufficient to find that his reference was a false one. Mr Kokumo must have known this. He deliberately provided (or had some other person provide) a false email address and false telephone number together with a false reference from a device traced to Ipswich by its IP address. With the existence of Virtual Private Networks (which mask one IP address behind another), it is not possible to say whether this was a third individual submitting this false reference for Mr Kokumo from Suffolk or the registrant himself using a VPN to mask his location and submit it in a way that did not flag it up as fraud. In any event, it was not Colleague 5 who submitted the reference, and she very clearly stated this in her evidence. Mr Kokumo must have known it was not from her, based on the evidence she has provided. Mr Kokumo accepted that he had provided details to Quad Recruitment Agency Limited purporting to be those of Colleague 5. The panel could see no innocent explanation for so doing, and Mr Kokumo's denial of this charge contained none.

In light of the reasons as outlined above, the panel determined that Mr Kokumo deliberately submitted an employment reference he knew to be false, something that is clearly dishonest by the standards of ordinary people, and therefore the panel found this charge proved.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so, whether Mr Kokumo'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 suitability to remain on the register unrestricted.

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 Kokumo's fitness to practise is currently impaired as a result of that misconduct.

The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives (2015)' (the Code) in making its decision.

Submissions on misconduct and impairment

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

Mr Underwood invited the panel to take the view that the facts found proved amount to misconduct.

Mr Underwood identified the specific, relevant standards where he suggested Mr Kokumo's actions breached fundamental tenets of the nursing profession and amounted to misconduct.

Mr Underwood referred the panel to the relevant parts of the Code which he submitted Mr Kokumo had breached, they were as follows:

- 10.3 - complete records accurately and without any falsification – in relation to charges 1d, 1e, 1f and 8a.
- 10.1 - complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event – in relation to charges 3a, 3b, 3c and 4c
- 11.1 - only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions – in relation to charges 6a and 6b
- 18.4 - take all steps to keep medicines stored securely – in relation to charge 6c
- 18.2 - keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs – in relation to charge 7
- 20.2 - act with honesty and integrity at all times – in relation to the several charges found proved by the panel relating to dishonesty. Mr Underwood submitted that this alone, aside from the other breaches outlined, is sufficient for a finding of misconduct.

Mr Underwood submitted that the concerns are serious and wide ranging and public confidence in the nursing profession would be undermined should a finding of misconduct not be made.

Mr Underwood moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. Reference was made to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) and Grant [2011] EWHC 927 (Admin).*

Mr Underwood submitted that all four limbs of Dame Janet Smith's test are engaged. He invited the panel to make a finding of impairment to protect the public and to uphold the public interest. He submitted that there is very little evidence of insight in relation to Mr Kokumo's behaviour and no insight into his dishonesty. Mr Kokumo has also not provided evidence of any reflection, save for the short statement from him accompanying his response to the charges. This was limited to stating that he did not intend to attend this hearing.

Mr Underwood submitted that without any evidence of insight or remediation from Mr Kokumo, his practice remains impaired. Furthermore, he submitted that Mr Kokumo's unaddressed repeated dishonesty was not remediated and there was no prospect of it being remediated.

The panel accepted the advice of the legal assessor which included reference to the following cases: *Nandi v GMC* [2004] EWHC 2317 (Admin), *Mallon v GMC* [2007] CSIH 17, *Holton v GMC* [2006] EWHC 2960 (Admin), *Meadow v GMC* [2007] QB 462, *Cohen v GMC* [2008] EWHC 581 (Admin), *Grant*, *SRA v Sharma [*2010] EWHC 2022 (Admin) and *Parkinson v NMC* [2010] EWHC 1898 (Admin).

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 Kokumo's actions did fall significantly short of the standards expected of a registered nurse, and that his actions amounted to a breach of the 2015 Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *1.1 treat people with kindness, respect and compassion*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay*
>
> ***10 Keep clear and accurate records relevant to your practice***
> *10.1 complete records at the time or as soon as possible after an event, recording if the notes are written sometime after the event*
> *10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements*
>
> ***11 Be accountable for your decisions to delegate tasks and duties to other people***
> *11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions*
>
> ***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***
> *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*

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs

18.4 take all steps to keep medicines stored securely

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

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

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'

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 the charges admitted and found proved were serious and amounted to misconduct.

In reaching this conclusion, the panel first considered whether each individual proven charge amount to misconduct. It was so satisfied.

The concerns arose from a failure of care for Resident A, it later being discovered that Mr Kokumo's account and documentation was dishonest. Supervision during his notice period revealed further shortcomings in Mr Kokumo's practice in several important ways including lack of care for patients, failing to follow policies, record keeping and in the administration of controlled drugs. These issues did not appear to be related to a lack of competence but to be failure to practice professionally, a wilful disregard of nursing protocols.

The panel considered Mr Kokumo to be an experienced nurse and who had adequate training. It noted that Mr Kokumo successfully completed his induction period at the Home and impressed colleagues with his competence and attitude. However, his performance appears to have quickly deteriorated and Mr Kokumo failed to exercise the fundamental skills of a nurse.

With regard to the dishonesty charges, the panel was of the view that Mr Kokumo's conduct was very serious and would be considered deplorable by fellow practitioners and the public. In relation to Resident A, his dishonesty had been an attempt to conceal his actions and included being untruthful in his account about his role in what happened to Resident A and intentionally falsifying the Home's records about her care (or lack of it). In relation to the provision of a false reference, this was a premeditated deception involving forethought and planning.

The panel also noted that Mr Kokumo was absent from proceedings and had offered no mitigation in respect of any of the charges, and the panel could find none.

In these circumstances, the panel found that Mr Kokumo'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, because of the misconduct, Mr Kokumo'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 both honest and professional. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of *CHRE v NMC and Grant* in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that s/he:*

a) *has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*

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

c) *has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*

d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*

The panel considered that all four limbs of this test were applicable to Mr Kokumo. The panel finds that residents were put at risk of serious harm as a result of Mr Kokumo's misconduct. Mr Kokumo's misconduct breached fundamental tenets of the nursing profession and brought its reputation into disrepute. The panel decided that confidence in the nursing profession would be seriously undermined if its regulator did not find charges relating to dishonesty extremely serious.

The panel noted that Mr Kokumo had admitted some of his failings. However, there is no evidence of any efforts to strengthen his practice. The panel noted that Mr Kokumo has not been practising as a registered nurse for some time. However, there is no evidence that he has demonstrated insight into his actions and the impact they had/could have had on patients, colleagues, the public and the wider profession, and no evidence of remorse. The panel has also not received any reflective pieces from Mr Kokumo. The panel considered that there has been no evidence of a change in circumstances since the incidents occurred and the issues have not been addressed by Mr Kokumo. It concluded that Mr Kokumo still presents a risk of harm to patients, and that there was a risk of repetition of dishonesty, of failures in providing fundamental care, in record keeping and in the administration of controlled drugs.

The panel took into account the fact that the misconduct found proved in this case included more than one finding of dishonesty, first in covering up for a mistake which led to patient harm and secondly providing a false reference. It considered Mr Kokumo's lack of admissions to the dishonesty charges, despite accepting the factual basis for the charges, showed a lack of insight. He had accepted that he had falsified records and had himself provided a glowing reference purporting to be from the manager of the home, when she had recently dismissed him from his employment for the multiple failures leading these charges. Any reasonable member of the public and fellow practitioners would know these actions to be dishonest. The panel noted that dishonesty is difficult to remedy and there was no evidence from Mr Kokumo that he has made any efforts or attempts to do so.

While Mr Kokumo made admissions to some of the charges the panel was unable to identify anything in the evidence before it to indicate that Mr Kokumo has strengthened his practice or addressed the issues reflected in the charges found proved.

The panel was of the view that there remains a risk of harm and repetition as it has no information or evidence before it from Mr Kokumo that indicates otherwise.

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 proper professional standards for members of those professions.

Mr Kokumo's actions were serious and brought the profession into disrepute, and also involve elements of dishonesty. The panel decided that a finding of impairment is necessary on the grounds of public protection.

The panel also determined that a finding of impairment on public interest grounds is required because the serious concerns underlying the charges found proved have not been addressed by Mr Kokumo, and it is important to uphold professional standards within the profession. The panel concluded that because these were serious matters of dishonesty, together with unresolved issues with controlled drugs, poor record keeping and patient care then public confidence in the profession would be undermined if a finding of current impairment was not made in this case. It therefore also finds Mr Kokumo's fitness to practise impaired on the grounds of public interest.

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

Sanction

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

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

Submissions on sanction

The Notice of Hearing, dated 1 September 2022, was sent by the NMC to Mr Kokumo and had advised him that it would seek the imposition of a striking off order if a panel found his fitness to practise currently impaired.

Mr Underwood referred the panel to the guidance and factors to consider before deciding on sanctions and the need to be proportionate to find a fair balance between Mr Kokumo's interests and the NMC's overarching principle of public protection. He submitted that the purpose of sanctions is to protect the public as opposed to punishing the registrant.

Mr Underwood invited the panel to consider the sanctions in ascending order, starting with the least restrictive. He submitted that the panel should take the appropriate action in protecting the public and addressing the public interest concerns identified. Mr Underwood directed the panel to consider the more serious sanctions available to it. He invited the panel to consider whether Mr Kokumo's conduct and behaviour is incompatible with him remaining on the NMC register.

Mr Underwood submitted that there were a number of aggravating and mitigating factors which the panel may consider relevant. Addressing aggravating factors, Mr Underwood submitted that Mr Kokumo's case involves a pattern of misconduct involving multiple incidents of dishonesty and that he has demonstrated a lack of insight into his failings. Addressing mitigating factors, Mr Underwood submitted that Mr Kokumo has made some admissions and that the evidence, provided by the witnesses Mr Kokumo has worked with, suggests that he was a good nurse prior to the incidents.

Mr Underwood submitted that the concerns are so serious that the panel should consider whether temporary removal from the NMC register is sufficient to address the public protection and public interest elements of this case. He drew the panel's attention to the NMC's guidance on dishonesty and submitted that Mr Kokumo's behaviour in this respect was premeditated and systemic.

In light of the seriousness of the charges found proved, the actual harm caused to a patient and the number of patients put at risk by the repeated conduct of Mr Kokumo; his lack of insight and his decision to disengage with the NMC. Mr Underwood submitted that removal from the register, either on a temporary or permanent basis, was the only appropriate form of sanction. He invited the panel to consider that permanent removal from the register by way of striking-off order was the only appropriate sanction.

Decision and reasons on sanction

Having found Mr Kokumo'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 Kokumo breached the fundamental tenets of the nursing profession; and breached his duty of trust as a registered nurse.
- There were two counts of dishonest conduct, one of which was a breach of the professional duty of candour and one which was pre-meditated and for personal gain.
- Mr Kokumo's actions put vulnerable patients at risk of serious harm and caused actual harm to a patient.
- There was a pattern of repeated misconduct other than dishonesty which lasted for a significant period of time; despite repeated attempts to rectify these concerns.
- Mr Kokumo's failings were wide-ranging and involved various aspects of the nursing practice.
- Mr Kokumo has not demonstrated sufficient scope and depth of insight or remediation and he also failed to accept the dishonest nature of his actions.

The panel also took into account the following mitigating features:

- Mr Kokumo admitted some of the facts.
- The evidence provided by the witnesses suggest that Mr Kokumo was a good nurse prior to the incidents.

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 Kokumo'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 Kokumo'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 a conditions of practice order on Mr Kokumo's nursing registration would be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel is of the view that there are no practical or workable conditions that could be formulated, given the nature of the concerns identified. Whilst the panel had determined that the clinical deficiencies were capable of remediation, it was not satisfied that a conditions of practice order was sufficient to address Mr Kokumo's dishonesty, having regard to the public protection and public interest elements of this case. The panel noted that Mr Kukumo's dishonest conduct was not a one-off incident, was not opportunistic or spontaneous conduct, that he was seeking direct personal gain, that the dishonest action concerning Resident A involved actual harm to Resident A, and that the incidences of dishonesty were not incidents in Mr Kukumo's private life. The panel was also mindful that notwithstanding the supervision Mr Kokumo had received, he made a series of clinical errors. The panel had found Mr Kokumo to be lacking insight. Currently, there is very little or no evidence that Mr Kokumo appreciates the serious ramifications of his acts and omissions, and the impact this could have had on patients and their families, colleagues, employers, the nursing profession and the wider public as a whole.

In taking account of the above, the panel determined that placing a conditions of practice order on Mr Kokumo's nursing registration would not adequately address the seriousness of this case, nor would it satisfy the public interest considerations.

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;*

As none of the four factors above applied to Mr Kokumo's case the panel was of the view that a suspension order would not be appropriate. The conduct, as highlighted by the facts found proved, was a significant departure from the standards expected of a registered nurse. The panel noted that the serious breaches of the fundamental tenets of the profession evidenced by Mr Kokumo's actions is incompatible with Mr Kukumo remaining on the register.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction. A suspension order would expire at the end of the period of suspension. There is nothing to indicate that Mr Kukumo would be safe to practise without restriction at the end of a period of suspension.

Finally, in considering a striking-off order, the panel took note of the following paragraphs 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?*

Taking account of the above, the panel determined that Mr Kokumo's dishonesty and misconduct was not merely a serious departure from the standards expected of a registered nurse and a serious breach of the fundamental tenets of the nursing profession, it was fundamentally incompatible with him remaining on the NMC register. In the panel's judgement, to allow someone who had behaved in this way to maintain his NMC registration would undermine public confidence in the nursing profession and in the NMC as a regulatory body.

In reaching its decision, the panel bore in mind that its decision would have an adverse effect on Mr Kokumo both professionally and personally. However, the panel was satisfied that the need to protect the public and address the public interest elements of this case outweighs the impact on Mr Kokumo in this regard.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. The panel has concluded that nothing short of striking Mr Kokumo from the register would be sufficient in this case to declare and uphold standards, and to maintain the reputation of the profession and of the NMC as its regulator. This was because Mr Kokumo's actions brought the profession into disrepute, adversely affecting the public's view of registered nurses.

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

This will be confirmed to Mr Kokumo in writing.

Submissions on interim order

Mr Underwood invited the panel to impose an interim suspension order for a period of 18 months. He submitted that this interim order is necessary on the grounds of public protection and it is also in the public interest, having regard to the panel's findings.

Decision and reasons on interim order

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

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing the substantive order. Owing to the seriousness of the misconduct in this case, along with the risk of repetition identified, it determined that Mr Kokumo's acts and omissions were sufficiently serious to justify the imposition of an interim suspension order until the striking-off order takes effect. In the panel's judgement, public confidence in the regulatory process would be damaged if Mr Kokumo were to be permitted to practise as a registered nurse prior to the substantive order coming into effect.

The panel decided to impose an interim suspension order in the circumstances of this case. To conclude otherwise would be incompatible with its earlier findings.

The panel therefore imposed an interim suspension order for a period of 18 months, in case an appeal takes that length of time.

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

That concludes this determination.