

# The last thing the NHS needs is more regulation



Dr Peter Carter

In December 2021 I was shocked when it emerged that two police officers who had been assigned to guard the bodies of two sisters who had been murdered in a park in north London, photographed and shared their images on a WhatsApp site.

They described the two murdered women as “two dead birds”.

Both officers were dismissed from the police and following a prosecution they were sent to prison for 2 years and 9 months each. They were described in court of having dehumanised the two victims for “their

own amusement” I reflected at the time how shocking that the deceased should be so disrespected and how low these two officers had sunk.

*A combination of voyeurism and despicable behaviour.*

In December 2024 I became aware that seven probation officers had viewed data in relation to the homicides by Valdo Calocane of three people in Nottingham. The Ministry of Justice deemed the

breaches insufficient to warrant disciplinary action.

As a result, HM Prison and Probation service found that three of the officers breached data policies which resulted in internal informal improvement actions rather than full disciplinary proceedings.

**I find this hard to understand.**

Earlier in 2024, Police Officer Matthew Gell was found guilty of gross misconduct for opening files on Calocane and forwarding the contents to two people outside the force. He was issued with a final written warning.

A special constable IIsadin Skenderaj has been sacked by Nottinghamshire Police Force for viewing footage of the bodies of Barnaby Webber and Grace O'Malley-Kumar being placed into body bags.

Several other police officers were investigated and disciplined for unauthorised access of incident logs and body

worn camera footage of the attacks.

*Call me naive but it never occurred to me that staff in the NHS in any significant numbers would do such a thing.*

One of the cornerstones of the combined health service professions in relation to patient care is confidentiality.

It was with some shock that on Thursday 21st May, Nottingham University Hospital NHS Trust (NUH) announced; they had sacked 11 members of staff and given final written warnings to 12 others of their staff, who had...

.... viewed the case notes of the victims of Valdo Calocane without any legitimate reason to do so.

The Trust then later acknowledged that in total, 150 members of staff had accessed the

case notes and that there was an ongoing investigation to establish how many of these people had a legitimate reason to do so,

This is the latest development into one of the most harrowing and distressing incidents in the history of the NHS. Three people killed and three others run over by Calocane in the van he stole from his third victim.

When serious and untoward incidents happen in the NHS there is a tendency to rewrite the existing rules and policies.

It also also common to state that lessons will be learnt from the event.

**This approach in my opinion is misguided.**

The current policies and protocols across NHS organisations, combined with the codes of conduct of regulators such as the General Medical Council and the Nursing and Midwifery Council are sufficient. The remedy of addressing these transgressions is via the

existing regulations and that individuals have to be held to account. It simply doesn't stand up to scrutiny that any individual who has accessed a patient record without permission can plead ignorance.

We also have to examine why it is that so-called professional people would do such a thing, quite aside from the distress it has caused to the relatives of the deceased and those who were injured by Calocane.

As a former NHS Trust CEO, I would be highlighting the events at Nottingham via the Trust intranet and newsletter reminding people that unauthorised access to a patient's case notes is a serious offence and will result in disciplinary action that may, in the absence of any mitigation, result in dismissal and referral to the respective regulator such as the GMC and the NMC.

The families of the deceased have asked for a detailed explanation of the breaches and

they wish to have the following data in relation to the 150 staff.

- 1 What role did they hold.
- 2 What exactly did they look at.
- 3 When did they look at it.
- 4 Why did they access it.
- 5 The time and date of access.
- 6 What action they took after access (sic).
- 7 What action was taken.
- 8 How was the decision made.
- 9 What was the outcome.
- 10 What other bodies have they been referred to.

The three families have put a deadline of the 31st July on their request.

These questions will be very testing for the NUH Trust. On one hand they are committed to being open and transparent with the families, on the other they will say they have a duty to protect staff who may have been disciplined, but due to mitigation are still employed. It will be

interesting to observe how the Trust navigate themselves through this challenging period.

There is also the possibility of criminal prosecutions which may compromise any disclosure. We will cross that bridge in due course.

Undoubtedly the Nottingham Inquiry is going to reveal a whole host of challenging issues and concerns about the Calocane case specifically, but also and the on-going management of people with severe mental illness more generally.

Whatever the outcome of this testing period for the NHS what is not needed is a whole set of new regulations making access to patients records more complex.

I also dread the thought that any member of staff has made inappropriate comments about the deceased.

Having watched much of the evidence that has been given in the inquiry, it is clear that there will be difficult questions for

many of the individuals  
and their employers.

Holding individuals to  
account who have not  
conducted themselves in  
accordance with basic  
decency or who have  
been non-compliant with  
existing protocols is the  
way forward.

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