The privilege against self-incrimination and the Duty of Candour (A UK perspective)

written by Imogen Hildred | 15 April 2016

1. Commentators have asked about the legal consequences of a health service body or other registered person under the Regulated Activities Regulations 2014 providing a notification of a patient safety incident under Regulation 20 (2) upon information provided by an individual doctor.

Would that material be admissible against the individual doctor in (say) some later criminal prosecution in relation to the same event?

2. This raises the correlated issues as to whether:

(a) The right against self incrimination is infringed under UK domestic law

(b) The Regulations would violate Article 6 of the European Convention (dealt with separately)

3. On the topic of whether legal professional privilege is maintained, this must be so a doctor can seek advice with impunity (see *R v Derby Magistrates Court exp B* [1996] AC 487).

4. This however leaves unanswered how the doctor should comply with his/her employer/provider's request for information and his own ethical duty under Good Medical Practice (GMC) to provide an honest explanation as to what has occurred in the course of treatment. It will already be noted that the 2014 Regulations impose the duty to provide the notification of a patient safety incident on the registered person/provider. The Regulations do not impose this duty directly upon the individual doctor.

Background to the privilege against self-incrimination

5. This privilege is "*deep rooted*" in English Law (See *Lam Chi-Ming v R* [1991] 2 AC 212 at [22]). The privilege contains two elements :

(i) The right to silence

(ii) The privilege to protect all citizens from being compelled to condemn themselves

The former is more about immunity. The latter will usually invoke issues as to the admissibility of evidence and the right to claim privilege. Historically, the protection under (ii) was aimed more often than not against involuntary confessions (see *R v Director of Serious Fraud Squad exp Smith* [1993] AC 1 at 42 H, a case involving the legitimacy of requiring answers in the investigation of fraud under s. 2 Criminal Justice Act 1967 at a point in time (post-charge) when questions would not normally be permitted in the conventional criminal context).

Immunities under the right to silence

6. It is not sufficient to group these immunities under one head. Each one may be engaged at a different level and the intervention of a statute will need to be construed in the particular context of the motive behind the particular immunity.

7. The six immunities are (some of which have no application here):

> (1) A general immunity possessed by all from being compelled on pain of punishment to answer questions
>
> (2) A general immunity possessed by all persons from being compelled on pain of punishment to answer questions which may incriminate them.
>
> (3) A specific immunity possessed by all persons under suspicion of a crime whilst being interviewed by the police from being compelled on pain of punishment to answer any questions of any kind.
>
> (4) A specific immunity possessed by accused persons undergoing trial from being compelled to give evidence and from being compelled to answer questions from the dock.
>
> (5) A specific immunity possessed by persons who have been charged with a criminal offence from having questions material to the offence addressed to them by police officers or person in authority.
>
> (6) [Immunity against comment for not giving evidence at trial]

These immunities are clearly not absolute. Thus under (1) in our daily lives we may be asked questions concerning civic duties or obligations; to answer electoral enquires, road traffic issues, parking permit details and so on. More intrusive legislature would include the bankruptcy jurisdiction as old as the 16th Century where a person can face an inquisitorial process on pain of punishment. That jurisdiction impinges on immunity (2) as the Regulations here indirectly could be said to be engaged.

"Nevertheless, there is a strong presumption against interpreting a statute as taking away the right of silence at least in some of its forms" -ex parte Smith 40 C-D

Compulsion of the individual?

8. One obstacle facing a practitioner is that it can be said that it is the impact of his/her professional duties (under Good medical practice) and his/her duties to his employer (in contract and under GMC good medical practice) which propel him/her to answer and not the 2014 Regulations. As stated above, there is no compulsory statutory duty on the individual to provide an explanation as to the treatment that has occurred. However, this rather ignores the practical realities of a doctor declining to cooperate in providing information for his/her employer's notification of a safety incident under Regulation 20. Refusal to do so would be most likely to lead to a referral to the GMC, as well as potentially internal disciplinary proceedings with or without interim suspension. Dismissal from the doctor's post would certainly be an option for the employer. For the purposes therefore of this talk, it is assumed that there is for all intents and purposes a practical compulsion exerted by

employers' duty under the regulations upon the individual doctor to provide an explanation.

Privilege against self-incrimination (UK)

9. This concerns whether the person can be compelled to condemn him/herself. This deals more with the admissibility of evidence. As, stated, the right to a privilege not to self incriminate oneself has been stated to be "*deep rooted in English Law*" (see Lord Griffiths in *Lam v Chi-Ming v The Queen* [1991] 2 AC 212 at [222]). However, following on from the UK jurisprudence as to the right to silence, the following points can be noted:

(1) The right is a qualified not absolute right. See *Brown v Stott* [2003] 1 AC 681 (a case involving a police officer requiring a person to say who was driving a car)
(2) Where the legislature overrides it by necessary implication, the statute must be observed.
(3) Where the statute is silent as to whether the evidence should be admissible, then it will depend on the proper construction and purpose of the statute. See *Customs and Excise v Harz* [1967] 1 AC 760 at [816] (legislature permitting commissioners to require answers as to purchase or importation of goods).
(4) The derogation from the fundamental rule should be proportionate.

(a) It should serve a legitimate aim.
(b) The interference with the right should be only be such as is necessarily required to achieve the legitimate aim ; see *R (Daly) v Secretary of State for the Home Department* [2001] 2 AC 53
(c) It should be compatible with Article 6 of the European Convention on Human Rights.

(5) (a) As to c, Article 6 is an absolute right, but there is no express reference in Article 6 to the right to silence or the privilege against self-incrimination,

(b) The approach to take is to ask:
(i) is the right absolute or capable of restriction or modification?
(ii) if it is not absolute, does the restriction serve a legitimate aim in the public interest?
(iii) if so, is there a reasonable relationship of proportionality between the means employed and the aim sought to be realised.

In *Brown v Stott* [2003] AC 681, a Scottish motorist was required to answer who was driving a vehicle (in circumstances where a suspicion of a crime had been entertained) and was subsequently convicted of drink/driving offence following the admission. The relevant statute, of the Road Traffic Act 1988 had required the person to answer.

(1) The intrusion related to a single question and was therefore modest.
(2) There are evidential safeguards [eg of PACE 1978]
(3) Danger on the roads is an important social issue
(4) The rights of other road users was relevant.

Regulated activities (duty of candour)

10. Taken at its highest, the Regulations require a registered person/provider to give a notification of a safety incident based upon information gleaned in most cases from a practitioner or practitioner(s) with the consequences that

(i) the practitioner may incriminate himself or
(ii) expose himself to other potential criminal enquiries.

Albeit that the route is more tortuous than (say) in a coronial inquiry, there is scope to say that the practitioner may find his claim to privilege eroded.

Is the erosion of any privilege by Regulation 20 legitimate?

11. (1) The doctor's ethical duty is to inform the patient. There is therefore a strong moral argument for the privilege to be restricted; morality in the law of doctor/patient relationships is a substantive force (see C*hester v Afshar* [2005] AC 134).
(2) The Regulations clearly have in mind the service user's rights to know what has happened.
(3) The disclosure of all the relevant facts under Regulation 20 to the relevant person would serve a useful social model for appropriate medical care.
(4) The disclosure of all the facts would not be disproportionate given the need to piece together all the medical evidence.
(5) The compulsion against the registered user under which such information is sought (a fine of £1,250) is modest.
(6) There has always been an ethical incongruence between candour before treatment and reticence after.
(7) The public interest is served in the monitoring of doctors' performances.

Is it proportionate?

12. (1) See above at paragraph 11.
(2) Any admission to some other offence would be subject to s. 78 of PACE 1984 for its admissibility at trial.
(3) The gain to the service user can be enormous (see the *Mid Staffs Report: impact on the Moore-Robinson family)*.

Under UK domestic law, it would seem that the Regulated Activities Regulations 2014 would be endorsed. The indirect impact on doctors would potentially expose them to providing explanations which might later be used in subsequent criminal proceedings. Claiming that this undermines the right against self-incrimination would seem unlikely to succeed.