Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Meeting
Wednesday 5 August 2026 – Friday 7 August 2026

Nursing and Midwifery Council
2 Stratford Place, Montfichet Road, London, E20 1EJ

Name of Registrant:	**Victoria Louise Huzzard**
NMC PIN:	14E1980E
Part(s) of the register:	Registered Nurse - Adult (RNA) 11 September 2014
Relevant Location:	Lincolnshire
Type of case:	Misconduct
Panel members:	Geraldine O'Hare (Chair, Lay member) Michelle Wells-Braithwaite (Registrant member) Raj Chauhan (Lay member)
Legal Assessor:	Nigel Ingram
Hearings Coordinator:	Emily Mae Christie
Facts proved:	Charges 1a, 1b, 1c, 1d, 1e, 1f, 1g, 2a, 2b, 2c, 2d, 2e, 3
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Interim suspension order (18 months)**

Decision and reasons on service of Notice of Meeting

The panel was informed at the start of this meeting that the Notice of Meeting had been sent to Ms Huzzard's registered address by recorded delivery and by first class post on 2 July 2026.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Meeting provided details of the allegation, and that the meeting would take place on or after 5 August 2026.

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

Details of charge

That you, a registered nurse:

1) On 23 March 2022, at Holly Tree Lodge Care Home:

    a) Administered 10mgs of Zomorph to Resident A instead of 20mgs as prescribed.

    b) Recorded that you administered 20mgs of Zomorph to Resident A when you had not.

    c) Did not administer Calcichew D3 or did not sign the MAR chart that you had administered Calcichew D3 to Resident B.

    d) Did not administer or did not sign the MAR chart that you had administered one or more of the following medications to Resident C:

        i) Sodium chloride tabs

        ii) Clopidogrel tablets

iii) Tamsulosin capsules

e) Did not administer or did not sign the MAR chart that you had administered one or more of the following medications to Resident D:

i) Carbamazepine

ii) Calcium supplements

f) Did not administer Risperidone or did not sign the MAR chart that you had administered Risperidone to Resident E.

g) Did not sign the controlled drugs book for the administration of a buprenorphine patch to Resident F.

2) On 1 April 2022 at Eaton Court Care Home:

a) In relation to Resident G, did not administer 100mg pregabalin in the presence of a witness.

b) Did not count the medication (pregabalin) in the presence of a witness.

c) Did not dispose of 100mg pregabalin tablet in the presence of a witness.

d) Signed as Colleague A [Ms Ruth Garrard] in the destroyed book indicating that they had witnessed the disposal of 100mg pregabalin.

e) Signed as Colleague A [Ms Ruth Garrard] in the controlled drugs book indicating that they had witnessed the administration of 200mg of pregabalin.

3) Your conduct in Charge 2d and/or 2e was dishonest in that you deliberately sought to represent that Colleague A [Ms Ruth Garrard] had witnessed you administer and/or dispose of medication when you knew they had not.

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

Background

On 14 April 2022, the NMC received a referral from Hamilton Cross (the agency) regarding Ms Huzzard, a registered nurse who had been working for the agency as an agency nurse. The referral concerned two incidents at two care homes. The incidents are alleged to have occurred on two separate dates. The first was on 23 March 2022 at Holly Tree Care Home (Holly Tree), and the second was on 1 April 2022 at Eaton Court Care Home (Eaton Court).

In relation to the incident on 23 March 2022 at Holly Tree, it is alleged that Ms Huzzard failed to administer the full prescribed dose of Zomorph, 20mg, comprising two tablets of 10mg each, to Resident A during her shift. This was discovered during a subsequent drug count, which established there was one more tablet of 10mg remaining in stock than there should have been, had the full dose been administered. The Medication Administration Record (MAR) chart recorded that Zomorph had been administered, but did not confirm the dose. Further, it is alleged that on the same date, Ms Huzzard failed to sign the MAR charts for the administration of six medications for Residents B, C, D, and E, and failed to sign the controlled drugs book for the administration of a Buprenorphine patch for Resident F.

In relation to the incident on 1 April 2022 at Eaton Court, it is alleged that Ms Huzzard administered Pregabalin to Resident G without following the internal controlled drugs procedures. Allegedly, she did not count, administer, or dispose of the medication in the presence of a witness. Although records show Ms Garrard's signature for both the administration and the disposal of the medication, Ms Garrard denied being present for either action and maintained that the signatures were not hers.

Decision and reasons on facts

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

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will

be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

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

- Ms Anne Atkinson: Manager of Holly Tree at the material time;
- Ms Ruth Garrard: Colleague A, and a Health Care Assistant at Eaton Court at the material time;
- Ms Anne Ruttle: A registered nurse and Nurse Manager at Eaton Court at the material time.

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

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

Charge 1a and 1b

'That you, a registered nurse:

1) On 23 March 2022, at Holly Tree Lodge Care Home:

a) Administered 10mgs of Zomorph to Resident A instead of 20mgs as prescribed.

b) Recorded that you administered 20mgs of Zomorph to Resident A when you had not.'

This charge is found proved.

In reaching this decision, the panel took into account Resident A's MAR chart and controlled drug book; the witness statement of Ms Atkinson; the Administration of Medicines Policy; and Ms Huzzard's reflective account.

The panel took into account Resident A's MAR chart, which indicated that they were given the full dose of Zomorph. It noted that Resident A required a 20mg dose, which would require them to be given two *'caps'*, meaning they were required two capsules of 10mg each. The panel also noted there was no indication on Resident A's chart that there was an alteration of the dose or a rationale for this.

However, the panel then considered Resident A's Controlled Drug Book page for *'Morphine Sulphate 10mg MR. Caps Zomorph'*. It noted that on 23 March 2022, at 07:15, there were 22 capsules left in stock, and that at 19:15, there were 21 capsules left in stock. The panel was of the view that the reduction of one capsule indicated that Resident A had only been given 10mg of Zomorph, rather than the prescribed 20mg dose, which would have required two 10mg capsules. It also considered that the other entries on the page supported this, as each entry would be reduced by two capsules each time.

The panel took into account the witness statement of Ms Atkinson, who explained the following:

> *'According to the documentation gathered, Ms. Huzzard correctly followed the controlled drugs administration procedure. However, she failed to correctly corroborate the adequate dose to be administered… As can be clearly seen on the page, there are two administrations of zomorph indicated for March 23rd, 2022. The first one indicates there are 22 capsules remaining in stock, while the second one indicates 21 capsules remain. This shows that only one capsule of zomorph was administered on that occasion. If two capsules had been administered, then the count should indicate 20 capsules remaining.'*

The panel was of the view that Ms Atkinson's statement was consistent with the documentary evidence produced on both Resident A's MAR chart and Resident A's Controlled Drug Book.

The panel noted the following section of the Administration of Medicines Policy:

> *'In addition, acting in the interests of the Service User, the practitioner will:-*
> *…*
> *6. Make clear and contemporaneous records of the administration of all medicines administered or deliberately withheld, ensuring that any written entries and the signature are clear and legible;'*

The panel also took into account Ms Huzzard's explanation of the incident. Ms Huzzard completed a document titled *'Reflective Account following a Medicine Administration Error'*. In her reflection under the section titled *'What was happening before error occurred*', Ms Huzzard explained:

> *'PRN pain relief requested by resident and their visitors, whilst I was finishing 1800hr drug round. I assessed resident and checked when next dose of Zomorph was due. Zomorph was due 20 minutes later, so I made clinical decision to administer only 5ml of Oromorph PRN and then timed dose of Zomorph to follow. Decision and reasoning discussed with resident(two visitors still present at time of discussion). Resident had mental capacity.'*

The panel was of the view that whilst this was a credible explanation for making the clinical decision, it should have been accurately documented on Resident A's MAR chart with an indication of her rationale as required by Holly Tree's Administration of Medicines Policy.

In all the circumstances, the panel determined that on the balance of probabilities, on 23 March 2022, Ms Huzzard administered 10 mg of Zomorph to Resident A instead of the required 20 mg as prescribed and recorded that she had administered 20mg of Zomorph to Resident A when she had not. In light of this, the panel found charges 1a and 1b proved.

Charge 1c

'That you, a registered nurse:

1) On 23 March 2022, at Holly Tree Lodge Care Home:

c) Did not administer Calcichew D3 or did not sign the MAR chart that you had administered Calcichew D3 to Resident B.'

This charge is found proved.

In reaching this decision, the panel considered the charge in two limbs. It first considered whether, on 23 March 2022, Ms Huzzard did not administer Calcichew D3 to Resident B. It then went on to consider the second limb, that on 23 March 2022, Ms Huzzard did not sign the MAR chart that she had administered Calcichew D3 to Resident B.

In considering the first limb of this charge, the panel took into account the witness statement of Ms Atkinson. In her statement, she explained *'For Resident B, Ms. Huzzard missed signing for Calcichew D3.'* The panel was of the view that this indicated that Ms Huzzard did administer the medication to Resident B.

The panel also took into account Ms Huzzard's explanation in her reflection. Under the section titled *'Description of what happened: (including time reported from time error made)*', Ms Huzzard explained:

> *'I also believes (sic) that all regular 1800hr medications were administered but allows (sic) that a documentation error on MARS sheet may have occurred due to interruption by two visitors and care staff regarding administering PRN pain relief.'*

The panel found no additional evidence in relation to the first limb of this charge. In light of this, it was of the view that, on the balance of probabilities, on 23 March 2022, Ms Huzzard did administer Calcichew D3 to Resident B. Therefore, the panel found the first limb of charge 1c not proved.

In light of this, the panel went on to consider the second limb of the charge, namely whether Ms Huzzard failed to sign the MAR chart to record that she had administered Calcichew D3 to Resident B. The panel took into account Resident B's MAR chart. Although the time for the relevant entry appeared to have been redacted, the panel noted that the box requiring a signature to indicate that the medication had been administered on 23 March 2022 was blank.

The panel also took into account Ms Huzzard's reflective account, in which she stated that she believed all regular 18:00 medications had been administered, but accepted that a documentation error on the MAR chart may have occurred.

In the circumstances, the panel determined that in the absence of a signature in the relevant box on Resident B's MAR chart, and Ms Huzzard's acceptance that there may have been a documentation error, it was more likely than not that Ms Huzzard had not signed the MAR chart to record that she had administered Calcichew D3 to Resident B. Accordingly, the panel found the second limb of charge 1c proved.

In light of this, the panel therefore found charge 1c proved.

Charge 1d(i), 1d(ii), and 1d(iii)

'That you, a registered nurse:

1) On 23 March 2022, at Holly Tree Lodge Care Home:

d) Did not administer or did not sign the MAR chart that you had administered one or more of the following medications to Resident C:

i) Sodium chloride tabs

ii) Clopidogrel tablets

iii) Tamsulosin capsules'

This charge is found proved.

In reaching this decision, the panel considered the charge in two limbs for each medication listed. It first considered whether, on 23 March 2022, Ms Huzzard did not administer Sodium chloride tabs, Clopidogrel tablets, and Tamsulosin capsules to Resident C. It then

went on to consider the second limb, that on 23 March 2022, Ms Huzzard did not sign the MAR chart that she had administered Sodium chloride tabs, Clopidogrel tablets, and Tamsulosin capsules to Resident C.

In considering the first limb of this charge, the panel took into account the witness statement of Ms Atkinson. In her statement, she explained *'For Resident C, Ms. Huzzard missed signing for sodium chloride tabs, clopidogrel tablets and tamsulosin capsules.'* The panel was of the view that this indicated that Ms Huzzard did administer the medications to Resident C.

The panel also took into account Ms Huzzard's explanation in her reflection. Under the section titled *'Description of what happened: (including time reported from time error made)*', Ms Huzzard explained:

> *'I also believes (sic) that all regular 1800hr medications were administered but allows (sic) that a documentation error on MARS sheet may have occurred due to interruption by two visitors and care staff regarding administering PRN pain relief.'*

The panel found no additional evidence in relation to the first limb of this charge. In light of this, it was of the view that, on the balance of probabilities, on 23 March 2022, Ms Huzzard did administer Sodium chloride tabs, Clopidogrel tablets, and Tamsulosin capsules to Resident C. Therefore, the panel found the first limb of charges 1d(i), 1d(ii), and 1d(iii) not proved.

Accordingly, the panel went on to consider the second limb of the charge, namely whether Ms Huzzard failed to sign the MAR chart to record that she had administered Sodium chloride tabs, Clopidogrel tablets, and Tamsulosin capsules to Resident C.

The panel took into account Resident C's MAR chart. It noted that the box requiring a signature confirming that the medications had been administered on 23 March 2022 were blank.

The panel also took into account Ms Huzzard's reflective account, in which she stated that she believed all regular 18:00 medications had been administered, but accepted that a documentation error on the MAR chart may have occurred. However, the panel noted that the Clopidogrel tablets and Tamsulosin capsules were due at 08:00, by which Ms Huzzard's reflection did not account for.

In the circumstances, the panel determined that in the absence of a signature in the relevant boxes on Resident C's MAR chart, and Ms Huzzard's acceptance that there may have been a documentation error, it was more likely than not that Ms Huzzard had not signed the MAR chart to record that she had administered Sodium chloride tabs, Clopidogrel tablets, and Tamsulosin capsules to Resident C. Accordingly, the panel found the second limb of charges 1d(i), 1d(ii), and 1d(iii) proved.

In light of this, the panel therefore found charges 1d(i), 1d(ii), and 1d(iii) proved.

Charge 1e(i), and 1e(ii)

'That you, a registered nurse:

1) *On 23 March 2022, at Holly Tree Lodge Care Home:*
    e) *Did not administer or did not sign the MAR chart that you had administered one or more of the following medications to Resident D:*
        i) *Carbamazepine*
        ii) *Calcium supplements'*

This charge is found proved.

In reaching this decision, the panel considered the charge in two limbs for each medication listed. It first considered whether, on 23 March 2022, Ms Huzzard did not administer carbamazepine and calcium supplements to Resident D. It then went on to consider the second limb, that on 23 March 2022, Ms Huzzard did not sign the MAR chart that she had administered carbamazepine and calcium supplements to Resident D.

In considering the first limb of this charge, the panel took into account the witness statement of Ms Atkinson. In her statement she explained *'Por (sic) Resident D, Ms.*

Huzzard failed to sign for the administration of carbamazepine and calcium supplements.' The panel was of the view that this indicated that Ms Huzzard did administer the medications to Resident D.

The panel also took into account Ms Huzzard's explanation in her reflection. Under the section titled *'Description of what happened: (including time reported from time error made)*', Ms Huzzard explained:

> *'I also believes (sic) that all regular 1800hr medications were administered but allows (sic) that a documentation error on MARS sheet may have occurred due to interruption by two visitors and care staff regarding administering PRN pain relief.'*

The panel found no additional evidence in relation to the first limb of this charge. In light of this, it was of the view that, on the balance of probabilities, on 23 March 2022, Ms Huzzard did administer carbamazepine and calcium supplements to Resident D. Therefore, the panel found the first limb of charges 1e(i) and 1e(ii) not proved.

Accordingly, the panel went on to consider the second limb of the charge, namely whether Ms Huzzard failed to sign the MAR chart to record that she had administered carbamazepine and calcium supplements to Resident D.

The panel took into account Resident D's MAR chart. Although the time for the relevant entry for each medication was redacted. The panel noted that the box requiring a signature confirming that the medications had been administered on 23 March 2022 was blank.

The panel also took into account Ms Huzzard's reflective account, in which she stated that she believed all regular 18:00 medications had been administered, but accepted that a documentation error on the MAR chart may have occurred.

In the circumstances, the panel determined that in the absence of a signature in the relevant boxes on Resident D's MAR chart, and Ms Huzzard's acceptance that there may have been a documentation error, it was more likely than not that Ms Huzzard had not signed the MAR chart to record that she had administered carbamazepine and calcium

supplements to Resident D. Accordingly, the panel found the second limb of charges 1e(i) and 1e(ii) proved.

Therefore, the panel found charges 1e(i) and 1e(ii) proved.

Charge 1f

'That you, a registered nurse:

1) On 23 March 2022, at Holly Tree Lodge Care Home:

f) Did not administer Risperidone or did not sign the MAR chart that you had administered Risperidone to Resident E.'

This charge is found proved.

In reaching this decision, the panel considered the charge in two limbs. It first considered whether, on 23 March 2022, Ms Huzzard did not administer Risperidone to Resident E. It then went on to consider the second limb, that on 23 March 2022, Ms Huzzard did not sign the MAR chart that she had administered Risperidone to Resident E.

In considering the first limb of this charge, the panel took into account the witness statement of Ms Atkinson. In her statement she explained *'For Resident E, Ms. Huzzard failed to sign for the administration of one dose of risperidone.'* The panel was of the view that this indicated that Ms Huzzard did administer the medication to Resident E.

The panel found no additional evidence in relation to the first limb of this charge. In light of this, it was of the view that, on the balance of probabilities, on 23 March 2022, Ms Huzzard did administer Risperidone to Resident E. Therefore, the panel found the first limb of charge 1f not proved.

Accordingly, the panel went on to consider the second limb of the charge, namely whether Ms Huzzard failed to sign the MAR chart to record that she had administered Risperidone to Resident E. The panel took into account Resident E's MAR chart. The panel noted that the box requiring a signature to indicate that the medication had been administered on 23 March 2022 was blank.

In the circumstances, the panel determined that in the absence of a signature in the relevant box on Resident E's MAR chart, it was more likely than not that Ms Huzzard had not signed the MAR chart to record that she had administered Risperidone to Resident E. Accordingly, the panel found the second limb of charge 1f proved.

Therefore, the panel found charge 1f proved.

Charge 1g

'That you, a registered nurse:

1) On 23 March 2022, at Holly Tree Lodge Care Home:

g) Did not sign the controlled drugs book for the administration of a buprenorphine patch to Resident F.'

This charge is found proved.

In reaching this decision, the panel took into account Resident F's controlled drug book, Ms Atkinson's witness statement, and Ms Huzzard's reflection.

The panel first considered Resident F's controlled drugs book. It noted that the drug was recorded at the top of the page as *'Butrans 5mg'*. The panel was satisfied that Butrans is a brand name for Buprenorphine. It further noted that on 23 March 2022, there was no signature to record the administration of the patch in the controlled drugs book. However, the stock balance had decreased by one patch, indicating that a patch had been removed from stock. This was supported by Resident F's MAR chart, which showed a signature in the relevant box on 23 March 2022.

The panel also took into account the witness statement of Ms Atkinson. In her statement, she explained:

'Regarding Resident F, Ms Huzzard only missed signing the administration of the butec patch in the CD book. Butec patches are administered for pain management, as they release buprenorphine over a 7 day period. The administration of butec patches must follow the controlled drugs protocol.'

The panel was of the view that Ms Atkinson's statement was consistent with the documentary evidence produced on both Resident F's MAR chart and Resident F's Controlled Drug Book.

The panel also took into account Ms Huzzard's explanation in her reflection. Under the section titled *'Description of what happened: (including time reported from time error made)*', Ms Huzzard explained:

> *'I believes (sic) that all scheduled medication and PRN medication was administered and controlled drugs were witnessed and signed for in control drug book.'*

The panel found that Ms Huzzard's account was not consistent with the documentary evidence before it from Resident F's MAR chart and controlled drug book, as well as Ms Atkinson's witness statement.

In the circumstances, the panel determined that, on the balance of probabilities, on 23 March 2022, Ms Huzzard had not signed the controlled drugs book for the administration of a Buprenorphine patch to Resident F. In light of this, the panel found charge 1g proved.

Charge 2a

'That you, a registered nurse:

2) On 1 April 2022 at Eaton Court Care Home:

a) In relation to Resident G, did not administer 100mg pregabalin in the presence of a witness.

This charge is found proved.

In reaching this decision, the panel took into account Resident G's MAR chart and the witness statements of Ms Garrard.

The panel first considered Resident G's MAR chart. It noted that Resident G was prescribed 100mg Pregabalin with the instruction of *'One To Be Taken At morning'*. The panel also noted that Resident G was also prescribed 200mg Pregabalin with the instruction *'Take ONE at NIGHT'*. The panel noted that at the time of this incident, Resident G was due 200mg Pregabalin. However, the panel was of the view that for the purpose of this charge, the dosage of the Pregabalin was not material.

The panel then took into account the contemporaneous written statement of Ms Garrard, dated 2 April 2022, and noted the following:

> *'I went to the room with nurse to check CD's nurse had her back to me and she was getting medication out of the cupboard and then she went, I thought she had gone to get her computer. Nurse didn't ask me to count any medication at all. She came back a few minutes later I asked her where the computer was she said she hadn't brought it so asked her where she had been she said that she had taken the tablets up.'*

The panel noted that this account was supported by Ms Garrard's witness statement, in which she stated the following:

> *'…However, when she returned she told me that she had gone upstairs to administer the medication. I asked her why she had done this but she did not say. I do not recall what she said. I just remember that she did not mention the reason why she had gone upstairs to administer the medication. She did not administer the drug as she signed the destroyed book.'*

The panel found Ms Garrad's contemporaneous account to be credible and was consistent with her witness statement.

The panel noted that Ms Huzzard had not provided a reflection or account in relation to this charge.

In all the circumstances, the panel determined that, on the balance of probabilities, Ms Huzzard did not administer 100mg Pregabalin in the presence of a witness. Therefore, the panel found charge 2a proved.

Charge 2b and 2c

'That you, a registered nurse:

2) On 1 April 2022 at Eaton Court Care Home:

b) Did not count the medication (pregabalin) in the presence of a witness.

c) Did not dispose of 100mg pregabalin tablet in the presence of a witness.'

This charges are found proved.

In reaching this decision, the panel took into account the witness statements of Ms Garrard.

The panel took into account the contemporaneous written statement of Ms Garrard, dated 2 April 2022, . It noted the following:

> *'When doing CD checks at 01:00 approx the 100mg pregabalin was count of 18 but nurse said it was 17 asked why this was. Nurse said it was wasted. Asked why she said that she had dropped it. At no time did the nurse ask me to check or count medication being dispensed. I wasn't asked to sign the destroying book. Finished check and went to do 2am round.'*

The panel noted that this was consistent with Ms Garrad's witness statement, specifically:

> *'Later that night (at around 1:00 am) we went back to the treatment room to do the general stock check for controlled drugs. While performing it, I realised that there was one pregabalin 100 mg tablet missing. The CD book claimed that the count was 18 while there were 17 left. I asked Ms. Huzzard about this, and she claimed that she had to discard one tablet as it had fallen to the floor. I further asked why had she not mentioned this before,*

and she could not provide a reason. She just told me that she had destroyed it. I then carried on with my work.'

The panel found Ms Garrad's contemporaneous account to be credible and was consistent with her witness statement.

The panel noted that Ms Huzzard had not provided a reflection or an account in relation to these charges.

In the circumstances, the panel found that, on the balance of probabilities, Ms Huzzard did not count the medication in the presence of a witness nor did she dispose of 100mg Pregabalin tablet in the presence of a witness. Therefore, the panel found charge 2b and 2c proved.

Charge 2d

'That you, a registered nurse:

2) On 1 April 2022 at Eaton Court Care Home:

d) Signed as Colleague A [Ms Ruth Garrard] in the destroyed book indicating that they had witnessed the disposal of 100mg pregabalin.'

This charge is found proved.

In reaching this decision, the panel took into account Ms Garrard's contemporaneous written statement; the witness statements of Ms Garrard and Ms Ruttle; and the destruction book page for 100mg Pregabalin.

The panel considered Ms Garrard's contemporaneous written statement, dated 2 April 2022, in relation to this charge. It noted the following *'I started to think how had she destroyed meds, I checked the file to find that my signature had been forged.'*

The panel considered that this was consistent with Ms Garrard's witness statement, where she stated:

> *'At around 6:00am I went to the treatment room and checked the destroyed book. I then saw that my signature was written for a destroyed tablet of 100 mg pregabalin. I did not sign the destroyed book at all.'*

The panel also took into account Ms Ruttle's witness statement. Although she was not a direct witness, she was the Nurse Manager at Eaton Court at the time. In her witness statement, the panel noted:

> *'At around 6 am RG became worried about the previous interaction with Ms. Huzzard and checked the destroyed book. There she realised that Ms. Huzzard had forged her signature in it, witnessing the destruction of a 100 mg pregabalin tablet.'*

In light of this, the panel found that, on the balance of probabilities, Ms Huzzard signed Ms Garrard's name in the destroyed book, indicating that she had witnessed the disposal of 100mg Pregabalin. Therefore, the panel found charge 2d proved.

Charge 2e

> *'That you, a registered nurse:*
>
> *2) On 1 April 2022 at Eaton Court Care Home:*
>
> *e) Signed as Colleague A [Ms Ruth Garrard] in the controlled drugs book indicating that they had witnessed the administration of 200mg of pregabalin.'*

This charge is found proved.

In reaching this decision, the panel took into account Ms Garrard's contemporaneous written statement; the witness statements of Ms Garrard and Ms Ruttle; and Resident G's controlled drug book for Pregabalin 200mg.

The panel considered Ms Garrard's contemporaneous written statement, dated 2 April 2022, in relation to this charge. It noted the following *'When I came to work 2/4/22 I noticed that the nurse had signed my signature on Pregabalin 200mg.'*

The panel considered that this was consistent with Ms Garrard's witness statement, where she stated:

> *'The next day when I returned to the care home I went to check the CD book. There I realised that the CD book that I had signed was the 100 mg pregabalin, not the 200 mg… Furthermore, I noticed that my signature was written on the 200 mg pregabalin page too. I did not sign the CD book twice. The signature on this page did not look like mine.'*

The panel also took into account Ms Ruttle's witness statement, who although was not a direct witness, was the Nurse Manager at the time. In her witness statement, the panel noted:

> *'At around 6 am RG became worried about the previous interaction with Ms. Huzzard and checked the destroyed book. There she realised that Ms. Huzzard had forged her signature in it, witnessing the destruction of a 100 mg pregabalin tablet. She then checked the pregabalin 200mg CD book page, and noticed that Ms. Huzzard had also forged her signature there as a witness to the administration of the medication.'*

In the circumstances, the panel found that, on the balance of probabilities, Ms Huzzard signed Ms Garrard's name in the controlled drugs book, indicating that she had witnessed the administration of 200mg of Pregabalin. Therefore, the panel found charge 2e proved.

Charge 3

> *'That you, a registered nurse:*
>
> *3) Your conduct in Charge 2d and/or 2e was dishonest in that you deliberately sought to represent that Colleague A [Ms Ruth Garrard] had*

witnessed you administer and/or dispose of medication when you knew they had not.'

This charge is found proved.

In reaching its decision on this charge, the panel referred to the NMC guidance titled *'Making decisions on dishonesty charges and the professional duty of candour'* (FtP-2a-iii, last updated 31 July 2026), as well as the test for dishonesty as outlined in *Ivey v Genting Casinos (UK) Ltd* [2017] UKSC, paragraph 74:

> *'When dishonesty is in question 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.'*

In considering this, the panel was of the view that, as a registered nurse for a period of 8 years, Ms Huzzard would have known that she must not sign a controlled drugs book using the name of another person who was required to witness the administration and disposal of a controlled drug. The panel further determined that Ms Huzzard should have known that her actions were wrong as she administered and disposed of a controlled drug without a witness in accordance with the Eaton Court's '*Medication Management Protocol*' and then signed Ms Garrard's name to indicate that Ms Garrard had witnessed those actions when she had not.

Having determined that Ms Huzzard would have known that her actions sought to conceal her wrongdoing, the panel was of the view that, by applying the standards of ordinary and decent people, her actions at charges 2d and 2e were dishonest.

Accordingly, the panel found that on the balance of probabilities, Ms Huzzard's actions at charges 2d and 2e were dishonest, in that she deliberately sought to represent that Ms Garrard had witnessed her administer and dispose of medication when she knew Ms Garrard had not. Therefore, the panel found charge 3 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 Ms Huzzard'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 safely and effectively without restriction.

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, Ms Huzzard's fitness to practise is currently impaired as a result of that misconduct.

Representations on misconduct and impairment

In its statement of case, in relation to its submissions on misconduct, the NMC referred the panel to the relevant case law, including *Roylance v General Medical Council* [1999] UKPC 16 and *Nandi v General Medical Council* [2004] EWHC 2317 (Admin).

The NMC invited the panel to take the view that the facts found proved amount to misconduct. The NMC referred the panel to the terms of '*The Code: Professional standards of practice and behaviour for nurses and midwives (2015)*' (the Code). It

identified the following specific and relevant standards where Ms Huzzard's actions breached the Code, namely:

> ***'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*
>
> ***6 Always practise in line with the best available evidence***
> ***To achieve this, you must:***
> *6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services*
> *6.2 maintain the knowledge and skills you need for safe and effective practice*
>
> ***8 Work co-operatively***
> ***To achieve this, you must:***
> *…*
> *8.2 maintain effective communication with colleagues*
> *…*
> *8.5 work with colleagues to preserve the safety of those receiving care*
> *8.6 share information to identify and reduce risk*
>
> ***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***
> ***To achieve this, you must****:*
> *…*
> *18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs*
> ***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'

The NMC submitted:

> *'Whilst not all breaches of the NMC Code will constitute serious professional misconduct it is submitted that the acts in this case do amount to such because Ms Huzzard committed dishonest behaviour (with reference to the dishonesty charges: 2d + 2e). Such acts were both clinical and attitudinal in nature as the dishonesty was directly linked to practice.*
>
> *In the NMC's submission Ms Huzzard's conduct fell far below the standards to be expected of a registered nurse and amounted to serious professional misconduct.'*

In its submissions on impairment, the NMC referred the panel to the relevant case law, including *Council for the Regulation of Health Care Professionals v GMC and Biswas* [2006] EWHC 464; *Meadow v General Medical Council* [2006] EWCA Civ 1390; *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin); and *R (on application of Cohen) v General Medical Council* [2008] EWHC 581 (Admin).

The NMC submitted that the questions set out by Dame Janet Smith in the fifth Shipman Report, as confirmed in the case of *Grant* [2011], are instructive in reaching a conclusion

on impairment. It submitted that all four questions can be answered in the affirmative. Setting them out specifically, in relation to question 1, the NMC submitted:

> *'Ms Huzzard's clinical skills and practice have been called into question regarding drug maladministration, and her dishonest conduct regarding signing as Colleague A is serious and created an unwarranted risk of harm to patients. Medication is prescribed by medical practitioners because it is necessary for the health, safety and wellbeing. If a Resident has not received prescribed medication or received the correct dose it has the potential to result in a deterioration of a health condition and cause discomfort or pain.'*

In relation to question 2, the NMC submitted:

> *'Such a finding is inescapable given all the circumstances of the case, the nature of the charges and the lack of remediation. The public, quite rightly, expects registrants to be individuals of unimpeachable probity and the NMC is tasked by statute to: (1) promote and maintain public confidence in the profession and (2) promote and maintain proper professional standards and conduct.'*

In relation to question 3, the NMC submitted:

> *'With reference to the Code, Ms Huzzard has clearly breached fundamental tenets of the nursing profession by failing to act with honesty and promote and maintain trust and professionalism. The breaches have not been remediated and accordingly the risk remains going forward.'*

In relation to question 4, the NMC submitted:

> *'Signing as Colleague A to say that drugs had been administered and destroyed are dishonest acts and Charges 2d + 2e are dishonesty charges. This misconduct is difficult to remediate and in the NMC's submission the risk of repetition remains live going forward.'*

The NMC went on to address the helpful considerations posed in *Cohen* [2008], which are as follows:

> *'1. Whether the concern is easily remediable;*
> *2. Whether it has in fact been remedied; and*
> *3. Whether it is highly unlikely to be repeated.'*

In relation to these questions, the NMC submitted:

> *'With regard to question 1, the misconduct in this case is not easily remediable because there are allegations involving dishonest conduct (charges 2d + 2e). NMC guidance sets out that there are a small number of concerns that are so serious that they may be less easy to put right: these include dishonesty.*
>
> *With regard to question 2, Ms Huzzard has admitted charges 1a + 1b, but her insight is not fully developed, and she has not demonstrated remediation, proper reflection, strengthened practice or learning arising out of this matter. Further, in respect of training, it is submitted that she has not undertaken relevant training in respect of the regulatory concerns involved in this case.*
>
> *With regard to question 3, the conduct is highly likely to be repeated. Despite Ms Huzzard's admissions to some of the charges, in circumstances where insight is not fully developed, and there is limited reflection and strengthening of practice/remediation, it is asserted that there is a risk that Ms Huzzard will repeat such behaviour in the future.*
>
> *It is noted that Ms Huzzard is not currently working as a registered nurse.*'

The NMC submitted *'that Ms Huzzard poses a continuing risk to the health, safety and wellbeing of the public because she has displayed no meaningful insight. This is because she has not demonstrated proper remediation, reflection, strengthened practice or learning arising out of this matter. Further, in respect of training, it is submitted that she has not*

undertaken relevant training in respect of the regulatory concerns involved in this case. Accordingly, she continues to pose a risk to the public.' Therefore, the NMC invited the panel to find Ms Huzzard impaired on the grounds of public protection.

In relation to impairment on the grounds of public interest, the NMC submitted:

> *'Consideration of the public interest therefore requires the Fitness to Practise Committee to decide whether a finding of impairment is needed to uphold proper professional standards and/or to maintain public confidence in the profession.*
>
> *In upholding proper professional standards and conduct and maintaining public confidence in the profession, the Fitness to Practise Committee will need to consider whether the concern is easy to put right. For example, it might be possible to address clinical errors with suitable training. A concern which hasn't been put right is likely to require a finding of impairment to uphold professional standards and maintain public confidence.*
>
> *However, there are types of concerns that are so serious that, even if the professional addresses the behaviour, a finding of impairment is required either to uphold proper professional standards and conduct or to maintain public confidence in the profession.*
>
> *We consider there is a public interest in a finding of impairment being made in this case to declare and uphold proper standards of conduct and behaviour. Ms Huzzard's conduct engages the public interest because her conduct, and its potential ramifications, was too serious to not be adjudicated on by a Panel.'*

In light of its submissions, the NMC invited the panel to find Ms Huzzard's fitness to practise impaired on the grounds of both public protection and public interest.

The panel accepted the advice of the legal assessor.

Decision and reasons on misconduct

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

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

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

*'**1 Treat people as individuals and uphold their dignity***
To achieve this, you must:

…

1.2 make sure you deliver the fundamentals of care effectively

6 Always practise in line with the best available evidence
To achieve this, you must:

…

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

8 Work co-operatively
To achieve this, you must:

…

8.5 work with colleagues to preserve the safety of those receiving care

10 Keep clear and accurate records relevant to your practice
This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
To achieve this, you must:

…

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

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
To achieve this, you must:

…

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

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
To achieve this, you must:

19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place

…

19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the

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'

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 Ms Huzzard's actions included errors in medication administration and record keeping, which are fundamental to nursing practice. Additionally, she worked in a care home, caring for vulnerable residents, and was

responsible for the safe administration of medication those residents relied on for their care. Furthermore, inaccurate recording of the administration of controlled drugs can give rise to the risk of serious harm.

The panel also considered that Ms Huzzard's conduct was dishonest. Ms Huzzard had forged Ms Garrard's signature to conceal the fact that she had administered and destroyed controlled drugs without a witness, which was not in line with Eaton Court's controlled drug policies. The panel considered that, although this took place during a single shift, it was nevertheless a deliberate and calculated action because she returned later in the shift to forge the signatures. She had also returned to ask Ms Garrard to sign the controlled drug book to say that Ms Garrard had witnessed the counting and administration of medication when she had not.

Accordingly, the panel found that Ms Huzzard's actions fell seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if, as a result of the misconduct, Ms Huzzard's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on *'Impairment'* (DMA-1, 28 January 2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

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 *Grant* [2011] 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 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.'*

In considering *'limb a'*, the panel determined that at the time of the incidents, Ms Huzzard put the residents in her care at risk of serious harm. The panel considered that Ms Huzzard's misconduct, in failing to administer the correct dosage of medication to Resident

A, put that resident at risk of harm because she failed to administer the correct dose of medication, which could have resulted in a deterioration of their health condition, causing discomfort or pain. In relation to the record-keeping errors, the panel was of the view that this could have put residents at risk of harm by confusing colleagues and leading to residents receiving more medication than they required. This could have resulted in serious harm, especially because some of the medications were controlled drugs.

The panel then considered *'limbs b and c'.* It was of the view that Ms Huzzard's misconduct had brought the nursing profession into disrepute, especially in light of her calculated dishonesty in forging Ms Garrard's signature, as well as her multiple record-keeping errors. The panel also found that Ms Huzzard had breached fundamental tenets of the nursing profession by failing to act with honesty and promote and maintain trust and professionalism.

In relation to *'limb d'*, the panel determined that Ms Huzzard's misconduct in forging Ms Garrard's signature to conceal the fact that she had administered and destroyed controlled drugs without a witness was dishonest. The panel was satisfied that confidence in the nursing profession would be undermined if its regulator did not find charges relating to dishonesty extremely serious.

Before considering whether Ms Huzzard is liable in the future for putting patients at an unwarranted risk of harm, bringing the profession into disrepute, breaching the fundamental tenets of the profession, or acting dishonestly, the panel considered the factors set out in *Cohen* [2008].

The panel first considered whether the concern could be addressed, taking into account the NMC guidance titled *'Can the concern be addressed?'* (FTP-16a, last updated 27 February 2024). In particular, the panel noted:

> *'Examples of conduct which may not be possible to address, and where steps such as training courses or supervision at work are unlikely to address the concerns include:*
>
> - *…*

- *dishonesty, particularly if it was serious and sustained over a period of time, or is directly linked to the nurse, midwife or nursing associate's professional practice*
- *…'*

The panel considered that although Ms Huzzard's misconduct occurred during a single shift, in the panel's view, it was calculated and indicative of an underlying attitudinal issue, arising from her disregard for the safety of the patients in her care. Furthermore, her misconduct was dishonest and directly linked to her professional practice. In light of this, the panel determined that Ms Huzzard's misconduct is not easily remediable.

The panel next considered the NMC guidance titled *'Has the concern been addressed?'* (FTP-16b, last updated 25 March 2026). It first considered Ms Huzzard's insight. The panel noted that Ms Huzzard provided a reflective account following the incidents at Holly Tree on 23 March 2022. However, the panel was of the view that in this reflection, Ms Huzzard apportioned blame to the activity around her and did not take accountability for her actions. It also noted that Ms Huzzard has not provided anything further to this reflection, other than stating that she does not wish to continue practising as a nurse and would not engage with the NMC. In light of this, the panel determined that Ms Huzzard has minimal insight.

The panel went on to consider whether Ms Huzzard has taken steps to strengthen her practice. However, in light of her lack of engagement, the panel was unable to identify anything to demonstrate this. Accordingly, the panel found no evidence to indicate that Ms Huzzard has remediated her misconduct.

Having found that Ms Huzzard has minimal insight and has not remediated or strengthened her practice, the panel returned to the test set out by Dame Janet Smith. The panel determined that, in light of Ms Huzzard's minimal insight, lack of remediation and lack of strengthened practice, she would be liable in the future to put patients at unwarranted risk of harm, bring the nursing profession into disrepute, breach fundamental tenets of the nursing profession, and act dishonestly.

The panel then considered the NMC guidance, titled *'Is it highly unlikely that the conduct will be repeated?'* (FTP-16c, last updated 14 April 2021). The panel was of the view that, in light of Ms Huzzard's minimal insight, lack of remediation and lack of strengthened practice, there is a risk of repetition.

In all the circumstances, the panel determined that a finding of impairment is necessary on the grounds of public protection.

The panel took into account the overarching objectives of the NMC: to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on the grounds of public interest is required because Ms Huzzard's misconduct involved dishonesty, medication administration failures and inaccurate record keeping of medication, including controlled drugs. It considered that her misconduct was a serious departure from the standards expected of a registered nurse and that a finding of impairment was necessary to uphold proper professional standards and maintain public confidence in the profession. In addition, the panel concluded that public confidence in the nursing profession would be undermined if a finding of impairment were not made in this case and therefore also found Ms Huzzard's fitness to practise impaired on the grounds of public interest.

Having regard to all of the above, the panel was satisfied that Ms Huzzard'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 Ms Huzzard off the register. The effect of this order is that the NMC register will show that Ms Huzzard 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 regard to the NMC guidance titled *'The sanctions available'* (SAN-2, last updated 28 January 2026).

The panel accepted the advice of the legal assessor.

Representations on sanction

In its statement of case, the NMC invited the panel to consider the NMC guidance on sanctions. The NMC submitted that the aggravating and mitigating factors are as follows:

> ***'Aggravating factors***
> *1. Attitudinal issues and dishonesty.*
> *2. Lack of insight and remediation.*
> *3. Deliberate breaches of the Code*
> *4. Premeditated*
> *5. Breach of trust*
> *6. Failure to engage in the Fitness to Practise (FtP) process, without good reason*
>
> ***Mitigating factors***
> *1. No patient harm crystalised*
> *2. No prior regulatory history*
> *3. Admitted to charges 1a + 1b.'*

The NMC then addressed what sanction would be appropriate in the context of the facts. It submitted:

> *'Taking no further action would evidently be inappropriate in this case given the gravity of the misconduct. There are dishonesty allegations. There is a real risk of repetition of the issues which means that more must be done by way of sanction to protect the public from harm and to maintain public confidence in the profession. The same arguments are applicable in respect of a caution.*

With regard to a Conditions of Practice Order, this would not appropriately address the public protection and public interest concerns in this case because there are no workable conditions that can be formulated to address the attitudinal issues in this case. Further, a Conditions of Practice Order would not be appropriate as Ms Huzzard has disengaged from the NMC and says she no longer wishes to practice as a nurse.

With regard to a suspension order, the NMC would invite the panel to conclude that a suspension order is not the appropriate sanction in this case either, for the following reasons:

b) The concerns in this case are serious and highlight a deep-seated attitudinal issue. Dishonesty is difficult to remediate and constitutes a serious attitudinal failing.
c) The dishonesty was not an isolated one-off event.
d) Ms Huzzard has limited insight into her conduct and she has not remediated the concerns. As such, there remains a significant risk of repetition and as such, a risk to patients.
e) The charges found proved are at the most serious end of the spectrum and call into question Ms Huzzard's suitability to continue practising.
f) Ms Huzzard has not engaged with the NMC.'

In considering a striking-off order, the NMC referred the panel to the NMC guidance, titled *'Striking-off order'* (SAN-2e, last updated 28 January 2026). It submitted that the answers to the key considerations are as follows:

'(1) Do the charges found proved raise fundamental questions about their professionalism? In the NMC's submission the answer is: ***yes.***
(2) Can public confidence in the profession be maintained if the professional is not removed from the Register? In the NMC's submission the answer is: ***no.***

(3) Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards? In the NMC's submission the answer is: ***Yes, but Ms Huzzard has made it clear that she will not engage or offer any insight into the concerns.***
(4) Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced? In the NMC's submission the answer is: ***No. Ms Huzzard has stated that she no longer wants to be a nurse.****'*

The NMC also referred the panel to the NMC guidance titled *'Sanctions for the highest risk cases'* (SAN-4, last updated 31 July 2026), and referred it to the specific section:

'Honesty is of central importance to a professional's practice because of the large degree of trust placed in them. Therefore, allegations of dishonesty will almost always put the public at risk of the professional not being trustworthy; because of this a professional who has acted dishonestly will always be at risk of strike-off.'

The NMC submitted:

'The guidance lists premeditated, systematic or longstanding deception as forms of dishonesty which are most likely to call into question whether a nurse, midwife or nursing associate should be allowed to remain on the register.

Ms Huzzard's lack of insight, her forging of a colleague's signature to conceal the fact that the administration and destruction of medication was not witnessed, and the underlying attitudinal concerns mean that a striking-off order is the most appropriate and proportionate sanction.

It is the NMC's submission, that Ms Huzzard's dishonesty is serious enough to justify removal from the register. In considering proportionality and in balancing the public interest and need for protection of the public against

Ms Huzzard's own interests, the NMC would submit that the most appropriate and proportionate sanction in all the circumstances of the case is a striking off order.'

Decision and reasons on sanction

Having found Ms Huzzard's fitness to practise currently impaired, the panel went on to consider 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 decision on sanction is a matter for the panel independently exercising its own judgment. The panel had regard to SAN-2.

The panel took into account the following aggravating features:

- An abuse of a position of trust;
- Conduct which deliberately or recklessly puts people receiving care at risk of suffering harm;
- Deliberate breaches of the Code;
- Repetition of dishonesty;
- Minimal insight;
- Vulnerability of residents in the care home;
- Element of premeditation in her dishonesty; and
- Failure to attend hearings, or to engage in the Fitness to Practise (FtP) process, without good reason.

The panel also took into account the following mitigating features:

- No direct harm caused to the residents; and
- A limited reflective account for one of 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.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (SAN-2b, last updated 28 January 2026) in which the following is stated:

'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'

The panel considered that Ms Huzzard's misconduct was not at the lower end of the spectrum, and it found that there is a risk to patient and public safety. The panel therefore determined that a sanction that does not restrict Ms Huzzard's practice would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a conditions of practice on Ms Huzzard's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on *'Conditions of practice order'* (SAN-2c, last updated 28 January 2026). Having regard to the nature and seriousness of Ms Huzzard's conduct, the panel determined that a conditions of practice order would not be appropriate in the circumstances. Furthermore, having found that Ms Huzzard's misconduct involves dishonesty, which it found to be calculated and indicative of an underlying attitudinal issue, the panel considered that there are no relevant, proportionate, workable or measurable conditions that could be formulated to protect patients and to uphold professional standards.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (SAN-2d, last updated 28 January 2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*
- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to weigh up before imposing a suspension. It noted the following list of circumstances that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could be managed by Ms Huzzard being temporarily removed from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness and nature of the facts found proved. Given Ms Huzzard's lack of engagement, minimal insight, and no evidence of strengthened practice or remorse, the panel considered that there is no realistic possibility that Ms Huzzard could address the concerns to a level sufficient to return to practice safely.

The panel had regard to SAN-4, specifically the section titled *'Cases involving dishonesty'*. The panel noted:

'Generally, the forms of dishonesty which are most likely to require consideration of striking-off will involve (but are not limited to):

- *deliberately breaching the professional duty of candour by covering up when things have gone wrong, especially if this could cause harm to people receiving care*
- *misuse of power*
- *personal or financial gain from a breach of trust*
- *direct risk to people receiving care*
- *premeditated, systematic or longstanding deception.'*

The panel was of the view that Ms Huzzard's dishonesty was premeditated, in that it was deliberate and calculated because she returned later in the shift to forge the signatures. She had also returned to ask Ms Garrard to sign the controlled drug book to say that Ms Garrard had witnessed the counting and administration of medication when she had not. Furthermore, the purpose of her dishonesty was to conceal the fact that she had administered and destroyed controlled drugs without a witness. Having regard to all of the above, the panel determined that this case falls within the definition of being a '*highest risk case'*.

In this particular case, the panel determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.
The panel considered a striking-off order, and had regard to the following considerations as set out in SAN-2e:

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*
- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel found that the charges found proved raise fundamental questions about Ms Huzzard's professionalism and that her actions were significant departures from the standards expected of a registered nurse, and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Huzzard's actions were serious and that to allow her to continue practising would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and taking into account all the evidence before it, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the matters it identified, in particular the effect of Ms Huzzard's actions in bringing the profession into disrepute by adversely affecting the public's view of how a registered nurse should conduct herself, the panel has concluded that nothing short of this would be sufficient in this case.

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 Ms Huzzard in writing.

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 in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Huzzard's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Representations on interim order

The panel took into account the representations made by the NMC, namely:

'A substantive order made will not come into effect until 28 days after receipt of the decision letter by Ms Huzzard. If an appeal is lodged within the period allowed, the order will not take effect, pending the appeal outcome which could take up to 18 months. It must therefore be considered whether an interim order is necessary to cover the period of time before the substantive order takes effect. It should be noted that if an interim order is not imposed Ms Huzzard would be at liberty to practise without restriction until the time allowed to appeal has expired or until any appeal lodged had been determined.

The NMC therefore applies for an interim suspension order for a period of 18 months on the grounds that it is necessary to protect the public and the wider public interest pending any appeal that may be made in respect of the striking off order. If no appeal is made, then the interim suspension order would automatically fall away and be replaced by the striking off order 28 days after Ms Huzzard is sent the decision of this hearing in writing.'

Decision and reasons on interim order

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

The panel concluded that an interim conditions of practice order would not be appropriate or proportionate in this case, for the reasons already identified in the panel's determination to impose the substantive order. The panel therefore imposed an interim suspension order for 18 months to protect the public and the wider public interest, should Ms Huzzard make an appeal during the 28 days it takes for the striking-off order to come into effect.

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

That concludes this determination.