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Judgment	
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[2018] IEHC 112

THE HIGH COURT

[2017 No. 9908P]

IN THE MATTER OF A. A MINOR BORN ON 2000 AND IN THE MATTER OF THE INHERENT JURISDICTION OF THE HIGH COURT AND IN THE MATTER OF THE CHILD CARE ACT, 1991 (AS AMENDED) AND IN THE MATTER OF ARTICLE 34.3 AND ARTICLE 40.3 OF THE CONSTITUTION

BETWEEN:

THE CHILD AND FAMILY AGENCY

PLAINTIFF

-AND-

A. A MINOR REPRESENTED BY ORDER BY HIS SOLICITOR AND NEXT FRIEND GINA CLEARY

AND

C.

DEFENDANTS

JUDGMENT of Mr. Justice Twomey delivered on the 21st February, 2018.

Summary

1. Can a doctor disclose the HIV status of her patient, without the consent and against

the will of that patient, to a person who the doctor believes is having unprotected sex with that patient and so is at risk of contracting HIV? That is the key legal issue to be decided by this Court. The broader issue which lies behind this question is in what circumstances can a doctor breach his or her duty of patient confidentiality because of the risk of harm to a third party?

2. This case is unprecedented in the Irish courts since it seeks an order to breach patient confidentiality for the benefit of a third party. Counsel indicated that in deciding the key legal issue at stake, this Court was entering unchartered waters as it raises for the first time the issue of how exceptional must the circumstances be for a doctor to breach the confidentiality of a patient. No Irish caselaw was opened to the Court and in relation to the foreign caselaw that was opened to the Court, counsel accepted that the facts of those cases were very different from the facts in this case and so these cases were of limited assistance.

3. The legal issue at stake is complicated somewhat by the fact that there is also a significant factual dispute between the parties. The doctors in this case have been advised that there is a risk that the defendant (A) is having unprotected sex with (B). While A acknowledges that B is a very good friend of his, he denies that she is his girlfriend and equally denies that they have ever had sex. Accordingly, from his perspective, he can see so no basis for his HIV status to be disclosed to her. B is not a party to these proceedings and is unaware of their existence and is also unaware of the HIV status of A. Medical evidence was provided to the effect that this is one of the rare situations where disclosure of patient information without consent is justifiable in order to prevent harm to another person.

4. For the reasons set out below, this Court determined that the appropriate test to apply to determine whether patient confidentiality should be breached is whether:

> on the balance of probabilities, the failure to breach patient confidentiality creates a significant risk of death or very serious harm to an innocent third party.

5. Applying this test, this Court concludes that the plaintiff has failed to establish on the balance of probabilities that A is having sex with B, let alone that he is having unprotected sex with her. On this basis, this Court concludes that there is no risk to B of her contracting HIV and so no basis for the breach of patient confidentiality.

6. However, even if this Court is wrong on this factual dispute and B and A are having sex, this Court also concludes on the basis of the medical evidence that the contracting of HIV, although a significant condition, is no longer a terminal condition, but rather a chronic and lifelong condition that can be managed. Accordingly, it is not a 'very serious harm' to justify a breach of patient confidentiality. In addition, there is not, in this Court's view, a '*significant risk'* of that harm. This is because the risk of contracting HIV through sexual intercourse is in the order of 0.04%. Furthermore, this risk can itself by reduced by 99.9% by the use of condoms (if A is taking his antiretroviral drugs), or by 80% (if A is not taking those drugs). In addition, since the risk of contracting HIV can be reduced so significantly by B (by the use of condoms), this Court also concludes that if B and A were having unprotected sex, B would not be an '*innocent third party'* in the legal sense (and not in a moral sense) since she would be undertaking an activity which she knows, or should know, carries a risk of contracting sexually transmitted diseases, one of which is HIV.

7. In all of these circumstances, this Court concludes that there is no basis for breaching A's patient confidentiality, even if he was engaging in unprotected sex with B. To put the matter another way, this Court concludes for the reasons set out below that the public interest in ensuring that patients can have absolute confidence in revealing their most

private medical and personal information to doctors, without fear of disclosure to third parties, supersedes the right of B to be warned that if she engages in unprotected sexual intercourse with A, she risks contracting HIV.

8. Although these proceedings were supported by well-intentioned doctors who had the interests of B at heart, this Court is cognisant of the intended and unintended consequences of the order being sought on all medical professionals. In particular, it seems to this Court that if an order was granted giving a medical professional the right to breach patient confidentiality where a patient has a sexually transmissible disease, that right would necessarily carry with it a responsibility for medical professionals in the future to decide, in cases of sexually transmissible diseases, whether a sexual partner of the patient needed to be notified of the harm to which he or she was exposed. And of course with this responsibility could come liability for those medical professionals who failed to breach patient confidentiality, where that failure leads to harm to a third party. This Court cannot ignore the fact that this is one of the possible consequences of the order being sought by the medical professionals in this case.

Background facts

9. The plaintiff in this case is the Child and Family Agency (the "CFA"). The reason for this is because A is a few weeks short of his 18th birthday and has been in the statutory care of the CFA since March, 2015. Currently however he resides quite happily with his family and is likely to do so at least until his 18th birthday. While it was clear from his direct evidence that A is an intelligent and capable person, evidence was also provided to this Court that he has in the past exhibited significant behavioural issues and has taken drugs and alcohol. In this regard, although there is clearly a close relationship between A and his mother, she has had to call the gardaÃ in relation to his threats and actions on more than one occasion.

The ages of A and B

10. B is not in the care of the CFA and she is also a few weeks short of her 18th birthday. It was pointed out by counsel for the CFA that the Agency has a duty of care to all children in the State, whether in its care or not. However, counsel for the CFA also accepted that the issue in this case transcends the fact that one is dealing with two people, A and B, who are close to their 18th birthdays and thus still not adults as a matter of law. This is because counsel for CFA indicated to the Court that the CFA would take these proceedings even if both A and B were over 18.

11. This is not surprising since the key issue at stake for all the parties is whether the CFA (and indeed a doctor or other medical person) is permitted to breach patient confidentiality to prevent harm occurring to a third party, in this case the transmission of HIV, and it is accepted by the CFA that this legal issue arises whether A and B are 17 going on 18 or 18 going on 19.

The CFA, rather than a doctor, seeking to breach doctor/patient confidentiality

12. It is also relevant to note that nothing much turns on the identity of the plaintiff in this case. It so happens that it is the CFA, rather than a doctor, which is seeking to breach the patient confidentiality that normally exists between medical professionals and a patient. This is because it is the CFA that has the relevant information regarding the HIV status of A, as well as the information regarding the alleged sexual relationship between A and B. However, it could just as easily be a doctor who had the same information and was seeking an order from this Court clarifying the extent of patient confidentiality in these circumstances.

The proceedings

13. These proceedings were issued by the CFA against A and they were also issued

against his mother C, since A is still under 18. The proceedings seek:

> “A Declaration that the Child and Family Agency is entitled lawfully to disclose the fact of the first Defendant’s HIV condition and status to B in order to afford her the opportunity of availing of such medical and healthcare testing, treatment and counselling as may be indicated, notwithstanding the first Defendant’s refusal to consent to such disclosure.”

14. The CFA in making this application rely on the medical opinion, *inter alia*, of D, Consultant Paediatrician and Infectious Disease Specialist, who avers in her affidavit that this was:

> “an extremely difficult situation and it was with great reluctance that we ever advise disclosure of a patient’s status without their consent or support, but in my professional opinion this is one of the rare situations where disclosure of patient information without their consent is justifiable to prevent harm to another identifiable person who is potentially at risk.”

Motivation for proceedings – CFA fear of being sued by B?

15. We live in a litigious society where injured plaintiffs seek significant damages from third parties who they say caused or could have prevented their injuries. As such, it would not have been a surprise if a motivation for these proceedings had been a desire on the part of the CFA to eliminate the possibility of such an action by B against the CFA (or indeed against the doctors involved in A’s care), should she contract HIV.

16. If such a hypothetical case were to arise, it would be one where B might allege that patient confidentiality should have been breached to protect her from harm. The American case of *Tarasoff v. Regents of University of California* (1976) 551 P. 2d 334 is an example of a case involving a third party seeking to sue medical professionals for a failure to breach patient confidentiality. In that case, the Supreme Court of California held that a therapist could owe a duty of care to a third party who was not his patient. That case involved a Mr. Poddar who had been detained in a psychiatric hospital prior to shooting and stabbing Ms. Tatiana Tarasoff to death. Ms. Tarasoff’s parents sued Dr. Moore, a therapist in whom Mr. Poddar had confided that he intended to kill Ms. Tarasoff. The case dealt with the preliminary issue of whether the parents could have a cause of action against the therapist in whom Mr. Poddar had confided and his superior, Dr. Powelson, even though Ms. Tarasoff was not the patient of either therapist. The Supreme Court of California held that there could be such a cause of action. At para 7, the court states:

> “we conclude that plaintiffs can amend their complaints to state a cause of action against defendant therapists by asserting that the therapists in fact determined that Poddar presented a serious danger of violence to Tatiana, or pursuant to the standards of their profession should have so determined, but nevertheless failed to exercise reasonable care to protect from that danger.”

17. For this reason, a risk of such an action by B against a doctor or the CFA for the failure to warn B in the circumstances of this case cannot be discounted. However, counsel for the CFA explained that the sole reason that the CFA is seeking a declaration from this Court entitling it to make the disclosure is because of a concern for B’s wellbeing. It is not out of a fear that B, if she contracted HIV, might subsequently sue the CFA for the personal injury which resulted from her not being warned of the risk.

The circumstances of the relationship

18. A has had HIV since birth. B is one of A’s closest friends, but A denies that she is his girlfriend and he has also denied that they have ever had sex. The CFA is of the view that despite A’s denials, B is A’s girlfriend and it believes that they are having sex. The

CFA is also of the view that A is not using condoms.

19. In reaching its conclusions, the CFA relies on the fact that A has admitted to having sex previously with others, that he was ambivalent in his answers to a social worker regarding whether on those occasions he had used condoms, that social media photographs were produced in evidence of A and B which showed them posing together with tags such as "*love her*" and with them exchanging a kiss on the lips, which photographs the CFA says are consistent with them being boyfriend and girlfriend. For his part, A himself and his counsel, indicated that these photographs are simply the way that young people who are close friends express themselves on social media.

20. The CFA also relied on a log of the almost daily contact between A and B during the summer and autumn of 2017, such that it seems clear that A and B, even if they are not boyfriend and girlfriend, are very close friends. In support of its application, the CFA also relied on the fact that A refused the offer of condoms from the CFA, although for his part, A stated this was because he had enough condoms, not that he did not use condoms.

21. Particular reliance was placed by the CFA on the fact that gardaÃ forced entry into A' bedroom one morning in June of 2017 (as he was absent from his residential care home) and that at that time B was in A's bed in a t-shirt and was bare-legged while A had left. A explained that B had not spent the night in his bed, but that she had called in that morning and when the gardaÃ were at the locked bedroom door, he asked her to get into bed and pretend she was asleep while he left .

22. In summary, the CFA rely on the fact that while none of this evidence on its own is persuasive in convincing a court that A and B are having sex, the cumulative effect of this evidence is such that a court could infer that A is having sex with B. Counsel for A's mother, C, pointed out that despite all this circumstantial evidence, and in particular the evidence that A and B spend a lot of time together, no evidence was produced, from the staff of the residential home in which A previously resided or from social workers dealing with his care, that A and B are in an intimate relationship.

Evidence which might support a finding that A and B are having sex

23. However, two incidents are particularly relevant regarding whether A and B are in a sexual relationship. One is the fact that in a meeting between A's mother, C, and E, a social worker with the CFA, about the necessity for the disclosure to B of A's HIV status, C suggested that before disclosing A's status, B should be tested for HIV. It is difficult to believe that A's mother would have suggested this course of action unless she believed that A was having sex with B. On the other hand, that is not direct evidence that A is having sex with B, let alone unprotected sex, but rather a mother's belief that her son might be having sex and so it is just another factor in determining whether on the balance of probabilities A and B are having sex.

24. It is also relevant that E from the CFA, who was a convincing witness, gave evidence that at a meeting on the 28th June, 2017, C told him that B was staying overnight in her home with A. There is a typed note of this meeting which was prepared on the 28th June, 2017, and in her evidence C explains this note by stating that she actually said a group of A's friends, rather than just B, were staying overnight.

25. Equally relevant is the fact that the reaction of A to the CFA's desire to disclose his HIV status to B was a very extreme and angry reaction, which appears to be more consistent with his having sex with B than not. This is because if he was not having sex with B then there would be no risk to her and thus the disclosure of his HIV status would simply be the disclosure to B that her very close friend, A, had HIV. However if in fact A was having sex with B then the disclosure to B that A had HIV would no doubt lead to a

very angry and distressed reaction from B that A had sex with her without disclosing his status. This could explain the extreme reaction of A to his HIV status being disclosed to B. On the other hand of course, A is clearly very anxious that no one, even some of his very close friends, should be told of his HIV status as he is very conscious of the stigma attaching to it and one cannot discount the fact that his extreme reaction is based on his very strong desire to ensure that no one ever learns of his HIV status, until he is ready to tell them.

A is a very honest person

26. A was described by his social worker, E, as the most honest person he had ever met and he said that A does not lie. For its part, this Court found A to be a convincing witness. However, this is not to say that this Court does not believe that there is a risk that he is lying about whether he is having sex with B. This is because he has kept his HIV status as a secret and a personal matter for many years and he feels extremely strongly that he does not want it disclosed because he has had difficulty coming to terms with the fact that he has an incurable disease.

27. In addition he stated in evidence that his friends are unaware that he is HIV positive, which is a disease they would make jokes about as they wrongly equate HIV with AIDS and they believe that a person with HIV will die. A gave evidence to the Court that he plans to disclose his HIV status to the person he plans to settle down with, when that time comes. A is so anxious not to have his HIV status disclosed, that he has claimed that if it was disclosed his life would be ruined. For this reason, although a very honest witness, it is not inconceivable that, because he feels so strongly about not disclosing his HIV status to anyone, he would lie about whether he is in a sexual relationship with B in order to ensure that his HIV status is not disclosed without his consent. The CFA clearly believe that this is the case.

28. E, the social worker with the CFA is extremely worried that A is having sex with B, that this sex is unprotected and that for this reason the CFA feels that it should disclose, through appropriate medical specialists, A's HIV status to B.

Medical evidence on the risk of B contracting HIV

29. A further factor in the assessment of the risk of harm to B if she were having unprotected sex with A is the issue of whether A consistently takes his antiretroviral drugs and the risk of the HIV virus becoming contractible through sexual contact as a result of his failing to do so.

30. Expert medical evidence in relation to this issue was provided by D, Consultant Paediatrician and Infectious Disease Specialist and Dr. Fiona Lyons, Consultant Physician in Genitourinary and HIV Medicine. D is one of the doctors who treats A, while Dr. Lyons provided her opinion in this case, as the CFA sought a second opinion from her on the issues involved in this case.

31. It was clear from this medical evidence that enormous strides have been made in the treatment of HIV, so that while HIV is a lifelong condition, no evidence was produced that it was a life-shortening condition and D described it as a "*chronic condition that people manage*". Part of managing the condition is the taking of antiretroviral medication on a daily basis. This ensures, *inter alia*, that the person infected with the HIV virus does not have a detectable viral load. This then means that HIV is for all intents and purposes not communicable by sexual activity or otherwise, particularly if condoms are used. However the reverse is also the case so that if a person such as A fails to take his antiretroviral medication consistently then that person is likely to have a detectable viral load and a person having unprotected sex with him is then exposed to the risk of contracting the HIV virus.

Failure by A to take his antiretroviral drugs
32. An issue in this case is that for considerable parts of 2017, and in particular between May and July in 2017, A was not taking his antiretroviral drugs on a daily basis. Evidence of A's medication log was provided which showed that in June he only took his drugs on 14 out of 30 days. D gave evidence that a patient could lose virological control, i.e. have a detectable viral load, after as little as seven days of not taking drugs. Virological control is then recovered by the consistent taking of antiretroviral drugs. However, it was also the case that, as noted by D in a letter dated 23rd August, 2017, to E of the CFA, that A was tested for his detectable viral load on five occasions in 2017 and on each of those occasions he did not have a detectable viral load which she stated "*should be reassuring*" in the context of the possibility of A transmitting HIV to B.

33. Nonetheless, D was of the view that as a result of the evidence that A was not consistently taking his antiretroviral drugs there was a risk that a person having sex with A could contract HIV. In a letter dated 8th November, 2015, on this issue, D put the risk of infection from having sex with a person with a detectable viral load at 0.04%, although it was accepted by both D and Dr. Lyons that this figure was not completely reliable and it could in fact be higher.

34. Based on the direct evidence given by A it seems clear that he is now even more aware of the importance of his taking the antiretroviral drugs on a consistent basis. However, based on the medical evidence this Court would conclude that on the balance of probabilities A could have lost virological control, *albeit* briefly, at some stage during the period May to July 2017.

Use of condoms by A
35. When questioned by the Court about the use of condoms in the context of transmission of HIV, D stated:

> "Q: …then can I ask you a further question, in relation to the use of condoms, what is the medical…"
>
> A: Condoms are a very effective in preventing transmission and reduce transmission if used consistently up to 99.9%, not 100% but a very effective way of preventing transmission.".

36. It seems to this Court that this answer presupposes that the person with HIV does not have a detectable viral load at that time. This is because in her letter to the solicitors for the CFA on the 11th November, 2015, D states:

> "Condom use can reduce the risk of sexual transmission by 80%. Using both condoms together with antiretroviral therapy can reduce it more than 99%. Unprotected sex with someone with a detectable level of virus in their blood poses a definite risk of transmission."

37. This evidence was also consistent with A's evidence when he was cross examined on this issue by counsel for the CFA, since he stated:

> Q: "And if you used a condom when you were having sex do you need to tell the person you are with about your HIV status?"
>
> A: "No, I asked D and she says "no, if you are using a [condom] and then especially if you are taking your meds, there's no need."

Medical evidence regarding the effect of disclosure on A
38. For his part, A states that if his HIV status was disclosed to B, he would be devastated such that he would kill himself. This is because of the social stigma of having HIV and the fact that he did not disclose this fact in his community, particularly where

HIV status is wrongly equated with AIDS and with certain death.

39. Dr. Gerry McCarney, Consultant Child & Adolescent Psychiatrist gave evidence regarding his assessment of A and he concluded that A was not clinically depressed, nor does he require medication for a psychiatric illness. However, and perhaps not surprisingly, Dr. McCarney gave evidence that it was not possible to predict accurately whether A would kill himself, particularly as he had taken an overdose of tablets on two previous occasions. Equally however Dr. McCarney could not eliminate the possibility that A's claim that he would kill himself was simply a ploy by A to ensure that this HIV status was not disclosed to B.

40. Dr. McCarney's main concern about the disclosure of A's HIV status was that patient confidentiality once breached was irreversible since one had no control over to whom the information would be provided. The logic of this position, which point was also made by A himself, is that once one person knows, everybody knows, particularly in the age of social media. Accordingly, it was Dr. McCarney's view that one should be as certain as possible of a risk of serious harm to an individual before patient confidentiality is breached. He also referred to the fact that one needed to consider the consequences of the disclosure on A, namely the threat of suicide, and not just the harm that could be caused to B if she was not made aware that A has HIV.

Conclusions regarding the medical evidence

41. The following conclusions can be made therefore. For B to contract HIV, a number of things need to happen:

- first, A has to fail to take his antiretroviral drugs consistently,
- secondly, A needs to be having sex with B, which he has denied,
- thirdly, the assumption that A is having unprotected sex with B is a significant factor in the risk of her contracting HIV. although it is possible that HIV could be contracted using condoms,

42. In those circumstances, were B to have sex with A, she would have a risk of somewhere in the region of 0.04% of contracting a disease which is not life threatening, but is a chronic condition.

43. In these circumstances the CFA, in reliance on the evidence of D and Dr. Lyons, is seeking an order from this Court to breach patient confidentiality and notify B, without A's consent, that A has HIV.

44. D has averred that it is "*clinically and ethically*" justified to disclose A's HIV status to B without his consent because there is "a real threat of serious illness".

45. Dr. Lyons averred that "*given the missed doses of medication as stated in the medication log, there is a real possibility that A would have periods of loss of virological control"* which means that "*transmission to another individual through unprotected sex is a real possibility".*

46. Dr. Lyons also averred that:

> "where there is a duty of care to two individuals, one of whom was at risk, breach of patient confidentiality and disclosure to the individual at risk is the guided course of action in line with the Medical Council of Ireland Guide to Professional Conduct and Ethics for Doctors, 2016."

47. Although simply a non-statutory guide and so not legally binding, it is relevant

nonetheless to set out Paragraph 28.1 of that Guide:

> "Disclosure of patient information without their consent may be justifiable in exceptional circumstances when it is necessary to protect the patient or others from serious risk of death or serious harm. You should obtain consent of the patient to the disclosure if possible."

48. In the context of obtaining a patient's consent, it is of course relevant to record that in this case, attempts were made by the CFA to obtain the consent of A to the disclosure of his HIV status, but for the reasons already stated, including the fact that A claimed he and B were not having sex, A was not willing to consent to such disclosure

Conclusions regarding the factual dispute

49. In light of all of this evidence, this Court has little hesitation in concluding that there is a possibility that A is having sexual intercourse with B. This Court is also conscious of the fact that A and B could be engaging in sexual activity which falls short of sexual intercourse, even though the basis of the claim that patient confidentiality should be breached in this case is that they are engaging in sexual intercourse.

50. However, in order for this Court to conclude on the balance of probabilities that A is actually having full sexual intercourse with B, something more is required and nowhere, in this Court's view, is there that factor or combination of factors that tips the balance in favour of such a finding. Therefore, this Court finds that the CFA has not discharged the onus on it to prove on the balance of probabilities that A is having sex with B.

51. Indeed, even if this Court were to find on the balance of probabilities that A was having sex with B, this Court is of the view that on the balance of probabilities any such sex is not unprotected sex. This is because A is fully aware of the seriousness of the HIV virus and of the stigma attached to it, since he has regarded it as having changed his life and he is aware that it is transmissible by unprotected sex. Further, he is also aware that the reckless transmission of the virus by him to B by his engaging in unprotected sex with her, could constitute a criminal offence under the Non-Fatal Offences Against the Person Act, 1997. It is also relevant to note that the CFA was anxious to point out that it is not alleging that A would transmit the virus maliciously or by deceit to B. For these reasons and because of the obvious regard which A has for B, it is this Court's view that even if this Court is wrong, and A is having sexual intercourse with B, it is of the view that, while A may have been ambivalent about his use of condoms in a reply to a social worker regarding his having sex with another individual previously, A would not put B at risk by having unprotected sex with her.

52. Similarly this Court is of the view that on the balance of probabilities A lost his virological control in the past for a brief period, yet on the balance of probabilities it does not believe that he will lose it in the future. This is based on this Court's assessment of A's acknowledgement of the importance, for his own health and the health of others, of him retaining virological control.

Caselaw on breach of patient confidentiality

53. It is common case that there may be circumstances in which professionals, including doctors, may be entitled to breach confidentiality owed to their patients, customers or clients. This is because, as noted by Bingham L.J. in the English Court of Appeal case of *W v. Edgell* [1990] WLR 471 at p. 488:

> "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 personal duty of confidence: *Attorney-General v.*

> *Mulholland, Attorney-General v. Foster* [1963] 2 Q.S. 286. In *Parry-Jones v. Law Society* [1969] 1 Ch. 1 a solicitor's duty of confidence towards his clients was held to be over-ridden by his duty to comply with the law of the land, which required him to produce documents for inspection under the Solicitors' Accountants Rules. A doctor's duty of confidence to his patient may be overridden by clear statutory language (as in *Hunter v. Mann* [1974] Q.S. 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.S. 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.S. 396 and *Lion Laboratories v. Evans* [1985] Q.S. 526."

The question for this Court relates to the specific area of patient confidentiality and the leading English case on this area is the *Edgell* case from which this quotation is taken.

W v. Edgell – risk of a bomb being planted by a known killer

54. In the *Edgell* case the Court of Appeal found that the public interest justified a breach of patient confidentiality. That case involved the plaintiff, Mr. W, who was suffering from paranoid schizophrenia and who had previously shot and killed five people. His plea of diminished responsibility had been accepted at his trial and he was sentenced to be detained without limit of time in a secure hospital. Subsequently, in order to support his application to be moved to a less secure unit and eventually into the community, Mr. W engaged Mr. Edgell, an independent consultant psychiatrist. Rather than supporting Mr. W's application, Mr. Edgell's conclusion was that Mr. W had a long standing and continuing interest in home-made bomb making and that he was still a danger to the public. Once this became apparent to Mr. W, he withdrew his application to be moved from the secure hospital but he also refused to consent to Mr. Edgell disclosing the report to the medical officer of the secure hospital. Despite the absence of consent, Mr. Edgell disclosed his report to the medical officer of the secure hospital and also the Secretary of State in the United Kingdom. In considering whether Mr. Edgell had thereby breached his duty of patient confidentiality, the Court of Appeal accepted that Mr. Edgell had a duty of confidentiality to Mr. W since he was clearly his doctor for the purposes outlined. In this context and of obvious relevance to the present case, Bingham L.J. noted at p. 491 of his judgment that:

> "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."

55. Since a disclosure of a patient's mental or physical wellbeing without his consent would injure the interests of a patient, it is clear that the Court of Appeal was placing a high threshold to be passed for the breaching of patient confidentiality. It seems clear that this is because not only is there the private interest of the patient at stake, in the sense of the right of every patient to privacy in relation to his medical condition, but also there is a broader public interest in ensuring that when patients disclose matters to their doctor the patient must have full confidence that it will not be disclosed without his consent save in the most extreme circumstances. Without such a high threshold, patients would be reluctant to seek medical help, particularly if they had communicable diseases with a stigma attached to having them and they felt that their community or indeed the wider public would be notified of the fact that they had such a disease.

56. In deciding whether to disclose a patient's confidential information, it is clear that there is a balancing of interests. This concept was referred to at p. 488 of Bingham L.J.'s judgment where he quoted from Lord Goff of Chieveley in his "*Spycatcher*" speech:

> "...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."

57. Applying this balancing exercise, the Court of Appeal found that the public interest in protecting third parties against possible death, resulting from a bomb planted by Mr. W a known killer, justified the breach of patient confidentiality in this case. As is noted hereunder, there may also be a public interest in not disclosing patient information, since there is a public interest in ensuring that members of the public have confidence that when they disclose their medical condition to medical professionals their details will not be disclosed save in exceptional circumstances.

***Z v. Finland* – risk that a victim of sexual assault may have contracted HIV**

58. The European Court of Human Rights decision in *Z v. Finland* (1998) 25 EHRR 371 is relevant because it dealt with a situation relating to HIV, *albeit* in the context of the prosecution of the criminal offence of sexual assault. That case concerned Ms. Z who had been infected with HIV by her husband Mr. X. He had been convicted of rape and the authorities in Finland were investigating a complaint by another individual, Ms. M, of a sexual offence by Mr. X. Once the authorities discovered that Mr. X had HIV, they opened an investigation into whether the sexual offence constituted attempted manslaughter. In connection with this investigation, the authorities obtained orders compelling Ms. Z's doctors to give evidence and they seized Ms. Z's medical records. Ms. Z alleged this amounted to a violation of her right to privacy. The issue, as in the case before this Court, came down to conflicting interests – Ms. Z's interest in having her medical data kept private and the public interest in prosecuting the crime of attempted manslaughter.

59. At para. 95 of the judgment, the Court refers to the protection of medical data as being of fundamental importance to the enjoyment of one's right to respect for privacy as guaranteed by Article 8 of the Convention on Human Rights. The Court goes on to state that:

> "Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment, and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community".

After referring to these considerations, the Court makes specific reference to HIV in the following terms at para. 96:

> "The above considerations are especially valid as regards protection of the confidentiality of information about a person's HIV infection. The disclosure of such data may dramatically affect his or her private and family life, as well as social and employment situation, by exposing him or her to opprobrium and the risk of ostracism. For this reason it may also discourage persons from seeking diagnosis or treatment and thus undermine any preventative efforts by the community to contain the pandemic […]
>
> In view of the highly intimate and sensitive nature of information concerning a person's HIV status, any State measures compelling communication or disclosure of such information without the consent of the patient call for the most careful scrutiny on the part of the Court, as

> do the safeguards designed to secure an effective protection".

While acknowledging the need for the "*most careful scrutiny*" of the basis for any disclosure of a patient's HIV status, the Court concluded that the public interest in favour of the investigation and prosecution of Mr. X for attempted manslaughter amounted to a sufficient reason to permit the breach of the fundamental right of a person to privacy of their medical information.

Y v Turkey – disclosure of HIV status of a patient to treating doctors

60. In *Y v. Turkey*, (unreported, ECtHR, 2nd February, 2015), the applicant also had HIV and he was admitted to hospital having been found unconscious at his home by his relatives who informed the ambulance staff that he was HIV positive. The ambulance staff informed the hospital staff of this fact on his admission to hospital, without first informing the applicant or his relatives. The Court rejected his complaint that the disclosure of his HIV status to the hospital staff by the ambulance staff without consent breached his Article 8 right to privacy.

61. At para. 68 of the unofficial translation of the French language judgment, the Court stated, in the context of the disclosure of the applicant's HIV status that:

> "It can not be ruled out that the disclosure of such information could have devastating consequences for the data subject's private and family life and his social and professional situation, exposing him to stigma and the risk of exclusion. The interest in protecting the confidentiality of such information will therefore weigh heavily in the balance when it comes to determining whether the interference was proportionate to the legitimate aim pursued, knowing that such interference can not be reconciled with Article 8 of the Convention only if it seeks to defend a vital aspect of the public interest."

At para 73, the Court stated:

> "...the Court recalls that it has already found that people living with HIV are a vulnerable group, long since victims of prejudice and stigmatization (Kiyutin *v Russia*, No. 2700/10, Â§ 64, ECHR 2011). It reaffirms in this regard the importance of confidentiality of medical information concerning them in order to reduce the risks of stigmatization linked to this disease and to allow these persons to have access, without discrimination, to health care."

62. Nonetheless, in the circumstances of this case, the Court found that the disclosure of the patient's HIV status was justifiable. In finding that the disclosure was justifiable and did not involve a breach of the plaintiff's rights to privacy under Article 8 of the ECHR, it is relevant to note that the disclosure in that case was made in the medical interests of the applicant while he was unconscious and in particular the Court noted at para. 80 of the judgment that the disclosure was only made to medical staff:

> "In addition, nothing comes to establish that people not involved in his medical care have been informed of his HIV status."

In this respect, it is very different from the proposed disclosure in this case which is to B who is clearly not involved in A's medical care.

With a right comes responsibility

63. Having considered these and the other cases which have been opened, this Court is in little doubt that if the factual circumstances that arose in the *Edgell* case were to arise before this Court, namely a significant risk of death to a member or members of the public from a known killer, a doctor would be entitled to breach patient confidentiality in order to seek to prevent the death of an innocent third party.

64. Indeed, not only would a doctor be entitled to breach confidentiality in those

circumstances, it seems clear that he or she would have a duty to act to seek to prevent innocent deaths. It is important to remember that this is a likely consequence of the right to disclose being sought by the CFA in this case, and supported by the doctors whose expert evidence is relied upon, namely that with the right to breach patient confidentiality comes a responsibility to exercise that right in appropriate circumstances. In addition, of course, with that right may also come liability to third parties, who suffer as a result of the CFA (or a doctor's) failure to exercise the right to breach patient confidentiality, if that failure leads to personal injury to a third party.

65. These and other consequences are relevant to this Court's consideration of whether a right to breach confidentiality arises in the present case.

66. For this reason, when this Court is considering whether it is in the public interest that this Court grants the CFA (or indeed a doctor) the right to disclose the HIV status of a patient to his or her sexual partner without consent, this Court cannot ignore the likely effect on the doctor and patient relationship and indeed on the liability of doctors to third parties who might allege that they were harmed by a doctor's failure to disclose. This is because while the plaintiff in this case is the CFA, it could just as easily be a medical professional who is in possession of the same information as the CFA and could be seeking the order.

Is there a duty to disclose where the risk of harm is short of the risk of death?
67. As previously noted, in reliance on the *Edgell* case, this Court accepts that there is a right to breach patient confidentiality and disclose information to a third party, not concerned with the patient's medical care, where there is a risk of death to members of the public.

68. An issue not directly considered in *Edgell* is whether risk of harm, which is short of death, would justify a breach of patient confidentiality in favour of a third party. It is this Court's view that the answer to that question is yes. Thus, if the patient in *Edgell* had disclosed to his doctor that he wished to cause very serious harm, which was short of death, this would, in this Court's view, also merit a breach of patient confidentiality.

69. To put it another way, this Court is of the view that the public interest in protecting unsuspecting members of the public from very serious harm takes precedence over the interest of a patient in keeping his medical information confidential as well as taking precedence over the public interest in ensuring that patients when they go to doctors can expect their medical information to be kept confidential.

Breaching patient confidentiality to protect innocent third parties
70. The *Edgell* case involved innocent third parties or unsuspecting members of the public, in the sense that they had no way of knowing that there might be a risk of injury from Mr. W, nor indeed was there be any way in which they could protect themselves from a bomb planted by Mr. W.

71. In the case before this Court, the person sought to be protected, B, is not an 'innocent third party' in the view of the CFA, not in a moral sense but in the sense of assuming risk. This is because the CFA believes that B is voluntarily engaging in activities which carry with them a certain degree of risk, namely unprotected sexual intercourse, notwithstanding A's denials that he is having sex with B. In this Court's view, and based on the CFA's version of events, the fact that that B is voluntarily engaging in unprotected sex, is a factor to be weighed in the balance, when balancing the right to privacy of A, the public interest in protecting patient confidentiality and the interest in seeking to prevent unnecessary harm to B.

The test to be applied to a breach of patient confidentiality in this case

72. In light of the foregoing caselaw, this Court concludes that only the most compelling circumstances would justify the CFA disclosing A's HIV status to B, without his consent. This high bar to disclosure is not because this Court does not believe that there is merit or a public interest in seeking to protect B from contracting a communicable disease. Rather it is that there is a greater public interest in all patients and prospective patients knowing that their personal medical information will not be disclosed, save in the most extreme of circumstances (particularly in relation to preventing the spread of communicable diseases, referenced in *Z v. Finland*, in containing a pandemic). This then raises the question of what is meant by compelling circumstances.

73. Since this is a civil matter, rather than a criminal matter, it is this Court's view that the appropriate test to apply in determining the issue in this case is whether on the balance of probabilities the failure to breach patient confidentiality creates a significant risk of death or very serious harm to an innocent third party.

74. In considering whether the threshold of a "*significant risk of death or very serious harm*" is crossed in the particular circumstances of this case, regard has to be had to the balancing of interests, namely between the interest of A whose privacy is being breached, the interest of B, the individual at risk of harm and the public interest in ensuring that the public at large has the confidence to disclose the most private details about their health and private lives to doctors.

Issues of concern and relevant considerations for the order being sought

75. Before applying to the circumstances of this case, the test which has been set down by this Court, it is worth noting that the first step in determining whether an order should be granted in this case is to determine, as a matter of fact, whether A and B are having sex. This is because if they are not having sex then it is common case that no disclosure is required. This raises for this Court issues of more general concern if the order sought was to be granted. These will next be considered as well as the other considerations relevant to the order being sought.

A court examining in a civil case whether two people are having sex

76. The first issue is that to obtain the order sought, the CFA is asking this Court, despite A's denials, to determine as a matter of fact, under civil, as distinct from criminal law, whether A and B are having sex. This brings home the breadth of the order which is being sought for the first time in the Irish courts, namely a breach of a patient's confidentiality, and indeed the precedent which it could create. In particular, it raises the possibility that if the order is granted in this case, in similar cases in the future regarding serious diseases which are contractible by sexual intercourse, the applicant for the order will be providing evidence, and the Court will be involved in determining in a civil case, whether two consenting adults are having sex or to put it another way what is going on behind closed bedroom doors.

GardaÃ metaphorically in the bedroom

77. This leads to a matter of more general concern regarding the involvement of the State in the matters of individual freedom. In considering the orders sought in this case, one is dealing with civil, rather than criminal, law. Nonetheless this Court is struck by the unease of the Supreme Court in *McGee v. Ireland* [1974] IR 284, during a much more conservative era, with the notion of having the "*police in the bedroom*". In that case the unease was expressed by Griffin J. in the context of a married woman importing contraception in breach of criminal law and the constitutionality of such a law. Even then, the notion of having gardaÃ, metaphorically at least, in the bedroom was nonetheless a matter of concern to Griffin J. At p. 335 of his judgment he quoted from the judgment of Douglas J. from the US Supreme Court case of *Griswold v. Connecticut* (1965) 381 U.S. 479 where he stated:

> "Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives? The very idea is repulsive to the notions of privacy surrounding the marriage relationship."

78. In this case, it is not the gardaÃ who are in the bedroom, since whether A is having sex with B is not a criminal matter in this case. However, one has the law in the bedroom, metaphorically at least. This is because the State, through the CFA and in order to protect a third party from unwittingly contracting HIV, is effectively alleging that A is breaching civil law by his negligent behaviour by having unprotected sex with B without disclosing his HIV status to her, justifying its seeking an order from this Court. Although no malice is being alleged against A, there is an implicit suggestion in this case that he could be guilty of a criminal offence under the Non-Fatal Offences Against the Person Act, 1997, if his behaviour was deemed to be reckless. Thus, the State in the form of the CFA is intervening to seek to notify B of A's HIV status in order to prevent her from being harmed.

79. This Court would not put the issue as strongly as Douglas J., and say that it is repulsive to notions of privacy to have the State or indeed doctors metaphorically in the bedroom. This is because this is not a case where the State had passed and was seeking to enforce laws making the use of contraception illegal (as in the *McGee* case), but rather a case where the State and the doctors are motivated by a desire to protect a third party from harm.

80. Nonetheless, this Court would express some unease at ordering the CFA (or doctors) that they are entitled to disclose patient information based on what they believe is going on behind closed bedroom doors between two consenting persons, who are as close to adulthood as makes no difference. The consequences of such an order, for future cases, cannot be ignored by this Court when considering whether it is in the public interest to breach patient confidentiality in this case.

GardaÃ literally in the bedroom

81. In a slightly surreal coincidence, the CFA, in support of its claim that A is having sex with B, rely on a garda raid of A's bedroom in his family home and a garda's evidence that B was bare-legged and wearing a t-shirt in A's bed, even though this is a civil matter and not a criminal matter.

82. It is important therefore to clarify that the reason that the gardaÃ were in A's bedroom was because he was reported missing from his residential placement and because the gardaÃ were looking for him. So while this is a case where the gardaÃ were *actually* in the bedroom and a garda's evidence from the bedroom is being relied upon to allege that A is having sex with B, the fact that the gardaÃ were in the bedroom is not a determinative fact in this Court's decision, since their purpose in being there was not to investigate whether A and B were having sex, but rather to track down the whereabouts of A.

A paternalistic approach to people's welfare

83. Even though the gardaÃ were not involved in protecting B's welfare, the State, in the form of the CFA, is involved in making determinations regarding the nature of A's and B's relationship, in order to protect B from a serious and life-long condition, as the CFA feels that disclosure should be made in this case. Thus, although somewhat removed from the paternalistic State of the *McGee* case which sought to enforce religious morals through its criminal law, one is nonetheless dealing with a type of paternalism. This paternalism is one which seeks to also enter bedrooms, metaphorically at least, but this time to protect a young woman from her alleged own lack of care (by having sex with someone without using condoms) and thereby prevent her from suffering personal injury (in the form of a communicable disease). This paternalism seeks to breach the privacy and affect the liberty of an individual to conduct his love life/relationships how he wants. It is this paternalistic approach, *albeit* one that is well

intentioned, which would cause this Court some unease. However, it is relevant to point out that it is clear that the CFA have only the best interests of B in mind in taking this approach

A court examining in a civil case whether a couple are using condoms
84. Another issue of general concern regarding the type of order sought is that, if it is established as a matter of probability to be the case that A and B are having sex, it seems that the next step in determining whether to breach patient confidentiality, is determining whether A and B are using condoms. This is because it seems clear that there is a considerable difference between the risk to which B is exposed if she is having unprotected sex, versus the risk to her if she is having protected sex, in which case the risk is effectively eliminated, particularly if A is taking his antiretroviral drugs. Indeed, it seems clear to this Court that if B was having only protected sex with B that the doctors might not be supporting the application to disclose A's HIV status to B, particularly if A was taking his antiretroviral drugs.

85. This raises the possibility that if the order is granted in this case, then in similar cases in the future regarding serious diseases which are contractible by sexual intercourse, the applicant for the order will be providing evidence, and the Court will be involved in determining, whether the parties are using condoms.

Use of condoms and doctors believing patients
86. In a similar vein, it is worth noting that if the order sought was granted, doctors might have to decide if their patients were using condoms. To put this issue in the language used in court proceedings, doctors might have to decide whether it was reasonable for them to assume that their patients were using condoms or whether it was reasonable for them to accept the answer from a patient that he/she was using condoms, if there was some contrary evidence. If it was not reasonable to accept those answers, a doctor might have to notify the third party, if the patient refused to do so, in the event of the order in this case being granted. This is because, in this Court's view, this is where the order sought in this case logically leads. This is because if A was practising safe sex, it seems that the doctors might not be supporting the CFA in its application for the order to notify B of A's HIV status. Accordingly, the use of condoms in cases such as this would become a key issue if the Court was to grant the order sought.

Responsibility of adults for their own safety
87. Although this is a case which is about the breach of patient confidentiality, in a broader sense it is also a case about personal injury and people taking responsibility for their own actions.

88. This is because if the order sought is granted, doctors will have a right to breach patient confidentiality in the circumstances outlined in this case. However, as previously noted, along with this right will come responsibility, namely the obligation upon a doctor to consider in suitable cases, involving serious communicable sexual diseases, whether the doctor has a responsibility to notify a third party of that disease. Of course, a failure on the part of the doctor to discharge this responsibility could lead to a liability in damages to third parties who are personally injured by this failure.

89. So while this case is primarily about whether the CFA or a doctor should breach patient confidentiality to protect a third party from harm, underlying this issue is the extent to which individuals such as B are responsible for their own safety and the extent to which third parties such as doctors owe her a duty to advise her of risks to which her actions are exposing her. This is because the application for the order in this case is based to some degree on the belief on the part of the CFA that B is choosing to have unprotected sex with A, which is not an activity that is not without risk.

90. In this regard, it is this Court's view that B, who is almost an adult, should be aware that if she has unprotected sex, she risks contracting sexually transmitted infections including HIV. Thus, if B decides to have unprotected sex with A, she is already assuming the risk of contracting HIV, although she may believe that the risk thereof is very small, since she is unaware of A's HIV status. Clearly, her whole attitude to sex with A is likely to change dramatically if she discovers that A has HIV. Significantly, there is no evidence before this Court that B is other than a reasonably intelligent young woman of 17 going on 18 and so would not expose herself to risk of communicable diseases by having unprotected sex with B, but that if she did decide to do so, that she would not be aware of the risks which are generally associated with having unprotected sex.

91. On this basis, if B decides to risk damage to her health by having unprotected sex, this Court must decide whether it is in the public interest to breach A's patient confidentiality in order to notify her that whatever risk she believed she was taking by having unprotected sex, is in fact much greater than she had realised. The public interest that there might otherwise be in breaching patient confidentiality in order to protect a vulnerable or innocent third party (akin to the innocent Ms. Tarasoff who was murdered in the *Tarasoff v. Regents of University of California* case) is not present in this case, since the third party, who might be affected by the failure to breach patient confidentiality, is voluntarily undertaking an action with risk associated, namely unprotected sexual intercourse.

92. In this regard, this Court is cognisant of the recent pronouncements of the Court of Appeal in relation to personal injuries. The Court of Appeal has made it clear that adults need to take responsibility for their own safety and cannot blame third parties for personal injury that would not have occurred if they had taken more responsibility for their own safety. In particular, in the case of *O'Flynn v. Cherry Hill Inns Ltd*. [2017] IECA 211 at para. 37, Irvine J. held that:

> "Adult members of society are obliged to take care for their own safety and cannot divest themselves of responsibility for their actions."

93. This principle is equally applicable to this case, even if one is dealing with B, who is a few weeks short of adulthood. This is because it is this Court's view that if B decides to have sex with A without protection, or indeed if any person decides to have sex with another without protection, he or she must appreciate that they are assuming a risk, and it is not necessarily the duty of third parties or indeed a State body such as the CFA to warn them of the risk that they might be exposed to sexually transmitted infections, some of which can be minor and others which can be very serious and have lifelong consequences, including but not limited to HIV. B has the personal freedom to engage in unprotected sex if she wishes, but she must accept responsibility for the risks attaching to such actions and in particular she cannot seek to blame third parties if those risks come to pass, even if the consequences are worse than she might have expected.

94. To put this conclusion another way, a doctor is not necessarily entitled (or indeed obliged) to inform a person who is having sex with his/her patient without protection that the patient has HIV. This is because that person, if an adult, should not need to be warned that he/she is already taking a risk of contracting very significant diseases. It so happens that HIV is just one of those diseases that is communicable through sex, *albeit* a serious one. It follows that doctors are entitled to assume that third parties take precautions for their own safety and doctors are not entitled (or obliged) to breach patient confidentiality to warn third parties of the particular type of virus or sexually transmitted infection or other communicable disease that they risk contracting from that doctor's patient. To conclude otherwise, in this Court's view, could lead to a form of 'nanny state' where persons do not take responsibility for their own actions and where they could put responsibility on others, in this case doctors, for personal injury that is

caused by their own acts or omissions.

95. Yet in this Court's view this is the logical corollary of the order being sought by the CFA, since what the CFA is requesting is a power to disclose the confidential medical information of A to a third party. However, with this power would come responsibility to exercise that power appropriately and more specifically a liability to third parties where that power is not exercised when it should have been. This is because if this Court were to grant the order sought, it is inherent in the granting of such an order that the duty that a doctor owes to a third party, in this case B, can override the duty of confidentiality that the doctor owes his patient. It would then mean that in other similar cases a failure by a doctor to notify a person who is having sex with one of his patients, who has a communicable disease, could result in that doctor being held liable for the personal injury caused to that person from having sex with that doctor's patient, without having being warned by that doctor.

96. This could lead to a situation where doctors in order to practice defensive medicine (by which is meant practising medicine in a way which prioritises the reduction of the risk of being sued), would have to consider, where they have a patient with a serious communicable disease, whether they should be breaching the patient's confidentiality and notifying any person who the doctor has reason to believe is having sex with that patient.

97. This Court believes the granting of the order in this case could put an intolerable burden on doctors to consider whether patient confidentiality needs to be breached in every case in which they have a patient with a communicable disease. State agencies and doctors would be turned into actors in a type of 'nanny state' where people had to be warned that the person they were having sex with might not be up front about, *inter alia*, their state of health, when instead it is this Court's view that adults need to take responsibility for the results of any risks which they decide to assume.

The public interest in patients remaining open and frank with their doctors

98. As is clear from the case of *Z v. Finland*, there is a compelling public interest in ensuring that there is no disincentive to patients with communicable diseases, with the attendant social stigma, from seeking medical advice and that there is no disincentive to them being completely open and frank with their medical advisers. The health of the community as a whole is at stake and needs to be protected by ensuring that medical advice is always sought by patients who have communicable diseases. It seems to this Court that if the order was granted, it would operate as a disincentive to those with sexually transmissible diseases from seeking medical advice. This is because such persons would perceive that there would be a risk that their doctor would disclose this fact to their alleged sexual partners (if the patient refused to do so). In this Court's view, this would be detrimental to society as a whole since it could lead to patients with communicable diseases failing to seek medical advice which could result in those diseases not being treated and becoming more prevalent in the community.

The public interest in not requiring doctors to monitor a patient's sex life

99. The fact that the public interest favours the refusal of the order sought in the current case is, in this Court's view, also highlighted by the consequences which would flow if such an order, permitting the breach of patient confidentiality, was granted.

100. If this Court was to find that the CFA had a right (with the consequent responsibility) to disclose to a patient's sexual partner that the patient has HIV, this begs the question of how is the CFA to react, if and when A engages with future sexual partners.

101. Is the CFA (or indeed a doctor who has the same information as the CFA) under a

duty to monitor A's love life to see if there are future girlfriends who need to be warned? If so, in relation to this future girlfriend, is the CFA obliged to monitor that A is taking his medication, then monitor if the nature of this relationship is platonic or sexual, then monitor whether she and A are having full sexual intercourse, then monitor if A is using condoms, all with a view to warning this new girlfriend that she might contract a particular communicable disease, in this instance HIV, by having sex with A without protection? It is this Court's view that these are the possible future consequences of the granting of the order sought in this case and so militate against the granting of that order.

The public interest and the consequences of the order being sought

102. This Court cannot ignore the fact that the order being sought in this case is unprecedented in the Irish courts, namely an order to breach patient confidentiality for the benefit of a third party. This Court is cognisant of the consequences which flow from the order, if granted, not just in relation to B, but also A's future sexual partners but significantly also in relation to other cases where doctors have sexually active patients with communicable diseases. If the order is granted, it might, for example, be seen to impose upon doctors a duty to start asking about the identity of the sexual partners of their patients with communicable diseases and it could be seen to impose a duty upon the doctors to notify those third parties of their partner's disease, if the patient refused to do so.

103. Although this is clearly impractical and raises the prospect of a 'nanny state', rather than one where there is personal freedom and individual responsibility for one's actions, this would nonetheless be, in this Court's view, the logical consequence of the order being sought.

104. This highlights the impractical nature of what would be required of the CFA (and indeed doctors since the order being sought has particular relevance to how doctors practice medicine) if a power (with the consequent responsibility) to breach confidentiality was granted in the specific circumstances of this case.

A owes B a duty of care and could be guilty of criminal offence

105. A further factor against granting the order in this case, is the fact that quite apart from the order being sought, the law already provides some recourse for, and protection of a person in B's position under both civil law and criminal law were she contract HIV from A.

106. Thus, under civil law it seems clear to this Court that based on the medical evidence provided, if A were to fail to take his antiretroviral drugs for a number of days, then he has a duty to inform B that he is HIV positive before having unprotected sex with her. If he were to fail to do so, and B was to contract HIV, it seems very likely that he would be liable to B in damages.

107. In addition, under criminal law, in the same scenario, A would be liable to prosecution for a criminal offence under the provisions of the Non-Fatal Offences Against the Person Act, 1997, for the harm which he causes B.

108. In this regard therefore, the law already does provide some protection, in the sense of providing a very significant disincentive to A from risking harm to B. While it is acknowledged that neither civil law nor criminal law can prevent B being exposed to harm should A ignore these disincentives, it is equally important to note that the harm in question is not the risk of death or of a terminal illness, but rather the contracting of a "*chronic condition*". In this context, it is relevant for this Court that both civil law and criminal law impose a duty on A not to expose B to the risk of contracting HIV, when this Court is considering whether the further step of breaching patient confidentiality

should be taken to protect B. This is particularly so in the present case, since evidence was provided by A that he had been advised, presumably by his doctors or the CFA, of the fact that he could be guilty of a criminal offence if he were to have unprotected sex when he had a detectable viral load. These factors also support a finding that the public interest in maintaining patient confidentiality takes precedence over the interest in protecting B from the risk of contracting HIV.

Application of the test in this case
109. For the reasons set out in detail above, this Court concludes there is not enough evidence for the Court to find on the balance of probabilities that A is having sexual intercourse with B. Even if it is wrong on this issue, this Court concludes that on the balance of probabilities that any such sex is not unprotected sex.

110. For this reason, this Court concludes that there is no risk of death or very serious harm to B and so it rejects the application for the order entitling the CFA to breach patient confidentiality in this case. As this is an important area of law for doctors and patients alike, it is important to consider the position, if this Court is wrong in its conclusion that B is not having unprotected sex with A.

If A was having unprotected sex with B
111. It is this Court's view that even if this Court is wrong and B is having unprotected sex with A, this Court would not grant the order sought on the grounds that the right to breach patient confidentiality would only arise where one was dealing with very serious harm to an innocent third party.

112. In this regard, if B chooses to have unprotected sex, B is not an innocent third party, not in a moral sense, but in the sense that she is willingly undertaking the risk of contracting communicable diseases by having unprotected sex. In such a situation, it is this Court's view that there is no right on the part of doctors to breach patient confidentiality in order to warn B that one of diseases she is risking contracting, is HIV and that A has HIV. Similarly it is not for the CFA or any other emanation of the State to adopt a paternalistic approach to the welfare of others and intervene in a situation where a person consciously takes on a risk himself or herself. This is because, while it is not common knowledge that A has HIV, it is common knowledge that sexually transmitted infections, including HIV, are contractible by unprotected sex and so B should be aware of this risk. In these circumstances B's interest in being warned that she might contract diseases (which risk she should already know), and in particular HIV, if she chooses to have unprotected sex with A, does not override the public interest in preserving patient confidentiality.

If B was an innocent third party, is there a very serious harm to justify disclosure?
113. Even if this court had found that B was an innocent third party (in the sense that there was nothing she did which reduced or eliminated the risk of her being harmed), this Court is of the view that the circumstances of this case do not meet the threshold of there being a risk of very serious harm to justify the breach of patient confidentiality.

114. This is because although HIV is still a significant condition, it is no longer a terminal disease since in the words of D it is a "*chronic condition that people manage*". For this reason, it is this Court's view that the public interest in ensuring that patients have full confidence that their doctors will not disclose their medical condition to third parties, without the patient's consent, overrides the interest in seeking to prevent one individual contracting a disease of this seriousness.

115. This is because it is this Court's view that there is a greater public interest in ensuring that persons with HIV are not dis-incentivised from, first seeking proper

medical attention (out of fear of having their status disclosed because, *inter alia*, of the stigma attached to HIV) and secondly in ensuring that in dealing with a doctor, patients are not dis-incentivised from being completely honest about their sexual partners or indeed their sexual practises out of a fear of disclosure by that doctor.

116. It is this Court's view that the public interest in ensuring that there is not an increase in communicable diseases by the failure of those with HIV and other communicable diseases to seek medical intervention, would outweigh the interest in warning one individual, B, of the risk of her contracting what is not a life-threatening condition, but one which can be managed. Accordingly, this Court would put the interests of the community as a whole above the interests of one individual in the context of a condition that would be significant for that individual, but would not in this Court's view amount to very serious harm so as to warrant the breaching of patient confidentiality.

If there is a very serious harm, is there a significant risk of that harm?
117. Even if there was a risk of very serious harm in this case, it is this Court's view that the risk of that harm occurring may in fact be too low to warrant a breach of patient confidentiality.

118. Although this issue does somewhat overlap with the issue of whether there is an 'innocent third party' at risk in the particular circumstances of this case (since the risk of infection can be reduced or almost eliminated by B ensuring that condoms are used), it is this Court's view that a significant risk of harm is not present in the current case. This is because medical evidence was provided to the Court that the risk of contracting HIV from each time a person has unprotected sex is in the region of 0.04%. In addition, in her oral evidence to the Court, D stated that the risk of transmission of HIV can be prevented by the consistent use of condoms by up to 99.9% if A does not have a detectable viral load. In this regard, B was tested for his detectable viral load on five occasions in 2017 and on each of the five occasions he did not have a detectable viral load which D regarded as "*reassuring*".

119. When weighing up the public interest of maintaining patient confidentiality against the interest of protecting a person in B's position, it is this Court's view that it would put the public interest (in the sense, *inter alia*, of the interests of the community in ensuring that there is no disincentive to people with communicable diseases seeking medical assistance) above the interests of one individual, where the risk to that individual of being harmed is in range of 0.04%, which risk can itself be reduced by up to 99.9% by the use of condoms (although if A had a viral load, it seems that the reduction in risk by using a condom would be closer to 80%).

No absence of concern for B's welfare
120. It is important to note that the foregoing conclusions are not based on a rejection of the laudable concerns on the part of the CFA and the doctors involved for B's welfare. While this Court is equally concerned for B's welfare, it must balance that concern with the public interest in ensuring that patients, with any form of serious communicable disease, would continue to have the confidence to seek medical assistance without any concerns that their private medical condition might be revealed to third parties without their consent, except in the most exceptional circumstances, such as were present in the case of *Edgell* where there was a risk of a bomb attack and in the case of *Tarasoff* where there was a stated intention to kill a named individual.

Conclusion
121. It is this Court's conclusion that the circumstances in this case do not justify the breach of patient confidentiality. This Court concludes that the CFA has not established on the balance of probabilities that A is having unprotected sexual intercourse with B.

Indeed, if B was willing to have unprotected sex with A and assume all the risks that are associated with unprotected sex, then it is this Court's view that the risk of HIV infection in such circumstances, being somewhere in the region of 0.04% and the fact that HIV is not a terminal illness, is not such as to justify breaching a patient's right to confidentiality, which should only be breached in exceptional circumstances.

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