

medConfidential note to NDG Review

1. Inside NHS England, FDP and SPR are run as a single project; the Health Bill will narrow the National Data Opt-out; and child social care and mental health notes may be swept in, as a fait accompli by those who believe public acceptability is optional, as evidenced by the clause in the Health Bill that anything in the SPR can have any Duty of Confidentiality removed whenever Secretary of State wishes.

Creeps, voyeurs and ghouls: NHS England sides with abusers over the victims

2. We first draw attention to the many parallels between the handling of opt-outs and patient choice, and the mishandling of the [ongoing NHS crisis](#) about [creeps, voyeurs and ghouls](#) snooping on medical notes. While we'll consider this in detail in an annex, but it must be noted here that many of the individuals in NHSE mishandling inappropriate access are the same people in the same jobs making decisions about the FDP and SPR, and other previous programmes. It may become clear why meaningful accountability isn't something NHS England does, and this piece of NDG work at this stage of the abolition of NHSE may offer an opportunity to change that.
3. It is the natural state of a bureaucracy to pretend that their existing processes do not need to change in the face of a new capability, and past patient choice can be disregarded after any change at all. Details of a high profile patient are likely to be on their wikipedia page, which allows a search which can evade some S-flag restrictions. How's that going to work for the SPR? From public communications, it seems the working assumption of the NHSE FDP/SPR team is that past protections don't apply to their big new database.

The discussion (and lack thereof) around child social care

4. The legislative basis for the SPR includes child social care, in that it is not restricted to adult social care. We would expect that some discussions have been had between the NDG team, who operate under a statutory remit that excludes child social care, and the Department of Health in England SPR team who have written legislation that will include it. We understand DH/E did not materially engage with those responsible for child social care in DfE.
5. It is unclear how the NDG expects professionals to give a substantive and informed response to the consultation without any guidance on where this is going. Will SPR include child social care, or not? What is the NDG position on remit? Will the voyeurs who go creeping through the NHS records of anyone they choose have access to the text of child social care notes, or the fact that they exist? Will the "single story" summary about a patient include them? Will that be done any better than the way the London Care Record already makes notes of mental health sessions available to anyone in London who chooses to look?

Scope

6. We observe that the recent change in Ministers was used by the programme as an opportunity to demote the “FDP” brand and [instead use](#) the “SPR” brand, as if changing the name will make the programme any less toxic in the public eye.
7. There is no published description of the scope of this work. Survey respondents therefore have no way of knowing, or of knowing whether the NDG knows, that inside NHSE the Federated Data Platform (FDP) and the Single Patient Record (SPR) are treated as a single project with no boundaries between them. That breaches the NDG's primary mantra: no surprises. If the NDG cannot say what the programme is to respondents, both the NDG and DH/E must expect that people will be surprised by the parts the DH/E are either unwilling or unable to explain.
8. Similarly, it is unclear whether the Health Bill will pass Parliament without any public statement that the NHS Data Opt Out is being reduced in scope, and COPI Regulations will be rewritten to permit arbitrary reuses of data even when patients believe they have objected, and such changes will cover all material in the SPR including the textual notes. This lack of disclosure is not going to increase confidence in the programme.¹

DH/E has a track record of keeping the NDG in the dark

9. There is [evidence and precedent](#) for the NHSE keeping the NDG in the dark.² As [covered in the FT](#), the FDP programme and leadership said, prior to launch, that they would give the NDG sight of the communications plan. No sight was given until approaching publication, so either the comms plan was very late in existing at all, or NHSE withheld it from the NDG despite promising otherwise. Readers can draw their own conclusions on the relative likelihoods of each.
10. “Data sovereignty” is a hot topic, and NHS England’s supplier never misses an opportunity to argue that they are a British company, except, that is, when writing to the Secretary of State for Health and Social Care, when it was made very clear that Palantir UK is a subsidiary of the US company [Palantir Inc.](#) It appears the NHS duty of candour doesn’t apply to DH/E communications.

¹ We also are aware of a claim that 44,000+ people have emailed a DPA objection to NHSE. DH/E can choose to ignore and dismiss these, and thereby undermine transparency and trust yet again, or DH/E can use this opportunity to communicate directly and honestly to inform patients both what NHSE is doing, and how they can express those rights effectively, including for their dependent children, and the steps people can take if they are unsatisfied with that offer. We expect NHSE comms will do the NHSE thing and make their mess even worse. If NHSE refuses to deliver the data protection rights that the public have, that’s NHSE’s failing not the public’s. We may address this topic in a followup note as NHSE proceeds to mishandle this in ways that are entirely foreseeable.

² For these purposes we shall pretend it was not deliberate deception; funny how these ‘mistakes’ always go in Palantir/NHSE’s favour.

11. Consequences are not something that NDG-relevant parts of NHS England have ever had to care about. The [paperwork process](#) almost deliberately designed to punish parents who wish to opt out their children.

The public are kept in the dark too

12. If this had been a programme run by NHS Digital, there would have been detailed board papers published every few months, with a report and public figures of progress. Instead this programme says “[The views and data presented are those of the individual trusts or integrated care boards featured and have not been verified or quality assured by NHS England](#)” whereas the trusts involved admit [they also did not write them](#) either. This confirmation raises the likelihood that NHSE’s suppliers are writing up their own reviews of their own products, which NHSE then gladly presents as the views of individual hospitals. The “not been verified or quality assured” seems *entirely* correct.
13. It remains entirely possible that the SPR-not-FDP plan was drawn up on the back of a fag packet while rushing to the meeting to present it, despite all the evidence known to medConfidential that it existed long before that. DH/E simply promised something they knew they could slither out of delivering.

Profits and staff feelings, not patients, drive programme thinking; it shows.

14. An advocate for the FDP programme joined the public deliberation process, and when some attendees didn’t like what they heard, they said so at the table during the discussion. The well-informed advocate then repeated what they had said, as they felt the participant had seemingly not understood the first few times. With true dedication to the programme, the insistence was repeated over lunch, until the member of the public escaped. The victim of NHSE’s bullying then called medConfidential, and gave a clear summary of the advocated position on FDP (a better one than the programme has managed at times), but they simply didn’t agree with it, and the advocate refused to listen to any other perspectives; questions were treated as insubordination. Then someone else from the table called with concerns from observing the interaction. The programme advocate also told others that they thought the discussion had gone very well, and while some of the public didn’t understand at first, after it was repeated several times, eventually they came round.
15. The public rationale for FDP is incoherent to the point of irrelevance. The private FDP rationale is a) Palantir sold them a vision of absolutism and control over the NHS, b) [Dr Kevin Fong's powerful evidence to the Covid-19 Inquiry](#) describing a failure which was felt personally by those who started pushing FDP as their magic bullet.

(How to tell if) FDP is flailing

16. In the absence of external vision and leadership in the programme, NHS England does what all bureaucracies do, and uses whatever metric it has easily available as a proxy for outcomes.

17. The letter from Minister Frith to the Health Select Committee suggests DH/E has chosen the National Data Opt Out figures as its proxy for public support. Using opt outs is catastrophically harmful beyond belief; we would suggest the NDG asks the AMRC CEO for her views on this topic.

Prioritisation around AI agents

18. An AI that works for you to analyse your full medical history and discover referrals or tests that have been missed will save lives.³ However, that's not the primary use as it doesn't make anyone any money. Apple has announced they will [give users additional capabilities](#) to protect material on their devices from agents running wild. Today Facebook/Meta offer apps which access any data available anywhere on a device to find their users' deepest fears to inform the design and display of ads which pierce their users' deepest fears and drive clicks. What would Zuck/Elon's advertising bots do with all a patient's psychotherapy notes as recorded by the Maudsley, copied via the London Care Record to their device, and then copied again into hostile AIs (the only redeeming situation in this scenario is that it's not yet widespread⁴ and child social care notes won't be included until the SPR is imposed).
19. This is equivalent to controversy around decisions made about a [population screening](#) programme which have an entirely different cost/benefit tradeoff to the decision by any one person. NHS England will use Palantir-hosted AIs to do what is best for NHS England at the population scale, but that may not be the best decision for any individual patient (exhibit B: [minimum waits](#)). Such choices can be justified as saving some lives and helping some patients but that it helps someone else doesn't matter if your loved one is on the losing end of the tradeoff. We cover related topics in our piece on [Dog Cancer](#) and the followup piece which we should have called [Human Cancer](#).
20. The tech bros are fond of [the joke about the Torment Nexus](#), a thing built because it's good for the company building it, not necessarily any patient NHSE throws into torment as [Ministers flail around](#). Patients have the right to make whatever choices they wish, but NHSE deciding on the FDP-only solution which most benefits the vendor's lockin and the shareholders of their supplier, while simultaneously refusing meaningful informed public debate, is the choice one would expect from the unchanged data culture that insisted that care.data and GDPR were good programmes, and from staff who still insist they personally were right and the public were entirely wrong. That doesn't age well.

³ cf penultimate paragraph of Chapter 52, "What does Jeremy Think: Jeremy Heywood and the Making of Modern Britain"

⁴ NHS England blocks the App from running on a Mac, but your friendly AI will explain how to get around that in a few seconds. As with many NHS England choices, the choice feels good inside NHS England and is utterly ineffective as a barrier to the determined or those with an AI assistant to do the legwork.

What to do about it – Have an NDG Review!

21. Once again, the NDG has been asked to bail DH/E out of a data mess of its own creation, which it was warned against, and into which it insisted on digging itself ever deeper. The NDG's clinical experience may offer analogies upon which to draw.
22. The lack of published boundaries of this work allows the NDG to use expertise and external input to add to the programme what should have been there from the start.
23. One reason NHS England likes Reviews and less formal paperwork is that, in practice, it has succeeded in [bullying Review authors](#) into writing nothing it disagrees with, and it expects to micromanage the timing, briefings, and perception of any publication. Any meaningful change is repeatedly and deliberately watered down to nothing. While this approach may have hidden harms away from public view, the bill always comes due eventually.
24. Other policy zombies rolling forward on autopilot include:
 - a. Transparency on data reuse – how is the work progressing to allow Ministers to share NHS data under the Digital Economy Act? (To inform this work, the NDG may wish to ask DH/E for an assessment of how the [promises made at the abolition of NHS Digital were kept](#). One need only to look at the public figures in the final board pack for NHS Digital to see how much has disappeared from the public domain under NHS England – what was published proactively is now only [available under FOI](#), and often [NHSE simply refuse to reply](#) until [the ICO enforces disclosure](#))
 - b. Who will write the “single story” that the Health Bill introduces? Will it be written by AI? What will the model/prompt be? What happens when a patient disagrees with the summary? Will it include mental health data (outpatient? inpatient?), and if so, will the psychiatric diagnoses and reasoning for a patient be included in the SPR summary? Will that summary be visible wherever the NHS logo is shown, to staff who would never be able to see the original notes but will be expected to read the summary?
 - c. COPI reform and exemption of DH/E from opt outs, without any change in the law, as if telling the public they have fewer rights because it makes actions of bureaucracy easier has ever gone down well.
25. The NDG should include inappropriate access via national systems within this Review, because they are all Spine based and in the process of moving to FDP. NHS England instead told victims of inappropriate access to reject the evidence of their eyes and ears; with enormous central power arrayed against them, it was the most essential command emanating from the Gray meeting room where Privacy, Transparency and Trust were all undermined by deliberate actions. Subtle arguments which no patient can be expected to understand, and NHSE's PTT refuses to answer.

What to do about it – Separate platform providers from product providers⁵

26. NHSE's choices allow one supplier to offer the underlying platform, and tools/products which run on the platform. If Palantir lose the platform contract, they have indicated they will withdraw their cancer360 from NHS availability (on the basis that they will not support it running on a competitor's platform). While this is their current contractual right, it is also holding cancer patients hostage for commercial reasons, and can be entirely avoided by DH/E requiring a company to offer products on the platform, or the platform itself, but never both.
27. Similarly, for tools where NHSE mandates use in some circumstances, there must always be multiple competing tools from different providers prior to NHSE issuing that mandate. NHSE chose to mandate a sole-supplier product, by choice creating a Palantir monopoly that it now uses to justify using only Palantir.
28. NHSE has long complained about the duopoly of TPP/EMIS* in GP services, but seems to have been convinced that the solution to an idiosyncratic duopoly is an idiosyncratic monopoly. As if that will go better; especially when it was the monopoly lobbyists doing the convincing.

What to do about it – confidence building measures

29. FDP never cared about public or professional acceptability, and has assumed that if they just lobby enough the companies involved will get what they want. As an approach, [it worked](#) for [UK Biobank](#) for [a while](#).
30. The notions of Privacy, Transparency and Trust within NHS England, DH/E and the NHS more widely are being undermined because decisions in Gray meeting rooms at NHS England have repeatedly, progressively, and deliberately deprioritised public confidence in favour of short term expediency. Those costs are now coming due.
31. The SPR has been promoted as the cure to all ills, and the supposed benefits have long been promised, dating back to the Summary Care Record of the very early 2000s where the [same promises](#) around benefits and safeguards were made, and generally got broken.
32. It is unclear whether the “single story” in the SPR which so enthused previous Ministers will be written in the first instance by Palantir's AIs, the cheapest of which may be Elon Musk's Grok, or whether it will be up to patients. The Single Palantir Record is a catchy name, and we thank NHSE comms for that opportunity.
33. We expect no change from a programme that believes it has no reason to change – as there was none with the many debacles before it. As with prior programmes of NHS England, the US company [Palantir Inc](#) seems to believe that because something can be done, then they must be the ones to do it irrespective of public acceptability. It seems the sensible British public take a different view. When the NHS

⁵ We go into this in more detail in [A Plan for The Medium Goodbye to Palantir – medConfidential](#)

finds itself in such a mess, DH/E reaches for an NDG Review to advise on what should happen, and NHSE will remain in institutional denial and obstinacy until accepting the findings and denying it ever remotely considered otherwise.

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Annex on “Inappropriate Access”

34. Abuses of the medical records of [three dead girls in Southport](#) and [an alive boy in Cambridgeshire](#) have resulted in no meaningful action at a national level where NHS England owns the liability, and where NHS England is data controller, and where NHS England does the data processing for the audit logs it knows and admits exist, and where there are cases where access could never have been appropriate, and where there is already national data guardian. What more is needed?
35. Looking at the website and LinkedIn of the National Data Guardian,⁶ patients could reasonably assume that the NDG agrees with the NHS IG team who believe that “[unauthorised, inappropriate and unjustifiable access to confidential patient information](#)” is both a never event and one actual prevention. Perhaps NHSE’s media monitoring didn’t consider the NDG as relevant when Sky News answered “[Why NHS staff are targeting terror attack victims](#)” or HSJ reported “[Hundreds sacked for snooping on patient records](#)”. That would be commensurate with the NHSE idea of “action”, not merely [one letter](#) but [two](#) (from which one can infer the insufficiency⁷ of the first letter). It is surprising the NDG has said nothing so far, but the Review allows a long-form response that incident response cannot offer.
36. Does the NDG's panel also believe that NHS staff only snoop on the records of high-profile patients, when there is plenty of evidence they snoop on people they know? What will it take for the panel, and NHSE's PTT and IG team, to admit they vastly underestimated the scale of the abuse? These stories emerge one at a time because DH/E denies the problem, responds ineffectively, and refuses to tell patients how their records are accessed.
37. Public concern about creeps, voyeurs and ghouls misusing their access is related to the secrecy NHSE insists on maintaining over audit trails (unless the police are already involved). Much of that public concern is entirely legitimate and proven by the abuses in the public domain and those yet to come.
38. Sir Jim Mackey has warned that every breach damages the trust the Single Patient Record will depend on. The fix is already within NHS England's control: show patients the logs NHS England already has.

⁶ And most notably Understanding Patient Data hosted by the NHS Confederation Alliance, so this is not a dereliction unique to the NDG. DHSC saying nothing material merely meets expectations. Paragraph 64 also applies here.

⁷ We’re tempted to [do something fun](#) with the posters... <https://medconfidential.org/2026/ministers-promised-you-d-control-your-data-the-health-bill-and-nhs-england-say-otherwise/>

NHSE's letters only cover "high profile" patients or incidents

39. NHS England's IG guidance suggests the punishment is not for the snooping, but for being inept enough to choose a high-profile victim and getting caught. After Southport, NHS England's only complaint was that the hospital hadn't told NHSE. After the inappropriate access to the records of one Cambridgeshire boy, NHSE emphasised that the hospital had learnt enough to tell the patient. Both were high-profile incidents. NHSE guidance is silent on everyone else, because in most cases NHSE has no way of knowing whether an access was legitimate, and NHSE tacitly⁸ encouraging Trusts to sweep abuses under the carpet would not be unprecedented. It is what NHS England does.
40. NHSE's letter focuses on "[a high profile incident or patient](#)" – because NHSE only responds to headlines.
41. The independent NDG can use this Review to provide recommendations, unless the NDG agrees that reading NHSE's letters is all the system needs to do.

Trust action is necessary but not sufficient

42. Action by Trusts is necessary, but it is entirely insufficient. Trusts employ the staff who abuse systems, and Trusts are data controllers for Trust systems, and internal action is far simpler than multi-organisation coordination. A Trust can only see its own systems unless other records are provided by other parts of the NHS. No single Trust sees what the whole National Health Service sees.
43. The Trust sometimes has to be actively involved because no patient (and no national audit) can tell whether a member of staff in Immunology is snooping on a child on a paediatric ward who never went near Immunology – that requires the Trust to investigate. Those accesses could be entirely reasonable, they could be down right creepy.
44. Addenbrooke's/CUH is no better or worse than any other Trust despite the number of abuses connected to them. Some of the steps they have taken recently should help prevent further abuses – most staff being forced to type their passwords to open the result of a patient search, but subsequent incidents show it is a speed bump, not a definitive barrier.

National audit trails *already exist* and *visibility* must be prioritised⁹

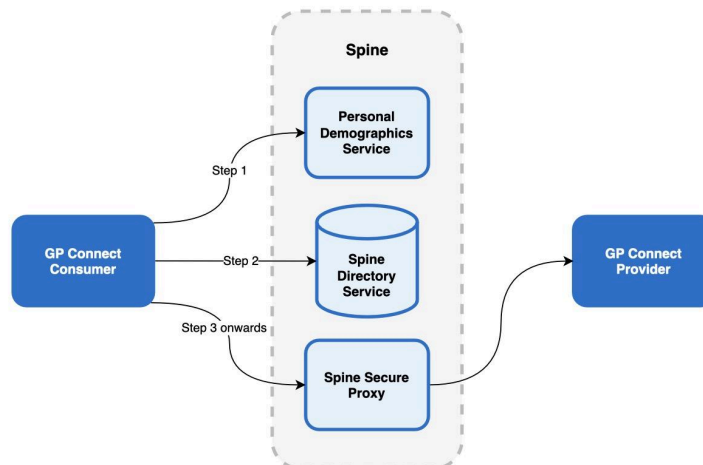
45. NHS England says that "[PDS keeps a full audit of all record access](#)", and the [Spine Secure Proxy performs](#) "auditing of requests... and transaction logging" with "users, including role," and "organisation"... "is retained for audit purposes".

⁸ Being generous

⁹ The "How" of integration with the NHS App will follow publicly as a case study of the dysfunction of the NHSE approach to changes in the app. You turn an elephant one step at a time.

46. That audit trail is held by NHS England, it is controlled by NHS England, it should be visible to patients in the NHS App, because NHS England already logs every access that crosses the boundary of the grey box, including demographic data in PDS and clinical data in GP Connect:

How it works



[Source: NHS England Digital](#)

47. The first time each day¹⁰ that a patient's record is accessed, the Trust system already checks with the national Spine and PDS that information held locally is not out of date. For every patient accessed at least once a day,¹¹ at least one line drops in the NHS England national logs. It doesn't do anything for the [second to fortieth staff](#) who look up a record, but it does highlight the rogue staff member with "wider criminal behaviour" or an obsession with a particular victim: [Murder victim's medical records wrongfully accessed by NHS staff](#).

48. NHS England knew and logged that a deceased patient's records were accessed "on seven separate occasions", including "twice on what would have been Michaela's birthday"¹². This "disturbing" access is something the NHS England audit trail knew happened – there's no other legitimate access on those days. "Michaela is dead, she's defenceless, she can't stand up for herself" while NHS England withholds the evidence it has about the face of ghoulish behaviour by NHS staff. Does the Panel believe this is the only time this happened?

49. Shown to patients, national audit data shows when a hospital system does a check against the Spine for the patient's details. Repeated abuse will show up as repeated

¹⁰ Sometimes more often, but no less often than every 24 hours, sometimes every six or eight. While that is a relevant debate in clinical safety terms, it is immaterial here.

¹¹ The obligation is "regularly". Some do it every 6-8 hours, the minimum is every 24. For these purposes it doesn't matter very much.

¹² [Murder victim's medical records wrongfully accessed by NHS staff](#) – BBC News.

lines. Those audit lines sit in logs NHS England holds and is responsible for, and which it refuses to show patients in the NHS App. NHS England only intermittently discloses the contents of those logs when the patient makes a Subject Access Request for the data held by NHSE.

50. Any single one of those audit lines would have prompted questions, and NHSE have chosen a coverup, in exactly the same way some NHS officials insisted Martha's Rule was unnecessary. It should not be necessary, but in reality, it is.
51. If DH/E shows patients what it has today, it's reasonable to assume SPR will do the same tomorrow. Since there is a point-blank refusal for what NHSE holds today, it's reasonable to assume those same staff will continue to refuse for new systems tomorrow, simply because the same people in the same organisations have refused for decades. The logo on the door makes no difference.
52. NHSE in the pre-abolition state holds records of accesses but is insufficiently curious of real world actions,¹³ so NHSE refuses to do the main thing¹⁴ that resolves the problem: Tell patients when their records have been accessed.

Before SPR, not later, maybe, possibly, long after SPR is already being abused

53. The Health Bill and the SPR will make access much wider, to more data – all adult social care, and all child social care, as data remains in the record for life (and will always be analysed and read by the AIs doing diagnoses). Everything stored anywhere the NHS logo is seen, all copied to the Secretary of State for them to decide how it's used – everything in SPR will go on sale via the [NHS England price list](#) as the [Biobank precedent](#) has become a playbook.¹⁵
54. DH/E will make many self-serving claims about how SPR/FDP will be perfect and patients must accept DH/E's decision to place them at risk until then. The best way for DH/E to show they will deliver on any promises is to use FDP to show patients how Summary Care Record, Spine, GP Connect are accessed today. Patients are sensible – they draw conclusions from the information they are given, or the information deliberately withheld from them.
55. Patients do not see the distinction between different DH/E silos and bureaucratic boundaries. NHS England may claim that the FDP and SPR are different projects when it is convenient for NHSE, but the public simply see the NHS and the NHS's

¹³ It is also unlikely that zero researchers are as curious as NHS clerical staff. Where data is disseminated, NHSE has no way to know whether researchers have read the linked medical history of victims that they have access to, usually copied to the secrecy of their own computers. Each patient covered in this document is [easily identified](#) in the coded data from the events that they were involved in. It seems the position of "leading" UK "Health Data Research" entities is that every researcher they support is less curious than the "small minority" of NHS staff who go creeping. We similarly assess it highly unlikely that the "measures" put in place in the reckless access to CPRD via HDRUK provides any protection to any victim like "has asthma" and then "has asthma + bitten by crocodile". See also: <https://medconfidential.org/wp-content/uploads/2026/08/2026-08-09-cprd-co-connect-reckless.pdf>.

¹⁴ Chapter 3 of the Goldacre Review remains relevant.

¹⁵ More on this should be available after the NDG deadline for survey responses.

use of data, and headlines of “inappropriate access” where they have no way to know it hasn’t happened to them. 99 patients out of 100, or 999 out of 1000, probably have nothing to worry about, but NHS England gives them no reassurance. The output from this NDG work should reflect patient expectations, as NDG Reviews have previously. The NDG mantra of “no surprises” must hold.

56. The NDG role was created in the wreckage of care.data when the public did not have any insight into what happened to secondary uses of their data. In the 12 years since, the only scandals have been from adjacent entities (PHE cancer registry, HDRUK’s Foresight) who believed that the rules on transparency and accountability should not apply to them. DHSC also thinks the transparency rules shouldn’t apply to them e.g. [DARS-NIC-759355-H7B9S](#) and legislative changes in the Health Bill to allow the Secretary of State to [remove any](#) “(a) obligations of confidence owed by the person making the disclosure, or (b) any other restrictions on disclosure.”

Tell patients who accessed their records, and new scandals largely just stop

57. Maintaining confidence in the use of NHS data is not like curing cancer, it is something we know how to do easily today. When transparency begins, and staff are aware that when they look the patients will know, all the nasty surprises stop, and the scandals stop.

58. The principle of audit of access needs to apply to direct care for all NHSE run national systems.

59. DH/E can tell patients; they simply refuse. protections shouldn’t depend on who the patient is (victim, suspect or “high profile patient”). The missing piece which only DH/E can do is visibility of access to those who wish to see (the proxy for capacity is the existing NHS App flag for visibility of prospective access to correspondence, documents and test results etc.).

NHSE’s institutional response and culture matches that of their favoured supplier

60. NHSE has spent hundreds of millions on FDP to process data. FDP / Foundry can show patients a statement of accesses to their data from the logs NHS England already holds, so the continued refusal is a political choice not a technical limit. So, it is a choice where this NDG Review can recommend changes (unless NHSE vetoes, again).
61. NHSE’s claims echo this paragraph from [Max Chafkin’s book on Peter Thiel and Palantir](#) (page 95):

Palantir's privacy paper trail would become central to the company's pitch to the public. Karp seemed sincere but it was never clear how seriously clients took the idea. One of Palantir's former engineers recalled meetings during which government clients would suggest trying to use the database to look up an ex-girlfriend immediately after hearing the whole privacy spiel. Palantir employees would never object to these requests, this person said. Instead, they would remind the clients that searches were logged—and then allow them to look up whoever they wanted, no matter how flimsy the pretext.

62. In the same fashion, what does the NDG, and the Panel, (and for that matter DH/E readers) think some staff would have done immediately after reading employer guidance on inappropriate access?
63. With meaningful audit visible to patients the opportunistic abuses will quickly cease, the routine accesses would show patients what normal patterns are, and the truly dreadful would be clearly visible.
64. There are more stories on "inappropriate access" to come. Worse ones.

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