IN THE FIRST-TIER TRIBUNAL **Case No. EA/2013/0176**
GENERAL REGULATORY CHAMBER
[INFORMATION RIGHTS]

ON APPEAL FROM:

Information Commissioner's
Decision Notice No: FS50492136
Dated: 31 July 2013

Appellant: Mrs Colleen Foster

Respondent: The Information Commissioner

Heard at: Harlow Magistrates Court

Date of hearing: 3 December 2013

Date of decision: 13 January 2014

Before
CHRIS RYAN
(Judge)
and
HENRY FITZHUGH
DAVID WILKINSON

Attendances:

The Appellant appeared in person.
The Respondent did not appear and was not represented.

Subject matter: Duty to confirm or deny s.1(1)(a)
Personal data s.40

IN THE FIRST-TIER TRIBUNAL **Case No. EA/2013/0176**
GENERAL REGULATORY CHAMBER

DECISION OF THE FIRST-TIER TRIBUNAL

The appeal is allowed and the Decision Notice date 31 July 2013 is substituted by the following notice:

Substituted Decision Notice
FS50492136

Public Authority:	Nursing and Midwifery Council
Address:	23 Portland Place London W1B 1PZ
Complainant:	Mr and Mrs C Foster

For the reasons set out in the Reasons for Decision below the Public Authority is directed to inform the Complainant, within 35 days of the date of this Decision Notice, whether or not it holds the information requested by the Complainant in a request for information dated 8 December 2012, the terms of which request appear in paragraph 6 of the original Decision Notice. If the Public Authority issues a confirmation that the information does exist it should, at the same time, either disclose the requested information to the Complainant or set out its detailed arguments for asserting that disclosure should not be made.

REASONS FOR DECISION

Background

1. The Appellant's son, Gary Foster, died on 14 October 2007. He had been undergoing treatment for cancer and earlier in the year had agreed to take part in a clinical research trial designed to investigate a more intensive therapy for those suffering from "poor prognosis" testicular cancer. He died as the result of having been administered a significant overdose of Bleomycin over a period of several weeks in the course of that trial, leading to fatal lung disease. His death and the medical treatment he received have since been investigated in a number of ways, including the following:
    a. An inquest concluded that there was overwhelming evidence that Mr Foster died as the result of an accidental prescribing error and that the set up of an electronic prescribing system had contributed to the error.
    b. The coroner who had conducted the inquest subsequently declined to take action over an allegation by the Appellant that one of the doctors on the care team had given incorrect evidence during the inquest about the quality of the chest x-ray procedures carried out at the time. The coroner considered that this would not have had an impact on his conclusions, given the other evidence provided to him.
    c. A civil action brought against the hospital by Mr Foster's fiancée was, the Appellant informed us at the hearing, settled following an admission of liability.
    d. The clinician responsible for the operation of the clinical trial at the hospital was investigated by the General Medical Council, which issued a highly critical determination in October 2012, although it concluded that the individual's fitness to practice was not impaired and that the appropriate sanction was a warning.
    e. Another doctor on the care team was also investigated by the General Medical Council although we have no evidence about the outcome.
    f. The Appellant has also asked the General Medical Council to investigate a medical practitioner who provided evidence to the Medical Practitioners Tribunal Service which the Appellant believes was untruthful and incomplete.

g. The Nursing and Midwifery Council ("NMC") investigated a complaint by the Appellant about the conduct of the individual, who we will refer to as "X", who was a nurse with particular responsibilities on the care team.

2. The appeal arises out of the last of those investigations. The complaints procedure administered by the NMC has two stages. The first stage is designed to determine whether or not the matter should be referred to the NMC's Fitness to Practice Panel. If it is, then the Panel will meet in public and its decision will be made publicly available. But if the complaint does not proceed beyond the first stage, (either because a decision is made not to investigate or because the NMC's Investigating Committee Panel concludes that the complaint does not justify a reference to the Fitness to Practice Panel), then the process remains confidential. The rationale appears to be that an individual's professional reputation should not be undermined by the publication of allegations that are found not to have sufficient merit to justify being referred to the Fitness to Practice Panel.

3. In this case the NMC concluded that the complaint against X did not justify being referred to the Fitness to Practice Panel as there was no case to answer. That conclusion was reached after solicitors instructed on behalf of the NMC had interviewed a number of witnesses and had provided advice to the Panel based on that evidence. The process therefore ended at the first stage, without any publicity.

<u>The Request for Information and the Information Commissioner's Decision Notice.</u>

4. The Appellant was concerned that the NMC had been unjustifiably lenient on X and that the complaints procedure had not been operated fairly. She therefore wrote to the NMC on 8 December 2012 in the following terms:

> *"Please can you forward to us the names of the [number redacted] witnesses interviewed at the Investigating Committee hearing which took place on [date redacted]"*
> *"Also we would appreciate a copy of all the case material which we have not received as yet."*

We refer to this communication as "the Information Request".

5. The Information Request was made under section 1 of the Freedom of Information Act 2000 ("FOIA"). This imposes on any public authority to which it applies an obligation to state whether or not it holds requested information. However, if the information is categorised as "exempt information" under one or more of the statutory provisions set out in Part II of FOIA, the duty to confirm or deny may not apply to that information.

6. The NMC's response to the information request was to assert that it was entitled to issue such a "neither confirm nor deny" response on the basis of FOIA section 40(5)(b)(i). In context it reads:

> "*The duty to confirm or deny –*
> *(a)…*
> *(b) does not arise in relation to …information if or to the extent that …-*
> *(i) the giving to a member of the public of the confirmation or denial that would have to be given to comply with section 1(1)(a) would (apart from this Act) contravene any of the data protection principles …."*

7. In reality, of course, the Appellant already knew that a complaint against X had been made, because she had instigated it. However, disclosure in response to a request under FOIA constitutes disclosure to the world at large and it was that disclosure that the NMC said would contravene X's data protection rights.

8. The NMC maintained its stance following an internal review requested by the Appellant, who then complained to the Information Commissioner about the way in which the Information Request had been handled. In a Decision Notice issued on 31 July 2013 the Information Commissioner decided that the information requested was for the identity of a living individual and information about an investigation into that individual's fitness to practice. This constituted that individual's personal data. Even confirming or denying whether the information was held or not would reveal whether or not a complaint had been made about that individual in his or her professional capacity. It was therefore necessary to consider whether confirming or denying would breach the data protection principles, in particular the

requirement of the First Data Protection Principle requiring personal data to be dealt with in a manner that was lawful and not unfair. The Information Commissioner concluded that the individual in question would have a reasonable expectation that information about a complaint would not be disclosed to the public unless and until it reached the public stage of the NMC's complaints procedure and that premature disclosure would cause damage to the individual's professional reputation and generate personal distress to him or her. Balanced against those considerations was a public interest in knowing that the competency of health professionals was being properly investigated. However, on balance, the Information Commissioner concluded that the giving of a confirmation or denial would breach the individual's rights in his or her personal data and that the NMC's stance had been justifiable.

The statutory provisions underlying the Decision Notice

9. Personal data is defined in section 1 of the Data Protection Act 1998 ("DPA") which provides:

> *"'personal data' means data which relate to a living individual who can be identified-*
>
> *(a) from those data, or*
>
> *(b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller"*

10. The data protection principles are set out in Part 1 of Schedule 1 to the DPA. The only one having application to the facts of this Appeal is the first data protection principle. It reads:

> *"Personal data shall be processed fairly and lawfully, and in particular shall not be processed unless-*
>
> *(a) at least one of the conditions in Schedule 2 is met …"*

Schedule 2 then sets out a number of conditions, but only one is relevant to the facts of this case. It is found in paragraph 6(1) and reads:

"The processing is necessary for the purposes of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject."

The Appeal to this Tribunal

11. The Appellant filed a Notice of Appeal with this Tribunal on 14 August 2013. She requested that her appeal be determined at a hearing. The Information Commissioner filed a Response to the Appeal and invited the Tribunal to join the NMC as a party. However, the Tribunal Registrar decided that this was not necessary and gave directions for a bundle of documents to be prepared and further written submissions to be filed, if this were thought desirable.

12. In the event the Information Commissioner decided not to attend the hearing. The Appellant, accompanied by her husband, attended the hearing and presented her arguments in favour of disclosure with clarity and firmness, despite the painful nature of the issues that were required to be addressed. Both she and her husband provided helpful answers to questions put to them by the Tribunal panel and, at our invitation, provided additional documents after the hearing, which filled in some of the gaps in our information about some of the investigations mentioned above.

13. The Appellant's Grounds of Appeal, supported by a letter and accompanying documents filed with the Tribunal a few days after the appeal had been launched, did not adopt the same structure as the Decision Notice. In essence the Appellant argued that, given all that had happened in relation to the treatment of her son and the subsequent investigations and enquiries, it was not right that the data protection rights of one particular member of the nursing staff should prevail over the need to bring the requested information to light. We did not detect a challenge to the Information Commissioner's conclusion that the requested information did constitute the personal data of X (and we are satisfied, in any event, that it did). As to the factors that were said to override the individual's rights in the privacy of that data and to justify disclosure, these were couched in terms that stressed the Appellant's very strongly held belief that she should not be denied access to information about

the death of her son and the actions of those responsible for his treatment in the weeks and months before he died. While those are very understandable sentiments we have to bear in mind that it is the public interest in disclosure that we must take into account. The statutory test which we must apply, therefore, requires us to consider the public interest in:

a. medical treatment being provided at a level of competence exceeding by some margin that administered to Mr Foster; and
b. the investigation of poor treatment being conducted with an appropriate degree of openness and transparency.

We are also required, by virtue of the factors to be taken into account under paragraph 6 of Schedule 2, to give consideration to the privacy rights of X. This is notwithstanding the vigorous arguments put forward by the Appellant to the effect that, given the pain and suffering experienced by Mr Foster and those close to him, those considerations should not be afforded any weight.

14. During the hearing of the appeal the Appellant repeated a statement in one of her earlier written submissions to the effect that she was not interested in knowing the identity of each witness, but only in knowing that the NMC's decision to terminate the complaint was not based solely on the evidence of other members of the care team whose own actions had been, or were being, investigated. Although not expressed in precisely these terms it was apparent that the Appellant felt that it would be unfair if X had been exonerated on the basis of evidence provided by members of the same care team who were themselves being investigated and who might therefore have a shared interest in supporting each other's version of events.

15. It is not for this Tribunal to investigate the precise responsibilities assumed by X or to assess how she performed in terms of technical proficiency or professional commitment. We have a narrow jurisdiction, for the purposes of this case, to balance the public and private interests we have identified above in order to determine whether we should order the very limited disclosure that would result from a confirm or deny response to the Information Request.

16. In that context we have given particular consideration to the record in the papers made available to us of the precise chronology of relevant events

around the time when the prescribing errors came to light. The relevant events are as follows:

a. Mr Foster agreed to participate in the clinical trials in early June 2007 and had completed the first two cycles of treatment by early July 2007.
b. On 24 August 2007 X reported the medication delivered during that period to the Medical Research Council ("MRC"), which was monitoring the trial. By that date Mr Foster had completed the third and fourth cycles.
c. Mr Foster completed the fifth cycle of treatment on 10 September 2007 and commenced the sixth cycle on 11 September 2007, which was week 13 of the trial. In the course of the coroner's questioning of X during the subsequent inquest into Mr Foster's death he remarked that the evidence he had heard previously indicated that at that stage there had been a suspicion of Bleomycin toxicity on the part of one of the doctors. X's response was that she had only become aware of this as the result of an email from the doctor a week later, on 18 September 2007.
d. The dosage of Bleomycin scheduled for 18 September 2007 was in fact not administered due to concerns about lung toxicity and a lung function test was conducted on the same day.
e. On 3 October 2003 the MRC wrote to X enclosing written queries about the conduct of the trial, in particular the evidence of excessive dosages having been administered. The evidence of X at the inquest was that she probably received the documents on about 5 October but, as there was nothing in the covering letter to alert her to the seriousness of the queries, she set the material on one side to be reviewed when time permitted.
f. On 4 October 2007 members of the medical team reviewed diagnostic material regarding the condition of Mr Foster's lungs and were sufficiently alarmed to ask him to come into the hospital for assessment. He declined to do so at that stage. However a decision was made at around this time to stop all treatment.
g. Mr Foster was admitted to the hospital on 8 October 2007. X has said that she did not become aware of this event until 10 October 2007. On the same day she sent a second batch of report forms to the MRC covering the third and fourth cycles of the trial.
h. On 14 October 2007 Mr Foster died.

i. The following day, a Monday, X reported the death to the MRC.
j. On 16 October 2007 X studied the MRC queries for the first time and, realising the degree of over-dosage noted there, convened a meeting of the care team at which it was agreed how and to whom the errors should be reported.

17. We should stress that this chronology is based solely on contemporaneous notes and a transcript of parts of the inquest hearing. We have not carried out a detailed investigation into what happened and it is not part of this Tribunal's role to do so. However, the delay between the time when lung damage became evident and a team meeting was convened to discuss the MRC queries has caused us some concern, particularly in light of the reference to a suspicion of excessive dosage some weeks previously. If it were to be the case that any member of the care team had realised the error earlier, but had not raised the alarm until after its very sad consequences had become clear, then there would seem to us to be strength in the Appellant's argument that the evidential basis for the decision of the NMC's Investigating Committee Panel required investigation. We believe that, applying the same factors for consideration on each side of the balancing exercise as the Information Commissioner did in his Decision Notice, this is sufficient to tip the balance in favour of disclosing whether or not the requested information was held at the relevant time.

18. In reaching that conclusion we reject the Information Commissioner's argument that it is always unfair, and therefore in breach of the Data Protection Principles, to make a statement that discloses the existence of a complaint of professional misconduct against an individual, where there has been no finding of wrongdoing or malpractice. That would create an inflexible test which prevented all relevant circumstances being taken into account. Nor do we accept the Information Commissioner's argument that the limited degree of disclosure involved in a "confirm or deny" response would constitute unwarranted interference into X's privacy, without satisfying a legitimate public interest in disclosure.

19. At this stage we are not, of course, deciding whether or not the information should be released to the Appellant, only whether the NMC should be required to make a FOIA disclosure as to whether or not it is held. It will then

be for the NMC to decide whether to proceed to disclose it or to argue against disclosure on the basis that the information is exempt from the obligations of disclosure or should not be disclosed for some other reason. We say nothing at this stage that might anticipate the arguments likely to be made at that stage by any of the parties involved in the matter.

20. In light of the above we have concluded that the Appeal should succeed and that the NMC should be directed to state, within 35 days, whether or not it held the requested information at the time when it received the Information Request. If the NMC discloses that it does hold the information then it should, at the same time, either disclose the information to the Appellant or state what exemption applies, or other reason exists, to justify a refusal to disclose. In that event the Tribunal will consider what further directions should be given in order to enable it to determine the consequential issue of whether or not the NMC should disclose the requested information.

21. Our decision is unanimous.

Chris Ryan
Judge

13 January 2014