

Confidentiality and the Sharing of Information

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Introduction

This paper considers the nature and extent of the duty of patient confidentiality in the mental health context, and examines the range circumstances in which it might be overridden, and the way in which such decisions may be taken. Particular consideration is given to the justifications given for breaches of patient confidentiality in the name of public safety and victims' rights. The paper also addresses rights of access to health information in the case of the incapable adult and the applicant to the MHRT.

The legal framework

Disclosure and sharing of information about a person's health (and social "condition") is governed by a complex statutory and common law framework. Individual access to and disclosure of records is governed principally the Data Protection Act 1998 ("DPA") – established to provide an over-arching scheme for all, not just health or social work, information. It is supplemented by the Access to Health Records Act 1990. Disclosure before and during litigation is governed by s33 and 34 Supreme Court Act 1981, s52 and 53 County Courts Act 1984 and Part 31 Civil Procedure Rules. There is guidance on confidentiality and disclosure such as that contained in The Protection and Use of Patient Information Guidance HSG(96)8 and HSC(2000)9, which may require higher standards than the DPA, and Confidentiality: Protecting and Providing Information issued by the GMC in June 2000. Since the coming into force of the Human Rights Act 1998 in 2000, public authorities and the Courts have further had to have regard to individual rights and positive obligations arising out of Art. 6 and 8 ECHR in respect of access to, and disclosure of information. Despite these extensive statutory structures, however, the common law retains an important role, demonstrated in the cases that still require the determination of the Courts where disclosure or sharing of information is concerned.

Description and discussion of the detailed provisions of the DPA is beyond the scope of this paper. A particularly useful summary of its provisions in relation to the health and social work records of those subject to the Mental Health Act 1983 ("MHA") is provided by Hale LJ in *R (S) v Plymouth City Council*¹:

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1 *R (S) v Plymouth City Council* [2002] 1 WLR 2583

All of the material requested is “personal data” within the meaning of the Act and so much of it as related to [the patient’s] “physical or mental health or condition” is “sensitive personal data” within the meaning of section 2(e). But the processing of even sensitive personal data is permitted where it is necessary in order to protect the vital interests of the data subject or another person in a case where consent cannot be given by or on behalf of the data subject (paragraph 3 of Schedule 3); or for the purpose of, or in connection with, any legal proceedings (including prospective legal proceedings) or for the purpose of obtaining legal advice, or where it is otherwise necessary for the purposes of establishing, exercising or defending legal rights (paragraph 6); or where it is necessary for the administration of justice, or for the exercise of any functions conferred on any person by or under an enactment (paragraph 7). It is common ground therefore, that the 1998 Act does not prevent the local authority disclosing this information. Nor, however, does it require the authority to do so.²

Article 8 of the ECHR provides:

- (1) Everyone has the right to respect for his private and family life, his home and his correspondence.
- (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The European Court has held that Art. 8 protects personal data, including health records, and that respect for the confidentiality of health records is a fundamental right in *Z v Finland* (1997) 25 EHRR 371:

... the court will take into account that the protection of personal data, not least medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the contracting parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community. The domestic law must therefore afford appropriate safeguards to prevent any such communication or disclosure of personal health data as may be inconsistent with the guarantees in article 8 of the Convention.³

Disclosure of any information for other than the purpose for which it was collected may also in itself constitute a breach of Art. 8(1) ECHR⁴.

As to the justification for breaches of Art. 8(1) contained in Art. 8(2), the European Court interprets the exceptions narrowly⁵. Firstly, for a disclosure to be in accordance with law it must be in accordance with a procedure which enables the data subject to foresee its operation

2 *above judgment paragraph 25 page 2593*

3 *Z v Finland* (1997) 25 EHRR 371 paragraph 95 page 405–406

4 *T V v Finland* DR 140 (1991)

5 *Klass v Germany* (1978) 2 EHRR 214 and *Funke v France* (1993) 16 EHRR 297.

reasonably clearly⁶. There should be adequate legal safeguards to protect against arbitrary interference in Art. 8(1) rights⁷. Secondly, the disclosure must be not only for one of the objectives identified in Art. 8(2), but the disclosure must be proportionate to that objective: a “fair balance” must be struck between the interests of the individual and society as a whole. In *Z v Finland* the European Court held that disclosure of an individual’s HIV status was only justified where there was an overriding public interest.

The common law will protect information given in confidence where it has the necessary quality of confidence⁸ and where the person proposing to disclose the information has obtained it in circumstances giving rise to an obligation of confidence⁹. In *R (Source Informatics) v Department of Health*¹⁰ the Court held that there was no breach of confidence where the information provided did not disclose the identity of the data subject, in that case about his use of medication. The common law obligation of confidence may be overridden where there is a legal requirement of disclosure, where the subject consents and where there is an overriding public interest. For instance, in *W v Egdell*¹¹ the Court of Appeal upheld the decision of a doctor asked to prepare an independent report on a patient for the MHRT to disclose the report to the Secretary of State although the patient had decided not to disclose it to the MHRT, and withdrawn his application. The report drew attention to a number of factors relevant to W’s treatment and dangerousness that had not previously been identified. It was held that the importance of the information with regard to public safety was so great that it outweighed the usual duty of confidence. Indeed, following the decision of the European Court in *Osman v UK*¹², it may be said that there is a positive obligation on public authorities, which might arguably include responsible medical officers, who have information that identifies a risk to the life of another individual, to disclose that information in order to protect his right to life under Art. 2 ECHR.

The nature and extent of the duty of confidentiality to patients

The nature and extent of the obligation of patient confidentiality was recently explored by the House of Lords in *Ashworth Hospital Authority v MGN Ltd* when their Lordships considered an application by the hospital for the disclosure of the identity of a journalist’s informant who had provided him with material concerning Ian Brady’s medical care. The parties agreed that leaks to the press of confidential information are undesirable because they have:

... a detrimental effect on security; treatment of patients and staff morale, because they may inhibit proper recording of patient information about patients; may deter patients from providing information about themselves; may damage the patient-doctor relationship, which rests on trust; may lead to assaults by patients on a patient about whom information is disclosed; may create an atmosphere of distrust amongst staff, which is detrimental to efficient and co-operative work; and give rise to fear of future (and potentially more damaging leaks).¹³

6 *Petra v Romania* (2001) 33 EHRR

7 *Malone v UK* (1984) 7 EHRR 14

8 *Saltman Engineering v Campbell* [1948] RPC 203

9 *Marcel v Police Commissioner* [1992] 1 AllER 72

10 *R (Source Informatics) v Department of Health* [2000] 1 AllER 786

11 *W v Egdell* [1990] 2 WLR 471

12 *Osman v UK* (2000) 29 EHRR 245

13 *Ashworth Hospital Authority v MGN Ltd* [2002] 1 WLR 2033, per Lord Woolf CJ paragraph 17 page 2037

It was also accepted that it was particularly important that patient records be full and accurate in special hospitals because otherwise warning signs might be overlooked inhibiting preventative action.

The question for the Court was how this substantial public interest in preserving patient confidentiality weighed against the public interest in the protection of journalists' sources. The newspaper invoked Art. 10 ECHR, the right to freedom of expression, in its defence and the oft-cited "chilling effect" of an order for source disclosure on the freedom of the press.¹⁴ Their Lordships ultimately found that on that occasion an order for disclosure was both necessary, in that it met a pressing social need, and not disproportionate, in respect of the aim which was being pursued.¹⁵ It was persuaded, in particular, by the following matters advanced on behalf of Ashworth:

... it is essential for the care and safety of individual patients and the safety of other patients and staff that relevant information is entered in the patients' notes ... those entries having been made, their integrity and confidentiality should be preserved ... psychiatry, more than any other branch of medicine, depends on a trusting relationship between therapists and patients ... the basis of virtually all assessment, diagnosis, treatment and analysis of risk is dependent on information provided by others ...if the staff feel that there is a possibility of what they report entering the public domain their reporting will be inhibited as they will think that this will place staff or patients at risk ...¹⁶

The Court relied upon *Z v Finland* as a guide to the significance of the wrong done by those who disclose medical records. It held that it would be "no bad thing" if its judgment had the effect of discouraging such disclosure in the future.

Their Lordships' judgment was not, however, the end of the story for Ashworth. The order for disclosure it obtained in the Lords was against the newspaper which duly identified the journalist who had provided it with the information. The journalist himself then refused to disclose his source. Proceedings were issued against him. An application for summary judgment on the grounds that his defence had no real prospect of success in the light of their Lordships' earlier judgment failed¹⁷. The Court of Appeal held that the issues in respect of Mr Ackroyd were different from those in respect of the newspaper and would not necessarily be determined in the same way, given the balancing exercise that the Court must carry out. The key factor was Mr Ackroyd's history as an investigative journalist exposing wrong-doing at Ashworth and other hospitals. There was a public interest in the exposure of wrong-doing at the hospital which might, at trial, justify non-disclosure. It might even be justified by Mr Ackroyd's need to protect his sources so as to enable him to expose wrong-doing in the future. It was also significant that Mr Ackroyd's sources received no payment for the disclosures. May LJ concluded the lead judgment thus:

Although there is a clear public interest in preserving the confidentiality of medical records, that alone cannot, in my view, be automatically regarded as an overriding requirement without examining the facts of a particular case. It would be an exceptional case indeed if a journalist were ordered to disclose the identity of his source without the facts of his case being fully examined.¹⁸

14 *Goodwin v UK* (1996) 22 EHRR 123 at paragraph 39 page 143

15 Pages 2050–2051 judgment

16 Paragraph 63 page 2051 judgment

17 *Mersey Care NHS Trust v Ackroyd Times*, 21 May 2003 and [2003] EWCA Civ 663

18 Paragraph 70 judgment per May LJ

Carnwath LJ, however, was concerned to guard the status of medical records more closely. His Lordship held:

...it would be inconsistent with the decision of the House of Lords to approach the present case other than on the basis that, other than in exceptional cases, there is an over-riding public interest in the protection of medical records from disclosure. In the interests of certainty in the law and the assurance of those responsible for such records, I would oppose any watering-down of that principle, even if it were open to sue to do so. There may be circumstances in which a departure from the normal rule is justified by the public interest; but the circumstances must be truly exceptional, and they must be directly relevant to the need for disclosure of the records in question.¹⁹

Examples of where the public interest in disclosure might outweigh the interest in medical confidentiality may therefore include not only “whistle-blowing” in respect of hospitals, but, on Mr Ackroyd’s submissions, in the care and treatment given to particularly high-profile individuals. He submitted that there is a public interest in knowing about their treatment, and even the basis for their criminal acts, and that argument was not rejected by the Court.

Although the decision in *Ackroyd* was merely concerned with whether his defence had no prospect of success, the judgment appears to have opened up the field of interests that might outweigh those of medical confidentiality. Certainly, it must be debatable whether the confidence of a high-profile criminal or notorious patient is more easily overridden than that of the unknown one. After all, such individuals cannot always be said to have voluntarily put themselves in the public eye where their crimes have been committed when seriously disordered. Further, if the care and treatment of such individuals may legitimately be a matter of overriding public interest, what aspects might be included? Difficulties often arise over leaks and reporting of rehabilitation trips for high-profile offenders. Once there is publicity it can become almost impossible for them to take place, to the detriment of the individual’s health, and perhaps prolonging his detention. If it is allowed that the public interest in such matters is so significant that it warrants disclosure, then the balancing exercise becomes extremely complex.

In almost the opposite situation, the right to protect their sources has been invoked by those protecting patients, those in residential care homes or receiving any social service. They argue that “whistle-blowers” or others who bring wrong-doing to light should have their identities protected. In *Leach v National Care Standards Commission*, unreported, Master Yoxall, 30 October 2002, upheld the NCSC’s refusal to disclose the source of, ultimately disproved, allegations of abuse and neglect at a residential care home for the elderly. The claimant sought disclosure in order to bring defamation proceedings given the damage the allegations had caused to his business. The Court found that the public interest in the protection of the vulnerable from abuse, and the particular need for independent reporting in respect of those who may not be able to raise the alarm themselves, outweighed the claimant’s interests in disclosure.

¹⁹ Paragraph 75

The administration of the obligation of confidentiality and the right to access: incapable adults and the DPA²⁰

A significant defect in the all-embracing scheme provided by the DPA is its failure to deal comprehensively with incapable adults as data subjects.²¹ While s7 DPA gives the data subject a range of entitlements to the provision of information²² it does not say who may make the requests on behalf of an incapable adult, or to whom the information requested should be provided. The DPA does not require that a request come from the data subject himself, and therefore it is arguable that it may be made on his behalf. The guidance in HSC2000/9 supports the view that a third party may make the request on behalf of the incapable adult.²³

However, even if a third party may properly request information on behalf of an incapable adult, the response may only be given to the data subject under s7 DPA. This undermines the utility of a request being made by a third party if the data subject is incapable of understanding the product. More fundamentally, it is questionable whether, given the restrictions on processing information, the DPA is intended to allow a third party to request and receive information on behalf of a data subject. It is quite easy to see how such an arrangement might be abused. It is right that there is an obligation on the data controller not to disclose information if it would be likely to cause significant harm to the physical or mental health or condition of the mental subject or any other person, or where the information was provided in the expectation that it would not be disclosed²⁴, however, this falls far short of the “best interests” test upon which reliance is usually placed when taking decisions about the lives of incapable adults.

While abuse by the third party is a risk, equally a lack of information creates another set of risks for the incapable adult. Information is required for relatives and carers to have proper input into decisions about the health and social care of the incapable. In the absence of a clear statutory scheme under the DPA, it is left to the discretion of individual professionals to decide whether to, and how much, information to disclose. Questions may arise not only as to the suitability of particular treatments or placements, but also as to the entitlement to free care, for instance under s117 MHA or because eligibility criteria for continuing health care are met. Without information, those acting on behalf of the capable are significantly hampered.

What then, are the alternatives, for allowing access to information for a person acting on behalf of an incapable adult? Some decisions about the disclosure to third parties of health and social care information concerning incapable adults can be made within existent statutory frameworks. Firstly, a nearest relative has the following entitlements under the MHA:

1. To have a doctor examine a patient for the purpose of advising as to the exercise of the nearest relative’s power of discharge. The doctor concerned has the right to require production of and to inspect records in relation to the detention and treatment of the patient. (s24 MHA)

20 I am grateful for the assistance of Kristina Stern and Nicola Greaney of 39 Essex Street in preparing this part of the paper.

21 The repealed scheme did deal with the issue.

22 Being informed whether or not data about him is being processed, the purpose of the data-processing, the persons to whom it may be disclosed, being provided with the data itself, decision-making about him.

23 Paragraph 5.2

24 Regulation 5 of the Data Protection (Subject Access Modification) (Health) Order 2000 and the Data Protection (Subject Access Modification) (Social Work) Order 2000

2. To have a patient examined and to require production of medical records relating to detention and treatment for the purposes of advising whether an application to an MHRT should be made. (s76 MHA)
3. Hospital managers are obliged to inform the nearest relative, unless the patient objects, of the provisions under which the patient is detained, and their rights to apply to the MHRT. (s132 MHA)
4. To have all the documents before the MHRT disclosed, where the nearest relative is the applicant, unless the MHRT is satisfied that the disclosure would adversely affect the health or welfare of the patient or others. (r12 MHRT Rules 1984)

The entitlement of the nearest relative to information concerning an incapable adult subject to the MHA in circumstances broader than this was tested in *R (S) v Plymouth City Council*²⁵. S, the mother and nearest relative of a person subject to guardianship, sought disclosure of confidential medical and social work information concerning her son to allow her to make decisions about the exercise of her powers as nearest relative. S particularly sought disclosure of medical records, including medical recommendation forms, not only to herself but also to two experts engaged to advise her whether or not to apply to discharge her son from guardianship. The local authority refused disclosure. Hale LJ held that the issue fell to be decided with reference the common law and the Human Rights Act 1998 both of which required that:

...a balance must be struck between the public and private interests in maintaining the confidentiality of this information and the public and private interests in permitting, indeed requiring, its disclosure for certain purposes.²⁶

As to the content of the material sought, Hale LJ took the view that it was not uniform in character. Where files contained information that was, for example, a “straightforward description of everyday life” it would not need to be treated as confidential.²⁷ Further, Hale LJ held that an obligation of confidence may have different “breadths”: a report brought into existence for certain authorised purposes may be disclosed to those concerned with those purposes, although not to others.

Applying that approach to S’s case, Hale LJ saw little difficulty in disclosing medical recommendation forms to the nearest relative, with whom there had to be consultation about the matters addressed there, or documents that would be before an MHRT to which S was entitled to apply.²⁸ There was a clear distinction for her Ladyship between disclosure to an identified individual for an identified purpose, and wider disclosure.²⁹

Finally, Hale LJ relied upon the requirements of procedural fairness, at common law and under Art. 6 ECHR, which require that anything relevant to a Court’s adjudication is disclosed to both parties unless there is another sufficiently powerful interest to outweigh it, for example, a risk of harm to a child.³⁰ For such an interest to outweigh that of fairness, it must, as usual, have a proper objective, and be proportionate to that objective.

25 *R (S) v Plymouth City Council* [2002] 1 WLR 2583

28 Paragraph 34 page 2595.

26 *above* paragraph 32 page 2594

29 Paragraph 49 page 2599

27 Paragraph 33 page 2594. Although this approach may beg the question of what is confidential which may often depend on context.

30 Paragraph 36 page 2595

Hale LJ found that the relevant interests in S's case could be summarised thus:

...the confidentiality of the information sought; the proper administration of justice; the mother's right of access to legal advice to enable her to decide whether or not to exercise a right which is likely to lead to legal proceedings against her if she does so; the rights of both C and his mother to respect for their family life and adequate involvement in decision-making processes about it; C's right to respect for his private life; and the protection of C's health and welfare. In some cases there might also be an interest in the protection of other people, but that has not been seriously suggested here.³¹

Balancing these considerations, the Court concluded that they favoured an order for disclosure of the information sought to S and the experts that she had instructed.

There are three further authorities which offer some assistance in defining the nature and extent of common law rights and obligations in respect of the health records of incapable adults. In *R v Mid Glamorgan Family Health Services Authority ex p Mann*³² the Court considered the extent of hospitals' rights over health records. It held that a hospital must act in the best interests of its patient, or in that case ex-patient, in deciding to what to do with his records. The case was resolved by an agreement that the records would be disclosed to the applicant's expert.

In *R v Secretary of State for the Home Department ex parte Amnesty International, Kingdom of Belgium and others*, unreported, 15 February 2000, the Court directed the disclosure of the medical report on General Pinochet to those states which sought his extradition. It was satisfied that the requirements of fairness outweighed those of confidentiality.

In *A Health Authority v X*³³ the Court of Appeal again identified a particular public interest that outweighed that of confidentiality – the public interest in effective disciplinary proceedings. The Court held that the substantial public interest in the proper administration of professional disciplinary proceedings, particularly in the field of medicine, was analogous to the public interest in the administration of the criminal justice system.

Having regard to these dicta, it might be argued that an appropriate scheme for access to and disclosure of the health and social work records of incapable adults should emerge from a broad construction of the DPA and its associated regulations in the light of the common law. The Data Protection (Subject Access) (Modification) (Health) Order 2000 proceeds on the basis that a person with parental responsibility, in the case of a child, or a person appointed by the Court of Protection³⁴, in the case of an adult incapable of managing his property and affairs, may request information on behalf of the child or incapable adult concerned. In the absence of such an individual, a litigation friend, nearest relative, or other "statutory" individual with an appropriate interest in the information sought, should be permitted to make a request on the incapable person's behalf. Where no relevant statutory scheme is engaged by the subject matter of the request, an appropriate individual, having regard to the incapable adult's best interests should be permitted to make the request. Certainly, it seems appropriate to tie the right of the third party to make the request and receive the information to both its subject matter and the third party's involvement in the life of the incapable adult. Indeed, it might be said that the assumption that an

³¹ Paragraph 48 page 2599

³² *R v Mid Glamorgan Family Health Services Authority ex p Mann* [1995] 1 AllER 356

³³ *A Health Authority v X* [2001] EWCA Civ 2014

³⁴ Guidance suggests that this might also be an attorney under an Enduring Power of Attorney.

attorney or individual appointed by the Court of Protection should be entitled so to act is flawed since their powers are expressly limited to business, legal and financial matters and do not extend to decisions about health and social care.³⁵

The data processor's decision to disclose should be made having regard, first, to the restrictions imposed by the DPA itself, and then, second, to the best interests of the incapable adult. While it must be admitted that such an approach involves a great stretch in the words of the DPA, it nevertheless provides a workable framework that does not deprive incapable adults of the benefits conferred by the DPA while at the same time providing them with a reasonable amount of protection from abuse.

Interpreting the DPA thus would fulfill the State's positive obligations to allow access to personal information (held to be a potential obligation in *Gaskin v UK*³⁶) and to take steps to ensure the physical and psychological integrity of the disabled (established in the context of the provision of community care services in *Botta v Italy*³⁷ and *R (Bernard) v LB Enfield*³⁸).

MHRT: withholding and disclosure of reports

Rule 6(4) MHRT Rules 1984 empowers those required to provide reports to the MHRT on a patient to withhold part of the report from him³⁹ if, in the opinion of authority preparing the report, it should be withheld on the ground that its disclosure would adversely effect his health or welfare of him or others. Rule 12(2) MHRT Rules provides that the MHRT must, in respect of documents which have been so withheld, consider whether disclosure to the patient would adversely effect the health or welfare of the patient or others. Plainly, the Human Rights Act 1998 now requires that the MHRT carrying out this balancing exercise informed by the ECHR. However, the rights potentially engaged are numerous, and each may point in a different direction:

1. Art. 2 may require non-disclosure to the patient where to do so would threaten the life of, say, an informant
2. Art. 8(1), similarly, may impose a positive obligation not to disclose to protect the physical and psychological health of another person, particularly a vulnerable person
3. Art. 8(1) ECHR may impose a positive obligation not to disclose where to do so would jeopardise the physical and psychological health of the patient,
4. Art. 8(1) might also require disclosure to the patient where he should be allowed access to personal information about himself
5. Art. 6, the right to a fair hearing, may also require disclosure to the patient and to his representatives, to enable him to meet the case against him. This right might be in direct conflict with the positive obligation to protect a patient's health under Art. 8(1).

In this sense, the human rights context introduces no trump consideration into the deliberations of an MHRT on the question of disclosure.

35 *Re F* [1990] 2 AC 1

36 *Gaskin v UK* (1989) 12 EHRR 36

37 *Botta v Italy* (1998) 26 EHRR 241

38 *R (Bernard) v LB Enfield* [2002] EWHC 2282 (Admin).

39 Or the nearest relative if he is the applicant.

Where the MHRT must balance the interests of the patient against the wider community, and those concerned with his treatment and care, it is reasonably clear how each party may make its case. However, a particular difficulty arises where the individual who may be threatened by the disclosure of information contained in a report to which the patient seeks access is not a party to the MHRT. Art. 6 would usually require that such an individual be enabled to make representations on the issue of disclosure, but there is no express provision in the Rules for such an application. It might be undesirable to make that individual a “party” to the MHRT under r7(f) MHRT Rules where it would be inappropriate for him to have access to all the reports or to attend the hearing. However, the MHRT might allow the individual concerned to make representations on the issue of disclosure alone pursuant to r22(4) MHRT Rules.

MHRT: victims’ rights to information

The Code of Practice issued under s118 MHA gives the following guidance as to the information to be provided to victims and their families in respect of patients detained under Part III of the Act.

Where a patient detained under Part III of the Act is both competent and willing to agree to the disclosure of specified information about his or her care, this should be encouraged to enable victims and victims’ families to be informed about progress. It can be important to a patient’s rehabilitation that victims understand what has been achieved in terms of modifying offending behaviour ... Without prejudice to a patient’s right to confidentiality, care teams should be ready to discuss with him or her the benefits of enabling some information to be given by professionals to victims, within the spirit of the *Victim’s Charter (Home Officer, 1996)*. The patient’s agreement to do so must be freely given and he or she will need to understand the implications of agreeing to information being given to the victim(s). Care must be taken not to exert any pressure on the patients or this may bring into question the validity of the consent.⁴⁰

The position of victims or the relatives of victims in the MHRT was considered in two cases concerning G, a patient, and T, his ex-partner and mother of the child he killed. T believed that she was at risk from G, should he be discharged. She was notified of his application to the MHRT by the local police. T attended the MHRT hearing asking to see the medical reports, be present throughout the hearing and make submissions to the MHRT. G did not agree. The MHRT did not think it appropriate to accede to T’s request given the information it already had before it, believing that T could draw any other relevant information to its attention by making written representations, which she was invited to do under r14(1) MHRT Rules 1983. T applied for judicial review of the MHRT’s decision but permission was, perhaps not surprisingly, refused.

The parameters of the power of the MHRT to allow victims, past or potential, to involve themselves in its proceedings are circumscribed thus:

1. It may give notice of the proceedings to any person who, in its opinion, should have an opportunity of being heard. (r7(f) MHRT Rules)

⁴⁰ In *Munjaz [2003] EWCA Civ 1036* the Court of Appeal held that, in respect of seclusion, the Code should be observed unless there is good reason to depart from it in relation to specific groups of patients with well-defined characteristics, or individual patients.

Although this decision was concerned with seclusion, it is arguable that a similar approach should obtain in respect of all matters where fundamental rights are engaged. That should include patient confidentiality.

2. It must sit in private unless the patient requests a hearing in public and it is satisfied that a hearing in public would not be contrary to the patient's interests. (r21(1))
3. It may admit to the hearing such persons on such terms as it thinks fit. (r21(3))
4. Information about proceedings before it, and the names of the persons concerned must remain private, save as the MHRT may direct. (r21(5))
5. Subject to rule 21(4), which gives the MHRT power to exclude persons from its proceedings, the MHRT may allow any person to take such part in a hearing as it thinks proper. (r22(4))
6. Before or during any hearing it may call for such further information or reports as it may think desirable, and may give directions as to the manner in which and the persons by whom such material is to be furnished. (r15)

It is readily apparent, however, that these rules might allow a MHRT to form the view that it was appropriate to allow a victim to attend, even if that involved him hearing the evidence. Such a decision should, however, involve the most careful balancing of the public interest in patient confidentiality as against safety, or, arguably, a fair hearing. It is difficult to imagine what interest an individual such as T might have which could not adequately be met by being allowed to make written, or perhaps oral, representations, without knowing what was said about the patient before the MHRT. Further, it is doubtful whether the MHRT would have the power to disclose the reports before it to such an individual given that the Rules only provide for service of them on the patient, responsible authority and Secretary of State.

In G's case the MHRT, having given T the opportunity to make representations, went on to direct that he be conditionally discharged. T, on learning of this decision, then asked to be told the conditions on G's discharge, and the reasons for its deferral. The MHRT declined, relying on the House of Lords' judgment *Pickering v Liverpool Daily Post and Echo Newspapers plc*⁴¹ where it was held that it was a contempt of Court to publish the fact that a named patient had made an application to the MHRT for discharge, the date, time or place of the hearing, that he had been released from detention, or the conditions on his discharge or the reasons for its decision. T applied for judicial review of that decision.⁴² In the course of that application she sought further information about the level of risk G was believed to pose to others.

Scott Baker J, as he then was, deciding T's application, held that *Pickering* was concerned with protecting patients from press intrusion. It was not authority for the proposition that the MHRT was never empowered to provide the information sought by T to others.⁴³ Their Lordships left open the possibility, in accordance with the provisions set out above, that the cloak of privacy around MHRT proceedings might be lifted at the MHRT's discretion. Scott Baker J took the view that this interpretation accords with the words of s78(2)(e) MHA⁴⁴ and that r21 of the 1983 Rules must be read in that way.⁴⁵

41 *Pickering v Liverpool Daily Post and Echo Newspapers plc* [1991] 2 AC 370

42 *(R (T) v MHRT* [2002] *Lloyd's Rep Med* 324)

43 Paragraphs 18–21

44 Which creates a power to make provision "For enabling

a Tribunal to exclude members of the public, or any specified class of members of the public, from any proceedings of the tribunal, or to prohibit the publication of reports of any such proceedings or the name of any of the persons concerned in such proceedings".

45 Paragraphs 28–34

Scott Baker J held that the MHRT, when considering whether information should be disclosed, should ask what “need” the person concerned has for the information sought.⁴⁶ Scott Baker J then applied that test to the information sought by T, which she said was necessary in the interests of her safety. His Lordship found that the usual conditions on discharge as to residence, supervision and medical treatment were not relevant to T. However, a condition that the patient should not live in a particular area or communicate with a particular individual might be relevant, and there was “no reason” why information of that nature should not be made public.⁴⁷ T’s arguments advanced under Arts. 2 and 8 ECHR were rejected on the grounds that the evidence was inadequate to show that the threshold for engagement of those provisions was met in her case.⁴⁸

It was believed at the time of the judgment that the making explicit of this power of the MHRT would create a new decision-making burden on it and pave the way for a significant number of applications. However, I and my colleagues are not aware of any. It is interesting to consider what other information it might in other circumstances be appropriate for the MHRT to disclose and to whom. It seems difficult to identify information beyond that allowed by Scott Baker J in his judgment which it might be appropriate to disclose when, fundamentally, a victim or his relatives must be obliged to rely on the expert judgment of the MHRT in making decisions as to discharge, and health and social care providers in managing the patient in the community.

It should also be noted that, while s69 Criminal Justice and Court Services Act 2000 imposes an obligation on the probation service to consult victims of violent and sexual offenders, on whom a “relevant” custodial sentence has been imposed, on the conditions and requirements that should be imposed on the offender on release, Parliament has made no equivalent provision in relation to patients detained under Part III MHA.

Information-sharing and MAPPs

The Code of Practice contemplates information-sharing between health professionals and others in the public interest, particularly the protection of personal and health safety, but considers that it will be “occasional”.⁴⁹ In recent years, however, information-sharing between health, social services, the police and probation has become something more than occasional, particularly in the sphere of forensic psychiatry and patients detained under Part III MHA. There is a detailed statutory framework for the registration, monitoring and information-sharing of sex offenders and those who may pose a risk to children and vulnerable adults under the Sex Offenders Act 1997, Protection of Children Act 1999, Education (Restriction of Employment) Regulations 2000, Care Standards Act 2000. These statutory provisions define quite closely what steps may be taken in the regulation of the lives of such individuals. Less well-defined, however, and used increasingly in respect of the group of patients mentioned above, are Multi-agency Public Protection Panels (“MAPPPs”). These were established in fulfillment of the obligation imposed on police and probation agencies by s67 Criminal Justice and Courts Service Act 2000 to “establish arrangements for the purposes of assessing and managing the risks posed in that area by ... relevant sexual and

46 Paragraph 26

47 Paragraph 27

48 Paragraphs 40–49

49 Paragraph 1.8: “Ordinarily, information about a patient should not be disclosed without the patient’s

consent. Occasionally it may be necessary to pass on particular information to professionals or others in the public interest, for instance where personal health or safety is at risk. Any such disclosure should be in accordance with the principles set out in the Guidance [i.e. HSG(96)18]

violent offenders, and other persons who are considered by (them) to be persons who may cause serious harm to the public". The Home Office's publications acknowledge that MAPPs' memberships now extend far beyond the police and probation to include social services, education services, housing services and mental health care providers.

The involvement of MAPPs in considering the arrangements for persons with mental disorder has two key consequences. Firstly, it is increasingly common for the MAPP or the police to make representations to an MHRT considering an individual's discharge based on their assessment of the risk that he may pose if discharged, focussing solely upon "risk" and without specific regard to the context of the individual's mental disorder. Thus, where an individual poses a risk regardless of his mental disorder, the police and probation may become involved in decisions about his discharge. MHRTs appear prepared to allow police representatives to attend hearings and make representations, although I am not aware of cases where they have been permitted to remain present to hear all the evidence.

The second consequence of MAPPs for patients is that they have established a new, statutory forum with the purpose of information-sharing. Of particular concern in a human rights context is the extent to which health information is shared at a MAPP. A MAPP meeting at which health care providers attend has the potential to create a de facto expectation that information will be shared in the interests of public protection, rather than the historical position reflected in the guidance where information might be shared "occasionally" and in "exceptional circumstances". Moreover, information that might properly be shared with one individual or agency, may then be shared with others for whom there is not the same justification. There is little or no opportunity for scrutiny of the decisions made to share health information in those fora. In those circumstances there must be a residual concern that patients' Art. 8 rights are not adequately protected by these arrangements. Health information may be shared for purposes other than for which it was originally collected. It may be shared in circumstances where patients know little about MAPPs and their work, what information will be shared there and the use to which it will be put. It may be shared in circumstances where a Court may not be satisfied that there is an overriding public interest in its disclosure, having regard to the requirements of proportionality, for example, where more than necessary information about an individual's health is disclosed to the police.