# SHARING INFORMATION WITH THE POLICE

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It is not uncommon to receive a request from the police for patient data. Consider the patient admitted after a fall down the stairs; it is suggested that his partner had caused the fall. The partner is in police custody , awaiting a court’s decision on bail the following day . The patient, at the time of the police enquiry , was intubated and ventilated, lacking capacity to decide whether to consent to the disclosure of his clinical details. What should our posi tion be in these circumstances? Sixty years ago Lord Denning made it clear that there is no general obligation for clinicians to disclose confidential information following a request the police. Naturally , a constable can always approach a court in the face of clinical refusal; it would be most unlikely that an NHS trust would refuse to comply with a court order to disclose. The DH suggests that doctors should consider disclosure if, among other considerations, the alleged o ff ence is grave and delayed but for prompt disclosure. Clinicians m ust disclose to the police any information iden - tifying a driver alleged of committing a tra ffi c o ff ence; and - even in the absence of a police request, their suspicions of a person’s involvement in terrorist activities. Less specifically , doctors must disclose to the police the admission of a person - w ounded by knife or gun, so that at least the constabulary is - made aware of an armed assailant in the neighbourhood. Whether the stabbed or shot person allows subsequent disclo - - sure of their identity rather depends on their capacity at the time. Naturally , if the patient consents to disclosure no prob - lem occurs. But some victims of assault may choose to remain silent, perhaps fearing more grievous injur y if they become identified as an informer. - The patient who lacks capacity poses a more di ffi cult prob - lem. If it seems likely that they will soon regain the ability to make their own decision, it would be prudent to await that recovery . If there is evidential material that could be lost during the lapse of time, such as clear scars or bruises or f ootprints, by all means have these images recorded, but await the patient’s capacitous consent before handing them to the police. At the other extreme, if the patient is unlikely to recover capacity after an assault, a grave o ff ence may have transpired, making disclo - sure in the absence of consent more palatable. If there is a simple stark binary choice between either respecting a person’s confidentiality or protecting them from death or serious harm, most clinicians would likely value life and limb over a notion of confidences. Guidance from DH suggests that unlawful killing , rape, treason and child abuse could all cross the ‘serious harm’ threshold. By contrast, theft, fraud and criminal damage would not. The leading case is of Dr Egdell, a psychiatrist instructed by 10 W , who had killed five people with extreme violence. W was - seeking review of his secure hospital order and hoped that Dr Egdell would provide a favourable report of his mental health. On the contrary , Dr Egdell found that W was highly danger - ous, fascinated by high explosives, and that the secure hospital’s sta ff were oblivious to the threat W continued to pose. Faced with the unhelpful report W’s solicitors did not pur - sue the application to the Mental Health Tribunal, but Dr Egdell felt his report should nonetheless go to the Home Sec -

retary and the medical director of the hospital. W disagreed. In subsequent litigation the Court of Appeal held that this dis - closure in the teeth of W’s capacitous opposition was justified and in the public interest. The breac h in confidentiality was made lawful by the real risk of serious harm to others should W be r eleased. - Frustratingly , the paucity of cases provides us with no fur - ther judicial gloss on this clinical dilemma. from SHARING INFORMATION WITH THE POLICE

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