Witness Name: Dr Crawford George MacDougall Fernie

Statement No: WITN0450001

Dated: 15 May 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR. CRAWFORD GEORGE MACDOUGALL FERNIE

I, Dr. Crawford George MacDougall Fernie, will say as follows: -

INTRODUCTION

1. I am the current Chair of the UK Caldicott Guardian Council (UKCGC).

2. My professional qualifications relevant to the roles that I currently hold, and the dates that I obtained those qualifications, are as follows:

1977	University of Glasgow: MB ChB
1984	Royal College of General Practitioners: MRCGP
1989	University of Glasgow: DFM (Diploma of Forensic Medicine)
1996	University of Glasgow: MPhil (Law & Ethics in Medicine)
2003	University of Strathclyde: LLB
2004	Royal College of General Practitioners: FRCGP
2006	Faculty of Forensic and Legal Medicine: FFFLM
2011	Royal College of Physicians of Edinburgh: FRCP Edin
2014	Royal College of Physicians of London: FRCP
2024	University of Greater Manchester: LLD (hc)

3. In 2011 I was awarded the BMA Association Medal.

4. Having graduated in medicine from the University of Glasgow, I spent 17 years as a general practitioner and from 1988 also worked as a forensic physician during

which time I became President of the Association of Forensic Physicians and subsequently the inaugural Registrar of the Faculty of Forensic and Legal Medicine, after which I became the 3rd President of the Faculty of Forensic and Legal Medicine. During this period, I chaired the BMA's UK Forensic Medicine Committee for 8 years and at one stage was a member of the BMA Medical Ethics Committee, also contributing advice on ethical issues.

5. In 1996 I joined the Medical and Dental Defence Union of Scotland as a medicolegal adviser, later promoted to Head of Medical Division after which I became a Senior Medico-Legal Adviser at the Medical Protection Society, Edinburgh where I focussed on Republic of Ireland and South African cases.

6. With the advent of reform of death certification review in the UK, in 2013 I was appointed as the first Senior Medical Reviewer for Scotland at Healthcare Improvement Scotland (HIS) which is a statutory role conferred on me by the Certification of Death (Scotland) Act 2011.

7. I had previously contributed to legal and ethical teaching at the University of Glasgow from 1994-2020, latterly as Honorary Senior Lecturer in Clinical Forensic Medicine. Between 2011 and 2013 I delivered both undergraduate and postgraduate lectures in medical law at University College Dublin. By 2023 I was invited to become a Visiting Professor at the Centre for Contemporary Coronial Law (CCCL), University of Greater Manchester where I was later awarded an honorary LLD.

8. During my 17 years as a medicolegal adviser, I would regularly interpret ethical situations for other doctors including on confidentiality so had a familiarity with the

Caldicott principles when they were introduced in 1997. On joining HIS, I became Deputy Caldicott Guardian, later succeeding the Medical Director in this role and became the nominated Scottish representative on the UK Caldicott Guardian Council in 2021. The vacancy for Vice-Chair arose in 2023 where I successfully negotiated a competitive selection process then similarly was appointed Chair of UKCGC in 2025.

9. In terms of my other relevant appointments and memberships, I am the Senior Medical Reviewer and Caldicott Guardian, the Healthcare Improvement Scotland Appraisal Lead for National Services Scotland and Partner Organisations, visiting Professor at the Centre for Contemporary Coronial Law at the University of Greater Manchester and Interim Chair for the Public Benefit and Privacy Panel for Scotland.

10. This witness statement is made to assist the Nottingham Inquiry (the "Inquiry") with matters set out in the Rule 9 Request dated 15 April 2026 (the "Request"), and it relates to the role, functions and decision-making processes of Caldicott Guardians working in health and social care organisations.

THE CALDICOTT PRINCIPLES

11. The Caldicott Principles were introduced in 1997 following a review of how the NHS handled patient information and they constitute a set of good practice guidelines applied widely across the field of health and social care information governance to ensure that people's data is kept safe and used appropriately. The Caldicott Principles were reviewed in 2013 and again in 2020, on both occasions the review

led to a new principle being added. They are now owned and maintained by the National Data Guardian (NDG).

12. The NDG in England was established in 2014 by the Department of Health to advise on the safe use of people's confidential health and care data and to assist in protecting against improper use. In 2018 the Health and Social Care (National Data Guardian) Act 2018 was passed placing the role of the NDG on a statutory basis. Under section 1(2) of that Act, the NDG may publish guidance about the processing of health and adult social care in England. By virtue of section 1(3), a public body exercising functions in relation to the health service and adult care must have regard to any such guidance as must certain other persons exercise health and care services.

13. The Caldicott Principles, along with an indication of applicability can be found on the Governments website. There are 8 Principles;

- Principle 1: Justify the purpose(s) for using confidential information.
- Principle 2: Use confidential information only when it is necessary.
- Principle 3: Use the minimum necessary confidential information.
- Principle 4: Access to confidential information should be on a strict need-to-know basis.
- Principle 5: Everyone with access to confidential information should be aware of their responsibilities.
- Principle 6: Comply with the law.
- Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality.
- Principle 8: Inform patients and service users about how their confidential information is used.

THE ROLE OF THE UKCGC

14. The UKCGC is the national body for Caldicott Guardians. It is not a statutory body. In October 2003, the then NHS Information Authority announced a new national organisation specifically for Caldicott Guardians working in health and social care.

15. Following the announcement, a small group of Caldicott Guardians from health and social care organisations worked on a constitution for the national group. This group launched in 2005 as the UKCGC under the chairmanship of Stephen Hinde, then Caldicott Guardian for BUPA.

16. Initially the UKCGC was sponsored by the National Programme for IT (NPfIT). Subsequently its sponsors were NHS Connecting for Health (CfH) which then became the Health and Social Care Information Centre (HSCIC) which has been known as NHS Digital since 2016. Since 2015, the UKCGC has been under the wing of the National Data Guardian for Health and Social Care (the NDG) and is a sub-committee of the NDG's Panel.

17. The UKCGC provides practical support, resources and networking opportunities for Caldicott Guardians and those fulfilling the Caldicott function within their organisation. The UKCGC is funded by the Office of the National Data Guardian and a secretariat function for the Council is run by its office staff. The UKCGC constitution 2025-28 sets out the aims, principles and governance of the UKCGC. A copy of this constitution is exhibited to this statement (see WITN0450002).

CALDICOTT GUARDIANS

18. Caldicott Guardians are senior people within an organisation who protect the confidentiality of information by considering the ethical and legal aspects of data sharing. They uphold the Caldicott Principles in their organisation, providing leadership and guidance on complex matters to ensure that data is used appropriately and that confidentiality is maintained.

19. It was the case that previously only NHS organisations and local authorities were required to appoint a Caldicott Guardian, but in 2021 the NDG published formal guidance about the appointment, role and responsibilities of Caldicott Guardians. This guidance widened the type and number of organisations expected to have a Caldicott Guardian to include other organisations providing services as part of the publicly funded health service, adult social care or adult carer support pursuant to arrangements with a public body. There are currently more than 38,820 Caldicott Guardians in the UK.

20. No specific training is necessary to undertake this role although it is clearly desirable and UKCGC recommends that any educational provision is by a Caldicott Guardian working in that area of practice where there is an opportunity for interactive discussion. As well as the Government website and 3 e-Learning For Healthcare (eLFH) modules on the UKCGC website (currently being updated), the UKCGC actively promotes various educational events which are free at the point of delivery including, the monthly breakfast club and bite-size evening classes. There is also an annual one-day virtual conference.

21. Requirements for assistance from the UKCGC will vary considerably and will depend on the knowledge, skills and experience of the Caldicott Guardian. In larger Trusts one would hope there would be a deputy as recommended in the checklist for new Caldicott Guardians on the UKCGC website, although, even here, there may be occasions when advice is required and the normal approach would be via the UKCGC portal which can be found via the "Support" link on this website. This gives guidance on when and how to seek advice for Caldicott Guardians who are struggling with a specific information-sharing or confidentiality scenario. They are invited to use our online portal and complete an online form which is acknowledged by the UKCGC within 3 working days of receipt, with an initial response being provided within 20 days of receipt.

22. For time-sensitive and urgent issues Caldicott Guardians are advised to seek advice from their local governance team or data protection officer, or a specialist solicitor. More immediate advice may be available from the Trust's legal advisors or one of the three UK Medical Defence Organisations (MDDUS, MDU and MPS) where I previously worked for two of these providers, all of which offer telephone advice including in the out-of-hours period.

RELEVANT LEGISLATION

23. When providing advice to Caldicott Guardians the UKCGC relies on the following legislation and Guidance;

- The Caldicott Principles (as detailed above).
- The Information Commissioner's Office (ICO) Guidance which can be found on their website (WITN0450003), including its Health Information page and its guide to data protection principles.

- British Medical Association (BMA) Core Ethics Guidance (WITN0450004) and their guide to Access to health records (WITN0450005 and WITN0450006), which again can be accessed via their own website.
- General Medical Council (GMC) guidance "Confidentiality: good practice in handling patient information" (see NUHT0000044) which provides professional standards and can be accessed via their website.
- Data protection legislation, the Access to Medical Reports Act 1998 and the Access to Health Records Act 1990.
- UK General Data Protection Regulation (UK GDPR).
- The Data Protection Act 2018.

24. When Caldicott Guardians make decisions about disclosing confidential patient information they also take into account all of the above legislation and guidance, but additionally, in relation to medical practitioners the GMC's Good Medical Practice guidance (NUHT0000045) is also applicable. This indicates an expectation that doctors have knowledge of relevant statute and caselaw. At page 8 there is guidance on "*Being competent*" and it lists 5 points;

    1. *You must be competent in all aspects of your work including, where applicable, formal leadership or management roles, research and teaching.*
    2. *You must recognise and work within the limits of your competence. You must only practise under the level of supervision appropriate to your role, knowledge, skills and training, and the task you're carrying out.*
    3. *You must keep up to date with guidelines and developments that affect your work.*
    4. *You must follow the law, our guidance on professional standards, and other regulations relevant to your work.*

5. *You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.*

25. I have been asked to comment in the context of mental health services, and patients who are being assessed or treated in an inpatient ward or in the community and who have declined clinically indicated mental health treatment when clinicians are concerned that the patient poses a risk to the public. In relation to whether clinicians can in these circumstances inform third parties such as the police, probation, family or potential victims of violence, there is normally an expectation that clinicians will respect confidentiality which is an ethical duty dating back to 5th century BC in the Hippocratic Oath and which is still acknowledged by graduands at medical school.

26. The GMC guidance (NUHT0000044) makes clear at paragraph 9 that "*Confidentiality is an important ethical and legal duty but it is not absolute. You may disclose personal information without breaching duties of confidentiality when any of the following circumstances applies*". There are 5 bases for releasing personal information and 9 e indicates that this is possible if "*The disclosure can be justified in the public interest (see paragraphs 22 - 23)*". There are certain caveats to this at paragraph 10 and at UKCGC we would also advise that a Caldicott Guardian systematically works through the Caldicott Principles which go somewhat beyond the GMC requirements.

27. A further important part of the process which we similarly recommend to Caldicott Guardians is included at paragraph 11 "*When you are satisfied that information*

should be disclosed, you should act promptly to disclose all relevant information. You should keep a record of your decision and actions.".

28. In previous iterations of this document, the GMC has specified that if a public interest disclosure is required this should be done promptly and to an appropriate agency, (see WITN0450007).

29. Paragraph 12 of the GMC guidance outlines the normal policy a doctor is expected to adopt when making this type of disclosure "*You should tell patients about disclosures you make that they would not reasonably expect, or check they have received information about such disclosures, unless that is not practicable or would undermine the purpose of the disclosure – for example, by prejudicing the prevention, detection or prosecution of serious crime*".

30. There are certain limited legislative circumstances when a statutory disclosure is required i.e. GMC obligatory guidance. Paragraph 61 of the GMC guidance "Legal requirements to disclose information for public protection purposes" states "*Some laws require disclosure of patient information for purposes such as the notification of infectious diseases and the prevention of terrorism. You must disclose information if it is required by law, including by the courts (see paragraphs 87 - 94).*".

31. In relation to disclosure required by statute, Paragraph 87 of the GMC guidance states "*There are a large number of laws that require disclosure of patient information – for purposes as diverse as the notification of infectious diseases, the provision of health and social care services, the prevention of terrorism and the investigation of road accidents.*". In doing so there are particular precautions

one should take which are laid out in paragraph 88 which states "*You must disclose information if it is required by law. You should a. satisfy yourself that personal information is needed, and the disclosure is required by law b. only disclose information relevant to the request, and only in the way required by the law c. tell patients about such disclosures whenever practicable, unless it would undermine the purpose of the disclosure to do so d. abide by patient objections where there is provision to do so.*".

32. In addition to terrorism, public health notification with infectious diseases, identifying drivers after road traffic accidents and female genital mutilation, there are few obligatory circumstances when disclosure is required but the regulatory advice is permissive inasmuch as if a failure to release information could result in death or serious harm then a doctor is expected to release that information. Indeed, in certain situations such as child protection where the best interests of the child are paramount, the anticipation is that if you do not make a necessary disclosure then it would be required to justify why you have not done so.

33. The medical regulator then goes on to outline when it is appropriate to release information and the individual has not agreed to this. Under the subheading "*Disclosures in the public interest*" and at paragraph 22 of the GMC guidance it states "Confidential *medical care is recognised in law as being in the public interest. The fact that people are encouraged to seek advice and treatment benefits society as a whole as well as the individual. But there can be a public interest in disclosing information if the benefits to an individual or society outweigh both the public and the patient's interest in keeping the information confidential. For example, disclosure may be justified to protect individuals or*

society from risks of serious harm, such as from serious communicable diseases or serious crime. You can find guidance on disclosing information in the public interest to prevent death or serious harm in paragraphs 63 - 70.".

34. The following paragraph of the guidance (NUHT0000044), paragraph 23 goes on to advise "*There may also be circumstances in which disclosing personal information without consent is justified in the public interest for important public benefits, other than to prevent death or serious harm, if there is no reasonably practicable alternative to using personal information. The circumstances in which the public interest would justify such disclosures are uncertain, however, so you should seek the advice of a Caldicott or data guardian or a legal adviser who is not directly connected with the use for which the disclosure is being considered before making the disclosure. You can find further guidance in paragraphs 106 - 112.*".

35. The GMC describes a balancing act between the right to privacy of an individual and where this may be overridden which is the issue in question in this particular case using the serious harm threshold.

36. There is no specific guidance produced or relied on by the UKCGC in this context, however the 7th Caldicott Principle makes clear;

Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality *Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.*

MULTI-AGENCY INFORMATION SHARING

37. I have been asked to consider and set out the circumstances when, in the absence of obtaining specific consent from the patient, it may be in the public interest for a clinician to disclose confidential patient information to the police and/or social services.

38. There is an important distinction between information sharing and public interest disclosure especially in a scenario where there is a degree of urgency. Generally accepted understanding is that there will be specific situations where there is justification for information to an *appropriate* agency with this being done in a timely fashion.

39. In relation to patients that have been admitted involuntarily under sections 2 or 3 of the Mental Health Act 1983 ("MHAA") to a general psychiatry inpatient ward, being admitted involuntarily should not affect the right to privacy and, indeed, whilst under section there would not be the immediate risk that might normally allow disclosure to prevent death or serious harm or prevention or detection of a serious crime.

40. In relation to situations where the patient has withdrawn consent to share information with their designated nearest relative and/or carer, a consideration as to why this position has changed may be relevant but the GMC guidance "Confidentiality: good practice in handling patient information" (NUHT0000044) at paragraph 46 reminds "*You might need to share personal information with a*

patient's relatives, friends or carers to enable you to assess the overall benefit to the patient. But that does not mean they have a general right of access to the patient's records or to be given irrelevant information about, for example, the patient's past healthcare.".

41. Also of relevance is paragraph 30 of the GMC guidance which relates to patients' objections to sharing information for their own care, "*If a patient objects to particular personal information being shared for their own care, you should not disclose the information unless it would be justified in the public interest, or is of overall benefit to a patient who lacks the capacity to make the decision. You can find further guidance on disclosures of information about adults who lack capacity to consent in paragraphs 41 - 49*." Further, at paragraph 31 of the guidance, "Y*ou should explain to the patient the potential consequences of a decision not to allow personal information to be shared with others who are providing their care. You should also consider with the patient whether any compromise can be reached. If, after discussion, a patient who has capacity to make the decision still objects to the disclosure of personal information that you are convinced is essential to provide safe care, you should explain that you cannot refer them or otherwise arrange for their treatment without also disclosing that information*.".

42. In relation to patients that have a known history of violence and aggression while acutely unwell, this issue should be factored into the threshold considerations.

43. If the clinician has reason to believe that the patient is likely to disengage from treatment following discharge from inpatient treatment, compliance is not an all or

nothing phenomenon and the likelihood to disengage is something I would expect to be incorporated into risk assessment prior to discharge and release from care may be conditional on [appropriate] information circumstances in that particular case.

44. I have been asked to consider whether my answers above would be different if the patient was admitted involuntarily under sections 2 or 3 of the MHAA to a forensic psychiatry ward. Firstly it is likely that there will be an explanation by the psychiatrist at the beginning of any consultation as to their role and the possibility of sharing information as the duty of confidentiality is not absolute and there might be situations when a limited amount of confidential information has to be released in addition to any formal report for court purposes. By virtue of any involvement within the criminal justice system, one would anticipate there would be heightened consideration of these issues because of the possible consequences.

45. I have also been asked to consider and set out the circumstances when, in the absence of obtaining specific consent from the patient, it may be in the public interest for a clinician to disclose confidential patient information to the police and/social services. If a patient is under the care of a community mental health team then again, appropriate information sharing should take place by initially discussing the benefits of this with the patient but also, potentially, explaining there may be situations when it may be necessary to disclose even if they object.

46. In relation to patients that have withdrawn consent to share information with their designated nearest relative and/or carer this would very much depend on the circumstances of that individual case and any risk of harm directed to them specifically.

47. Consideration of the *Tarasoff* doctrine may also be relevant here. This is a legal principle in US caselaw that says mental health professionals have a duty to warn or protect identifiable third parties if a patient poses a serious risk of violence towards them.

48. Although the *Tarasoff* doctrine may be factored in when contemplating the need for a disclosure there probably remains consensus amongst observers as commented upon in 2003 by the likely response to a *Tarasoff*-type case in the UK, Sheila McLean (the first International Bar Association Professor of Law and Ethics in Medicine who was influential in the teaching of these subjects) and JK Mason (a leading authority on medical law and ethics in the UK) have suggested that '*the probability is that there would be no legal obligation to warn the person at risk but that, should the doctor do so, the breach of confidentiality would be regarded as justified*' (Legal and Ethical Aspects of Healthcare-Cambridge University Press; Publication date: 24 August 2009; ISBN: 9780511545542 Chapter 3 p41, see WITN0450008). In short, both warning and not warning would be within the bounds of acceptable conduct, which leaves doctors with difficult judgements to make.

49. On mentioning *Tarasoff*, I usually compare this with the UK case of W v Egdell [1990] which was a Court of Appeal decision involving an appropriate disclosure to a relevant authority i.e. the hospital and Secretary of State as opposed to a more public utterance.

50. When teaching Caldicott Guardians in interpreting confidentiality, I have often remarked that I would prefer to defend a public interest disclosure with the proviso

of following the Caldicott Principles than fail to do this with consequent harm to an individual.

51. In relation to patients that have disengaged from treatment this would hang on the facts of a particular case. One would need to think about why the patient has disengaged and any existing or continuing risk to themselves and others with this aspect being within the remit of a psychiatrist who is very likely to have experience of that scenario.

52. If the clinician is considering discharging the patient from the care of the community mental health team Again, this would be an aspect of care familiar to a psychiatrist, part of which would involve a risk assessment with any release of information with or without their consent dependent on that.

53. In situations where the clinician has reason to believe that the patient will relapse and become acutely unwell, a precondition to discharge could be information sharing, (for example the place of residence if being released to a home environment), and the patient would need to remain an inpatient until this is sorted out.

54. In relation to the disclosure of information to a patient's family members, nearest relatives, victims of crime and other third parties, it is difficult to see practically how this could be done without going via the police. In UK law it is unlikely there is a requirement for a doctor to warn that individual person at risk. Even in the United States, there was recognition in Justice Clark's dissenting judgment in *Tarasoff* that "*by imposing a duty to warn, the majority contributes to the danger to society of violence by the mentally ill*".

55. I have been asked to consider when it may be in the public interest for a clinician to disclose confidential patient information to a patient's nearest relative or family, or to the patient's university. In both cases, you would need to ask to what end, what would be the specific purpose. To the best of my knowledge UKCGC has not advised this as an option and one would also have to be cautious not to cause unnecessary fear and alarm.

56. Paragraphs 10.20 and 10.21 of the Mental Health Act Code of Practice (DHSC0000007) contain the gold standard when it comes to the sharing of information by professionals to victims of mentally disordered offender patients, and although one would wish to encourage information sharing this should be a free and informed decision on behalf of the patient and not coercive nor conditional.

57. Where a patient has a history of assaulting others in places connected to their university of workplace whilst acutely unwell, if they have absconded from their place of detention then a prompt disclosure to an appropriate agency such as the police would be justified and, indeed, expected but if there is sufficient concern as to the possibility of this then it suggests that they should not be discharged at that time.

RECOMMENDATIONS

58. It is important to make it clear that I have not been privy to all of the facts and evidence in this tragic case. However, doing my best to assist the Inquiry, and based upon what I do know about these incidents, I would suggest that in the future

there should be greater use of Caldicott Guardians by Trusts so that there is ready availability of advice when a public interest disclosure is being actively considered. We should also ensure that Caldicott Guardians address their educational needs within any professional appraisal process by engaging in relevant CPD.

59. In terms of any improvements that could be made locally or nationally to multi-agency working I would recommend that more work be done to encourage understanding of respecting confidentiality, but also to improve knowledge of information sharing in a lawful, ethical and appropriate manner which maintains public confidence so that there remains a willingness to share information between clinicians and patients to the overall benefit of society.

60. I hope this statement assists the Inquiry in answering those questions set out in the Rule 9 Request.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 15 May 2026

Witness Name: Dr Crawford George MacDougall

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THE NOTTINGHAM INQUIRY

INDEX to First Witness Statement of Dr Crawford George MacDougall

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No.	Inquiry URN	Document Description
1	WITN0450002	UKCGC Constitution 2025-2028
2	WITN0450003	Information Commissioner Officer's Health Information [website]
3	WITN0450004	British Medical Association Core Ethics Guidance, dated February 2025
4	WITN0450005	British Medical Association Access to Health Records, dated September 2024
5	WITN0450006	British Medical Association Access to Health Records, dated May 2018
6	NUHT0000044	General Medical Council guidance, "Confidentiality: good practice in handling patient information"
7	NUHT0000045	General Medical Council guidance, "Good Medical Practice"
8	WITN0450007	General Medical Council guidance, "Confidentiality: Protecting and Providing Information" dated April 2004
9	WITN0450008	Legal and Ethical Aspects of Healthcare, Cambridge University Press, Chapter 3
10	DHSC0000007	Mental Health Act 1983: Code of Practice