Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Order Review Hearing
Wednesday, 27 May 2026

Virtual Hearing

Name of Registrant:	**Maureen Di Centa**
NMC PIN:	08Y0036E
Part(s) of the register:	Registered Nurse – Adult RNA – 07 July 2009
Relevant Location:	Lincolnshire
Type of case:	Misconduct
Panel members:	Anne Ng (Chair, Lay member) Claire Martin (Registrant member) Nicola Bryar (Lay member)
Legal Assessor:	Alain Gogarty
Hearings Coordinator:	Ifeoma Okere
Nursing and Midwifery Council:	Represented by Matthew Kewley, Case Presenter
Mrs Di Centa:	Not Present and not represented
Order being reviewed:	Conditions of practice order (12 months)
Fitness to practise:	Impaired
Outcome:	**Conditions of practice order (18 months) to come into effect at the end of 2 June 2026 in accordance with Article 30 (1)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Mrs Di Centa was not in attendance and that the Notice of Hearing had been sent to Mrs Di Centa's registered email address by secure email on 14 May 2026.

Further, the panel noted that the Notice of Hearing was also sent to Mrs Di Centa's former representative, Mr Simon Holborn, on 14 May 2026.

Mr Kewley, 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').

Mr Kewley submitted that the issue of service in this case was more complex than usual because the substantive order review had originally been listed for 12 May 2026, for which proper notice had been served in accordance with the Rules. However, that hearing did not commence due to lack of time. The NMC contacted Mrs Di Centa on 13 May 2026, to advise that the hearing had not gone ahead and to enquire whether she would waive the 28-day notice period to facilitate an earlier relisting.

Mr Kewley submitted that, whilst Mrs Di Centa had not expressly waived the notice period, the NMC could never have complied with the full 28-day requirement because the order was due to expire on 2 June 2026. He submitted that the Rules did not expressly prohibit a shorter notice period in exceptional circumstances such as these. Mr Kewley referred the panel to the case of *R (Hill) v Institute of Chartered Accountants of England and Wales* [2013] EWCA CIV 555.

Mr Kewley further submitted that there was no prejudice to Mrs Di Centa because she had already received proper notice for the original hearing on 12 May 2026 and had, in effect, been given additional time following the adjourned listing. He submitted that Mrs Di Centa had indicated via email that she no longer wished to engage with the NMC and there was no evidence that she intended to participate in the hearing in any event.

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the substantive order being reviewed, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Mrs Di Centa's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

The panel considered the chronology carefully. It noted that Mrs Di Centa had originally been given proper notice of the hearing listed for 12 May 2026. The panel further noted that she had subsequently been informed that the hearing had not proceeded and that it would be relisted. The panel also noted that Mrs Di Centa had continued to correspond with the NMC up until 13 May 2026, and was therefore aware that the review hearing remained outstanding and would proceed on a new date; 27 May 2026.

The panel accepted Mr Kewley's submission that the NMC could not practically provide a further 28-day notice period before the expiry of the substantive order. The panel considered that this situation had arisen through exceptional circumstances and not through any inefficiency or fault on the part of the NMC. The panel also considered that Mrs Di Centa would suffer no unfair prejudice by the hearing proceeding today, given that she had already been notified of the earlier hearing date, and had made it clear in correspondence that she did not intend to engage further with the NMC process.

In the light of all of the information available, the panel was satisfied that Mrs Di Centa had sufficient notice of the hearing.

Decision and reasons on proceeding in the absence of Mrs Di Centa

The panel next considered whether it should proceed in the absence of Mrs Di Centa, pursuant to Rule 21 of the Rules.

Mr Kewley referred the panel to the email sent by Mrs Di Centa to the NMC, dated 13 May 2026, which she stated:

‘I have stressed many times that I don’t wish to nurse again and will not engage with the NMC’

Mr Kewley submitted that Mrs Di Centa’s absence was voluntary. He submitted that there was no evidence to suggest that her absence was due to ill health, technical difficulties or any misunderstanding regarding the hearing date. He submitted that Mrs Di Centa had made clear in correspondence dated 13 May 2026 that she did not wish to engage further with the NMC.

Mr Kewley further submitted that there had been no request for an adjournment and no indication that Mrs Di Centa would attend any future hearing if this matter were adjourned. He submitted that Mrs Di Centa had had the full duration of the order to prepare reflective material, testimonials or any other evidence she wished the panel to consider but had chosen not to do so. He also submitted that there was a strong public interest in the expeditious disposal of this mandatory review hearing before expiry of the current order on 2 June 2026.

The panel accepted the advice of the legal assessor.

The panel determined to proceed in the absence of Mrs Di Centa. In reaching this decision, the panel considered the submissions of Mr Kewley, the advice of the legal assessor and all the information before it.

The panel noted that Mrs Di Centa had stated in correspondence sent to the NMC on 13 May 2026:

‘I have stressed many times that I don’t wish to nurse again and will not engage with the NMC.’

The panel determined that Mrs Di Centa had voluntarily absented herself from these proceedings. In reaching this decision, the panel noted that:

- Mrs Di Centa had clearly indicated that she no longer wished to engage with the NMC process;
- Mrs Di Centa had not applied for an adjournment;

- There was no indication that adjourning today’s hearing would secure her attendance at a future date; and
- There was a strong public interest in the timely review of the substantive order before its expiry on 2 June 2026, particularly given that the original findings related to public protection concerns.

The panel therefore determined that it was fair, proportionate and in the interests of justice to proceed in the absence of Mrs Di Centa.

Decision and reasons on review of the substantive order

The panel decided to extend the current conditions of practice order for a period of 18 months.

This order will come into effect at the end of 2 June 2026 in accordance with Article 30(1) of the Nursing and Midwifery Order 2001 (“the Order”).

This is the second review of a substantive conditions of practice order originally imposed by a Fitness to Practise Committee panel on 1 May 2025 for a period of 12 months. The order was reviewed early on 12 June 2025, at the request of Mrs Di Centa. At that review, the panel varied condition 5 of the order but otherwise confirmed the existing conditions of practice order.

The current order is due to expire at the end of 2 June 2026. The panel is reviewing the order pursuant to Article 30(1) of the Order.

The charges found proved which resulted in the imposition of the substantive order were as follows:

‘That you, a registered nurse:

1) *In respect of Patient B:*
    a) *On 24 March 2020 failed to,*
        i. *Order medication in timely manner*
        ii. *Ensure that a depot injection was administered.*

b) In April 2020 failed to record whether you had administered a depot injection

c) On 16 June 2020 failed to,

i. Order medication in a timely manner

ii. Ensure that a depot injection was administered

d) Failed to escalate the medication errors in respect of failing to administer the depot injections on:

i. 24 March 2020

ii. 16 June 2020

e) …

f) …

2) In respect of Patient A, in July 2020, failed to escalate a 6-kilogram weight loss from the previous month to a dietician.

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

The last reviewing panel determined the following with regard to impairment:

'[...] The panel noted that, over the intervening six weeks, you have not produced any further evidence to support developed insight or strengthened practice. The panel noted that the recommendations made in the original substantive determination included evidence that would be helpful to a reviewing panel. However, no evidence was provided.

The panel understood that it is your view that not only are you currently not impaired, but you also disagree with the findings of the previous panel. Despite these views, you could have provided a more in-depth reflection demonstrating greater insight into the findings. The panel heard that you have not been able to work over the past six weeks due to the nature of the conditions, but this would not have prevented you from providing an updated reflection. The panel decided that

you continue to provide limited evidence of insight and to deflect your roles and responsibilities onto failures of systems and processes.

> *[…]*

The panel noted that, although you did give some consideration to the impact of your failings on patients, concerns from the previous panel remain, particularly regarding your deflection from your role and responsibilities. This included blaming systems and failing to consider the impact of your failings on the risk of harm to patients, in particular the comments you made:

> *"I recognise that a missed depot injection for the resident in question could have led to seizures and blood loss, resulting in hospitalisation. It is important to note that this did not occur.'*
>
> *'Upon reflection if this event was to happen again, I would take it upon myself to detail in patient notes and the diary so this could be followed up as a failure in the system allowed this to go unnoticed.*
> *Due to a failure in the reporting system this was not identified at any level.*
>
> *'I have learnt that policies and procedures may not be as rigorous as intended leading results open to interpretation and not factual.''*

The panel noted that, at the time of the incidents that led to the facts found proved, you were the manager of the Pilgrim unit, with responsibilities for overseeing safe care to meet residents' needs. To date, the panel has not seen a reflection indicating your learning in respect of your failings and your leadership role. The panel therefore decided that a finding of continuing impairment is necessary on the grounds of public protection.

The panel has borne in mind that its primary function is to protect patients and the wider public interest which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel determined that, in this case, a finding of continuing impairment on public interest

grounds is also required given your failure to take responsibility in your leadership role.

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

The last reviewing panel determined the following with regard to sanction:

'The panel next considered whether imposing a further condition of practice order on your registration would still be a sufficient and appropriate response. The panel is mindful that any conditions imposed must be proportionate, measurable and workable.

The panel determined that it would be possible to formulate appropriate and practical conditions which would address the failings highlighted in this case. The panel was of the view that a condition of practice order is sufficient to protect patients and the wider public interest. In this case, there are conditions that could be formulated which would protect patients and uphold public confidence during the period they are in force.

The panel did not accept the application to vary Conditions 2 and 3. The panel noted that these failings took place while you were the nurse in charge. It considered that the suggestions put forward for supervision in your current role are very limited and not sufficiently robust. The panel heard from [Anthony Wolke], the deputy manager, who is a registered nurse working weekdays, is not always on site. The panel also noted the discussion about the support that may be available from the hospital service on the floor below but was informed of the hospital's complex nature and that the nursing staff would not be able to provide supervision or attend swiftly in the event of an emergency. Additionally, the panel observed that the hospital is a separate independent service, with your work being on the floor above.

In reaching its decision, the panel considered the previous panel's view, which states:

> *"The panel recognised that the conditions formulated are comprehensive and that you may need to change roles to fulfil them. However, it considered that the conditions were necessary to protect the public and that they were proportionate, as they would allow you to continue to practise as a registered nurse."*

The panel has however, decided to vary Condition 5 to include "… and to review a selection of your patient case notes. The frequency of meeting can be reduced at your manager's discretion."

The panel was of the view that to impose a suspension order or a striking-off order would be wholly disproportionate and would not be a reasonable response in the circumstances.'

Decision and reasons on current impairment

The panel has considered whether Mrs Di Centa's fitness to practise remains impaired. Whilst there is no statutory definition of fitness to practise, the NMC has defined fitness to practise as the ability of a professional on our register to practise as a nurse, midwife or nursing associate safely and effectively without restriction. In considering this case, the panel has carried out a comprehensive review of the order in light of the current circumstances. Whilst it has noted the decision of the last panel, this panel has exercised its own judgement as to current impairment.

The panel has had regard to all of the documentation before it as well as submissions made by Mr Kewley.

Mr Kewley reminded the panel that the original panel had found the concerns proved in relation to two vulnerable patients. The concerns included failures to order medication in a timely manner, failures to ensure medication was administered appropriately, failures to escalate medication concerns and failures to escalate significant weight loss in a patient. He submitted that the original panel had found that Mrs Di Centa demonstrated limited insight, and had a tendency to deflect responsibility onto systems and processes, rather than accept personal accountability.

Mr Kewley submitted that the first reviewing panel had reiterated those concerns and had also found that Mrs Di Centa had not produced any meaningful evidence of strengthened practice or further insight. He submitted that there had been no material change since the previous review and that Mrs Di Centa had not provided any reflective material, testimonials, evidence of training or evidence of remediation. He submitted that the persuasive burden on the registrant to demonstrate remediation and strengthened practice had not been discharged. He therefore submitted that the risk of repetition remained and that Mrs Di Centa's fitness to practise remained impaired on both public protection and public interest grounds.

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

In reaching its decision, the panel was mindful of the need to protect the public, maintain public confidence in the profession and to declare and uphold proper standards of conduct and performance.

The panel noted that the last reviewing panel found that Mrs Di Centa had limited insight and continued to deflect responsibility onto the systems and processes within which she was working. The last reviewing panel also determined that Mrs Di Centa had failed to adequately consider the impact of her failings and the associated risk of harm to vulnerable patients.

Today's panel received no further information from Mrs Di Centa demonstrating that her insight has developed. The panel had sight of the email correspondence between the NMC and Mrs Di Centa dated 13 May 2026, in which she stated that she '*will not engage with the NMC'* and no longer wished to continue nursing. The panel also had sight of an email from Mrs Di Centa dated 5 May 2026 in which she stated:

> *'I thought I made it clear that I shall not engage further with the NMC. […] I no longer will work as a nurse, I don't wish to put myself in a position of vexatious lies because I acted in the best interest of a patient and Hannah Blundell did not like it. The NMC chose to believe her lies on the balance of probability despite my evidence of the contrary.'*

The panel considered that these emails demonstrated that Mrs Di Centa continued to deny the findings against her, and continued to attribute blame to others rather than accepting responsibility for her actions. The panel determined that there remained a lack of meaningful insight into the concerns identified by the substantive panel. The panel noted that there was no reflective piece, no evidence of remediation, no testimonials and no evidence of any relevant training before it.

The panel further considered that there was no evidence before it demonstrating that Mrs Di Centa had taken steps to strengthen her practice. The panel noted that Mrs Di Centa stated that she no longer wished to continue nursing and there was no evidence that she had practised as a registered nurse since the substantive order was imposed. Accordingly, there was no evidence before the panel of a sustained period of safe practice, remediation, or evidence that she had maintained or updated her professional knowledge and skills.

The panel recalled that the original concerns involved failures to appropriately manage medication and failures to escalate significant weight loss in a vulnerable patient. The panel considered that these were serious concerns involving patient safety and risk of harm. The panel also noted the previous panel's findings that Mrs Di Centa had demonstrated a tendency to deflect responsibility onto systems and processes rather than accept personal accountability.

The panel considered that there remained a real risk of repetition because Mrs Di Centa had not demonstrated insight, had not strengthened her practice and continued to deny the findings against her. The panel reminded itself that the persuasive burden rested on Mrs Di Centa to demonstrate that her fitness to practise was no longer impaired. In the absence of any evidence of remediation or strengthened practice, the panel determined that Mrs Di Centa remained liable to repeat matters of the kind found proved.

The panel considered that members of the public would expect a nurse, particularly one in a managerial and leadership role, to recognise and address serious clinical failings involving vulnerable patients. The panel considered that Mrs Di Centa's continued lack of insight and failure to remediate meant that unrestricted practice could place patients at risk of harm.

Accordingly, the panel determined that a finding of current impairment remained necessary on public protection grounds.

The panel then considered the wider public interest. It bore in mind that its primary function is to protect patients and the wider public interest, which includes maintaining confidence in the nursing profession and upholding proper standards of conduct and performance. The panel considered that public confidence in the profession would be undermined if a finding of impairment were not made in circumstances where there remained a risk of repetition, an absence of remediation and a continuing failure to accept responsibility for serious failings involving vulnerable patients.

The panel also considered that fellow practitioners and the wider public would expect a nurse subject to a condition of practice order to engage with the regulatory process, demonstrate reflection and work towards remediation. The panel considered that members of the public would expect a nurse, particularly one in a managerial and leadership role, to recognise and address serious clinical failings involving vulnerable patients. The panel noted that Mrs Di Centa had not demonstrated any willingness to engage with the conditions imposed or to use the regulatory process as an opportunity to strengthen her practice.

Accordingly, the panel determined that a finding of a current impairment was also necessary on public interest grounds in order to maintain public confidence in the profession and uphold proper professional standards.

For these reasons, the panel finds that Mrs Di Centa's fitness to practise remains impaired.

Decision and reasons on sanction

Having found Mrs Di Centa's fitness to practise currently impaired, the panel then considered what, if any, sanction it should impose in this case. The panel noted that its powers are set out in Article 30 of the Order. The panel has also taken into account the 'NMC's Sanctions Guidance' (SG) and has borne in mind that the purpose of a sanction is not to be punitive, though any sanction imposed may have a punitive effect.

In reaching its decision, the panel had sight of the NMC Guidance, '*Removal from the register when there is a substantive order in place'* (Rev-2h), which stated:

> *'There is a persuasive burden on the professional at a substantive order review to demonstrate that they have fully acknowledged why past professional performance was deficient and through insight, application, education, supervision or other achievement sufficiently addressed the past impairments.*
>
> *While Suspension Orders and Conditions of Practice Orders can be varied or extended, they are not intended to exist indefinitely. In time the professional must be allowed to practise without restriction, or they must leave the register. It is neither in the interests of the public nor the professional's own interests that they are kept in limbo.*
>
> *Professionals who are not subject to fitness to practise proceedings have to revalidate every three years to stay on the register. In many cases it will be more appropriate for a professional to leave the register if they have been on a substantive order for this period of time and remain impaired.'*

The guidance further states, on determining whether to allow an order to lapse with a finding of impairment, or to impose a striking off order:

> *'Cases where **striking off** is likely to be appropriate include when:*
> - *the professional has shown limited engagement and/or insight,*
> - *the professional has breached a substantive order; or*
> - *the professional has otherwise made no or negligible progress towards addressing issues with their fitness to practise.*
>
> *Striking off will **not** usually be an appropriate outcome where:*
> - *the professional has engaged with the fitness to practise process; **and***
> - *the concerns relate solely to matters involving health or English language skills*
>
> *Our guidance on conditions of practice orders sets out that a nurse, midwife or nursing associate must comply with the conditions of a conditions of practice order. A*

deliberate failure to comply with a condition of practice order could be proper grounds for making a striking off order.' (emphasis as quoted)

The panel considered the above guidance. It determined that it would not be appropriate to allow the current conditions of practice order to lapse with a finding of impairment, given Mrs Di Centa's current non-engagement with this review, and that this case relates to misconduct, as opposed to health or a lack of knowledge of English.

Bearing the above in mind, the panel then considered what sanction, if any, to impose.

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 determined that it would be neither proportionate nor in the public interest to allow the order to lapse or take no further action given the continuing public protection concerns identified.

The panel next considered the imposition of a caution order. However, the panel determined that, due to the seriousness of the misconduct and the continuing risk of repetition identified, an order which did not restrict Mrs Di Centa's practice would be insufficient to protect the public or maintain confidence in the profession. The panel considered that the misconduct was not at the lower end of the spectrum and therefore a caution order would be inappropriate.

The panel then considered whether further conditions of practice order would remain appropriate and workable. The panel reminded itself that any conditions imposed must be proportionate, measurable, workable and capable of protecting the public.

The panel acknowledged that Mrs Di Centa had experienced difficulties complying with the current conditions, particularly those requiring indirect supervision and preventing her from acting as a unit manager or nurse in charge. The panel considered the information before it regarding Mrs Di Centa's previous role and accepted that the structure of her employment setting may have made compliance with those conditions difficult.

The panel noted that Mrs Di Centa had attempted to seek an alternative position with her then current employer where the conditions could be complied with. However, this was not possible with this employer. The panel has no evidence that she sought employment with an alternative employer.

The panel considered that the concerns in this case related to clinical failings, poor judgement and failures in leadership rather than deep-seated attitudinal problems, dishonesty or general incompetence. The panel also noted that the original substantive panel had determined that the concerns were capable of remediation. The panel was of the view that appropriate and workable conditions could continue to address the concerns identified whilst protecting patients and the wider public interest.

The panel considered whether a suspension order would be more appropriate, particularly in light of the NMC's submission that a short period of suspension could be imposed to encourage Mrs Di Centa to reflect and re-engage with the regulatory process. The panel noted the concerns regarding Mrs Di Centa's disengagement and her stated intention not to continue nursing. The panel also noted that a more severe sanction may be imposed if there continued to be no engagement and remediation.

However, the panel determined that a suspension order would not be constructive or proportionate at this stage. The panel considered that suspension would not provide Mrs Di Centa with any meaningful opportunity to demonstrate strengthened practice or remediation. The panel also considered that there remained a possibility that Mrs Di Centa could still remediate the concerns and safely return to nursing practice in an appropriately supervised setting.

The panel also considered whether a striking-off order would be appropriate. Whilst the panel acknowledged Mrs Di Centa's continued lack of engagement and absence of remediation, it concluded that striking off would be disproportionate at this stage. The panel took into account that Mrs Di Centa had been a nurse for a long period of time and that there remained no evidence of deep-seated attitudinal concerns fundamentally incompatible with remaining on the register.

The panel also considered that Mrs Di Centa appeared angry and frustrated with the regulatory process and may not have fully appreciated the consequences of continued non-engagement. The panel therefore considered it fair and proportionate to afford her one further opportunity to engage with the conditions of practice process and demonstrate insight, remediation and strengthened practice.

The panel concluded that a further condition of practice order would provide adequate protection to the public whilst also giving Mrs Di Centa a final opportunity to remediate her

practice. The panel was satisfied that the existing conditions remained appropriate, workable and proportionate.

The panel therefore determined, pursuant to Article 30(1)(a) of the Order, to extend the current conditions of practice order for a period of 18 months. The panel considered that this period would provide Mrs Di Centa with sufficient time to obtain suitable employment in a setting where she could comply with the conditions, demonstrate strengthened practice and develop insight into the concerns identified.

The panel also wished to make clear that a future reviewing panel may take a significantly less lenient view if Mrs Di Centa continues not to engage with the NMC process or fails to demonstrate meaningful remediation and progress. The panel considered that continued non-engagement and failure to remediate could ultimately place Mrs Di Centa at risk of removal from the register.

Accordingly, the panel determined, pursuant to Article 30(1)(a) to extend the conditions of practice order for a period of 18 months, which will come into effect on the expiry of the current order, namely at the end of 2 June 2026. It decided to impose the following conditions which it considered are appropriate and proportionate in this case:

> ‘For the purposes of these conditions, ‘employment’ and ‘work’ mean any paid or unpaid post in a nursing, midwifery or nursing associate role. Also, ‘course of study’ and ‘course’ mean any course of educational study connected to nursing, midwifery or nursing associates.

1. You must not work for more than one substantive employer or agency at any time, to ensure adequate supervision and oversight.

2. You must not work as a unit manager or nurse in charge of a shift.

3. You must only work in a setting where you are indirectly supervised by a registered nurse senior to yourself, who is physically present on the same shift.

4. You must develop a Personal Development Plan (PDP) with your line manager or supervisor to address the concerns raised in this case. The PDP must include:
   - Medication ordering, administration, and associated record-keeping;
   - Identification and escalation of clinical concerns, including medication errors, and associated record-keeping;
   - Adherence to and implementation of organisational policies and procedures.

5. You must meet weekly with your line manager or supervisor to discuss progress on the PDP and to review a selection of your patient case notes. The frequency of meeting can be reduced at your manager's discretion.

6. You must provide your NMC case officer with a copy of the updated PDP showing your progress and evidence of your compliance with it every three months.

7. You must undertake and successfully complete an accredited assessed and preferably face to face course in:
   - Safe ordering and administration of medication;
   - Record-keeping/Documentation.

8. You must provide your NMC case officer with copies of the content and outcome of any of the courses you have undertaken in Condition 7.

9. You must maintain a reflective log with entries at least fortnightly, setting out:
   - Specific incidents where you have escalated clinical concerns in line with policy;
   - What action you took;

- What you learned;
- How your practice has changed as a result.

Each entry must be signed by your line manager or supervisor, who must provide comments on your understanding and application of the relevant policy and procedure,

10. You must provide your NMC case officer with a copy of the reflective log and a signed supervisory report every three months.

11. You must keep the NMC informed about anywhere you are working by:
    a) Telling your case officer within seven days of accepting or leaving any employment.
    b) Giving your case officer your employer's contact details.

12. You must keep the NMC informed about anywhere you are studying by:
    a) Telling your case officer within seven days of accepting any course of study.
    b) Giving your case officer the name and contact details of the organisation offering that course of study.

13. You must immediately give a copy of these conditions to:
    a) Any organisation or person you work for.
    b) Any employers you apply to for work (at the time of application).
    c) Any establishment you apply to (at the time of application), or with which you are already enrolled, for a course of study.

14. You must tell your case officer, within seven days of your becoming aware of:

a) Any clinical incident you are involved in.
b) Any investigation started against you.
c) Any disciplinary proceedings taken against you.

15. You must allow your case officer to share, as necessary, details about your performance, your compliance with and / or progress under these conditions with:

    a) Any current or future employer.
    b) Any educational establishment.
    c) Any other person(s) involved in your retraining and/or supervision required by these conditions

The period of this order is for 18 months.

This conditions of practice order will take effect upon the expiry of the current conditions of practice order, namely at the end of 2 June 2026 in accordance with Article 30(1) of the Order.

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

Any future reviewing panel would be assisted by:

- Evidence of continued engagement with the NMC;
- A reflective piece addressing the concerns identified by the substantive panel;
- Evidence of remediation and strengthened practice;
- Evidence of completion of relevant training courses;
- Testimonials from managers, supervisors or colleagues; and
- Evidence of compliance with the conditions of practice order.

This will be confirmed to Mrs Di Centa in writing.

That concludes this determination.