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*359 W. v Egdell

Court of Appeal

9 November 1989

[1990] Ch. 359

Sir Stephen Brown P. , Bingham L.J. and Sir John May

Scott J. Sitting As Vice-Chancellor of the County Palatine of Lancaster

1989 Oct. 30, 31; Nov. 1; 9

1988 Nov. 22, 23, 24, 25, 28, 29; Dec. 9

Confidential Information—Breach of confidence—Public interest—Plaintiff detained as mental patient in secure hospital—Psychiatrist instructed by plaintiff to prepare independent report for use at mental health review tribunal—Plaintiff's application to tribunal withdrawn in view of unfavourable nature of report—Psychiatrist's disclosure of report to hospital—Copies of report sent to Home Office and tribunal—Whether psychiatrist in breach of duty of confidence owed to plaintiff

The plaintiff, who was suffering from paranoid schizophrenia, shot and killed five people and injured two others in 1974. At his trial, his plea of guilty to manslaughter on the ground of diminished responsibility was accepted and the court ordered that he be detained without limit of time in a secure hospital. In 1986, the plaintiff's responsible medical officer recommended to the Secretary of State that the plaintiff be transferred to a regional secure unit which could eventually lead to the plaintiff returning to the community. The Secretary of State refused consent. The plaintiff then applied to a mental health review tribunal and to support his application for a transfer to a regionally secure unit he sought a report from the defendant as an independent consultant psychiatrist. The defendant's report did not support the plaintiff's application, it disclosed that the plaintiff had a long standing and continuing interest in home made bombs and did not accept the view that the plaintiff was no longer a danger to the public. The plaintiff withdrew his application to the tribunal and refused to consent to the defendant disclosing the report to the medical officer at the secure hospital. The defendant, concerned that the report should be known to those treating the plaintiff, disclosed the report to the medical officer and copies were subsequently sent to the Secretary of State and the Department of Health and Social Security. When the Secretary of State, in accordance with section 71(2) of the Mental Health Act 1983 , referred the plaintiff's case to the mental health review tribunal in 1987, the plaintiff learnt that the defendant had disclosed his report and he issued writs claiming, inter alia, injunctions restraining the defendant from communicating the contents of his report and requiring him to deliver up all copies. The judge held, inter alia, that the duty of confidence owed by the defendant to the plaintiff not to divulge the contents of the report was overridden by the public interest in protecting the public by placing the report before the proper authorities and he dismissed the actions.

On appeal by the plaintiff: -

, dismissing the appeal, that, although the plaintiff had a personal interest to ensure that the confidence that he had reposed in the defendant was not breached, the maintenance of *360 the duty of confidence by a doctor to his patient was not a matter of private but of public interest; that the public interest in maintaining that confidence had to be balanced against the public interest in protecting others against possible violence; that the nature of the crimes committed by the plaintiff made it a matter of public interest that those responsible for treating and managing him had all the relevant information concerning his mental state before considering his release from hospital; that the information in the defendant's report was relevant information and the public interest in its restricted disclosure to the proper authorities outweighed the public interest that the

plaintiff's confidences should be respected; and that, since the defendant's disclosure had been properly made both in the public interest and in accordance with rule 81(g) of the General Medical Council's guidelines on professional conduct , the plaintiff's claims had properly been dismissed (post, pp. 416D-417A, 421C-G, 425B-D).

X v. Y [1988] 2 All E.R. 648 and Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109 , H.L.(E.) applied.

Per Bingham L.J. A restricted patient who believes himself unnecessarily confined has, of all members of society, perhaps the greatest need for a professional adviser who is truly independent and reliably discreet. Only the most compelling circumstances could justify a doctor in acting in a way which would injure the immediate interests of such a patient, as the patient perceived them, without obtaining his consent (post, p. 423B-C).

Decision of Scott J. post, p. 370D; [1989] 2 W.L.R. 689; [1989] 1 All E.R. 1089 affirmed.

The following cases are referred to in the judgments of the Court of Appeal:

Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109; [1988] 3 W.L.R. 776; [1988] 3 All E.R. 545, H.L.(E.) .

Attorney-General v. Mulholland; Attorney-General v. Foster [1963] 2 Q.B. 477; [1963] 2 W.L.R. 658; [1963] 1 All E.R. 767, C.A. .

Chantrey Martin v. Martin [1953] 2 Q.B. 286; [1953] 3 W.L.R. 459; [1953] 2 All E.R. 691, C.A. .

Hunter v. Mann [1974] Q.B. 767; [1974] 2 W.L.R. 742; [1974] 2 All E.R. 414, D.C. .

Initial Services Ltd. v. Putterill [1968] 1 Q.B. 396; [1967] 3 W.L.R. 1032; [1967] 3 All E.R. 145, C.A. .

Lion Laboratories Ltd. v. Evans [1985] Q.B. 526; [1984] 3 W.L.R. 539; [1984] 2 All E.R. 417, C.A. .

Parry-Jones v. Law Society [1969] 1 Ch. 1; [1968] 2 W.L.R. 397; [1968] 1 All E.R. 177, C.A. .

Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425

Tournier v. National Provincial and Union Bank of England [1924] 1 K.B. 461, C.A. .

X v. Y [1988] 2 All E.R. 648

The following additional cases were cited in argument before the Court of Appeal:

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A. B. v. C. D. (1851) 14 Dunlop 177

Bliss v. South East Thames Regional Health Authority [1987] I.C.R. 700, C.A. . *361

Francome v. Mirror Group Newspapers Ltd. [1984] 1 W.L.R. 892; [1984] 2 All E.R. 408, C.A. .

Fraser v. Evans [1969] 1 Q.B. 349; [1968] 3 W.L.R. 1172; [1969] 1 All E.R. 8, C.A. .

Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380; [1979] 3 All E.R. 177, C.A. .

Heywood v. Wellers [1976] Q.B. 446; [1976] 2 W.L.R. 101; [1976] 1 All E.R. 300, C.A. .

Hill v. Chief Constable of West Yorkshire [1989] A.C. 53; [1988] 2 W.L.R. 1049; [1988] 2 All E.R. 238, H.L.(E.) .

Jarvis v. Swans Tours Ltd. [1973] Q.B. 233; [1972] 3 W.L.R. 954; [1973] 1 All E.R. 71, C.A. .

Perry v. Sidney Phillips & Son [1982] 1 W.L.R. 1297; [1982] 3 All E.R. 705, C.A. .

Reg. v. Uljee [1982] 1 N.Z.L.R. 561

The following cases are referred to in the judgment of Scott J.:

Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109 ; [1988] 2 W.L.R. 805 ; [1988] 3 All E.R. 545 , Scott J. and C.A.; [1990] 1 A.C. 109; [1988] 3 W.L.R. 776; [1988] 3 All E.R. 545, H.L.(E.) .

Bliss v. South East Thames Regional Health Authority [1987] I.C.R. 700, C.A. .

Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380; [1979] 3 All E.R. 177, C.A. .

Hunter v. Mann [1974] Q.B. 767; [1974] 2 W.L.R. 742; [1974] 2 All E.R. 414, D.C. .

Parry-Jones v. Law Society [1969] 1 Ch. 1; [1968] 2 W.L.R. 397; [1968] 1 All E.R. 177, C.A. .

Reg. v. King [1983] 1 W.L.R. 411; [1983] 1 All E.R. 929, C.A. .

X. v. Y. [1988] 2 All E.R. 648

The following additional cases were cited in argument before Scott J.:

*362

A. B. v. C. D. (1851) 14 Dunlop 177

Albert (Prince) v. Strange (1849) 1 Mac. &; G. 25

Archer v. Brown [1985] Q.B. 401; [1984] 3 W.L.R. 350; [1984] 2 All E.R. 267

Argyll (Duchess of) v. Duke of Argyll [1967] Ch. 302; [1965] 2 W.L.R. 790; [1965] 1 All E.R. 611

Ashburton (Lord) v. Pape [1913] 2 Ch. 469, C.A. .

Ashingdane v. Secretary of State for Social Services (unreported), 18 February 1980 ; Court of Appeal (Civil Division) Transcript No. 47 of 1980, C.A. .

Attorney-General v. Associated Newspapers Group Plc. [1989] 1 W.L.R. 322; [1989] 1 All E.R. 604, D.C. .

Calcraft v. Guest [1898] 1 Q.B. 759, C.A. .

Comfort Hotels Ltd. v. Wembley Stadium Ltd. [1988] 1 W.L.R. 872; [1988] 3 All E.R. 53

D. v. National Society for the Prevention of Cruelty to Children [1978] A.C. 171; [1977] 2 W.L.R. 201; [1977] 1 All E.R. 589, H.L.(E.) .

Distillers Co. (Biochemicals) Ltd. v. Times Newspapers Ltd. [1975] Q.B. 613; [1974] 3 W.L.R. 728; [1975] 1 All E.R. 41

Francome v. Mirror Group Newspapers Ltd. [1984] 1 W.L.R. 892; [1984] 2 All E.R. 408, C.A. .

Fraser v. Evans [1969] 1 Q.B. 349; [1968] 3 W.L.R. 1172; [1969] 1 All E.R. 8, C.A. . *362

Gartside v. Outram (1856) 3 Jur.N.S. 39

Hubbard v. Vosper [1972] 2 Q.B. 84; [1972] 2 W.L.R. 389; [1972] 1 All E.R. 1023, C.A. .

I.T.C. Film Distributors Ltd. v. Video Exchange Ltd. [1982] Ch. 431; [1982] 3 W.L.R. 125; [1982] 2 All E.R. 241

Lion Laboratories Ltd. v. Evans [1985] Q.B. 526; [1984] 3 W.L.R. 539; [1984] 2 All E.R. 417, C.A. .

Malone v. Metropolitan Police Commissioner [1979] Ch. 344; [1979] 2 W.L.R. 700; [1979] 2 All E.R. 620

Reg. v. Board of Inland Revenue, Ex parte Goldberg [1989] Q.B. 267; [1988] 3 W.L.R. 522; [1988] 3 All E.R. 248, D.C. .

Reg. v. Bracknell Justices, Ex parte Griffiths [1976] A.C. 314; [1975] 3 W.L.R. 140; [1975] 2 All E.R. 881, H.L.(E.) .

Reg. v. Licensing Authority Established under Medicines Act 1968, Ex parte Smith Kline & French Laboratories Ltd. [1990] A.C. 64 ; [1988] 3 W.L.R. 896; [1989] 1 All E.R. 175, C.A. .

Reg. v. Statutory Visitors to St. Lawrence's Hospital, Caterham, Ex parte Pritchard [1953] 1 W.L.R. 1158; [1953] 2 All E.R. 766, D.C. .

Reg. v. Tompkins (1977) 67 Cr.App.R. 181, D.C. .

Reg. v. Uljee [1982] 1 N.Z.L.R. 561

Saltman Engineering Co. Ltd. v. Campbell Engineering Co. Ltd. (1948) 65 R.P.C. 203, C.A. .

Schering Chemicals Ltd. v. Falkman Ltd. [1982] Q.B. 1; [1981] 2 W.L.R. 848; [1981] 2 All E.R. 321, C.A. .

Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425

W. (E. E. M.), In re [1971] Ch. 123; [1970] 3 W.L.R. 87; [1970] 2 All E.R. 502 , Ct. of Protection

Waldron, Ex parte [1986] Q.B. 824; [1985] 3 W.L.R. 1090 ; sub nom., Reg. v. Hallstrom, Ex parte W. [1983] 3 All E.R. 775, C.A. .

Waugh v. British Railways Board [1980] A.C. 521; [1979] 3 W.L.R. 150; [1979] 2 All E.R. 1169, H.L.(E.) .

Weld-Blundell v. Stephens [1919] 1 K.B. 520, C.A. .

White v. Wilson (1806) 13 Ves.Jun. 87

Winch v. Jones [1986] Q.B. 296; [1985] 3 W.L.R. 729; [1985] 3 All E.R. 97, C.A. .

X. v. United Kingdom (1981) 4 E.H.R.R. 188

ACTION

On 22 December 1987, the plaintiff, W., a patient detained in a secure hospital, issued a writ against the first defendant, Dr. H. G. Egdell, claiming (1) an injunction restraining the defendant from communicating the contents of a report dated 29 July 1987 made by the defendant concerning the plaintiff or any other future report whether written or oral prepared by the defendant concerning the plaintiff to any person or persons and further from expressing any opinion whether written or oral concerning the plaintiff to any person or persons; (2) an injunction ordering the defendant to deliver up all copies of the report dated 29 July 1987 and any further reports or written information in the care custody or control of the defendant prepared by the defendant concerning the plaintiff. On the same day Judge O'Donoghue, sitting as a judge of the High Court, granted an ex parte injunction restraining the first defendant from communicating to any one the contents of his report, and that ex parte injunction was, by consent, continued until *363 trial. On 19 July 1988, the plaintiff issued a writ against the Secretary of State for the Department of Health and Social Security, the Secretary of State for the Home Office, the Moss Side and Park Lane Hospitals Board and the Mersey Mental Health Review Tribunal, claiming similar relief, but also claiming against the Home Office and the hospitals board, damages for breach of the duty of confidentiality, including aggravated damages. On 27 July 1988, an order was made consolidating the two actions.

The facts are stated in the judgment.

Geoffrey Robertson Q.C. and Nicholas Orr for the plaintiff. The report prepared by Dr. Egdell for the Mental Health Review Tribunal proceedings contains confidential information about the plaintiff, and is not solely opinion. Its disclosure was a gross breach of the duty of confidentiality resting on Dr. Egdell

in the circumstances. The report should be treated as confidential on two grounds: first, because the plaintiff was seeking advice in relation to legal proceedings from an expert, and confidentiality is essential to the administration of justice. The duty of confidence which he owed is binding in every case. With the exeception only when the adviser finds himself or herself privy in some way to criminal conduct. Secondly because there existed between the plaintiff and Dr. Egdell the relationship of doctor and patient. The duty of confidence is of particular importance to the practice of psychiatry, which is so dependent for any insight it might vouchsafe into the workings of the mind, on utter candour and trust from the patient.

The plaintiff was a mental patient detained without limit of time in a secure hospital. The only avenue open to him for his discharge was by means of an application to the Mental Health Review Tribunal. The plaintiff had made such an application to the tribunal, and for that purpose a psychiatric report had been commissioned. That application was withdrawn after the receipt of Dr. Egdell's adverse report, which was the only adverse report as to his mental condition during the last four years. Although it was adverse the plaintiff and his solicitors decided to act upon its recommendation and go through the further tests recommended, so that doubts as to the plaintiff's mental state could be removed, and meanwhile decided that the report must remain confidential. Strict instructions were given to Dr. Egdell against disclosure, but Dr. Egdell, without intimating his intention to either the plaintiff or his solicitors, decided that the report should be seen by those who had responsibility for the plaintiff. The report was prepared simply for the plaintiff and his legal advisers, and Dr. Egdell had no right to assume that it would certainly be shown to the tribunal, or to supply copies of it to third parties. A copy of the report was sent or found its way, in circumstances of some mystery, to the Home Office, who made use of it, copies being sent to the tribunal. There were thus also breaches of confidence by the second to fifth defendants. The report was re-typed, with the name of the intended recipient altered to disguise the fact that it had been prepared for the plaintiff's solicitors. Use of the report should not be permitted, and this action has been brought to restore the plaintiff, so far as possible, to his position before the *364 confidence owed to him by Dr. Egdell was breached. The plaintiff is entitled to restrain all the defendants from making use of the report. The court cannot restore to the plaintiff the peace of mind that he enjoyed prior to the breach. It can also re-assert the principle which it is contended is vital to public safety, that all mental patients can feel free to make full disclosure of their innermost thoughts and fantasies to those retained by them to advise them professionally, especially when such advice is for the purpose of legal proceedings. The reports of the Aavold Committee, which was established so as to assist the Home Secretary in exercising his discretionary functions, are kept confidential and are not disclosed to the tribunal.

The tribunal has a power to discharge a patient, which is exceptional to the normal control exercised by the Home Secretary. [Reference was made to sections 70, 71, 72 and 73 of the Mental Health Act 1983 .] Dr. Egdell's affidavit evidence shows (i) that his report was formed in circumstances involving a duty of confidence; (ii) that he knows that his report was for use in legal proceedings, so that the ordinary principles of legal professional privilege applied; (iii) that he breached that duty by disclosing his report and its contents to Dr. Hunter; (iv) that he took steps to ensure that a copy of his report should be sent to the Home Office. At the time of these breaches there was no present threat of discharge, involving any risk to the public. The risk in this case was merely that the plaintiff would be transferred to a regional secure unit, at some time in the future in 1988. The public interest defence is on the basis of an overriding duty to the public, and it must therefore depend on the extent of the risk to the public which is involved. To justify a breach of confidence the nature of the material disclosed must be serious, or be capable of being classified as "dynamite." An example would be a confession of an intention to kill.

The opinions expressed in Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425 provide the fullest forensic discussion of the public interest exception, although they relate to the facts far removed from the present case. Here, at the time of the breach in August 1987, there was no prospect of the plaintiff being set at liberty, since the tribunal application had been withdrawn and he was under the control of the Home Office, which as Dr. Egdell knew was opposed not only to the plaintiff's discharge but even to his removal to the less strict regime of a regional secure unit. The report merely highlights information already known that might become buried in the records and voices differences in diagnosis, of a speculative nature requiring further tests to be performed; but nothing of immediate risk to the public. It is accepted that once Dr. Hunter was in receipt of the report, he might be under some duty to disclose matters to the Home Office, but that duty was not strong enough or important enough to override the plaintiff's private right of confidence. The only relief sought against the hospital is the return of the document to the plaintiff. [Reference was made to Duchess of Argyll v. Duke of Argyll [1967] Ch. 302 , In re W. (E. E. M.) [1971] Ch. 123 ; White v.

Wilson (1806) 13 Ves.Jun. 87 and Prince Albert v. Strange (1849) 1 Mac. & G. 25 .] The Secretary of State has a discretion as to what "information" he supplies under *365 rule 6(2) of the MentalHealth Review Tribunal Rules 1983 (S.I. 1983 No.942) . He has no inevitable duty to forward the report to the tribunal. The breaches of the Home Office were in sending the report to Dr. Coorey, in using the report itself as a "statement" and in sending it to the tribunal.

The public interest in disclosure is undermined by the public Interest sacrificed by disclosure, i.e. the protection of documents prepared for use in legal proceedings and the ability of patients to make full and frank disclosure to their psychiatrists. [Reference was made to X. v. United Kingdom (1981) 4 E.H.R.R. 188 ; Attorney-General v. Associated Newspapers Group Plc. [1989] 1 W.L.R. 322 ; Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109 ; A.B. v. C.D. (1851) 14 Dunlop 177; X. v. Y. [1988] 2 All E.R. 648 , 653, 657, 661 and Reg. v. Board of Inland Revenue, Ex parte Goldberg [1989] Q.B. 267 .]

Statutory exceptions to a doctor's duty of confidence are to be found in the case of communicable diseases: see Public Health Act 1936 ; in the case of information about terrorist activities: see Prevention of Terrorism (Temporary Provision) Act 1976 and in the case of the identification of drivers of stolen cars, see Road Traffic Act 1972 and Hunter V. Mann [1974] Q.B. 767 . [Reference was made to Tarasoff v. Regents of the University of California (1976) 17 Cal.3d 425.] There is a public interest in encouraging patients in getting an independent psychiatric assessment. Patients have a right to such an assessment in confidence, and it is desirable that patients should be able to place trust in psychiatrists. A patient subject to a restriction order should in the public interest be able to speak without inhibition to an independent psychiatrist for the purpose of receiving as assessment of his mental condition, because the psychiatrist may recommend treatment. On the question of legal professional privilege: see Cross on Evidence, 5th ed. (1979), p. 388, the Police and Criminal Evidence Act 1984, sections 8, 9, and 10(1)(b) and (c) ; Comfort Hotels Ltd. v. Wembley Stadium Ltd. [1988] 1 W.L.R. 872 ; Lord Ashburton v. Pape [1913] 2 Ch. 469 ; Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380 , 1385 per Lord Denning M.R. and Distillers Co. (Biochemicals) Ltd. v. Times Newspaper Ltd. [1975] Q.B. 613 . [Reference was also made to I.T.C. Film Distributors Ltd. v. Video Exchange Ltd. [1982] Ch. 431 ; Reg. v. Tompkins (1977) 67 Cr.App.R. 181 ; Reg. v. Uljee [1982] 1 N.Z.L.R. 561 ; Calcraft v. Guest [1899] 1 Q.B. 759 ; Reg. v. Statutory Visitors to St. Lawrence's Hospital, Caterham, Ex parte Pritchard [1953] 1 W.L.R. 1158 ; the Police and Criminal Evidence Act 1984, section 10 and Reg. v. King [1983] 1 W.L.R. 411 .] There is a distinction between communications which pass between client and expert, and evidence in writing which only came into being for the purpose of examination and documents already in existence which are sent to the expert for the purpose of being examined by him. The latter are not privileged, whereas the former are. [Reference was made to Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380 , 1385D-E.] The plaintiff should have the full protection of legal privilege up to the point at which a clear public interest requires it to be set aside. It is accepted that the balance of public interests may be different where third parties are concerned: Schering Chemicals Ltd. v. Falkman Ltd. [1982] 1 Q.B. 1 . *366 The remedies sought are, as against Dr. Egdell, delivery up of copies of the report, an injunction restraining use, damages or equitable compensation, and damages for injured feeling (Archer v. Brown [1985] Q.B. 401): as against the second and the third defendants, delivery up of copies and an injunction against use of the information, damages and declaratory relief, and similarly also as against the fourth and fifth defendants. [Reference was also made to D. v. National Society for the Prevention of Cruelty to Children [1978] A.C. 171 ; Gartside v. Outram (1856) 3 Jur.N.S. 39 , and Saltman Engineering Co. Ltd. v. Campbell Engineering Co. Ltd. (1948) 65 R.P.C. 203 .]

Kieran Coonan for Dr. Egdell, the first defendant. Dr. Egdell's report did not provide an alternative diagnosis to that of the other doctors who had examined the plaintiff; it merely pointed to a possible alternative based on the information derived from the plaintiff of his long standing interest in explosives and guns. Dr. Cope's report referred to the fact that "his interest in guns shooting and fireworks has been present for many years." The report was dated 15 May 1985, and concluded that "a further period of assessment is required" and examination of his "pre-morbid personality" before a transfer to a regional secure unit could be considered. There was evidence of explosives and bomb-making at the time of or immediately before the commission of the index offences. But although there was some reference to the plaintiff's interest in explosives to be found in the records on the file at the hospital, this aspect of the case was not dealt with by his responsible medical officer, Dr. Ghosh, in any of her reports. The opinion of those in charge of the plaintiff seemed to be that there were now no overt symptoms of psychosis and that his paranoid schizophrenia had been brought under control. If the opinion of Dr. Egdell is correct, then it would be of crucial importance in any

decision as to the management of the plaintiff. It seems that Dr. Cope's earlier report must have been overlooked. Dr. Egdell's report while agreeing that at the time of the index offences the plaintiff was suffering from a mental illness, referred to the possibility that the illness might be due to a paranoid psychosis rather than a paranoid schizophrenia, or in other words that he was suffering from a psychopathic deviant personality. He concluded that "his interest in guns was profound, very prolonged, and in the last years before the offence, clearly abnormal." The sole issue is that of public interest, in connection with the relationship of doctor and patient, and the duty of confidence arising from that relationship. The issue of legal professional privilege does not affect the position of Dr. Egdell.

Of the alleged breaches of confidence complained of, the retyping of the report and the failure to inform the plaintiff's solicitors of the intention to disclose the report to the hospital authorities are irrelevant. Dr. Egdell felt strongly about the matter; he would not lightly break the General Medical Council's guidelines, but wished merely that the facts which he had learnt from his interview should be placed on record. In his opinion the plaintiff might be suffering from a paranoid psychosis: that view was supported by Dr. Boyd's report of July 1984. It appeared *367 to Dr. Egdell that that possible diagnosis had been overlooked in the more recent assessment of the plaintiff's mental state.

There were two public interests in favour of disclosure: a reduction in the risks to public safety from the commission of future criminal acts by preventing the discharge of a mental patient unless there was no doubt of the lack of any danger to the public that might be caused thereby and the performance of the statutory duties imposed upon the responsible medical officer in charge of the patient, the Home Office and the Mental Health Review Tribunal. There can be no general rule since every case depends on its individual circumstances. The questions that needed to be asked were: (i) was there at the time of disclosure a risk to public safety in the event of a possible release of the plaintiff being ordered by the tribunal? And in this regard any risk is a serious risk. It should be borne in mind that the first stages towards the plaintiff's discharge had been set in motion in November 1984, and that that had been followed by the reports of Dr. Cope and of Dr. Tulloch supporting his transfer to a regional secure unit, (ii) would disclosure reduce the risk? While disclosure should be no greater than reasonably necessary, any damage to the plaintiff's right to confidentiality would be overridden by the public interest in disclosure. The overriding question was "would a reasonable psychiatrist placed in Dr. Egdell's position and believing the facts to be as stated in his report have acted as he did in breaching his duty of confidence in dealing with the case of a patient who had killed five times, and who unless the diagnosis was absolutely right, might, if released, kill again?"

Correct diagnosis is vital in the management of a mental patient and any information as to the patient's mental state should be made available to those who are charged with the task of deciding as to his future. The disclosure which Dr. Egdell made to Dr. Hunter at the hospital was not broader than was necessary. This was not a case similar to Francome v. Mirror Group Newspapers Ltd. [1984] 1 W.L.R. 892 . While it is accepted that there is a public interest in people being able to unburden themselves to psychiatrists, Dr. Egdell, after his interview, was in possession of new information, the significance of which was rejected by Dr. Ghosh. [Reference was also made to Fraser v. Evans [1969] 1 Q.B. 349 ; Tarasoff v. Regents of the University of California , 17 Cal. 3d 425; X. v. Y. [1988] 2 All E.R. 648 and Reg. v. Licensing Authority Established under Medicines Act 1968, Ex parte Smith Kline & French Laboratories Ltd. [1990] A.C. 64 .]

John Laws and Philip Havers for the second, third and fourth defendants. Under the Crown Proceedings Act 1947 , no injunction can be granted against the Crown: see section 21 of the Act. In lieu thereof declarations may be granted, setting out the rights of the parties. Similarly no order may be made against the Crown for the delivery up of land or other property: section 21(1)(b) . If Dr. Egdell is not held to be liable, then clearly the Home Secretary should not be held liable either. This is accepted also by the plaintiff's counsel. The public interest is a matter which arises generally in relation to the law of confidence. There are reasons why the Home Secretary should succeed in this case, irrespective of whether Dr. Egdell is held liable or not, owing to the *368 public responsibility of the Department of State. Questions of legal professional privilege may arise if a self-standing cause of action is asserted to restrain breaches of privilege. On the facts of the present case the presence or absence of Dr. Egdell's report from the decision-making process, would, on the plaintiff's own evidence, affect his chances of transfer or discharge, and it is thus a highly material document for the purposes not only of assessing, but also of containing any danger to the public that the plaintiff represents. There may be cases in which, on balance, the reports of psychiatrists on restricted patients are not sufficiently material to justify disclosure.

Dr. Egdell will be successful in his defence if he can establish a just cause or excuse based upon the requirements of the public interest for disclosing his report, in effect, to the second to fourth defendants; such public interest can only consist in the need for those defendants to have such material in their hands for the purpose of forming fully informed views as to the proper future handling of the patient having regard to the interests of public safety and their responsibilities; if Dr. Egdell's defence succeeds, then the second to fourth defendants are also bound to succeed because, ex hypothesi, it will have been held that the public interest requiring them to have access to such material overrides any duty of confidence, even that owed by the primary confidee. The submissions advanced on Dr. Egdell's behalf are therefore adopted. [References were made to Lion Laboratories Ltd. v. Evans [1985] Q.B. 526 ; Hubbard v. Vosper [1972] 2 Q.B. 84 and Malone v. Metropolitan Police Commissioner [1979] Ch. 344 .]

The responsibilities of the Department of Health and of the Hospital Board are, so far as relevant, contained in section 4 of the National Health Service Act 1977 (as amended), section 145 of the Mental Health Act 1983 ; the Mental Health Review Tribunal Rules of 1983 and in particular rule 6 of those rules. The result is that if the Secretary of State has in his hands information of the sort contained in Dr. Egdell's report he is bound to take it into account in forming his view as to the patient's suitability for discharge or transfer. The report is clearly relevant to the formation of that view and may be of critical importance. The Secretary of State cannot properly leave out of account something that in discharge of his duty to the public he is required to have regard to. Were such a document to be left out of account it could form the basis for a judicial review. The question is whether the statutory duty applies to all information from whatever source. The onus of showing that the Home Secretary's responsibility was in some way circumscribed must rest with the plaintiff. In Parry-Jones v. Law Society [1969] 1 Ch. 1 , 7, 9, the contractual duty of confidence was overridden by the Law Society's statutory rules. In Hunter v. Mann [1974] Q.B. 767 , 774, the statutory duty of a doctor overrode his duty of confidentiality.

The hospital board is an arm or agent of the Secretary of State to which the management of the hospital board is entrusted. Disclosure of Dr. Egdell's report to the hospital board was made to it in that capacity. The board has a general public responsibility for the containment and care of the patients. Section 41(6) of the Mental Health Act 1983 requires the responsible medical officer to report periodically on the *369 patient to the Secretary of State. The same duties apply to the Home Secretary under rule 6(2) as apply to the Secretary of State for Health, as responsible authority, under rule 6(1) of the rules. [Reference was also made to section 42(1) and (3), 67(1), 71(1), 72(1)(b) and 73(1), (4) and (5) of the Mental Health Act 1983 .] So neither the Home Office nor the Department of Health have acted unlawfully; the plaintiff has no case for relief.

On the question of legal privilege, the plaintiff's arguments are not correct. There is no property in a witness, even if the witness is an expert witness. Dr. Egdell would be a compellable witness; see rule 14 of the Mental Health Review Tribunal Rules 1983 . He could also volunteer his evidence. In regard to compellability Dr. Egdell, as a doctor, is in a totally different position from a solicitor who is not a compellable witness: see Cross on Evidence, 5th ed. (1979), p. 388. [Reference was made to Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380 , 1385, 1387 and Reg. v. King [1983] 1 W.L.R. 411 , 413, 415.] The facts that were revealed by the plaintiff to Dr. Egdell are not such as are protected by privilege. The plaintiff could be asked about his previous history in the witness box, because the facts were already in existence. But the manner of relating them may also be relevant. A distinction must however be drawn between "instructions" and "opinion." The privilege is only against production in court. Damages for disappointment are limited to cases of breach of contract in relation to holidays.

Nigel Pleming for the Mersey Mental Health Review Tribunal. The tribunal wishes to take a neutral stance in this matter. It adopts the submissions made by the other defendants, so far as relevant. In short if the Home Office has a right to send Dr. Egdell's report to the Mental Health Review Tribunal, then the tribunal has a power to receive it. The court has no jurisdiction to entertain the case asserted against the tribunal; see section 139 of the Mental Health Act 1983 . Dr. Egdell's report was received by the tribunal under rule 6(2) of the Mental Health Review Tribunal Rules 1983 made pursuant to section 78(2)(g) of the Mental Health Act 1983 . It was thus received in exercise of a statutory power. The report was distributed in accordance with the power set in rule 12 of the rules. The Mental Health Review Tribunal, as a health authority, constitutes a "person" within the meaning of section 139 of the Act of 1983: see section 139(4) . The protection afforded by section 139 cannot be waived: see Reg. v. Bracknell Justices, Ex parte Griffiths [1976] A.C. 314 and Ashingdane v. Secretary of State for Social Services (unreported) 18 February 1980; Court of Appeal (Civil Division) Transcript No. 47 of

1980. There is no allegation of bad faith or absence of reasonable care, nor could there be. Section 139 only restricts civil or criminal proceedings against a party: see Ex parte Waldron [1986] Q.B. 824 . It therefore follows that the only route open to the plaintiff, as against the tribunal, is by means of judicial review. Now that the tribunal is seized of the report it would be wrong for the tribunal to act in pretended ignorance of the information which it contains. The role of the Mental Health Review Tribunal is unusual in that it is inquisitorial: see *370 rules 11, 14, 15, and 22(2) of the Mental Health Review TribunalRules 1983 . The statutory duties imposed upon the tribunal are concerned largely with the gathering of information. In order to make an order the tribunal must be satisfied about a negative, namely that the patient is not dangerous. Reliance is placed upon Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380 , with particular reference to the words of Lord Denning M.R. at p. 1384G-H:

Robertson Q.C. in reply. It is conceded that there is no allegation of bad faith or of lack of care being advanced. The tribunal is not "a person," its unsolicited receipt of the report was not an act done pursuant to statute. References to liability in the Act means liability to "damages." Finally section 139 should be construed narrowly, and the plaintiff is entitled to a declaration. [Reference was made to Reg. v. Bracknell Justices, Ex parte Griffiths [1976] A.C. 314 ; Winch v. Jones [1986] Q.B. 296 ; White v. Wilson (1806) 13 Ves. Jun. 87; Ex parte Waldron [1986] Q.B. 824 ; Waugh v. British Railways Board [1980] A.C. 521 and Weld-Blundell v. Stephens [1919] 1 K.B. 520 .]

Disclosure of adverse reports by psychiatrists etc. would reduce the number of independent reports being sought and would thus be detrimental in the interests of public safety.

9 December 1988. SCOTT J.

read the following judgment. This case has required an examination in an unusual context of the breadth of the duty of confidentiality owed by a doctor to his patient. The patient is the plaintiff, to whom I will refer as "W." The first defendant, Dr. Egdell, is the doctor. At the beginning of the trial I made an order under section 11 of the Contempt of Court Act 1981 prohibiting the publication of the name of the plaintiff. I propose to continue that order. It may be that the details given in this judgment of the background to the case will enable those who are minded to do so to identify the plaintiff. That possibility is unfortunate but, in my view, unavoidable if this judgment is to be made public. No one has suggested it should not be made public.

About ten years ago W. shot the four members of a neighbouring family. He shot another neighbour who had come to investigate the shooting. He then drove off in his car, throwing hand-made bombs as he did so. Later the same day he shot two more people, not neighbours, but strangers to him. Five of his victims died of their injuries. The other two needed major surgery for serious bullet wounds. W. was diagnosed as suffering from paranoid schizophrenia. It was believed by the doctors who examined him that he had been suffering from this illness for about two years before the offences. The illness involved delusions that he was being persecuted by his neighbours. In the circumstances W.'s plea of guilty to manslaughter on the grounds of diminished responsibility was accepted by the Crown and he was convicted accordingly. Orders were made under sections 60 and 65 of the Mental Health Act 1959 , now sections 37 and 41 of the Mental Health Act 1983 , providing for his detention without limit of time. He was at first detained at Broadmoor Hospital. In 1981 he was transferred, in accordance with a transfer direction given by the Home Secretary, to a secure hospital in the North *371 of England. References hereafter in this judgment to "the hospital" will be references to this hospital where W. is still detained.

I must describe in some detail the statutory scheme under which W., and persons like him, are detained. Section 37(2)(a) of the Mental Health Act 1983 enables a hospital order to be made if, inter alia:

> "the court is satisfied . . . that the offender is suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment . . ."

Section 41(1) provides:

> "Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the

> offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section, either without limit of time or during such period as may be specified in the order; and an order under this section shall be known as 'a restriction order'."

Section 41(3) sets out the restrictions that apply to a person subject to a restriction order. These include the requirement that the transfer of the patient to another hospital can only be carried out with the consent of the Home Secretary: see subsection (3)(c)(ii) .

W. is subject to a hospital order and a restriction order; both orders were made by the Crown Court on his conviction.

Section 41(6) provides:

> "While a person is subject to a restriction order the responsible medical officer shall at such intervals (not exceeding one year) as the Secretary of State may direct examine and report to the Secretary of State on that person; and every report shall contain such particulars as the Secretary of State may require."

The "responsible medical officer" is the registered medical practitioner in charge of the patient: see section 55(1) . The Secretary of State referred to in subsection (6) is the Home Secretary.

From March 1984 to January 1988 W.'s responsible medical officer was Dr. Ghosh. Dr. Ghosh was transferred to Broadmoor Hospital in January 1988. Since then W.'s responsible medical officer has been Dr. Coorey. Both Dr. Ghosh and Dr. Coorey are consultant psychiatrists.

The Home Secretary has extensive powers over and in connection with persons subject to restriction orders. These powers are set out in section 42 of the Act of 1983. There is power under subsection (1) to direct that the special restrictions set out in section 41(3) shall cease to apply to the patient. The power is exercisable if the Home Secretary "is satisfied that . . . a restriction order is no longer required for the protection of the public from serious harm . . ."

Under subsection (2) the Home Secretary may, either absolutely or subject to conditions, discharge the patient from the secure hospital *372 where he is held. And subsection (3) gives power to the Home Secretary to recall a patient who has been conditionally discharged under subsection (2).

These statutory powers are discretionary powers and the Home Secretary is, in the exercise of his discretion, the guardian of the public interest. It is easy to conclude that the safety and protection of members of the public will be in the forefront of the Home Secretary's mind when contemplating the exercise of any of these discretions. And it may reasonably be expected that the Home Secretary will expect to be kept informed of all relevant matters and views concerning the patient in question. The contents of the patient's hospital file, including the reports from time to time submitted pursuant to section 41(6) and also the patient's case notes, will be available to the Home Secretary.

A patient subject to a restriction order has an alternative avenue by means of which to seek to be relieved from the restrictions imposed by the order. The Mental Health Act 1959 provided for the setting up of mental health review tribunals to review the cases of patients detained under the provisions of the Act. The system was continued by the Act of 1983: see section 64 . Four such tribunals have been established. The Mersey Mental Health Review Tribunal covers the area in which the hospital is situated. The constitution of mental health review tribunals is provided for in Schedule 2 to the Act of 1983. The members are nominated by the Lord Chancellor who also appoints a chairman. The members who constitute the tribunal for the purposes of a particular case will usually be three in number and will be nominated by the chairman. One will be a lawyer, another will have a medical, usually a psychiatric qualification. The procedure of tribunals is provided for in the Mental Health Review Tribunal Rules 1983 (S.I. 1983 No. 942) made pursuant to section 78 of the Act.

I must read some of the provisions of the Act of 1983 that relate to applications by or in respect of patients subject to restriction orders. Section 70 :

> "A patient who is a restricted patient . . . and is detained in a hospital may apply to a

> mental health review tribunal - (a) in the period between the expiration of six months and the expiration of 12 months beginning with the date of the relevant hospital order or transfer direction; and (b) in any subsequent period of 12 months."

Section 71 :

> "(1) The Secretary of State may at any time refer the case of a restricted patient to a mental health review tribunal. (2) The Secretary of State shall refer to a mental health review tribunal the case of any restricted patient detained in a hospital whose case has not been considered by such a tribunal, whether on his own application or otherwise, within the last three years . . . (6) For the purposes of subsection (5) above a person who applies to a tribunal but subsequently withdraws his application shall be treated as not having exercised his right to apply, and where a patient withdraws his application on a date after the expiration of the period there *373 mentioned, the Secretary of State shall refer his case as soon as possible after that date."

Section 72 :

> "(1) Where application is made to a mental health review tribunal by or in respect of a patient who is liable to be detained under this Act, the tribunal may in any case direct that the patient be discharged, and . . . (b) the tribunal shall direct the discharge of a patient liable to be detained . . . if they are satisfied - (i) that he is not then suffering from mental illness, psychopathic disorder, severe mental impairment or mental impairment or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or (ii) that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment."

Section 73 :

> "(1) Where an application to a mental health review tribunal is made by a restricted patient who is subject to a restriction order, or where the case of such a patient is referred to such a tribunal, the tribunal shall direct the absolute discharge of the patient if satisfied - (a) as to the matters mentioned in paragraph (b)(i) or (ii) of section 72(1) above; and (b) that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment. (2) Where in the case of any such patient as is mentioned in subsection (1) above the tribunal are satisfied as to the matters referred to in paragraph (a) of that subsection but not as to the matter referred to in paragraph (b) of that subsection the tribunal shall direct the conditional discharge of the patient. (3) Where a patient is absolutely discharged under this section he shall thereupon cease to be liable to be detained by virtue of the relevant hospital order, and the restriction order shall cease to have effect accordingly."

The effect of these statutory provisions in relation to a patient subject to a restriction order is that a tribunal has, strictly, three courses open to it on a review of the patient's case. The tribunal can make no order. It can direct the absolute discharge of the patient. Or it can direct the conditional discharge of the patient. The tribunal is obliged to direct the discharge of the patient, absolutely or conditionally as the case may be, if it is satisfied that the statutory criteria have been established. In cases where a tribunal is not so satisfied and, therefore, does not direct the discharge of the patient, it has become a common practice for the tribunal to make recommendations in relation to the patient. These recommendations do not have binding force.

I should refer also to section 76 . Subsection (1) provides:

> "For the purpose of advising whether an application to a mental health review tribunal should be made by or in respect of a patient who is liable to be detained . . . or of furnishing information as to the condition of a patient for the purposes of such an application, *374 any registered medical practitioner authorised by or on behalf of the patient or other person who is entitled to make or has made the application - (a) may at

> any reasonable time visit the patient and examine him in private, and (b) may require the production of and inspect any records relating to the detention or treatment of the patient in any hospital."

In the Mental Health Tribunal Rules 1983, rule 6 provides:

> "(1) The responsible authority shall send a statement to the tribunal and, in the case of a restricted patient, the Secretary of State, as soon as practicable and in any case within three weeks of its receipt of the notice of application; and such statement shall contain - (a) the information specified in Part A of Schedule 1 to these rules, in so far as it is within the knowledge of the responsible authority; and (b) the report specified in paragraph 1 of Part B of that Schedule; and (c) the other reports specified in Part B of that Schedule, in so far as it is reasonably practicable to provide them. (2) Where the patient is a restricted patient, the Secretary of State shall send to the tribunal, as soon as practicable and in any case within three weeks of receipt by him of the authority's statement, a statement of such further information relevant to the application as may be available to him . . . (4) Any part of the authority's statement or the Secretary of State's statement which, in the opinion of - (a) (in the case of the authority's statement), the responsible authority; or (b) (in the case of the Secretary of State's statement), the Secretary of State, should be withheld from the applicant or (where he is not the applicant), the patient on the ground that its disclosure would adversely affect the health or welfare of the patient or others, shall be made in a separate document in which shall be set out the reasons for believing that its disclosure would have that effect. (5) On receipt of any statement provided in accordance with paragraph (1), (2) or (3) the tribunal shall send a copy to the applicant and (where he is not the applicant), the patient, excluding any part of any statement which is contained in a separate document in accordance with paragraph (4)."

I need not read the rest of rule 6. The reference in rule 6 to the "responsible authority" is a reference to the Secretary of State for Health: see rule 2 , section 145 of the Act of 1983 and section 4 of the National Health Service Act 1977 . The reference to the Secretary of State is, in the rules as in the Act, a reference to the Home Secretary.

Under Part A of Schedule 1 to the Rules, basic information regarding the patient and his history must be given. Under Part B, the following information is required to be given:

> "1. An up-to-date medical report, prepared for the tribunal, including the relevant history and a full report on the patient's mental condition. 2. An up-to-date social circumstances report prepared for the tribunal, including reports on the following - (a) the patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting; (b) the *375 opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged; (c) the availability of community support and relevant medical facilities; (d) the financial circumstances of the patient. 3. The views of the authority on the suitability of the patient for discharge. 4. Any other information or observations on the application which the authority wishes to make."

It is to be noted that the obligations imposed on the Secretary of State for Health under rule 6(1) and on the Home Secretary under rule 6(2) to provide the tribunal with information are mandatory statutory obligations.

It is important also to notice that the nature of a hearing before a mental health review tribunal is inquisitorial, not adversarial. This appears particularly from the following rules:

> " 11 . At any time before the hearing of the application, the medical member, or, where the tribunal includes more than one, at least one of them, shall examine the patient and take such other steps as he considers necessary to form an opinion of the patient's mental condition; and for this purpose the patient may be seen in private and all his medical records may be examined by the medical member, who may take such notes and copies of them as he may require, for use in connection with the application . . .

> " 14 (1) For the purpose of obtaining information, the tribunal may take evidence on oath and subpoena any witness to appear before it or to produce documents, and the president of the tribunal shall have the powers of an arbitrator under section 12(3) of the Arbitration Act 1950 . . . but no person shall be compelled to give any evidence or produce any document which he could not be compelled to give or produce on the trial of an action. (2). The tribunal may receive in evidence any document or information notwithstanding that such document or information would be inadmissible in a court of law.
>
> " 15 (1) Before or during any hearing the tribunal 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 . . .
>
> "22 . . . (2) At any time before the application is determined, the tribunal or any one or more of its members may interview the patient, and shall interview him if he so requests, and the interview may, and shall, if the patient so requests, take place in the absence of any other person."

There are therefore, two avenues by means of which a patient subject to a restriction order may seek to be discharged. He can apply to the Home Secretary and rely on the Home Secretary's discretionary powers. Or he may apply to a tribunal and endeavour to satisfy the statutory criteria which, if satisfied, will oblige the tribunal to order his discharge, either absolutely or conditionally.

Having described the statutory scheme regulating the detention of persons such as W., I must now turn to outline the history of W.'s *376 detention at the hospital. On 24 October 1983 a tribunal reviewed his case. No order or recommendation was made. On 27 November 1984 a tribunal again reviewed his case. Again, no order was made but the tribunal recommended that W. be transferred from the hospital to a "regional secure unit." Regional secure units are a relatively recent development in the treatment of patients such as W. Regional secure units are referred to in paragraph 4 of the affidavit of Dr. Kay, an experienced forensic psychiatrist. He says:

> "In the last few years the method of releasing patients back into the community has changed and instead of his responsible medical officer having to face the choice between continued detention or freedom in the community there is now an interim state (the regional secure unit) where he can be observed under less strict conditions without any risk to the public. The multi-disciplinary teams who treat patients in regional secure units have developed a different kind of expertise to the teams that have to work within special hospitals where, although security is high, the chances of testing out the patient are limited. The regime in a regional secure unit would be to initially assess the patient under conditions of very high observation even greater than he is receiving at the present time."

In recommending W.'s transfer to a regional secure unit the chairman of the tribunal said this (I take the passage from the affidavit sworn by Mr. Ronald, W.'s solicitor, on 5 September 1988). The reasons were given by Judge Andrew, who presided over the tribunal:

> "(i) We were well aware that the enormity of the index offence required us to be extremely cautious in considering the application to recommend a transfer, albeit to a regional secure unit. (ii) The index offence was committed when the patient was acutely mentally ill. (iii) That the illness has now been reliably diagnosed to be paranoid schizophrenia. (iv) The patient's condition is stable and his mental illness has been satisfactorily controlled by modest dosage of drugs for about three years. (v) There were no overt symptoms of psychosis and the demeanour and responses of the patient at the hearing confirmed the unanimous medical opinion that his schizophrenia had been brought under control."

Then this comment was added by Judge Andrew: "His underlying medical condition is such that he will require treatment by drugs for the remainder of his life."

Barnsley Hall Hospital has a regional secure unit. The consultant forensic psychiatrist at Barnsley Hall Hospital is Dr. Rosemarie Cope. Following the recommendation by the tribunal, Dr. Ghosh invited Dr.

Cope to examine W. in order to assess his suitability for transfer to Barnsley Hall Hospital. I should emphasise that W.'s transfer to a regional secure unit would, in view of section 41(3)(c)(ii) of the Act, require the consent of the Home Secretary.

Dr. Cope examined W. and made a report dated 15 May 1985. Dr. Cope expressed this opinion: *377

> "[W.'s] symptoms have resolved with treatment and he is no longer actively psychotic. However although he was perfectly law-abiding and had a good work record, certain aspects of his pre-morbid personality could be regarded as abnormal. He was a loner, had formed no significant inter-personal relationships and was more interested in mechanical things than people. His interest in guns, shooting and fireworks had been present for many years. A move to a less secure setting would be regarded as the first stage in his eventual discharge to the community. Before considering this move I feel that a further period of assessment is required, including an assessment of his home situation and family, as well as further exploration of his pre-morbid personality."

In view of Dr. Cope's conclusions Dr. Ghosh requested a Dr. Tulloch to carry out an assessment of W.'s personality, including, if possible, his pre-morbid personality. Dr. Tulloch had seven sessions with W. and wrote a report dated 18 April 1986. In the report Dr. Tulloch said:

> "It is not possible to shed much light on [W.'s] pre-morbid personality from this assessment . . . One way to look more closely at his pre-morbid personality and current functioning would be to engage in an active, exploratory, psychotherapeutic process. Two problems present themselves however. Firstly, [he] may not be as motivated as would be necessary given his investment in moving to [a regional secure unit]. Secondly, within the relatively sheltered confines of [the hospital] the exploration may be less meaningful than in conditions where [he] was exposed to actual and significant demands. From this perspective a move to [a regional secure unit] may indeed be more helpful. It should also be borne in mind that [he] is not an 'immediate' danger. He was clearly mentally ill at the time of his offences, this process having built up over a prolonged period. Given that he is now stabilised on medication his dangerousness is significantly reduced. [A regional secure unit] would, therefore, seem to be an appropriate placement. Exploration of his personality at a more detailed level would be useful in terms of preparation for future community survival and this can probably be achieved more readily within [a regional secure unit] context."

This report, therefore, supported the proposal for W.'s transfer to a regional secure unit, albeit in somewhat guarded terms.

Having received Dr. Tulloch's report, Dr. Ghosh invited Dr. Cope to reassess W. Dr. Cope had a session with W. on 18 June 1986 and reported thereon by a letter dated 20 June 1986. The letter said, inter alia:

> "The question of his potential future dangerousness is of crucial importance. At the time of committing the offence he was obviously disturbed. He was overtly psychotic, and there was evidence of a gradual deterioration in his mental state in the two years preceding the offence. The history obtained from him and various relatives would suggest that his pre-morbid personality was not markedly abnormal and there was no suggestion of paranoid traits. This, *378 coupled with his favourable response to treatment, would reduce anxiety about his prognosis. He has good insight into his illness and has matured while in hospital."

The letter concluded:

> "Realistically at the present time I feel I can go no further than to say that I would be prepared to consider him for a place in our medium secure unit should the Home Office and Aarvold Committee agree to his transfer."

The Aarvold Committee is an advisory committee established to assist the Home Secretary in exercising his various discretionary powers under the Act.

Following receipt of Dr. Cope's second report Dr. Ghosh recommended to the Home Secretary that W. be transferred to the regional secure unit at Barnsley Hall Hospital. The Home Secretary's response to this recommendation was contained in a letter dated 20 May 1987, written by Mr. Eggleston of the Home Office to Dr. Ghosh. Consent was refused. In the letter Mr. Eggleston commented:

> "Although there seems no doubt that W. was suffering from persecutory delusions at the time, the violence was not confined to the subjects of these delusions."

Having rehearsed the story of the offences the letter continued:

> "The Home Secretary cannot help but conclude that, following offences of such extreme and indiscriminate violence, there is a need for the utmost caution and a very long period of stable behaviour before the patient can begin a programme of rehabilitation."

The letter then referred to W.'s long-standing interest in guns and said:

> "[The Home Secretary] finds it difficult to accept . . . that his interest in guns was simply a past hobby and was not pathological. While W. will clearly have no legitimate access to firearms in the future, even the remote possibility of a pathological trait which might manifest itself in other forms of violent behavour must, given the gravity of the index offences, be a matter of considerable concern . . . the Home Secretary would feel more confident about agreeing to W. moving out of conditions of maximum security if the patient's interest in weapons were more fully explored and explained. Furthermore . . . he would wish to see a prolonged period of stability before he could consent to W. moving to a less secure hospital. In this respect, he has indicated that, if some re-assurance can be provided on the question of W.'s interest in firearms, he would be prepared to consider the case for W.'s moving to a secure unit in perhaps 18 months' time."

In the face of the Home Secretary's unwillingness to accept Dr. Ghosh's recommendation for a transfer to a regional secure unit, W. decided to pursue the alternative avenue, namely, to make an application to the mental health review tribunal. The gist of Dr. Ghosh's reports *379 had been that W.'s offences were attributable to the paranoid schizophrenia from which he had been suffering at the time, that he had been cured of that illness and that, provided he remained on suitable medication, he no longer represented a danger to the public. In the light of these reports W. was hoping to obtain from the tribunal a conditional discharge. So, on 1 April 1987, W.'s then solicitors, Messrs. E. Rex Makin & Co., sent to the tribunal W.'s application for a review of his case. The tribunal notified the Department of Health and Social Security and the Home Office of the application: see rule 4 of the Rules of 1983.

On 2 April 1987 W. was granted legal aid for the purposes of his application. The legal aid certificate authorised "an application to the mental health review tribunal under the Mental Health Act 1983 and to include an independent psychiatric report: . . ."

The statement required by rule 6(1) to be sent by the Secretary of State for Health to the tribunal was made by Dr. Ghosh and dated 19 May 1987. The statement said:

> "W. has been diagnosed as suffering from schizophrenia. His mental illness is now controlled by medication and he has been stable for the past five years. He has considerable insight into his mental state and accepts the need for continuing on medication. He also realises that he requires close and careful monitoring of his mental state. It is my opinion that W. requires to move gradually through graded security with maximum and intermediate supervision being available in the early stages. W. was recommended for transfer on 20 March 1985. He has been accepted by Dr. R. Cope for the . . . regional secure unit at Barnsley Hall Hospital on 20 June 1986, his previous mental health review tribunal supported a recommendation of transfer to a regional secure unit. We are still awaiting Home Office permission for such a move."

A copy of this statement was provided to W. and his solicitors.

The Home Office's statement, made pursuant to rule 6(2) , was dated June 1987. It, too, was disclosed to W. and his solicitors. The statement set out the circumstances of W.'s offences, referred to Dr. Ghosh's statement of 19 May 1987 and reiterated the Home Secretary's refusal to consent to W.'s transfer to a regional secure unit. The penultimate sentence of the Home Office statement said:

> "Furthermore [the Home Secretary] would feel more confident towards W.'s removal from conditions of maximum security when his interest in weapons has been more fully explored and explained and he would be prepared to consider the case for W. to move to a secure unit in perhaps 18 months' time in the light of these findings."

Notwithstanding that authority for an independent psychiatric report had been given by the legal aid certificate of 2 April 1987, the report was not bespoken until after W. and his solicitors had seen both Dr. Ghosh's statement of 19 May 1987 and the Home Office's statement of June 1987.

The independent psychiatrist instructed to give the report was Dr. Egdell. He is a distinguished consultant psychiatrist and a member of *380 the Mersey Mental Health Review Tribunal. His instructions were contained in a letter dated 2 July 1987 from Messrs. E. Rex Makin & Co. The first paragraph of the letter asked Dr. Egdell to "attend upon our client and complete a report for use at his forthcoming mental health review tribunal." For the purposes of the report Dr. Egdell reviewed the case records held at the hospital. These included the reports to which I have already referred and no doubt others as well. He had discussions about the case with Dr. Ghosh. He had brief interviews with some of the nurses at the hospital. And, on 23 July 1987, he had a long interview with W. himself. Based on this material he made a 10-page report dated 29 July 1987. The report contained two main sections. The first section summarised the information about W. that Dr. Egdell had obtained from the sources I have mentioned. The contents are set out under various sub-headings: "Personal background;" "Work and interests;" "Interest in guns;" "Interest in 'Fireworks';" "Alcohol history;" "Attitude to medication;" "Attitude to the victims and relatives in the index offence;" "Reports of nursing staff;" "Attitude to future problems." The sub-heading "Interest in 'Fireworks'" is of particular importance partly because the preparation and use by W. of home-made bombs had been part of the index offences and also because, although some reference to W.'s interest in explosives is to be found in the records on file at the hospital, Dr. Ghosh had not dealt with this aspect of W.'s history in any of her reports. The information given by W. to Dr. Egdell and recorded under this sub-heading seems, at least in its detail, not to have been previously disclosed. The references in previous reports to W.'s interest in bombs and explosives had been cursory, lacking in detail and had not indicated anything unusual that pre-dated the onset of the mental illness from which W. was suffering when the index offences were committed. Dr. Egdell's report on the other hand, records a long-standing interest by W. in making what W. seems euphemistically to have described as "fireworks." These so-called "fireworks" included sections of steel piping packed with explosive chemicals. The subsection under the heading "Interest in guns" contained considerable detail of W.'s long-standing interest in guns. This interest had, unlike W.'s interest in explosives, been well documented in previous reports on W. made by others.

The second section of Dr. Egdell's report is headed "Psychiatric opinion and recommendation." This too is divided into subsections. Under the sub-heading "Illness" Dr. Egdell agreed that at the time of the index offences W. was suffering from a mental illness, but Dr. Egdell referred to the possibility, first raised by Dr. Boyd in a report dated 30 July 1984, that the illness might be a paranoid psychosis rather than paranoid schizophrenia. The relevance of the distinction, according to Dr. Egdell, was that medication would be less effective in the former case than in the latter in protecting against a relapse. In the second paragraph under this sub-heading Dr. Egdell said: "I am not convinced that he really had insight into his illness . . ." This paragraph is in disagreement with the first paragraph of Dr. Ghosh's statement of 19 May 1987.

Under the sub-heading "Personality," Dr. Egdell said: *381

> "He has difficulty accepting or even listening to the views of others and would not even consider psychological treatment to explore or influence his former interests in firearms and explosives."

This conclusion is obviously relevant to the recommendation in Dr. Tulloch's report of 18 April 1986. Later under the same sub-heading Dr. Egdell said:

> "My overall opinion would be that W. has a clearly abnormal personality, particularly in regard to his relationships, to the management of his feelings and dealing with frustration and an unwillingness to look at his own personal problems in the past and in the future and to review the motivation lying behind the killings. I am reluctant at this stage to say that W. suffers from a psychopathic personality, as my contacts with him were confined to one interview, and also the report of the clinical psychologist, Mr. R. Tulloch of 18 April 1986. There does seem to be a serious conflict between the findings of Mr. Tulloch and my overall impression culled from various sources. I think it would be important for this conflict to be resolved before a decision is made on W.'s departure from [the hospital]."

This passage seems to me important. It reflects the possibility that underlying the mental illness from which W. was suffering at the time of the index offences, there might be a psychopathic deviant personality.

Under the sub-heading "Attitude to firearms" Dr. Egdell expressed this opinion:

> "his interests in guns was profound, very prolonged and, in the last years before the offence, clearly abnormal. In discussions with him of his current interests I found him totally unconvincing that he had in the past a passing interest in guns which has no relevance for the future."

Under the sub-heading "Home-made bombs" Dr. Egdell said:

> "My view would be that this all points to a seriously abnormal interest in the making of home-made bombs. He euphemistically calls them 'fireworks.' They are clearly much more dangerous than that."

Finally, under the sub-heading "Fitness for transfer to a regional secure unit" Dr. Egdell said:

> "In my view this should be considered after there has been clarification of W.'s personality, as recommended above, as well as further exploration of W.'s interests in guns and explosives . . . In summary I would strongly recommend that W. is not considered for transfer to a regional secure unit until the above recommendations are fulfilled. Even when these are completed there may be indications for further prolonged stay under the present secure conditions."

In the first paragraph under the last sub-heading Dr. Edgell expressed views about regional secure units that Dr. Kay in his affidavit, sworn on *382 16 November 1988, has disputed. Dr. Kay has considerable experience of regional secure units and Dr. Egdell, having read Dr. Kay's affidavit, has deferred to that experience. Dr. Egdell's misgivings about the suitability of the transfer of W. to a regional secure unit have, therefore, to some extent been shown to be unfounded.

There are several important features of Dr. Egdell's report for present purposes. First, it opposed Dr. Ghosh's recommendation for a transfer to a regional secure unit. Second, it expressed reservations about, if not disagreement with, Dr. Ghosh's opinion that W., now that his schizophrenic illness was cured or under control, was no longer a danger to the public. Third, it explored in greater detail than any other report the significance of W.'s interests in explosives.

Dr. Egdell sent his report to W.'s solicitors. It was his belief, when he did so, that the report would be placed before the tribunal at the forthcoming hearing. That belief was justified by the opening paragraph of the letter of 2 July 1987, as well as by a letter dated 6 July 1987 from W.'s solicitors advising Dr. Egdell that the tribunal would sit on 25 August 1987 and adding "We shall be pleased to see your report not less than two weeks before that date."

Mr. Robertson, counsel for W., argued that Dr. Egdell was not entitled to have assumed that his report

would be placed before the tribunal. The report was, he suggested, intended simply for the assistance of W. and his solicitors. I agree that it was open to W. and his solicitors, having received the report, to decide not to use it. But Dr. Egdell was, in my view, when he examined W., wrote his report and sent it to W.'s solicitors, reasonable in assuming that the report would be placed before the tribunal. It was, according to his letter of instructions, for that purpose that the report had been bespoken.

By a letter dated 18 August 1987, received by the tribunal on 19 August, W.'s solicitors withdrew his application to the tribunal. This was done in view of the contents of Dr. Egdell's report. On the same day, 19 August 1987, Dr. Egdell telephoned the tribunal to ask whether the tribunal had received a copy of his report.

Dr. Egdell was informed by the tribunal that a copy of his report had not been received and that W.'s application had been withdrawn.

Dr. Egdell knew from a telephone conversation he had had with Dr. Ghosh on a date between 24 and 27 July 1987, i.e., after his interview with W. on 23 July, that his views regarding W. were not accepted by Dr. Ghosh: see paragraph 4 of Dr. Egdell's fourth affidavit. So after learning that W.'s application to the tribunal had been withdrawn and that a copy of his report was not on W.'s file at the hospital, Dr. Egdell telephoned Dr. Hunter, the medical director at the hospital.

I can best explain how matters proceeded by reference to passages from the evidence. In paragraph 4 of his affidavit, sworn on 13 October 1988, Dr. Egdell says:

> "On learning that my report was not available to the mental health review tribunal I telephoned Dr. Hunter at [the hospital] for advice in this matter. This was the first occasion on which I spoke to Dr. Hunter about this patient. I explained my concern that my views were so different from those expressed by Dr. Ghosh (W.'s *383 responsible medical officer), and also my belief that two important matters relating to W.'s interests in firearms and explosives had not been properly explored or even appreciated. Dr. Hunter indicated that additional information about his patient was always helpful and indeed welcome. He asked me to contact W.'s solicitors as a matter of courtesy to see if they would agree to disclosure of my report of 29 July to Dr. Hunter. They declined to agree."

Dr. Egdell's terse "They declined to agree" is amplified by paragraph 9 of the affidavit of Mr. Ronald, W.'s solicitor, sworn on 5 September 1988. Mr. Ronald said:

> "Following 19 August and prior to 24 August [Dr. Egdell] telephoned to Mr. Brian Canavan to discuss the plaintiff's case. In the course of this conversation he was advised that the tribunal application had been withdrawn and he queried what would happen to his report. It was explained to him by Mr. Canavan that his report would be on their files and would not be drawn to anyone's attention. [Dr. Egdell] expressed a wish that the report be forwarded to [the hospital] so that they were aware of his findings, however, Mr. Canavan declined to do this in view of the clear instructions that he had received from the plaintiff."

What passed between Dr. Egdell and Dr. Hunter in their telephone conversation on 24 August 1987 is set out in a letter dated 25 April 1988, written by Dr. Hunter to Messrs. Irwin Mitchell, W.'s present solicitors. The letter said:

> "Dr. Egdell expressed the view that the material which he felt had been revealed from his examination cast a new light upon the patient's dangerousness and ought to be known to those responsible for his care and for the formulation of any recommendations for discharge. During this conversation I asked Dr. Egdell to forward to me a report in writing of his concerns about the patient and this report, dated 25 August 1987, was received in the hospital shortly thereafter."

Following that telephone conversation and in accordance with Dr. Hunter's request, recorded by Dr. Hunter in his letter, Dr. Egdell sent Dr. Hunter a report dated 25 August 1987. Dr. Egdell substituted

the name and address of Dr. Hunter for the name and address of Messrs. E. Rex Makin & Co., and he altered the opening paragraph so as to read: "The following report is provided at your formal verbal request to me on 25 August 1987." Thereapart the report sent to Dr. Hunter was identical with that dated 29 July 1987 that had been sent to W.'s solicitors.

It was Dr. Egdell's opinion that a copy of his report ought also to be supplied to the Home Office. Dr. Egdell pressed this opinion on Dr. Hunter and on 18 November 1987 wrote to Dr. Hunter in these terms:

> "I am sorry I have not yet received formal confirmation from you that the report prepared on W. dated 29 July 1987 has been made available in his case notes. I regret to have to say this, but without *384 this I shall feel obliged to send a copy directly to the Home Office. I would prefer to avoid this."

By letter dated 20 November 1987, signed by Dr. Ghosh, Dr. Egdell was informed that: "a copy of your report on the above patient was forwarded to the Home Office and a further copy is on our case notes."

Consistently with that, a copy of the report was received by the Home Office on 25 November 1987. On the same day a copy was received at the Department of Health and Social Security. There seems to be some mystery as to by whom, or on whose authority these copies were sent. I do not, however, think that the mystery is one that needs to be solved. There is no doubt that the Home Office and the D.H.S.S. did receive copies, nor that the copies were sent by someone at the hospital, nor that this was in accordance, at least so far as the Home Office is concerned - and nothing turns on the fact that a copy was sent to the D.H.S.S. - with Dr. Egdell's expressed wishes.

Another significant event took place on 25 November 1987. The Home Secretary referred W.'s case to the mental health review tribunal under section 71(2) of the Act. He was obliged to do so because W.'s case had not been before the tribunal within the last three years.

On 10 December 1987 the tribunal informed W. and the hospital of this referral of W.'s case. A statement pursuant to rule 6(1) was requested of the hospital. The news of the referral of W.'s case to the tribunal seems to have prompted Dr. Ghosh to communicate with W.'s solicitors and express misgivings about the use that might be made of Dr. Egdell's report. But the solicitors were not told by Dr. Ghosh that the Home Office already had a copy of the report. They were told that a copy was held by the hospital and that Dr. Egdell was pressing for a copy to be sent to the Home Office. This information prompted the issue of a writ against Dr. Egdell. The writ sought an injunction in these terms:

> "An injunction restraining the defendant whether by himself his servants or agents or otherwise from communicating the contents of a report dated 29 July 1987, made by the defendant concerning the plaintiff, or any other further report, whether written or oral, prepared by the defendant concerning the plaintiff, to any person or persons and, further, from expressing any opinion whether written or oral concerning the plaintiff to any person or persons."

Paragraph 2 of the prayer sought delivery up of any copies of the report held by Dr. Egdell and paragraph 3 claims damages for breach by Dr. Egdell of his duty of confidentiality. On the same day Judge O'Donoghue granted an ex parte injunction restraining Dr. Egdell from communicating to anyone the contents of the report. The ex parte injunction was, by consent, continued until trial.

In the meantime, of course, the procedures consequent upon the referral of W.'s case to the tribunal were progressing. Pursuant to the statutory duty imposed by rule 6(1) the administrator of the hospital sent to the tribunal a number of reports. These included a report dated 3 February 1988 by Dr. Coorey, who had replaced Dr. Ghosh as W.'s responsible medical officer. The reports sent to the tribunal did not *385 include a copy of Dr. Egdell's report, nor in his report of 3 February 1988 did Dr. Coorey make any reference to the Egdell report. In that report Dr. Coorey said:

> "A few weeks before the offence [W.] started to carry a pistol in a shoulder holster when he went out of the house - he had done so earlier but only to the shooting club - and

> also started making primitive bombs."

The inference that the making of bombs had begun only a few weeks before the index offences took place was contrary to Dr. Egdell's report of what W. had said to him. Dr. Coorey said in his report:

> "it is worth noting that the crucial factor which triggered off the killings was the onset of his paranoid illness and not some deviant trait in his personality."

Dr. Egdell in his report had expressed serious reservations about this view.

In about the middle of March 1988 the tribunal received a statement from the Home Office sent in compliance with rule 6(2) and forwarded a copy to W.'s solicitors and another to the hospital. The Home Office's statement was dated 11 March 1988. Section (C) is headed "Observations on Part B of the responsible authority's statement and the Secretary of State's observations on the patient's suitability for discharge." Dr. Egdell's report is not mentioned in section (C). Nonetheless, the contents of the Egdell report are the clear provenance of much of the contents of section (C). Much of the contents of Dr. Coorey's statement of 3 February 1988 is criticised and met by the deployment of material derived from Dr. Egdell's report. Section (C) ends with these remarks:

> "the Home Secretary would be most reluctant to agree to W. to moving to a regional secure unit without some further investigation of his personality and his interest in weapons, despite the difficulties which Dr. Coorey has identified in undertaking this work in a special hospital setting. In the Home Secretary's view the nature of W.'s offending makes it imperative that the fullest possible exploration is carried out into the reasons for his offences, and therefore the risks which his eventual discharge may present, before he begins a programme of rehabilitation. For these reasons, on the information currently available to him, the Home Secretary is still unable to agree to W. moving from the hospital to a regional secure unit."

Under cover of a letter of 8 April 1988 the Home Office sent to the tribunal a copy of Dr. Egdell's report. The letter said:

> "After further consideration we feel it necessary to clarify the observations at Part "C" of the Home Secretary's statement. It seems to us that the most appropriate way to do this would be to provide the tribunal which will hear W.'s application with a copy of a report in our possession by Dr. H. G. Egdell, consultant psychiatrist at the Royal Liverpool Hospital. A copy of that report is therefore enclosed."

*386 A copy of the Egdell report was sent also to Dr. Coorey.

The tribunal accepted the Egdell report as, I infer, relevant further information supplied by the Home Secretary pursuant to rule 6(2). Copies of the letter of 8 April and of the Egdell report were then sent by the tribunal to W.'s solicitors. Dr. Coorey, having seen a copy of the Home Office statement of 11 March 1988 wrote a letter dated 8 April 1988 to Mr. Eggleston. The letter said:

> "I have read your statement to the tribunal with great interest. In it you state 'It is on record that prior to the commission of the index offence he carried home-made bombs in his car and that he threw them from the car during the offence.' This creates the impression that W. had been driving around with the bombs in the car for some time prior to the offence. If my impression of what you meant to convey is correct I would appreciate copies of this report/record as we have nothing in our records to indicate any previous interest in bombs. We intend having a case conference on W. some time within the next four or five months and wonder whether you would feel it helpful to attend?"

This letter is of interest in that it seems to confirm the importance of what W. had said to Dr. Egdell about his interest in explosives. It seems, also, that the copy of Dr. Egdell's report sent to Dr. Hunter had not been shown to Dr. Coorey nor, contrary to what was said in Dr. Ghosh's letter of 20 November 1987, placed on W.'s file at the hospital.

The case conference referred to by Dr. Coorey took place on 23 June 1988. The proceedings are recorded in a minute prepared by Dr. Coorey. The conference was attended by, among others, Dr. Coorey, Dr. Tulloch, Mr. Eggleston and Dr. Kay. Dr. Egdell's report was discussed. Comments made by groups of nurses were read. Two groups of nurses supported the recommendation for the transfer of W. to a regional secure unit. The third group of nurses

> "felt that further stringent tests were required as W. was psychopathic, showed no remorse for his offence and still showed an interest in weapons."

I cite this passage because it expresses much the same view as Dr. Egdell had expressed in his report. The view was however criticised by Dr. Coorey. He regarded it as based on "unfounded allegations" and as "totally unhelpful in any objective evaluation of the patient." The minutes records that Dr. Coorey reiterated that the crucial factor which resulted in the killings was the onset of the mental illness and not W.'s interest in weapons nor a deviant trait in W.'s personality. This was the view that Dr. Ghosh, his predecessor, had been expressing. Then comes this passage in the minute:

> "It became apparent . . . that this view which was held by all the members of the [patient care team], except perhaps group one, was unacceptable to the Home Office who placed more credence on the report by Dr. Egdell in preference to the four or five reports by experienced forensic psychiatrists."

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There then follows in the minute reference to recent interviews which Dr. Coorey had had with W. In these interviews W. seems to have made remarks about his interest in guns and explosives at some variance with his remarks made at previous interviews and in particular with his remarks to Dr. Egdell. W.'s account to Dr. Coorey about his interest in "fireworks" is recorded by Dr. Coorey as having "tallied on the whole with that given by Dr. Egdell except on two important points." These are then outlined in the minute.

Dr. Egdell's suggestions regarding further psychiatric and psychological investigations of W. were discussed. The majority opinion seems to have been that these would not be likely to serve any useful purpose. Mr. Eggleston requested written comments from Dr. Coorey on Dr. Egdell's report, but Dr. Coorey was not willing, in view of the High Court injunction being sought, to comply with this request. In the minute the conclusion is recorded that W.'s offence

> "was a direct result of the paranoid psychosis he was suffering at that time and that, given careful follow-up, and continued medication . . . there is very little likelihood that W. would become involved in serious re-offending."

The formulation of this conclusion is, to a layman, remarkable. How "little" is "very little?" An alternative view might be that any likelihood of serious re-offending would be unacceptable. Be that as it may, Dr. Coorey's minute concluded with this sentence:

> "Given all these factors Dr. Coorey felt that there were strong reasons to doubt whether W.'s mental illness was not of a nature or degree which warranted his detention in hospital for medical treatment."

The case conference then agreed seven recommendations. These are recorded in the minute.

It seems from the case conference minute that many of those present believed the Home Secretary's attitude to W. to be attributable to political considerations consequent upon the Hungerford killings. It was felt that the Home Secretary's continued refusal to authorise W.'s transfer to a regional secure unit was not based on the merits of the case, but was based on political grounds. But it seems also that the contents of the Egdell report, both the information on which Dr. Egdell's opinions about W. were based and the opinions themselves, were responsible for three of the seven recommendations agreed upon at the case conference. The intrinsic relevance and importance of the Egdell report was thereby indirectly recognised.

There is a reference in the case conference minute to the possibility that a court order requiring copies of Dr. Egdell's report to be removed from W.'s file might be sought by W. against, presumably, the hospital. This possibility became a reality with the issue, on 19 July 1988, of a second writ, this time accompanied by a statement of claim. W. was again the plaintiff. The defendants were the Secretary of State for Health, the Home Secretary, Mosside and Park Lane Hospitals Board and the Mersey Mental Health Review Tribunal. The main relief sought *388 was an injunction to restrain the respective defendants from using or disclosing to anyone Dr. Egdell's report. Delivery up of all copies of the report were sought. Damages, including aggravated damages, for breach of the duty of confidentiality were sought against the Home Secretary and the hospitals board.

On 19 July 1988 the statement of claim in the first action, the action against Dr. Egdell, was served. On 27 July 1988 I made an order consolidating the two actions. It was at some stage, perhaps on 27 July, agreed that further pleadings would be dispensed with and that evidence would be given by affidavit. There have been a number of deponents. No cross-examination has been requested. These steps have enabled the action to come on for trial very quickly. The pending review by the tribunal of W.'s case has been adjourned sine die until the conclusion of the litigation.

The basis of W.'s case is that his interview with Dr. Egdell on 23 July 1987 and the report written by Dr. Egdell on the basis of that interview are, or ought to have been, protected from disclosure by the duty of confidence resting on Dr. Egdell as W.'s doctor. It is claimed that Dr. Egdell was in breach of his duty of confidence in telling Dr. Hunter about the report, in sending a copy of the report to Dr. Hunter and in urging the despatch of a copy to the Home Office. The hospital, represented by the fourth defendant ought, it is contended, to have recognised the confidential character of the report, came under a duty not to disclose it, and broke that duty by sending a copy to the Home Office. The Home Office likewise came under a duty to respect the confidential character of the report and broke that duty by sending a copy thereof to the tribunal. The claim against the Secretary of State for Health and against the tribunal is for an order that each be required to deliver up or destroy the copies of the report that each holds.

The case against each defendant is therefore based on the confidential character, first, of the communication between W. and Dr. Egdell on 23 July 1987 and, secondly, of Dr. Egdell's report. The doctor/patient relationship is relied on. The cases against the respective defendants are not, however, identical. The breadth and nature of the duty of confidence, if any, that affects each defendant must be separately assessed. In Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109 , the " Spycatcher " case, in the Court of Appeal, Sir John Donaldson M.R. said, at pp. 182-183:

> "In an earlier passage in his judgment Scott J. had considered whether the duty to maintain confidentiality was in all circumstances the same in relation to third parties who became possessed of confidential information as it was in relation to the primary confidant. . . . His conclusion was that it was not necessarily the same. I agree. The reason is that the third party recipient may be subject to some additional and conflicting duty which does not affect the primary confidant or may not be subject to some special duty which does affect that confidant. In such situations the equation is not the same in the case of the confidant and that of the third party and accordingly the result may be different."

*389 No disagreement with this statement of principle is to be found in the judgments in the House of Lords [1990] 1 A.C. 109 , 253.

I propose therefore to start with the case against Dr. Egdell. Mr. Robertson relies on two sources for the obligation of confidence or of non-disclosure on which W.'s action against Dr. Egdell is based. One source is implied contract, the other is equity. The two sources will in most cases cover the same ground.

It is convenient for me first to ask myself what duty of confidence a court of equity ought to regard as imposed on Dr. Egdell by the circumstances in which he obtained information from and about W. and prepared his report. It is in my judgment plain, and the contrary has not been suggested, that the circumstances did impose on Dr. Egdell a duty of confidence. If, for instance, Dr. Egdell had sold the contents of his report to a newspaper, I do not think any court of equity would hesitate for a moment before concluding that his conduct had been a breach of his duty of confidence. The question in the present case is not whether Dr. Egdell was under a duty of confidence; he plainly was. The question is as to the breadth of that duty. Did the duty extend so as to bar disclosure of the report to the

medical director of the hospital? Did it bar disclosure to the Home Office? In the " Spycatcher " case in the House of Lords [1990] 1 A.C. 109 Lord Goff of Chieveley after accepting, at p. 281:

> "the broad general principle . . . that a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it would be just in all the circumstances that he should be precluded from disclosing the information to others."

formulated three limiting principles. He said, at p. 282:

> "The third limiting principle is of far greater importance. It is that, although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply, as the learned judge pointed out, to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure."

In X. v. Y. [1988] 2 All E.R. 648 , a case which concerned doctors who were believed to be continuing to practice despite having contracted AIDS, Rose J. said, at p. 653:

> "In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients 'will not come forward if doctors are going to squeal on them.' Consequently, confidentiality is vital to secure public as well as private health, for *390 unless those infected come forward they cannot be counselled and self-treatment does not provide the best care."

The question in a particular case whether a duty of confidentiality extends to bar particular disclosures that the confidant has made or wants to make requires the court to balance the interest to be served by non-disclosure against the interest served by disclosure. Rose J. struck that balance. It came down, he held, in favour of non-disclosure. In the " Spycatcher " case, that balance too was struck. In that case the balance did not come down in favour of non-disclosure. I must endeavour to strike the balance in the present case.

A convenient starting point is the guidance given to doctors by the General Medical Council. The council publishes rules entitled: "Advice on standards of professional conduct and of medical ethics." Rules 79 and 80 provide :

> "79. The following guidance is given on the principles which should govern the confidentiality of information relating to patients.

"80. It is the doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner. The death of the patient does not absolve the doctor from this obligation." Rule 81 sets out circumstances where exceptions to rule 80 may be permitted. The exceptions include:

> "(a) If the patient or his legal adviser gives written and valid consent information to which the consent refers may be disclosed. (b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient . . . (f) If the doctor is directed to disclose information by a judge or other presiding officer of a court before whom he is appearing to give evidence, information may at that stage be disclosed. . . . But where litigation is in prospect, unless the patient has consented to disclosure or a formal court order has been made for disclosure, information should not be disclosed merely in response to

> demands from other persons such as another party's solicitor or an official of the court. (g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances, such as, for example, investigation by the police of a grave or very serious crime, would override the doctor's duty to maintain his patient's confidence."

These rules do not provide a definitive answer to the question raised in the present case as to the breadth of the duty of confidence owed by Dr. Egdell. They seem to me valuable, however, in showing the approach of the General Medical Council to the breadth of the doctor/patient duty of confidence. Rule 80 underlines the importance attached by the council to that duty. Rule 81 shows that the duty is not absolute. Sub-paragraphs (b) and (g) of rule 81 seem to me particularly relevant for present purposes. The duty of confidence does not prevent a doctor from *391 disclosing confidential information to other doctors charged with the care or treatment of the patient (sub-paragraph (b)). And sub-paragraph (g preserves the propriety of a doctor disclosing confidential information in the rare cases where the public interest overrides his duty to his patient.

The duty of confidence owed by Dr. Egdell to W. in the present case was both created and circumscribed by the particular circumstances of the case. So what were those particular circumstances as at June 1987? They were, in my view, these. W. was a person who had killed five people and seriously wounded two others. He had been diagnosed as suffering from mental illness and, not as a punishment but for the public safety, had been ordered to be detained without limit of time. He was subject to a restriction order. Dr. Ghosh, the psychiatrist who, from 1984 to 1987 had been responsible for W.'s treatment, regarded him as no longer a danger to the public provided he remained on suitable medication. She regarded the index offences as having been occasioned by mental illness from which he had been cured. W. was being detained at the hospital. While he remained there the authorities at the hospital were responsible for his treatment and care, for his "clinical management" to borrow the expression used in rule 81(b). A proposal was on foot for W.'s transfer to a regional secure unit. The Home Secretary had a discretion whether or not to allow the transfer. Public safety would be a paramount consideration for the Home Secretary in deciding how to exercise his discretion. W. had applied for his case to be reviewed by a tribunal. The tribunal had power to discharge him absolutely or conditionally. The tribunal could not discharge him unless satisfied that it was "not necessary for the health or safety of the patient or for the protection of other persons that he should receive medical treatment": see section 76(1)(b)(ii) of the Mental Health Act 1983 . But if the tribunal was so satisfied it would be bound to discharge him. Dr. Egdell was instructed to examine W. and to make a report "for use at the forthcoming mental health review tribunal." Facilities were provided at the hospital for Dr. Egdell to examine W. in private and to peruse W.'s hospital file: see section 76(1) of the Act of 1983. Dr. Egdell discussed W. with Dr. Ghosh before making his report. So the fact of Dr. Egdell's examination and that he was making a report were known to the hospital authorities.

These, in summary, seem to me to be the relevant circumstances pertaining at the time when Dr. Egdell examined W. and made his report.

Having examined W., Dr. Egdell formed the opinion that there was a possibility that W. had a psychopathic personality. He formed the opinion that insufficient significance might have been attached to W.'s interests in guns and explosives. He formed the opinion that further tests on and treatment of W. were advisable before a decision was taken to transfer W. to a regional secure unit, let alone to discharge him, conditionally or otherwise. Then having formed these opinions and having written his report, Dr. Egdell learned that the application to the tribunal had been withdrawn, that his report was not on file at the hospital, and that W. and W.'s solicitors proposed to suppress it.

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Did these circumstances impose on Dr. Egdell a duty not to disclose his opinions and his report to Dr. Hunter, the medical director at the hospital? In my judgment they did not. Dr. Egdell was expressing opinions which were relevant to the nature of the treatment and care to be accorded to W. at the hospital. Dr. Egdell was, in effect, recommending a change from the approach to treatment and care that Dr. Ghosh was following. He was expressing reservations about Dr. Ghosh's diagnosis. The case seems to me to fall squarely within sub-paragraph (b) of rule 81.

But I would base my conclusion on broader considerations than that. I decline to overlook the background to Dr. Egdell's examination of W. True it is that Dr. Egdell was engaged by W. He was the

doctor of W.'s choice. Nonetheless, in my opinion, the duty he owed to W. was not his only duty. W. was not an ordinary member of the public. He was, consequent upon the killings he had perpetrated, held in a secure hospital subject to a regime whereby decisions concerning his future were to be taken by public authorities, the Home Secretary or the tribunal. W.'s own interests would not be the only nor the main criterion in the taking of those decisions. The safety of the public would be the main criterion. In my view, a doctor called upon, as Dr. Egdell was, to examine a patient such as W. owes a duty not only to his patient but also a duty to the public. His duty to the public would require him, in my opinion, to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so, in my opinion, whether or not the patient instructed him not to do so.

Mr. Robertson argued that the dominant public interest was the public interest in patients being able to make full and frank disclosure to their doctors, and in particular to their psychiatrists, without fear that the doctor would disclose the information to others. I accept the general importance in the public interest that this should be so. It justifies the General Medical Council's rule 80 .

But Mr. Robertson's route from the general to the particular was not, to my mind, convincing. W. was not short of psychiatrists. A succession of them had attended him since the time when he committed the index offences. He had disclosed confidential information about himself to each of them. Each of them owed him a duty of confidence. None would have been entitled to sell the information to a newspaper or to make general disclosure of it. But the reports of each of these psychiatrists had been placed in W.'s file and were available to his responsible medical officer and to the Home Office. It was not suggested that this feature had inhibited W. in his dealings with these psychiatrists. Why should W.'s relationship with Dr. Egdell and the report of Dr. Egdell be differently treated? Mr. Robertson's answer would be, I think, that Dr. Egdell (like Dr. Boyd in 1984) was an independent psychiatrist employed by W. for the purpose of the examination in private referred to in section 76(1) . The other psychiatrists were psychiatrists within the hospital regime. So Dr. Egdell owed a duty of confidence more extensive than owed by the hospital psychiatrists. But this answer, in my opinion, confuses private interest with public interest. I readily accept that W. *393 had a strong private interest in barring disclosure of the Egdell report to the Home Office and, probably, to the hospital authorities as well. But what public interest is served by imposing on Dr. Egdell a duty of confidence more extensive than that owed by the hospital psychiatrists? Mr. Robertson's answer to that question was this. Independent psychiatric reports were, he said, of great assistance to tribunals. In about 80 per cent. of the cases reviewed by mental health review tribunals, independent psychiatric reports were submitted. If patients were held to be unable to suppress unfavourable reports, they would in future be unwilling to take the chance of commissioning such reports: alternatively they might not be wholly frank when being examined and the value of the independent reports would be reduced. I do not think that this answer has much weight. The possibility of a lack of frankness must always be present when a psychiatric examination takes place. An experienced psychiatrist would, I think, expect to be able to detect it. And the lack of frankness itself would constitute material of interest to the psychiatrist. As to the suggestion that the commissioning of independent reports will be reduced unless unfavourable ones can be suppressed, that likelihood does not seem to me in the least self-evident.

In truth, as it seems to me, the interest to be served by the duty of confidence for which Mr. Robertson contends is the private interest of W. and not any broader public interest. If I set the private interest of W. in the balance against the public interest served by disclosure of the report to Dr. Hunter and the Home Office, I find the weight of the public interest prevails.

I do not reach this conclusion in reliance on the importance of the information about W.'s interest in explosives, nor on the extent to which Dr. Egdell's fears about W.'s personality reveal some relevant risk to public safety, nor on any other specific part of the contents of the Egdell report. Rather, I base my conclusion on the particular circumstances in which the report was commissioned. If a patient in the position of W. commissions an independent psychiatrist's report, the duty of confidence that undoubtedly lies on the doctor who makes the report does not, in my judgment, bar the doctor from disclosing the report to the hospital that is charged with the care of the patient if the doctor judges the report to be relevant to the care and treatment of the patient, nor from disclosing the report to the Home Secretary if the doctor judges the report to be relevant to the exercise of the Home Secretary's discretionary powers in relation to that patient.

I accept that this conclusion places W. and persons like him in a position in which the duty of confidence owed by their psychiatrists is less extensive than the duty that would be owed by psychiatrists to ordinary members of the public. But this, in my view, is an inevitable result of the

circumstances that have led to W. being subjected to a restriction order under the Act of 1983. This limitation of W.'s rights is, in my judgment, justified by the need that, first, the hospital in charge of his clinical management, secondly, the Home Secretary, in whom very important discretionary powers are reposed, and, thirdly, the tribunal on whom the obligation in certain circumstances to order his discharge is placed, should be fully informed about W.

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In my judgment, therefore, the circumstances of this case did not impose on Dr. Egdell an obligation of conscience, an equitable obligation, to refrain from disclosing his report to Dr. Hunter, or to refrain from encouraging its disclosure to the Home Office. It follows also that that obligation cannot be imposed on Dr. Egdell by implied contract. If the officious bystander had asked the usual question, Dr. Egdell's answer would not have been the testy "of course." He would, I believe, have said that the question required very careful consideration. And after consideration he would, I think, have said that he would regard himself at entitled to disclose his report to the relevant authorities if, in his judgment, the public interest so required. If he had given that answer he would, in my judgment, have been right.

Mr. Robertson had an alternative to the equitable or contractual duty of confidence on which to base the obligation of non-disclosure for which he contended. He relied on legal privilege. The report was obtained for the purposes of the forthcoming tribunal hearing, that is to say, for forthcoming legal proceedings. Accordingly, he submitted, it was covered by legal professional privilege.

There are two authorities to which I should refer in dealing with this submission. Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380 concerned a handwriting expert who had given the plaintiff his opinion on the genuineness of a certain document. Subsequently he was asked by the defendant's solicitors to advise on the same point. He inadvertently forgot that he had already advised the plaintiff and gave an opinion to the defendant. His opinion must have been favourable to the defendant, for the defendant sought to call him as a witness at the trial and the plaintiff objected. Lord Denning M.R. said, at p. 1384:

> "So far as witnesses of fact are concerned, the law is as plain as can be. There is no property in a witness. The reason is because the court has a right to every man's evidence. Its primary duty is to ascertain the truth. Neither one side nor the other can debar the court from ascertaining the truth either by seeing a witness beforehand or by purchasing his evidence or by making communication to him. In no way can one side prohibit the other side from seeing a witness of fact, from getting the facts from him and from calling him to give evidence or from issuing him with a subpoena."

Then Lord Denning M.R. said, at p. 1385:

> "The question in this case is whether or not that principle applies to expert witnesses. They may have been told the substance of a party's case. They may have been given a great deal of confidential information on it. They may have given advice to the party. Does the rule apply to such a case?
>
> "Many of the communications between the solicitor and the expert witness will be privileged. They are protected by legal professional privilege. They cannot be communicated to the court except with the consent of the party concerned. That means that a great deal of the communications between the expert witness and the lawyer cannot be given in evidence to the court. If questions *395 were asked about it, then it would be the duty of the judge to protect the witness (and he would) by disallowing any questions which infringed the rule about legal professional privilege or the rule protecting information given in confidence - unless, of course, it was one of those rare cases which come before the courts from time to time where in spite of privilege or confidence the court does order a witness to give further evidence.
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> "Subject to that qualification, it seems to me that an expert witness falls into the same position as a witness of fact. The court is entitled, in order to ascertain the truth, to have the actual facts which he has observed adduced before it and to have his independent opinion on those facts."

The other case to which I would refer is Reg. v. King [1983] 1 W.L.R. 411 . In this case the defendant

was charged with conspiracy to defraud. His solicitors sent to a handwriting expert certain documents for examination. The prosecution desired to put in evidence the expert's opinion on these documents and served a subpoena on the expert for that purpose. It was contended for the defendant that the expert's opinion on these documents was protected by privilege. Dunn L.J., who gave the judgment of the court, said, at p. 413:

> "Mr. Smith, on behalf of the appellant, submitted in this court that any communication passing between a solicitor and a third party for the purpose of taking advice was privileged. He relied on a passage in Cross on Evidence, 5th ed. (1979), p. 286: 'The rationale of the head of legal professional privilege under consideration was succinctly stated by the Law Reform Committee to be "to facilitate the obtaining and preparation of evidence by a party to an action in support of his case." The privilege is essential to the adversary system of procedure which would be unworkable if parties were obliged to disclose communications with prospective witnesses.' While accepting that there is no property in a witness, Mr. Smith submitted that at common law an expert who had been consulted by solicitors for one party should not be called as a witness by the other party to give evidence as to any communication sent to him by the solicitors. Mr. Smith submitted that Exhibit 257 formed part of the communication from the appellant's solicitors to the expert."

Exhibit 257 was the document sent for examination. Dunn L.J. said, at p. 414:

> "Dealing first with the general position, the rule is that in the case of expert witnesses legal professional privilege attaches to confidential communications between the solicitor and the expert, but it does not attach to the chattels or documents upon which the expert based his opinion, nor to the independent opinion of the expert himself: see Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. . . . per Lord Denning M.R. The reasons for that are that there is no property in an expert witness any more than in any other witness and the court is entitled, in order to ascertain the truth, to have the actual facts which the expert has observed adduced before it in *396 considering his opinion. In general, then, no privilege will attach to Exhibit 257. It was one of the documents examined by Mr. Radley, upon which he based his opinion, and the court was entitled to have it adduced in evidence. Is there any difference because the document was examined in criminal proceedings rather than in civil proceedings? On principle we can see no reason why that should be so."

Exhibit 257 was a document which was in existence before proceedings commenced. It had not been brought into existence for the purpose of the proceedings themselves. So the question arises whether that would have made any difference to the result. Suppose the genuineness of a cheque is in question. If the cheque is submitted by one side to a handwriting expert for his opinion on the signature, the other side can call the expert to give evidence of that opinion. The Harmony case [1979] 1 W.L.R. 1380 and Reg. v. King [1983] 1 W.L.R. 411 establish that that is so. If a document already in existence before proceedings were contemplated had been, for purposes of comparison, submitted to the expert together with the cheque, the other side could put in evidence the expert's opinion not simply on the cheque but also on the other document, the "control" document: see Reg. v. King. But suppose the "control" document had been brought into existence after proceedings had commenced for the purpose of being submitted with the cheque to the handwriting expert. Mr. Robertson submitted that the other side could not call the expert to give opinion evidence on the comparison between the cheque and that "control" document. The reason, he said, is that that "control" document had been brought into existence for the purposes of the proceedings and so would be covered by legal privilege.

I do not accept that this distinction is a sound one. If a document is submitted to an expert witness for examination and if the opinion of the expert is relevant to an issue in the case, the expert is, in my judgment, in civil cases at least, a competent and compellable witness to give evidence of what has been put before him and of his opinion on it. Legal professional privilege attaches to documents brought into existence for the purpose of legal proceedings; but if such a document is placed before an expert witness for his opinion, it becomes, in my judgment, part of the facts on which the opinion is based. The expert cannot be barred when giving evidence of his opinion from referring to the facts on which the opinion is based, including, if it be the case, documents which, in the hands of solicitors,

would be covered by legal professional privilege.

There is, in my judgment, a clear and important distinction to be drawn between, on the one hand, instructions given to an expert witness and, on the other hand, the expert's opinion given pursuant to those instructions. The instructions are covered by legal professional privilege. The opinion is not. This distinction I take to be established by, in particular, the passage in Dunn L.J.'s judgment in Reg. v. King , at p. 414B.

In the present case the letter of instructions dated 2 July 1987 was covered by legal privilege. But Dr. Egdell did not disclose that letter. So *397 far as I know neither the hospital nor the Home Office has ever had a copy of it.

For the purposes of the examination itself, Dr. Egdell no doubt encouraged W. to be forthcoming about himself. W. communicated a great deal of information to Dr. Egdell, some of it information that does not seem previously to have been revealed. Mr. Robertson categorised all this information as information given for the purpose of legal proceedings, i.e. the tribunal hearing. The information was, he said, tantamount to instructions being given to Dr. Egdell by W. The information was therefore covered by legal professional privilege. I disagree. The more accurate analysis, in my judgment, is that the information acquired from W. formed part of the facts on which Dr. Egdell's opinion expressed in the report was based. Neither the opinion, nor the facts on which it was based, whether obtained from W. or from Dr. Egdell's perusal of the records, were, in my judgment, protected by legal professional privilege.

There is also, I think, a further answer to Mr. Robertson's reliance on legal professional privilege. The function of privilege is to protect material from being produced on discovery or being placed in evidence in legal proceedings. What is complained of in the present case is that Dr. Egdell supplied a copy of his report to the hospital and, indirectly, to the Home Secretary. Legal professional privilege is not a basis on which this complaint can be constructed.

In the result, in my judgment, the case against Dr. Egdell fails.

If I had found Dr. Egdell liable for breach of his duty of confidentiality I would have had to consider the issue on damages. It has, rightly in my opinion, not been argued by Mr. Robertson that W.'s continued detention subject to a restriction order, or continued detention at the hospital rather than at a regional secure unit, whether or not those things are to any extent attributable to the disclosure of the report, can sound in damages. It has been argued, however, that W. was caused shock and distress by Dr. Egdell's disclosure of the report and that that shock and distress should be reflected in an award of damages. An inquiry as to the amount of the damages is suggested.

The evidence that W. was caused shock or distress by Dr. Egdell's disclosure of the report is unconvincing. The affidavit sworn on 5 September 1988 by Mr. Ronald refers, at paragraph 8 to W.'s "shock that the first defendant did not support his application for discharge or transfer." A note of an interview that Mr. Ronald had with W. on 18 August 1987 records that W. "was absolutely shocked to find that Dr. Egdell did not back up his application for discharge or transfer." The absence of any evidence that W. was caused shock by the disclosure of the report, as opposed to shock by its contents, was the subject of comment in the course of counsel's submissions. The comment led to Mr. Robertson seeking leave to file an affidavit sworn by W. on 24 November 1988, the third day of the hearing. In paragraph 4 W. says: "I was extremely upset that this report had been disclosed because I though it was factually wrong in a number of ways." In paragraph 5 W. says that "I now feel very shocked and upset at what has happened, and I feel my record has been unfairly damaged by disclosure of this *398 inaccurate report on me." I gave leave for this affidavit to be filed but the circumstances of its late arrival deprived it of much cogency.

Further, it is, I think, open to question whether shock and distress caused by the unauthorised disclosure of confidential information can, in any event, properly be reflected in an award of damages.

In Bliss v. South East Thames Regional Health Authority [1987] I.C.R. 700 , 717-718, Dillon L.J. said:

> "The general rule laid down by the House of Lords in Addis v. Gramophone Co. Ltd. [1909] A.C. 488 is that where damages fall to be assessed for breach of contract rather than in tort it is not permissible to award general damages for frustration, mental distress, injured feelings or annoyance occasioned by the breach. Modern thinking tends to be that the amount of damages recoverable for a wrong should be the same

> whether the cause of action is laid in contract or in tort. But in the Addis case Lord Loreburn regarded the rule that damages for injured feelings cannot be recovered in contract for wrongful dismissal as too inveterate to be altered, and Lord James of Hereford supported his concurrence in the speech of Lord Loreburn by reference to his own experience at the Bar.
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> "There are exceptions now recognised where the contract which has been broken was itself a contract to provide peace of mind or freedom from distress: see Jarvis v. Swan Tours [1973] Q.B. 233 and Heywood v. Wellers [1976] Q.B. 446 . Those decisions, do not, however cover this present case.
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> "In Cox v. Philips Industries Ltd. [1976] I.C.R. 138 Lawson J. took the view that damages for distress, vexation and frustration, including consequent ill health, could be recovered for breach of a contract of employment if it could be said to have been in the contemplation of the parties that the breach would cause such distress, etc. For my part I do not think that that general approach is open to this court unless and until the House of Lords has reconsidered its decision in the Addis case."

This Court of Appeal authority seems to me to preclude W. from recovering damages (save nominal damages) to the extent that his claim is based on breach of an implied contractual term. I do not see any reason, on this point, why equity should not follow the law.

Accordingly, in my judgment, W. would not, even if I had found Dr. Egdell to be liable, have been entitled to damages. He would have had to be content with a declaration and an injunction.

I must now consider the position of the other defendants. If I am right in concluding that the case against Dr. Egdell fails, the case against the other defendants must also fail. But this case may go further and I ought, I think, to consider the position of the other defendants in case it should subsequently be held that Dr. Egdell was in breach of duty in disclosing his report to Dr. Hunter.

The hospital, acting by an unidentified person or persons, sent a copy of the report to the Home Office. The Home Office still holds a copy of the report and sent a copy to the tribunal. I must consider these matters on the hypothesis that the disclosure of the report to the *399 hospital was a breach by Dr. Egdell of the duty of confidence he owed to W.

There are two authorities which seem to me to be relevant. The first is Parry-Jones v. Law Society [1969] 1 Ch. 1 . The plaintiff was a solicitor on whom the Law Society had served a notice to produce for inspection his books of account and other documents. The notice was served pursuant to the rules made by the Law Society under section 29 of the Solicitors Act 1957 . The rules have statutory force. The plaintiff objected on the ground that the documents to be produced contained confidential information about his clients and that he owed his clients a duty not to disclose this information to others. Lord Denning M.R. said, at p. 8:

> "In my opinion that rule is a valid rule which overrides any privilege or confidence which otherwise might subsist between solicitor and client. It enables the Law Society for the public good to hold an investigation, even if it involves getting information as to clients' affairs. But they and their accountant must, of course, themselves respect the obligation of confidence. They must not use it for any purpose except the investigation, and any consequential proceedings."

Diplock L.J. said, at p. 9:

> "What we are concerned with here is the contractual duty of confidence, generally implied though sometimes expressed, between a solicitor and client. Such a duty exists not only between solicitor and client, but, for example, between banker and customer, doctor and patient and accountant and client. Such a duty of confidence is subject to, and overridden by, the duty of any party to that contract to comply with the law of the land. If it is the duty of such a party to a contract, whether at common law or under statute, to disclose in defined circumstances confidential information, then he must do so . . ."

The other case is Hunter v. Mann [1974] Q.B. 767 , which concerned the statutory obligation imposed by section 168 of the Road Traffic Act 1972 . A doctor was asked by a police officer to divulge the identity of the driver of a vehicle that had been involved in an accident. The doctor refused on the ground that he had obtained the information from a patient, namely, the driver, and that to divulge his identity would be in breach of his obligation of professional confidence. The doctor was convicted of contravening section 168(3) . He appealed. The Divisional Court dismissed his appeal. The statutory duty to disclose the information overrode the doctor's duty of confidence to his patient.

The scheme set up by the Act of 1983 for dealing with patients subject to restriction orders requires co-operation between the hospitals in which patients are held and the Home Secretary. The Home Secretary when deciding whether or not to exercise any of his discretionary powers under section 41(3) is dependent on the hospital in which the patient in question is held to supply him with relevant information about that patient. It could not, in my view, ever be right for the authorities of such a hospital to withhold from the Home Secretary relevant information about a patient subject to a restriction order. The importance for public *400 safety that the Home Secretary should be fully informed requires that that be so. Accordingly, even if Dr. Egdell were in breach of duty in disclosing his report to Dr. Hunter, the decision, by whoever took it, to send a copy of the report to the Home Secretary was not, in my judgment, a breach of any duty lying on the hospital. On the contrary, in my opinion, the hospital had a duty to send a copy to the Home Secretary. A fortiori, the Home Secretary was under a duty to send a copy of the report to the tribunal. Rule 6(2) of the Rules of 1983 places a statutory obligation on the Home Secretary to send to the tribunal for the purpose of cases being reviewed by the tribunal "a statement of such further information relevant to the application as may be available to him." The Egdell report was further information available to the Home Secretary. The Home Secretary's statutory duty under rule 6(2) overrode, in my judgment, any confidentiality attaching to the report.

Finally, I must consider the position of the tribunal. The tribunal holds copies of the Egdell report. It is, in my judgment, entitled to retain these copies and to make such use of them as it thinks fit on the hearing or the adjourned review of W.'s case. Both the public interest in the tribunal being fully informed and the inquisitorial nature of the tribunal's proceedings override any confidentiality attaching to the report.

In the result W.'s action fails, in my judgment, against each of the defendants. It does not fail because Dr. Egdell's conclusions are necessarily to be preferred to those of Dr. Ghosh, or of Dr. Coorey, or of Dr. Kay. I must emphasise that I have formed no opinion in favour of Dr. Egdell's views as opposed to those of the others. The action fails because Dr. Egdell's report is, in my view, relevant material to be taken into account by the hospital, by the Home Office and by the tribunal in the discharge of their respective functions regarding W. and because in the very special circumstances of this case the duty of confidence owed by Dr. Egdell to his patient W. does not bar disclosure of the report to those recipients.

It is for those recipients of the report to attribute to it such weight as they think it merits. The consolidated action is therefore dismissed.

Judgment for defendants with costs. (T. C. C. B.)

Representation

Irwin Mitchell, Sheffield ; Hempsons ; Treasury Solicitor .

APPEAL from Scott J.

By notice of appeal dated 29 March 1989, the plaintiff appealed on the grounds that (1) there was insufficient evidence upon which the judge could find that the defendant was entitled to assume that his report concerning the plaintiff would be put before the mental health review tribunal and such finding was inconsistent with the evidence of the defendant; (2) the judge was wrong in fact and in law in holding that having regard to all the circumstances and in particular for the purpose for which the report was prepared the defendant was entitled to disclose *401 his report to the medical director of the secure hospital for the reason set out in paragraph 81(b) of the General Medical Council's "Advice on standards of professional conduct and on medical ethics;" (3) the judge was wrong in law in holding that the interest of the plaintiff in seeking to uphold the confidentiality of the report was a private interest and did not fall to be balanced against the public interest justifying the disclosure of the report; (4) the judge was wrong in law in holding that the information disclosed by the plaintiff to

the defendant in the course of an interview leading to the preparation of the report and the opinions of the defendant expressed in the report based on information or otherwise were not the subject of legal professional privilege and so to be treated accordingly as subject to a duty of confidence; (5) the judge was wrong in fact and in law in holding on his determination of the balance of the interest for and against disclosure of the report that the interests favouring disclosure prevailed because in reaching his decision the judge placed excessive reliance upon the continued detention of the plaintiff in a secure hospital as being requisite in the public interest and failed to take any or any sufficient account of the public interests favouring the maintenance of confidentiality, in particular, that a person subject to detention should by himself and his advisers be able to prepare for proceedings to lead to his discharge without the risk that a confidential document prepared in the course of such preparation should be disclosed without the plaintiff's authority. Having regard to the interests to be taken properly into account in determining the balance, the judge ought to have held that the public interests favouring the maintenance of the confidentiality of the report should prevail; (6) the finding by the judge that the plaintiff did not suffer shock and distress as a result of the defendant's disclosure of the report and the subsequent distribution was against all the available evidence; (7) the judge erred in law in holding that an award of damages for the disclosure of confidential information in breach of a contractual duty of confidence could not be made in respect of the shock and distress suffered by the plaintiff.

By a respondent's notice under R.S.C., Ord. 58, r. 6(2)(b) the defendant gave notice of his intention to contend at the hearing of the appeal against the order of Scott J. made on 9 December 1988 that the judge's decision should be affirmed on the additional grounds that the defendant's disclosures of information and opinion set out in his report of 29 July 1987 were justified by the importance and novelty of that information and in particular that relating to the plaintiff's long standing interest in explosives which might bear upon a proper diagnosis of his mental condition, his treatment and the likelihood of serious re-offending by him in the future; and that the disclosures were justified by the cumulative effect of the matters relied upon by the judge.

The facts are stated in the judgment of Sir Stephen Brown P.

Geoffrey Robertson Q.C. and Nicholas Orr for the plaintiff. The main issue is whether and/or in what circumstances a psychiatrist retained by a restricted mental patient to advise in anticipated legal proceedings is entitled to disclose his confidential report to third parties when he had received express instructions from his client to the contrary. Scott J. *402 held that the duty of confidentiality owed to the patient served his private interest which was outweighed by the public interest that state authorities should be aware of all relevant information and opinion about restricted mental patients. See ante, pp. 399G-400D. Scott J. erred in holding that the public interest favouring disclosure prevailed. The interest was the private interest and also public interest that there should be confidentiality and trust between doctor and patient.

The statutory scheme which provides for the detention, transfer and eventually to the release of a restricted mental patient does not restrict or extinguish the common law rights of a restricted mental patient which demand the duty of confidentiality from his doctor especially in relation to applications to a mental health review tribunal. Those rights are recognised and facilitated by section 76 of the Mental Health Act 1983 . See also section 129 . The Act of 1983 preserves and protects confidentiality for restricted mental patients.

Dr. Egdell was retained by a letter from W.'s solicitors. He was asked to prepare a report on W.'s mental state which would be put before a mental health review tribunal. The terms of that retainer did not include any waiver of the duty of confidentiality. The solicitors gave no undertaking to place the report before the mental health review tribunal. There was express instruction to Dr. Egdell not to disclose the report to third parties. Dr. Egdell prepared a report which referred to information received during a private interview with W., from his case file and with conversations with hospital staff who expressed opinions about his past and present mental state and about his future treatment which was not his concern. He had been retained to write an opinion on his present mental state. That report was for legal proceedings. [Reference was made to Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd [1979] 1 W.L.R. 1380 and to Reg. v. Uljee [1982] 1 N.Z.L.R. 561 .]

Unless the judgment of Scott J. is overturned it means that a lower degree of confidentiality is owed to a restricted mental patient than to an ordinary member of the public. In fact, a restricted mental patient would have no protection except to be protected from the media. [Reference was made to Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425.]

It is accepted that W. had no absolute right to confidence but there was a qualified right and that right was not overridden by the public interest in disclosure. There was a twofold duty of confidentiality imposed on Dr. Egdell. There was the professional relationship between a doctor and his patient and the professional relationship came because the doctor had been retained by W. as an expert in pending legal proceedings. Those are cumulative and not alternative grounds for the duty of non-disclosure. Legal professional privilege could apply. There was further public interest that of encouraging full and frank disclosure which should have been placed in the balance against the public interest favouring disclosure.

There was a duty of confidence owed by Dr. Egdell to W. The burden of proof rests with him. It is for the defendant to prove that his duty was overridden by public interest considerations when he breached *403 his duty. [Reference was made to Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109 , 269.]

When it is alleged that a breach of confidence can be justified because the breach means the elimination or at least a reduction of the risk to public safety, the defendant has to show that such a risk is real, immediate and serious; that the risk would be substantially reduced by disclosure; that the disclosure should be more than is reasonably necessary to minimise the risk and that the consequent damage to the public interest protected by the duty of confidentiality is outweighed by the public interest requiring that the risk to public safety should be minimised. [Reference was made to X v. Y [1988] 2 All E.R. 648 ; A.B. v. C.D. (1851) 14 Dunlop 177 and Hunter v. Mann [1974] Q.B. 767 .] Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425 is an example of extreme circumstances. Only in the most extreme circumstances can a doctor breach the strict duty of confidence imposed on him. Reliance is placed on the decision of Rose J. in X v. Y [1988] 2 All E.R. 648

In the present case W. is not going to be released into the community. He is detained and will continue to be detained under secure conditions. Any change in his circumstances depends upon further expert examination and analysis. [Reference was made to Francome v. Mirror Group Newpapers Ltd. [1984] 1 W.L.R. 892 .]

The General Medical Council publishes rules entitled "Advice on standards of professional conduct and of medical ethics." See Rules 79, 80 and 81 . Dr. Egdell had no responsibility for the clinical decisions relating to W. Rule 81(b) did not apply to him. Scott J. erred when he considered that the case fell squarely upon Rule 81(b). Scott J. held that disclosure was justified under Rule 81(g). The relationship between doctors and patient is contractual. It is for the court to decide whether disclosure is justified. There was no duty to disclose the report to the Home Secretary. The public interest to maintain confidentiality between doctor and patient was the overriding public interest. [Reference was made to Jarvis v. Swans Tours Ltd. [1973] Q.B. 233 ; Heywood v. Wellers [1976] Q.B. 446 and Perry v. Sidney Phillips & Son [1982] 1 W.L.R. 1297 .]

Adrian Whitfield Q.C. and Kieran Coonan for the defendant. The court has been referred to the facts and the relevant statute law. W. was not the patient of Dr. Egdell but it is accepted that Dr. Egdell owed a duty of confidence to W. The psychiatrist had been instructed by W.'s solicitors to see W. and to prepare a report which was to be placed before a mental health review tribunal.

Privilege is a rule of evidence. The instructions to Dr. Egdell given by W.'s solicitors were covered by legal professional privilege. The communication by W. to Dr. Egdell during the interview were not so covered. A doctor can be compelled to divulge to a court what has been said to him by a patient: see Hunter v. Mann [1974] Q.B. 767 . [Reference was made to Harmony Shipping Co. S.A. v. Saudi Europe Line Ltd. [1979] 1 W.L.R. 1380 .] Repetition of the views expressed in the report whether oral or written given to someone other than W.'s *404 solicitor could not be privileged as that would be a restatement of views to which no privilege attached. Legal professional privilege is irrelevant.

Case law shows that the law recognises the public interest in maintaining confidence between doctor and patient, banker or accountant with client, employee and employer and perhaps journalist with informant. But that public interest in maintaining professional duties of confidence can be overridden when there is a strong public interest which requires the duty of confidence to be breached. [Reference was made to Attorney-General v. Mulholland; Attorney-General v. Foster [1963] Q.B. 477 ; Chantrey Martin v. Martin [1953] 2 Q.B. 286 ; Parry-Jones v. Law Society [1969] 1 Ch. 1 ; Initial Services Ltd. v. Putterill [1968] 1 Q.B. 396 ; Lion Laboratories v. Evans [1985] Q.B. 526 and Tournier v. National Provincial and Union Bank of Eingland [1924] 1 K.B. 461 .] Lord Goff of Chieveley states the limiting principle succinctly in Attorney-General v. Guardian Newspapers Ltd. (No.2) [1990] 1 A.C.

109 . The issue is whether there was an actionable breach of confidence. Scott J. identified the public interest in that patients should be able to make full and frank disclosures to doctors without the fear that the information would be disclosed to others. No greater obligation should be placed on psychiatrists than on others in the medical profession. Scott J. was correct when he held that a factor when assessing the weight which W. could place on that principle of public interest was the purpose for which it was invoked. As to whether Dr. Egdell had just cause or excuse for breaking the duty of confidentiality: see per Lord Denning M.R. in Fraser v. Evans [1969] 1 Q.B. 349 .

A number of factors justify the disclosure. There was the revelation that W. had a long standing interest in explosives and had possibly a deviant personality. Dr. Egdell was concerned about W.'s treatment and that his interest in explosives had been overlooked. The disclosure came within rule 81(b) and (g) of the "Advice on Standards of Professional Conduct and of Medical Ethics" issued by the General Medical Council.

Dr. Egdell had no alternative but to consider the safety of the general public and that safety was his main concern. There was no imminent risk to the public but it was of overweening importance to disclose material information promptly. A psychiatrist who keeps quiet about the dangerous qualities of a patient would not be liable in damages to a victim whose identity could be known in advance: see Hill v. Chief Constable of West Yorkshire [1989] A.C. 53 . [Reference was made to Tarasoff v. Regents of the University of California (1976) 17 Cal. 3d 425.] In such circumstances there would at least be a discretion and a moral duty to disclose as the disclosures would be not only in wider public interest to protect people from violence but would also be in the plaintiff's interest as well.

There was a heavy duty placed on Dr. Egdell to disclose the information. Scott J. considered that the evidence of shock and distress was unconvincing and the plaintiff was complaining that the report was inaccurate rather than complaining of the disclosure.

*405

There is no right to damages for shock and distress: see Bliss v. South East Thames Regional Health Authority [1987] I.C.R. 700 .

Cur. adv. vult.

9 November. The following judgments were handed down

SIR STEPHEN BROWN P.

This appeal raises in an unusually stark form the question of the nature and quality of the duty of confidence owed to a patient detained in a special hospital pursuant to a hospital order coupled with a restriction order by an independent consultant psychiatrist engaged on behalf of the patient to report on the state of his mental health in connection with a forthcoming application to a mental health review tribunal for his discharge.

The plaintiff, W., appeals to this court against the dismissal by Scott J. of his claim for damages and other relief against Dr. Egdell for alleged breach of confidence. The circumstances which led to his conviction and the making of the hospital order are summarised in the judgment of Scott J. ante, p. 370D. The judge described the circumstances, at pp. 370F-371A:

> "About ten years ago W. shot the four members of a neighbouring family. He shot another neighbour who had come to investigate the shooting. He then drove off in his car, throwing hand-made bombs as he did so. Later the same day he shot two more people, not neighbours, but strangers to him. Five of his victims died of their injuries. The other two needed major surgery for serious bullet wounds. W. was diagnosed as suffering from paranoid schizophrenia. It was believed by the doctors who examined him that he had been suffering from this illness for about two years before the offences. The illness involved delusions that he was being persecuted by his neighbours. In the circumstances W.'s plea of guilty to manslaughter on the grounds of diminished responsibility was accepted by the Crown and he was convicted accordingly. Orders were made under sections 60 and 65 of the Mental Health Act 1959 , now sections 37 and 41 of the Mental Health Act 1983 , providing for his detention without limit of time. He was at first detained at Broadmoor Hospital. In 1981 he was transferred, in accordance with a transfer direction given by the Home Secretary, to a secure hospital in the North of England. References hereafter in this judgment to 'the hospital' will be

references to this hospital where W. is still detained."

In 1984 a mental health review tribunal recommended W.'s transfer to a regional secure unit. This was intended to be a first stage in a rehabilitation programme leading to discharge into the community. The Secretary of State, however, refused to approve the transfer. The plaintiff's responsible medical officer, Dr. Chandra Ghosh, however, recommended to the Secretary of State that W. should be transferred to a regional secure unit. The Secretary of State refused to consent to a transfer by a letter of 20 May 1987 in which he set out his reasons. Shortly before that date W. had consulted solicitors with a view to making an application to a mental health review tribunal for his conditional discharge. He was granted legal aid for the purpose of his *406 application and the certificate included an authorisation to obtain an independent psychiatric report. On 19 May 1987 Dr. Ghosh as the responsible medical officer for W. made a statement pursuant to the Mental Health Review Tribunal Rules 1983 (S.I. 1983 No. 942) for the purposes of the forthcoming tribunal hearing. Her report under the heading "Present mental state" stated:

> "W. has been diagnosed as suffering from schizophrenia. His mental illness is now controlled by medication and he has been stable for the past five years. He has considerable insight into his mental state and accepts the need for continuing on medication. He also realises that he requires close and careful monitoring of his mental state. It is my opinion that W. requires to move gradually through graded security with maximum and immediate supervision being available in the early stages. W. was recommended for transfer on 20 March 1985. He has been accepted by Dr. R. Cope for the . . . regional secure unit at . . . hospital on 20 June 1986, his previous mental health review tribunal supported a recommendation of transfer to a regional secure unit. We are still awaiting Home Office permission for such a move."

A copy of that statement was sent to W.'s advisers. A statement by the Secretary of State for consideration by the tribunal followed in June 1987. That statement sets out the circumstances of the offences leading to W.'s admission to hospital and concluded with the Secretary of State's observations on the patient's suitability for discharge. It stated:

> "The Home Secretary has noted Dr. Ghosh's report of 19 May but, having given the most careful consideration to all the circumstances of the case, he is unable to consent to her recommendation to move W. to the [regional secure unit] at this time. He feels that there is a need for the utmost caution to be exercised in this case and he would expect W. to show a very long period of stable behaviour before commencing on a programme of rehabilitation, bearing in mind his indiscriminate violence towards his victims in the index offence. Furthermore, he would feel more confident towards W.'s removal from conditions of maximum security when his interest in weapons has been more fully explored and explained and he would be prepared to consider the case for W. to move to a secure unit in perhaps 18 months' time in the light of these findings. He will in all probability wish to refer any future proposals to the Advisory Board on Restricted Patients."

In late 1985 and early 1986 at the instance of Dr. Ghosh, W. underwent an assessment of his personality by a clinical psychologist, Mr. Tulloch. In his report of 18 April 1986 Mr. Tulloch said: "It is not possible to shed much light on [W.'s] pre-morbid personality from this assessment." Further:

> "It should also be borne in mind that W. is not an 'immediate' danger. He was clearly mentally ill at the time of his offences, this process having built up over a prolonged period. Given that he is now stabilised on medication his dangerousness is significantly *407 reduced. A [regional secure unit] would, therefore, seem to be an appropriate placement. Exploration of his personality at a more detailed level would be useful in terms of preparation for future community survival and this can probably be achieved more readily within [a regional secure unit] context."

It concluded with a "Summary":

> "This brief assessment of [W.'s] personality does not reveal any significant disturbance. Two main areas of dynamic tension, emotional dependence and self-concept, were noted although it is not possible to do more than speculate on their pre-morbid significance. Exploratory psychotherapy may be more helpful in this situation and it is suggested that this would be more appropriate in a regional secure unit setting."

On 2 July 1987 solicitors acting on behalf of the plaintiff instructed Dr. Egdell to report on W.'s mental state. Dr. Egdell is a distinguished consultant psychiatrist. He is also a clinical lecturer at a university and a member of a mental health review tribunal. His instructions were "to attend upon our client and complete a report for use at his forthcoming mental health review tribunal." Dr. Egdell submitted a report on 29 July 1987. It is a detailed psychiatric report. Under the heading "Interest in Fireworks," Dr. Egdell said:

> "At the age of about 10 or 12 he began to make fireworks to let them off in the back yard. As an adult he continued to make them regularly over a number of years. He would buy the ingredients from 'any chemist' and 'make them in the garage' 'for something to do.' He says that about once a month he would go off into the country to let them off and said he would perhaps explode a couple at a time. They would consist of a steel piping packed with chemicals and a fuse which he lit. He reports that on at least one occasion he let them off in a canal bank near home. He reports that he 'always' carried some made up explosives in his car. When asked if there was a potential danger he confidently replied 'there was no danger if you threw them far enough away.'
>
> "[W.] told me that immediately after the first shooting in the index offence he threw, he thinks, two or three of them out of the car and thinks two of them went off. When questioned further about this [W.] became very tense and said: 'I can't remember any more of that' and was unwilling to discuss this further. One opinion recorded in the report of the index offence was that the home made bombs were 'sophisticated'."

Dr. Egdell then gave his "Psychiatric opinion and recommendation." Under the heading "Illness" he said:

> "I was not convinced that he really had insight into his illness. He verbally stated that he accepted medication but this appeared to be to avoid being labelled as a 'psychopath' and secondly the illness was used as an excuse to avoid considering the motivation behind the killings. He may not even have faced up to this himself."

*408

Under the heading "Personality" Dr. Egdell said:

> "There was striking lack of remorse even at a simple verbal level. For example the wife at the garage 'made a fuss' so she was shot. He showed no concern for those who were wounded, their relatives or even the effects of his offence on his own family. My overall opinion would be that [W.] has a clearly abnormal personality, particularly in regard to his relationships, to the management of his feelings and dealing with frustration and an unwillingness to look at his own personal problems in the past and in the future and to review the motivation lying behind the killings. I am reluctant at this stage to say that [W.] suffers from a psychopathic personality, as my contacts with him were confined to one interview, and also the report of the clinical psychologist, Mr. R. Tulloch of 18 April 1986. There does seem to be a serious conflict between the findings of Mr. Tulloch and my overall impression culled from various sources. I think that it would be important for this conflict to be resolved before a decision is made on [W.'s] departure from [the secure] hospital."

Under the heading "Home made bombs" Dr. Egdell said:

> "Again this interest goes back to his school days. There is also the important record in the 1982 occupational reports stating that he said he was keen on bombs and there was the hint of a plan to bomb Windscale. He describes a life-long interest in making home made bombs and exploding them. He has done this on a very regular basis over very many years. There are also reports that he always carried some bombs in his car which illustrates how much they were a regular part of his life. He was clearly very aware of the precautions necessary to avoid injury to himself over the years. In the index offence he was prepared to use these to 'scare people off' with no apparent regard for the risk of injury to others. I would link his interest in home made bombs to his major interest in hospital in watching science documentaries and reading science fiction. My view would be that this all points to a seriously abnormal interest in the making of home made bombs. He euphemistically calls them 'fireworks.' They are clearly much more dangerous than that."

Under the heading "Fitness for transfer to a regional secure unit" Dr. Egdell said in summary:

> ". . . I would strongly recommend that [W.] is not considered for transfer to a regional secure unit until the above recommendations are fulfilled. Even when these are completed there may be indications for further prolonged stay under the present secure conditions."

Dr. Egdell added: "I have no objection to W. seeing this report."

It is clear that the report did not support the plaintiff's case for discharge or alternatively for transfer to a regional secure unit. It was seriously at variance with the reports and recommendations made by Dr. *409 Ghosh and the report made by Dr. Cope, the consultant psychiatrist at the regional secure unit. In particular Dr. Egdell's report contained new information which he stated came from the plaintiff himself concerning his long-standing interest in "fireworks" which in fact, according to the information recorded by Dr. Egdell, were bombs of a somewhat sophisticated nature.

After consideration of the report, the plaintiff through his solicitors withdrew his application to the tribunal by a letter dated 18 August 1987.

As a result of a telephone conversation which he had had with Dr. Ghosh at the end of July 1987, Dr. Egdell knew that his views about W. did not agree with hers. On 19 August 1987, not knowing that W.'s solicitors had withdrawn the application, Dr. Egdell telephoned the tribunal and asked whether it had received a copy of his report. He was told that a copy of his report had not been received and that W.'s application had been withdrawn.

In paragraph 4 of his affidavit, sworn on 13 October 1988, Dr. Egdell said:

> "On learning that my report was not available to the mental health review tribunal I telephoned Dr. Hunter [assistant medical director at the hospital] for advice in this matter. This was the first occasion on which I spoke to Dr. Hunter about this patient. I explained my concern that my views were so different from those expressed by Dr. Ghosh (W.'s responsible medical officer) and also my belief that two important matters relating to W.'s interest in firearms and explosives had not been properly explored or even appreciated. Dr. Hunter indicated that additional information about his patient was always helpful and indeed welcome. He asked me to contact W.'s solicitors as a matter of courtesy to see if they would agree to disclosure of my report of 29 July to Dr. Hunter. They declined to agree.

Dr. Hunter, the acting medical director of the hospital, is himself a consultant forensic psychiatrist.

In his judgment Scott J. said, ante, p. 383B-D:

> "Dr. Egdell's terse 'They declined to agree' is amplified by paragraph 9 of the affidavit of Mr. Ronald, W.'s solicitor, sworn on 5 September 1988. Mr. Ronald said: 'Following 19 August and prior to 24 August [Dr. Egdell] telephoned to Mr. Brian Canavan to discuss the plaintiff's case. In the course of this conversation he was advised that the tribunal application had been withdrawn and he queried what would happen to his report. It was

> explained to him by Mr. Canavan that his report would be on their files and would not be drawn to anyone's attention. [Dr. Egdell] expressed a wish that the report be forwarded to [the hospital] so that they were aware of his findings, however, Mr. Canavan declined to do this in view of the clear instructions that he had received from the plaintiff.'"

Scott J. continued, at p. 383D-G: *410

> "What passed between Dr. Egdell and Dr. Hunter in their telephone conversation on 24 August 1987 is set out in a letter dated 25 April 1988, written by Dr. Hunter to Messrs. Irwin Mitchell, W.'s present solicitors. The letter said: 'Dr. Egdell expressed the view that the material which he felt had been revealed from his examination cast a new light upon the patient's dangerousness and ought to be known to those responsible for his care and for the formulation of any recommendations for discharge. During this conversation I asked Dr. Egdell to forward to me a report in writing of his concerns about the patient and this report, dated 25 August 1987, was received in the hospital shortly thereafter.' Following that telephone conversation and in accordance with Dr. Hunter's request, recorded by Dr. Hunter in his letter, Dr. Egdell sent Dr. Hunter a report dated 25 August 1987. Dr. Egdell substituted the name and address of Dr. Hunter for the name and address of Messrs. E. Rex Makin & Co., and he altered the opening paragraph so as to read: 'The following report is provided at your formal verbal request to me on 25 August 1987.'"

The report sent to Dr. Hunter was identical with that dated 29 July 1987 that had been sent to W.'s solicitors. The judge added, at pp. 383H-384A:

> "It was Dr. Egdell's opinion that a copy of his report ought also to be supplied to the Home Office. Dr. Egdell pressed this opinion on Dr. Hunter and on 18 November 1987 wrote to Dr. Hunter in these terms: 'I am sorry I have not yet received formal confirmation from you that the report prepared on W. dated 29 July 1987 has been made available in his case notes. I regret to have to say this, but without this I shall feel obliged to send a copy directly to the Home Office. I would prefer to avoid this.' By a letter dated 20 November 1987, signed by Dr. Ghosh, Dr. Egdell was informed that: 'a copy of your report on the above patient was forwarded to the Home Office and a further copy is on our case notes.' "

On 25 November 1987 the Secretary of State referred W.'s case to the mental health review tribunal under section 7(2) of the Mental Health Act 1983 , which he was obliged to do because W.'s case had not been before the tribunal within the last three years.

On learning, apparently from Dr. Ghosh, that Dr. Egdell's report was held by the hospital and that Dr. Egdell was pressing for a copy to be sent to the Home Office, the plaintiff's solicitors commenced these proceedings against Dr. Egdell. Subsequently they also commenced separate proceedings against the Secretary of State for Health, the Home Secretary, the hospital board and the Mersey Mental Health Review Tribunal which were consolidated with the action against Dr. Egdell. The judge also dismissed those claims. They are not the subject of an appeal to this court.

The evidence in this case, by agreement, was given on affidavit. No witness was called for cross-examination. Dr. Egdell swore three affidavits. In an affidavit sworn on 15 February 1988 he said in paragraph 4: *411

> "Following perusal of the notes I am now satisfied that there is adequate material in the case notes to suggest that W.'s interest in guns was long standing and pre-dated his illness."

In paragraph 6 he said:

> "The existence of a long standing interest in explosives as well as guns is a pointer to a psychopathic disorder. So far Dr. Ghosh has rejected the question of psychopathic

> behaviour and has sought to explain [W.'s] bizarre behaviour on the basis of transient mental illness albeit now controlled by medication."

In paragraph 7 he said:

> "I do not see it as part of my duty in the public interest to proffer an alternative diagnosis but I do think it necessary in the public interest that [W.'s] confession to me about his long standing interest in explosives be made available to the Home Office and that I be released from my duty of confidentiality."

In an affidavit sworn on 13 October 1988 he said: "Throughout this matter I have acted in good faith."

In the course of his judgment, Scott J. said, at p. 388C-D:

> "The basis of W.'s case is that his interview with Dr. Egdell on 23 July 1987 and the report written by Dr. Egdell on the basis of that interview are, or ought to have been, protected from disclosure by the duty of confidence resting on Dr. Egdell as W.'s doctor. It is claimed that Dr. Egdell was in breach of his duty of confidence in telling Dr. Hunter about the report, in sending a copy of the report to Dr. Hunter and in urging the despatch of a copy to the Home Office."

He continued, at pp. 389B-390B:

> "It is convenient for me first to ask myself what duty of confidence a court of equity ought to regard as imposed on Dr. Egdell by the circumstances in which he obtained information from and about W. and prepared his report. It is in my judgment plain, and the contrary has not been suggested, that the circumstances did impose on Dr. Egdell a duty of confidence. If, for instance, Dr. Egdell had sold the contents of his report to a newspaper, I do not think any court of equity would hesitate for a moment before concluding that his conduct had been a breach of his duty of confidence. The question in the present case is not whether Dr. Egdell was under a duty of confidence; he plainly was. The question is as to the breadth of that duty. Did the duty extend so as to bar disclosure of the report to the medical director of the hospital? Did it bar disclosure to the Home Office? In the ' Spycatcher ' case [Attorney-General v. Guardian Newspapers Ltd. (No. 2)] in the House of Lords [1990] 1 A.C. 109 Lord Goff of Chieveley after accepting, at p. 281: 'the broad general principle . . . that a duty of confidence arises when confidential information comes to the knowledge of a person (the confidant) in circumstances where he has notice, or is held to have agreed, that the information is confidential, with the effect that it *412 would be just in all the circumstances that he should be precluded from disclosing the information to others' formulated three limiting principles. He said, at p. 282: 'The third limiting principle is of far greater importance. It is that, although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply, as the learned judge pointed out, to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure.'
>
> "In X v. Y [1988] 2 All E.R. 648 , a case which concerned doctors who were believed to be continuing to practice despite having contracted AIDS, Rose J. said, at p. 653: 'In the long run, preservation of confidentiality is the only way of securing public health; otherwise doctors will be discredited as a source of education, for future individual patients "will not come forward if doctors are going to squeal on them." Consequently, confidentiality is vital to secure public as well as private health, for unless those infected come forward they cannot be counselled and self-treatment does not provide the best care.' The question in a particular case whether a duty of confidentiality extends to bar particular disclosures that the confidant has made or wants to make requires the court to balance the interest to be served by non-disclosure against the interest served by disclosure. Rose J. struck that balance. It came down, he held, in favour of

> non-disclosure. In the ' Spycatcher ' case, that balance too was struck. In that case the balance did not come down in favour of non-disclosure. I must endeavour to strike the balance in the present case."

Mr. Robertson on behalf of W. agreed that the judge was required to carry out a balancing exercise. He said that it is a question of degree.

As a starting point Scott J. turned to "Advice on standards of professional conduct and on medical ethics" contained in the General Medical Council's "Blue Book" on "Professional Conduct and Discipline: Fitness to Practise." The judge said, at p. 390G-H:

> "These rules do not provide a definitive answer to the question raised in the present case as to the breadth of the duty of confidence owed by Dr. Egdell. They seem to me valuable, however, in showing the approach of the General Medical Council to the breadth of the doctor/patient duty of confidence."

These rules do not themselves have statutory authority. Nevertheless, the General Medical Council in exercising its disciplinary jurisdiction does so in pursuance of the provisions of the Medical Act 1983 . Under the heading "Professional confidence," paragraphs 79 to 82 provide:

> "79. The following guidance is given on the principles which should govern the confidentiality of information relating to patients. *413 "80. It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner. The death of the patient does not absolve the doctor from this obligation.
>
> "81. The circumstances where exceptions to the rule may be permitted are as follows: (a) If the patient or his legal adviser gives written and valid consent, information to which the consent refers may be disclosed. (b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient. To the extent that the doctor deems it necessary for the performance of their particular duties, confidential information may also be shared with other persons (nurses and other health care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence. (c) If in particular circumstances the doctor believes it undesirable on medical grounds to seek the patient's consent, information regarding the patient's health may sometimes be given in confidence to a close relative or person in a similar relationship to the patient. However, this guidance is qualified in paragraphs 83-85 below. (d) If in the doctor's opinion disclosure of information to a third party other than a relative would be in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be given. If the patient still refuses then only in exceptional cases should the doctor feel entitled to disregard his refusal. (e) Information may be disclosed to the appropriate authority in order to satisfy a specific statutory requirement, such as notification of an infectious disease. (f) If the doctor is directed to disclose information by a judge or other presiding officer of a court before whom he is appearing to give evidence, information may at that stage be disclosed. Similarly, a doctor may disclose information when he has been summoned by authority of a court in Scotland, or under the powers of a procurator-fiscal in Scotland to investigate sudden, suspicious or unexplained deaths, and appears to give evidence before a procurator-fiscal. Information may also be disclosed to a coroner or his nominated representative to the extent necessary to enable the coroner to determine whether an inquest should be held. But where litigation is in prospect, unless the patient has consented to disclosure or a formal court order has been made for disclosure, information should not be disclosed merely in response to demands from other persons such as another party's solicitor or an official of the court. (g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by

> the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence. *414 (h) Information may also be disclosed if necessary for the purpose of a medical research project which has been approved by a recognised ethical committee.
>
> "82. Whatever the circumstances, a doctor must always be prepared to justify his action if he has diclosed confidential information. If a doctor is in doubt whether any of the exceptions mentioned above would justify him in disclosing information in a particular situation he will be wise to seek advice from a medical defence society or professional association."

The judge said that sub-paragraphs (b) and (g) of rule 81 seemed to him to be particularly relevant. He then rehearsed the circumstances of the disclosure by Dr. Egdell of his report and asked the question, at p. 392A-D:

> "Did these circumstances impose on Dr. Egdell a duty not to disclose his opinions and his report to Dr. Hunter, the medical director at the hospital? In my judgment they did not. Dr. Egdell was expressing opinions which were relevant to the nature of the treatment and care to be accorded to W. at the hospital. Dr. Egdell was, in effect, recommending a change from the approach to treatment and care that Dr. Ghosh was following. He was expressing reservations about Dr. Ghosh's diagnosis. The case seems to me to fall squarely within sub-paragraph (b) of paragraph 81.
>
> "But I would base my conclusion on broader considerations than that. I decline to overlook the background to Dr. Egdell's examination of W. True it is that Dr. Egdell was engaged by W. He was the doctor of W.'s choice. Nonetheless, in my opinion, the duty he owed to W. was not his only duty. W. was not an ordinary member of the public. He was, consequent upon the killings he had perpetrated, held in a secure hospital subject to a regime whereby decisions concerning his future were to be taken by public authorities, the Home Secretary or the tribunal. W.'s own interests would not be the only nor the main criterion in the taking of those decisions. The safety of the public would be the main criterion. In my view, a doctor called upon, as Dr. Egdell was, to examine a patient such as W. owes a duty not only to his patient but also a duty to the public. His duty to the public would require him, in my opinion, to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so, in my opinion, whether or not the patient instructed him not to do so."

The judge then referred to Mr. Robertson's submission that the dominant public interest in the case was the public interest in patients being able to make full and frank disclosure to their doctors, and in particular to their psychiatrist, without fear that the doctor would disclose the information to others. The judge said, at p. 392E-F: "I accept the general importance in the public interest that this should be so. It justifies the General Medical Council's rule 80." He said, at pp. 393D-E, 394A:

> "In truth, as it seems to me, the interest to be served by the duty of confidence for which Mr. Robertson contends is the private interest *415 of W. and not any broader public interest. If I set the private interest of W. in the balance against the public interest served by disclosure of the report to Dr. Hunter and the Home Office, I find the weight of the public interest prevails. . . . In my judgment, therefore, the circumstances of this case did not impose on Dr. Egdell an obligation of conscience, an equitable obligation, to refrain from disclosing his report to Dr. Hunter, or to refrain from encouraging its disclosure to the Home Office."

In this court Mr. Robertson acknowledges that in addition to the duty of confidence admittedly owed by Dr. Egdell to W., it was necessary for the judge to consider the public interest in the disclosure by Dr. Egdell of his report to the authorities. There are two competing public interest considerations. However, he submitted that the dominant public interest was the duty of confidence owed by Dr. Egdell to W. The burden of proving that that duty was overridden by public interest considerations in disclosing his opinion to the public authorities rested fairly and squarely upon Dr. Egdell. He

contended that where the public interest relied upon to justify a breach of confidence is alleged to be the reduction or elimination of a risk to public safety, it must be shown: (a) that such a risk is real, immediate and serious; (b) that it will be substantially reduced by disclosure; (c) that the disclosure is no greater than is reasonably necessary to minimise the risk; and (d) that the consequent damage to the public interest protected by the duty of confidentiality is outweighed by the public interest in minimising the risk. He relied upon the decision of Rose J. in X v. Y [1988] 2 All E.R. 648 . He also cited a passage from the judgment of Boreham J. in Hunter v. Mann [1974] Q.B. 767 , 772:

> "The second proposition is this: that in common with other professional men, for instance a priest and there are of course others, the doctor is under a duty not to disclose, without the consent of his patient, information which he, the doctor, has gained in his professional capacity, save, says Mr. Bingham, in very exceptional circumstances. He quoted the example of the murderer still manic, who would be a menace to society. But, as Mr. Bingham says, save in such exceptional circumstances, the general rule applies. He adds that the law will enforce that duty."

He referred to the American case of Tarasoff v. University of California (1976) 17 Cal. 3d 425 as an example of extreme circumstances and submitted that only in the most extreme circumstances could a doctor be relieved from observing the strict duty of confidence imposed upon him by reason of his relationship with his patient. In this instance, said Mr. Robertson, there was no immediate prospect of W. being released or of being detained other than under secure conditions and furthermore any change in his circumstances would be conditional upon further expert analysis and recommendation.

The two interests which had to be balanced in this case were both public interests. The judge was wrong to refer to W.'s "private" interest. The judge was also in error, said Mr. Robertson, in saying: "The case seems to me to fall squarely within sub-paragraph (b) of [paragraph] 81" *416 of the General Medical Council's rules. Dr. Egdell did not have any clinical responsibility for W. and accordingly that particular rule could not be relied upon by Dr. Egdell in the present circumstances.

With reference to "legal privilege," Mr. Robertson submitted that in the context of this case it was highly relevant that the report was commissioned by solicitors acting on behalf of W. in the matter of his application to the tribunal. He argued that if legal privilege did not strictly apply to the report of Dr. Egdell as distinct from his instructions, nevertheless the context in which it was prepared added strength to the duty of confidence. He used the phrase "a cumulative effect."

Mr. Whitfield, on behalf of Dr. Egdell, argued that Dr. Egdell is acknowledged to be a responsible and experienced consultant psychiatrist having particular knowledge of the procedures relating to the management and treatment of restricted patients detained in secure conditions under the provisions of the Mental Health Act 1983 . His evidence on matters of fact was not challenged. It must be accepted that he was genuinely seriously concerned by the revelation of what seemed to him to be entirely new facts relating to W.'s long standing interest in guns and explosives. It is not challenged, he said, that he acted in good faith in disclosing his report to Dr. Hunter and in urging its disclosure to the Home Secretary. He plainly believed that he was acting in the public interest.

The balance of public interest clearly lay in the restricted disclosure of vital information to the director of the hospital and to the Secretary of State who had the onerous duty of safeguarding public safety.

In this case the number and nature of the killings by W. must inevitably give rise to the gravest concern for the safety of the public. The authorities responsible for W.'s treatment and management must be entitled to the fullest relevant information concerning his condition. It is clear that Dr. Egdell did have highly relevant information about W.'s condition which reflected upon his dangerousness. In my judgment the position came within the terms of paragraph 81, sub-paragraph (g) of the General Medical Council's rules. Furthermore, Dr. Egdell amply justified his action within the terms of paragraph 82 . The suppression of the material contained in his report would have deprived both the hospital and the Home Secretary of vital information, directly relevant to questions of public safety. Although it may be said that Dr. Egdell's action in disclosing his report to Dr. Hunter fell within the letter of paragraph 81(b) , the judge in fact based his conclusion on what he termed "broader considerations" - that is to say, the safety of the public. I agree with him.

In so far as the judge referred to the "private interest" of W., I do not consider that the passage in his judgment at p. 393D-E accurately stated the position. There are two competing public interests and it

is clear that by his reference to X v. Y [1988] 2 All E.R. 648 the judge was fully seized of this point. Of course W. has a private interest, but the duty of confidence owed to him is based on the broader ground of public interest described by Rose J. in X v. Y [1988] 2 All E.R. 648 .

I do not consider that this is a case of legal professional privilege, although it is, however, relevant as part of the background which gave rise to the issue of confidentiality.

*417

Accordingly I agree with the judge's decision to dismiss the plaintiff's claim. Dr. Egdell was clearly justified in taking the course that he did.

BINGHAM L.J. W.,

the plaintiff in this action, appeals against a decision of Scott J. made on 9 December 1988. The main issue in the appeal is an important one: what is the scope of the duty of confidence owed to a restricted mental patient by a psychiatrist engaged by the patient to report on his mental health for purposes of his forthcoming application to a mental health review tribunal?

The statutory provisions relevant to this appeal and the detailed facts giving rise to this action are set out clearly and comprehensively in the judgment of Scott J., ante, p. 370D. I shall not repeat that summary, which should be treated as incorporated in this judgment. I give only the barest summary of the facts needed to show how the appeal arises.

Some years ago, W. shot and killed five people and seriously wounded two others. He was charged with murder but pleaded guilty to manslaughter on the ground of diminished responsibility. He was agreed to be suffering from mental illness when the offences were committed. In the Crown Court a hospital order was made with a restriction on his discharge without limit of time. He was detained in Broadmoor Hospital for a time, and then in the special hospital where he remains. In 1984 a tribunal recommended W.'s transfer to a regional secure unit as the first trial step towards W.'s eventual rehabilitation and release. After further psychological tests and psychiatric assessments Dr. Ghosh, as W.'s responsible medical officer, advised the Secretary of State that W. should be transferred to a named regional secure unit. For reasons given at length in a letter of 20 May 1987 the Secretary of State did not then accept that advice. By then W. had already instructed solicitors to apply to a tribunal for a review of his case. His legal aid certificate covered an independent psychiatric report. Dr. Egdell, a consultant psychiatrist of repute, was accordingly instructed to attend upon W. and complete a report for use at the forthcoming tribunal. The tribunal was to sit on 25 August 1987 and Dr. Egdell was asked to deliver his report not less than two weeks before. Having discussed the case with others and interviewed W., Dr. Egdell was of opinion that certain potentially dangerous features of W.'s personality (in particular, a long-standing interest in explosives, dating from a period well before W.'s acute mental illness) had previously been insufficiently appreciated and explored. He did not favour W.'s transfer at that stage. He expressed this opinion in a long report dated 29 July 1987 which he sent to W.'s solicitors. The solicitors discussed the report with W. who instructed them that his application to the tribunal should be withdrawn and that he did not wish anyone to see the report. The application was withdrawn. Dr. Egdell (who did not then know of W.'s instructions) was concerned that his report might not be placed before the tribunal and on 19 August 1987 telephoned the tribunal to find out if it had or not. He learned that it had not, and that the application had been withdrawn. He knew his opinion differed from that of W.'s responsible medical officer, to whom he had spoken before completing his report, and accordingly spoke to the acting medical director (Dr. Hunter) at W.'s hospital who should, Dr. Egdell felt, *418 know of his findings and opinion. Dr. Hunter suggested that Dr. Egdell obtain the solicitors' consent to disclosure of the report. Dr. Egdell therefore telephoned the solicitors and was told that his report would be kept on the solicitors' files and not shown to anyone. Dr. Egdell made clear his wish that his report be forwarded to the hospital. The solicitors declined to do this in view of W.'s clear instructions.

On 24 August 1987 Dr. Egdell spoke to Dr. Hunter on the telephone again. Dr. Egdell expressed the view that the material which he felt had been revealed on his examination cast a new light on the patient's dangerousness and ought to be known to those responsible for his care and discharge. Dr. Hunter asked Dr. Egdell to forward a report in writing of his concerns. Dr. Egdell accordingly altered the introductory sentence in his report of 29 July 1987, re-addressed it, dated it 25 August 1987 and sent it to Dr. Hunter. At Dr. Egdell's urging a copy was later sent to the Home Office and placed with W.'s clinical case notes. On 22 December 1987 W. issued a writ against Dr. Egdell and an injunction was granted restraining Dr. Egdell from communicating the contents of the report save to W. or with

W.'s authority. W. did not know that the report had already been sent to the Home Office, but the matter was of concern to W. in particular because a periodic three-year review of his case was in train. The ex parte injunction was by consent continued until trial. In the meantime a second writ had been issued by W. against a number of public authorities (the Department of Health and Social Security, the Home Office, the hospital board and the tribunal). That action was consolidated with W.'s action against Dr. Egdell but there is no appeal against the judge's decision in favour of those authorities.

The action was tried on affidavit. There was no cross-examination. On 9 December 1988 the judge held that Dr. Egdell, although owing W. a duty of confidence, had not acted in breach of it in sending a copy of his report to Dr. Hunter. It is that conclusion which W. now challenges.

The philosophy underlying the statutory regime which the judge described is in my view clear. A man who commits crimes, however serious, when subject to severe mental illness is not to be treated as if he were of sound mind. He requires treatment in hospital, not punishment in prison. So an order may be made committing him to hospital. He may, however, represent a great and continuing danger to the public. So his confinement in hospital may be ordered to continue until the Home Secretary, as guardian of the public safety, adjudges it safe to release him or relax the conditions of his confinement. But a decision by the Home Secretary adverse to the patient is not conclusive. The patient may have recourse to an independent tribunal which, if certain conditions are satisfied, must order his discharge either conditionally or absolutely and which may make non-binding recommendations. Lest an inactive patient be forgotten, his case must be reviewed by the tribunal at three-yearly intervals. These provisions represent a careful balance between the legitimate desire of the patient to regain his freedom and the legitimate desire of the public to be protected against violence. The heavy responsibility of deciding how the balance should be struck in any given case at any given time rests in the first instance on *419 the Home Secretary and in the second on the tribunal. It is only by making a careful and informed assessment of the individual case that the potentially conflicting claims of humanity to the patient and protection of the public may be fairly and responsibly reconciled.

It has never been doubted that the circumstances here were such as to impose on Dr. Egdell a duty of confidence owed to W. He could not lawfully sell the contents of his report to a newspaper, as the judge held ante, p. 389B-C. Nor could he, without a breach of the law as well as professional etiquette, discuss the case in a learned article or in his memoirs or in gossiping with friends, unless he took appropriate steps to conceal the identity of W. It is not in issue here that a duty of confidence existed.

The breadth of such a duty in any case is, however, dependent on circumstances. Where a prison doctor examines a remand prisoner to determine his fitness to plead or a proposer for life insurance is examined by a doctor nominated by the insurance company or a personal injury plaintiff attends on the defendant's medical adviser or a prospective bidder instructs accountants to investigate (with its consent) the books of a target company, the professional man's duty of confidence towards the subject of his examination plainly does not bar disclosure of his findings to the party at whose instance he was appointed to make his examination. Here, however, Dr. Egdell was engaged by W., not by the tribunal or the hospital authorities. He assumed at first that his report would be communicated to the tribunal and thus became known to the authorities but he must, I think, have appreciated that W., and his legal advisers could decide not to adduce his report in evidence before the tribunal.

The decided cases very clearly establish: (1) that the law recognises an important public interest in maintaining professional duties of confidence; but (2) that the law treats such duties not as absolute but as liable to be overridden where there is held to be a stronger public interest in disclosure. Thus the public interest in the administration of justice may require a clergyman, a banker, a medical man, a journalist or an accountant to breach his professional duty of confidence: Attorney-General v. Mulholland, Attorney-General v. Foster [1963] 2 Q.B. 477 , 489-490, and Chantrey Martin v. Martin [1953] 2 Q.B. 286 . In Parry-Jones v. Law Society [1969] 1 Ch. 1 a solicitor's duty of confidence towards his clients was held to be overridden by his duty to comply with the law of the land, which required him to produce documents for inspection under the Solicitors' Accounts Rules. A doctor's duty of confidence to his patient may be overridden by clear statutory language (as in Hunter v. Mann [1974] Q.B. 767). A banker owes his customer an undoubted duty of confidence, but he may become subject to a duty to the public to disclose, as where danger to the state or public duty supersede the duty of agent to principal: Tournier v. National Provincial and Union Bank of England [1924] 1 K.B.

461 , 473, 486. An employee may justify breach of a duty of confidence towards his employer otherwise binding upon him when there is a public interest in the subject matter of his disclosure: Initial Services Ltd. v. Putterill [1968] 1 Q.B. 396 and Lion Laboratories v. Evans [1985] Q.B. 526 . These qualifications *420 of the duty of confidence arise not because that duty is not accorded legal recognition but for the reason clearly given by Lord Goff of Chieveley in his " Spycatcher " speech, Attorney-General v. Guardian Newspapers Ltd. (No. 2) [1990] 1 A.C. 109 , 282, quoted by Scott J., ante p. 389E-G:

> "The third limiting principle is of far greater importance. It is that, although the basis of the law's protection of confidence is that there is a public interest that confidences should be preserved and protected by the law, nevertheless that public interest may be outweighed by some other countervailing public interest which favours disclosure. This limitation may apply, as the learned judge pointed out, to all types of confidential information. It is this limiting principle which may require a court to carry out a balancing operation, weighing the public interest in maintaining confidence against a countervailing public interest favouring disclosure."

These principles were not in issue between the parties to this appeal. Mr. Robertson accepted that W.'s right to confidence was qualified and not absolute. But it is important to insist on the public interest in preserving W.'s right to confidence because Scott J., at pp. 392H-394A concluded that while W. had a strong private interest in barring disclosure of Dr. Egdell's report he could not rest his case on any broader public interest. Here, as I think, the judge fell into error. W. of course had a strong personal interest in regaining his freedom and no doubt regarded Dr. Egdell's report as an obstacle to that end. So he had a personal interest in restricting the report's circulation. But these private considerations should not be allowed to obscure the public interest in maintaining professional confidences. The fact that Dr. Egdell as an independent psychiatrist examined and reported on W. as a restricted mental patient under section 76 of the Mental Health Act 1983 does not deprive W. of his ordinary right to confidence underpinned, as such rights are, by the public interest. But it does mean that the balancing operation of which Lord Goff of Chieveley spoke falls to be carried out in circumstances of unusual difficulty and importance.

We were referred, as the judge was, to the current advice given by the General Medical Council to the medical profession pursuant to section 35 of the Medical Act 1983 . Paragraph 80 provides:

> "It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner . . ."

I do not doubt that this accurately states the general rule as the law now stands, and the contrary was not suggested. A disclosure compelled by statute or court order is not voluntary.

Paragraph 81 of the General Medical Council's advice lists the exceptions. [His Lordship set out sub-paragraphs (b) and (d) (see ante, p. 413B-C, D-E) and continued:] The judge regarded sub-paragraph (b) as accurately stating the law and held that Dr. Egdell's disclosure in the *421 present case fell squarely within it. I have some reservations about this conclusion. It is true that the disclosure here may be said to fall within the letter of the first sentence of sub-paragraph (b). But I think the sub-paragraph is directed towards the familiar situation in which consultants or other specialised experts report to the doctor with clinical responsibility for treating or advising the patient, and the second sentence shows that the doctor whose duty is in question is regarded as having a continuing professional relationship with the patient. I rather doubt if the draftsman of sub-paragraph (b) had in mind a consultant psychiatrist consulted on a single occasion

> "for the purpose of advising whether an application to a mental health review tribunal should be made by or in respect of a patient who is liable to be detained or subject to guardianship under Part II of the Mental Health Act 1983 or of furnishing information as to the condition of a patient for the purpose of such an application:" section 76(1) of the Act of 1983.

Nor do I think that Dr. Egdell, in making disclosure, was primarily motivated by the ordinary concern of

any doctor that a patient should receive the most efficacious treatment. Had that been his primary object, I think he would, consistently with the spirit of sub-paragraph (d), have tried to reason with W. to obtain his consent to disclosure in W.'s own interest. I need not, however, reach a final view. The judge preferred to rest his conclusion on a broader ground which was in effect the exception set out in paragraph 81(g) of the General Medical Council's advice, and I think that if the disclosure cannot be justified under that exception it would be unsafe to justify it under any other.

Paragraph 81(g) provides:

> "Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence."

It was this exception which, as I understand, the judge upheld and applied when he held, in what is perhaps the crucial passage in his judgment, at p. 392D-E:

> "In my view, a doctor called upon, as Dr. Egdell was, to examine a patient such as W. owes a duty not only to his patient but also a duty to the public. His duty to the public would require him, in my opinion, to place before the proper authorities the result of his examination if, in his opinion, the public interest so required. This would be so, in my opinion, whether or not the patient instructed him not to do so."

Mr. Robertson criticised this passage as wrongly leaving the question whether disclosure was justified or not to the subjective decision of the doctor. He made the same criticism of a passage where the judge said, at p. 393E-G:

> "If a patient in the position of W. commissions an independent psychiatrist's report, the duty of confidence that undoubtedly lies on *422 the doctor who makes the report does not, in my judgment, bar the doctor from disclosing the report to the hospital that is charged with the care of the patient if the doctor judges the report to be relevant to the care and treatment of the patient, nor from disclosing the report to the Home Secretary if the doctor judges the report to be relevant to the exercise of the Home Secretary's discretionary powers in relation to that patient."

In my opinion these criticisms are just. Where, as here, the relationship between doctor and patient is contractual, the question is whether the doctor's disclosure is or is not a breach of contract. The answer to that question must turn not on what the doctor thinks but on what the court rules. But it does not follow that the doctor's conclusion is irrelevant. In making its ruling the court will give such weight to the considered judgment of a professional man as seems in all the circumstances to be appropriate.

The parties were agreed, as I think rightly, that the crucial question in the present case was how, on the special facts of the case, the balance should be struck between the public interest in maintaining professional confidences and the public interest in protecting the public against possible violence. Mr. Robertson submitted that on the facts here the public interest in maintaining confidences was shown to be clearly preponderant. In support of that submission he drew our attention to a number of features of the case of which the most weighty were perhaps these:

(1) Section 76 of the Mental Health Act 1983 shows a clear parliamentary intention that a restricted patient should be free to seek advice and evidence for the specified purposes from a medical source outside the prison and secure hospital system. Section 129 ensures that the independent doctor may make a full examination and see all relevant documents. The examination may be in private, so that the authorities do not learn what passes between doctor and patient.

(2) The proper functioning of section 76 requires that a patient should feel free to bare his soul and open his mind without reserve to the independent doctor he has retained. This he will not do if a doctor is free, on forming an adverse opinion, to communicate it to those empowered to prevent the patient's release from hospital.

(3) Although the present situation is not one in which W. can assert legal professional privilege, and although tribunal proceedings are not strictly adversarial, the considerations which have given rise to

legal professional privilege underpin the public interest in preserving confidence in a situation such as the present. A party to a forthcoming application to a tribunal should be free to unburden himself to an adviser he has retained without fearing that any material damaging to his application will find its way without his consent into the hands of a party with interests adverse to his.

(4) Preservation of confidence would be conducive to the public safety: patients would be candid, so that problems such as those highlighted by Dr. Egdell would become known; and steps could be *423 taken to explore and if necessary treat the problems without disclosing the report.

(5) It is contrary to the public interest that patients such as W. should enjoy rights less extensive than those enjoyed by other members of the public, a result of his judgment which the judge expressly accepted: see p. 393G.

Of these considerations, I accept (1) as a powerful consideration in W.'s favour. A restricted patient who believes himself unnecessarily confined has, of all members of society, perhaps the greatest need for a professional adviser who is truly independent and reliably discreet. (2) also I, in some measure, accept, subject to the comment that if the patient is unforthcoming the doctor is bound to be guarded in his opinion. If the patient wishes to enlist the doctor's wholehearted support for his application, he has little choice but to be (or at least convince an expert interviewer that he is being) frank. I see great force in (3). Only the most compelling circumstances could justify a doctor in acting in a way which would injure the immediate interests of his patient, as the patient perceived them, without obtaining his consent. Point (4), if I correctly understand it, did not impress me. Mr. Robertson's submissions appeared to suggest that the problems highlighted by Dr. Egdell could be explored and if necessary treated without the hospital authorities being told what the problems were thought to be. I do not think this would be very satisfactory. As to (5), I agree that restricted patients should not enjoy rights of confidence less valuable than those enjoyed by other patients save in so far as any breach of confidence can be justified under the stringent terms of paragraph 81(g).

Mr. Whitfield for Dr. Egdell justified his client's disclosure of his report by relying on the risk to the safety of the public if the report were not disclosed. The steps of his argument, briefly summarised, were these. (1) As a result of his examination Dr. Egdell believed that W. had had a long-standing and abnormal interest in dangerous explosives dating from well before his period of acute illness.

(2) Dr. Egdell believed that this interest had been overlooked or insufficiently appreciated by those with clinical responsibility for W.

(3) Dr. Egdell believed that this interest could throw additional light on W.'s interest, also long-standing and in this instance well documented, in guns and shooting.

(4) Dr. Egdell believed that exploration of W.'s interest in explosives and further exploration of W.'s interest in guns and shooting might lead to a different and more sinister diagnosis of W.'s mental condition.

(5) Dr. Egdell believed that these explorations could best be conducted in the secure hospital where W. was.

(6) Dr. Egdell believed that W. might possibly be a future danger to members of the public if his interest in firearms and explosives continued after his discharge.

(7) Dr. Egdell believed that these matters should be brought to the attention of those responsible for W.'s care and treatment and for making decisions concerning his transfer and release.

Dr. Egdell's good faith was not in issue. Nor were his professional standing and competence. His opinions summarised in (1), (2) (3) and *424 (4) (although not accepted) were not criticised as ill-founded or irrational. Dr. Egdell deferred to the greater knowledge of another medical expert relied on by W. concerning the regime in a regional secure unit but did not (as I understood) modify his view that the explorations he favoured should take place before transfer.

Mr. Robertson contended that Dr. Egdell's belief summarised in (6) did not in all the circumstances justify disclosure of the report. There was, he said, no question of W.'s release, whether absolutely or conditionally, in the then foreseeable future. The Home Office had made plain that it would not sanction transfer to a regional secure unit for about 18 months. Even if he were transferred he would remain a patient of the special hospital for the first six months and the high staff ratio in such units would ensure a very high level of security thereafter. Much further testing would in any event be done

before W. was again at large. Disclosure of the report would do nothing to protect the public.

I do not find these points persuasive. When Dr. Egdell made his decision to disclose, one tribunal had already recommended W.'s transfer to a regional secure unit and the hospital authorities had urged that course. The Home Office had resisted transfer in a qualified manner but on a basis of inadequate information. It appeared to be only a matter of time, and probably not a very long time, before W. was transferred. The regional secure unit was to act as a staging post on W.'s journey back into the community. While W. would no doubt be further tested, such tests would not be focused on the source of Dr. Egdell's concern, which he quite rightly considered to have received inadequate attention up to then. Dr. Egdell had to act when he did or not at all.

There is one consideration which in my judgment, as in that of the judge, weighs the balance of public interest decisively in favour of disclosure. It may be shortly put. Where a man has committed multiple killings under the disability of serious mental illness, decisions which may lead directly or indirectly to his release from hospital should not be made unless a responsible authority is properly able to make an informed judgment that the risk of repetition is so small as to be acceptable. A consultant psychiatrist who becomes aware, even in the course of a confidential relationship, of information which leads him, in the exercise of what the court considers a sound professional judgment, to fear that such decisions may be made on the basis of inadequate information and with a real risk of consequent danger to the public is entitled to take such steps as are reasonable in all the circumstances to communicate the grounds of his concern to the responsible authorities. I have no doubt that the judge's decision in favour of Dr. Egdell was right on the facts of this case.

Mr. Robertson argued that even if Dr. Egdell was entitled to make some disclosure he should have disclosed only the crucial paragraph of his report and (I think) his opinion. I do not agree. An opinion, even from an eminent source, cannot be evaluated unless its factual premise is known, and a detailed 10-page report cannot be reliably assessed by perusing a brief extract.

No reference was made in argument before us (nor, so far as I know, before the judge) to the *425 European Convention for the Protection ofHuman Rights and Fundamental Freedoms , but I believe this decision to be in accordance with it. I would accept that *425 article 8(1) of the Convention may protect an individual against the disclosure of information protected by the duty of professional secrecy. But *425 article 8(2) envisages that circumstances may arise in which a public authority may legitimately interfere with exercise of that right in accordance with the law and where necessary in a democratic society in the interests of public safety or the prevention of crime. Here there was no interference by a public authority. Dr. Egdell did, as I conclude, act in accordance with the law. and his conduct was in my judgment necessary in the interests of public safety and the prevention of crime.

I would dismiss the appeal. Having reached that conclusion I do not think it necessary to consider whether, had W. succeeded, he could have recovered damages in contract for shock and distress.

SIR JOHN MAY.

I have had the advantage of reading the judgments prepared by Sir Stephen Brown P. and Bingham L.J. I respectfully agree with them. In the circumstances there is nothing I wish to add on my own account. I too would dismiss this appeal.

Representation

Irwin Mitchell, Sheffield ; Hempsons .

Appeal dismissed. No order for costs save legal aid taxation of appellant's cost. Leave to appeal refused. (M. B. D.)


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