Faculty of Forensic & Legal Medicine

Consent from patients who may have been seriously assaulted

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Introduction

A Forensic Physician (FP) has a responsibility to consider the issue of consent before undertaking an examination of a patient who may have been seriously assaulted. In the majority of cases, the examination will have both therapeutic and forensic components, for example treating an injury as well as documenting it in detail for the purposes of a subsequent medico-legal statement.

The General Medical Council (GMC) *'requires doctors to be satisfied that they have consent from a patient, or other valid authority, before undertaking any examination or investigation, providing treatment, or involving patients in teaching and research.'* Doctors are expected to follow the detailed guidance on consent produced by the GMC.[1] Failure to obtain consent for an examination, '*whatever the motive, may constitute an assault for which the practitioner may incur liability for damages in the law of tort*', *or may even constitute an offence in criminal law'*.[2] Alternatively, the patient (or their representative) may lodge a complaint with the GMC. However, there are certain provisions in law, for example, taking blood samples from *incapacitated drivers*.

The approach to consent from patients has changed over the years and been subject to review and influenced by the Courts, through for example, the Montgomery Judgement in 2015.[3] The GMC has undertaken a review of its consent guidance, and at the time of writing, its draft guidance on Consent is out for consultation.[4]

Since clinical forensic practice is undertaken by different disciplines, the same principles will apply to nurses and paramedics, who will refer to their own regulatory body's guidance/codes of practice, from the Nursing and Midwifery Council (NMC) and Health Care Professions Council (HCPC), respectively. Thus, the remainder of this document uses the term forensic clinician, to include doctors, nurses and paramedics. Nevertheless, it is essential that in such circumstances the clinician should be appropriately knowledgeable and skilled, and so they must always consider whether an examination or procedure is within their capability and competence.

In England and Wales, the *Mental Capacity Act, 2005*, applies to those over the age of 16 years, and states: *'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'*[5]

All clinicians must work in accordance with the five statutory principles of the Mental Capacity Act 2005,[5] (also detailed in the Code of Practice,[6]) and the *Adults with Incapacity Act 2000 (Scotland)*. These are:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Thus, there is a 'presumption of capacity'. Moreover, a person's capacity to make a decision depends on being able to understand and retain relevant information; they must then be able to consider that information as part of the decision-making process and communicate their decision. Therefore, a lack of capacity may:

- affect the ability to make some decisions, but not others, and/or
- be permanent or temporary, and/or
- fluctuate over time

At the time of writing, the Mental Capacity Act (Amendment) Bill is before parliament; it primarily addresses procedures for Deprivation of Liberty.

See below regarding the legislation in Northern Ireland and Scotland.

These guidelines offer advice to forensic clinicians who are asked to see a person, who may have been seriously physically or sexually assaulted, but lacks capacity to consent to a forensic medical examination. A delay in obtaining the relevant forensic evidence (for example forensic samples and the documentation of the presence or absence of injuries) could lead to a loss of information that might have assisted with the medical care and any criminal justice process. In these circumstances, the forensic clinician has a responsibility to give due consideration to proceeding (or not) with a forensic medical examination without the consent of the patient. Such decisions will only be justifiable where there is strong supporting evidence that the patient has been seriously physically or sexually assaulted and that the examination is deemed to be in the best interests of that patient. Best interests are not confined to medical interests but encompass emotional, social and welfare considerations; please see the final paragraph regarding decisions made in the 'public interest'.

The forensic clinician should approach this as a two-stage process, firstly whether or not to proceed with an examination and if they do, then, secondly make a decision what to do with the information and samples obtained: securely store or release them to police. If the forensic clinician decides not to proceed with the examination, they must make a plan to keep that decision under review.

The forensic clinician must be aware of the possible consequences should the patient regain capacity and disagree with the decision made, even when it was thought to be in the patient's best interests. The patient might:

- **disagree, but accept the decision (whether an examination was undertaken or not)**
- **complain to the clinician's employer, and/or**
- **complain to the clinician's regulatory body, and/or**
- **make a complaint to the police of 'assault', (if an examination took place), and/or**
- **seek redress in the civil courts, and/or**
- **speak to the media**

Adults who lack capacity

An adult (over 16 years) should not be considered to lack capacity unless:

- They have an impairment (temporary or permanent) of the mind or brain, or there is some sort of disturbance affecting the way their mind or brain works and;
- That impairment or disturbance means that the person is unable to make the decision in question at the time it needs to be made.[5]

Section 4 of the MCA, 2005,[5] requires the decision-maker to consider:

- Whether the individual concerned is likely to regain the capacity to make that particular decision in the future, and;
- If so, when that is likely to be.

Temporary loss of capacity due to intoxication

Patients who are intoxicated due to alcohol or drugs may temporarily lose their capacity. In such circumstances, the forensic assessment should normally be deferred until the patient's capacity has returned. The period for the deferment will depend on the type, time, amount and quantity of the substances that have been consumed. It may be necessary to assess the patient repeatedly within a given period to determine if the patient's capacity has returned. Consideration must be given to the immediate therapeutic needs of the patient and where and by whom these might be provided. It is essential that this is supported by good records and handover between clinicians, as well as good communication with police, and where, relevant a hospital or other clinician responsible for the patient's care. The forensic clinician may wish to remind police to consider obtaining early evidence particularly where there is a suspicion of drug facilitated sexual assault.

Special consideration should be given to patients with chronic substance misuse, such as those with alcohol dependency, where capacity may be impaired if they are completely drug free.

Serious injury

On occasions, patients are seriously injured during a physical or sexual assault and the ensuing injuries may result in loss of capacity (for example where the patient is unconscious).

In such circumstances it is often impossible to predict the likely duration of this incapacity. A mental capacity checklist may assist in the decision-making process, to ensure that all relevant considerations are addressed, as well as ensuring a good record of how a decision was made. There is also guidance on the general principles of and approach to consent contained within the Department of Health publication.[7]

If the clinician confirms that the patient lacks capacity to consent and believes this incapacity will persist for a considerable time, the forensic medical examination may be undertaken if the clinician considers that it is in the best interests of the patient. In these circumstances the clinician should:

1. Consider what therapeutic care the patient might require, and discuss this with the consultant; for example, this might include vaccinations, or for someone who may have been seriously sexually assaulted, emergency contraception, or post-exposure prophylaxis against HIV.
2. Inform the consultant who is responsible for the medical care of the patient of the nature and purpose of the proposed examination to ensure that they have no objections to it being undertaken; or if there are objections, whether it is possible to undertake a limited examination, for example where a patient who has a spinal fracture and must not be turned/moved. This may involve several conversations, recognising that capacity may fluctuate and a planned clinical intervention e.g. extubating a patient who is being ventilated, may not take place as planned. As noted above, excellent documentation, dialogue and handover between forensic and the hospital clinicians, particularly at the time of staff changeover is essential, including contact details.
3. Consider speaking to people close to the patient** about the nature and purpose of the proposed examination, in order to determine the person's past and present wishes or feelings, beliefs and values so that these can be taken into account.[5,6,7]
4. Consider obtaining the views of other people** who are close to the patient as well as, if relevant, the views of an attorney or deputy.[5,6,7] Where the patient is an adult (over 18 years), a family member is not able to consent or refuse on the patient's behalf unless they are an attorney appointed by the patient under a pre-existing Lasting Power of Attorney.
5. Document all of the above steps clearly in the medical records, and record why the forensic clinician believes the patient lacks capacity, and the specific decision is in the patient's best interests.
6. Consider seeking advice from their Trust/employer's legal department and/or the lead for Mental Capacity/ Adult Safeguarding, and/or their medical defence organisation. They should consult a senior, appropriately qualified and experienced FP for advice. However, ultimately it is the forensic clinician who is responsible and accountable for their decision whether to undertake the examination, or not.
7. Ensure, as far as is possible, there is discussion after the examination with the responsible consultant or clinician, and a record of the visit is in the patient's notes, along with any recommendations, for example, further therapeutic measures or advice regarding follow up care. The forensic clinician's contact details should also be provided.
8. Ensure that the patient is informed what has been done, and why, as soon as the patient is sufficiently recovered to understand. Ideally, this is the responsibility of the forensic clinician undertaking the examination, but it may have to be undertaken by the duty forensic clinician. However, it may have to be undertaken by police or the clinical staff.

Mental disorder

Whenever possible, when asked to examine a patient with a mental disorder, the assessment of that person's capacity to consent to the forensic medical examination should involve other relevant health professionals. If it is confirmed that the patient lacks capacity to consent, the forensic medical examination may only be undertaken if the forensic clinician considers that it is in the best interests of the patient.

In these circumstances the forensic clinician should adopt the approach as outlined above, and may also consider:

- having a family member or carer (or a responsible adult), who, ideally, knows the patient well, present during the examination in order to facilitate communication. If the patient does not accept or objects to the examination, it must be stopped.
- As before, when possible, ensure that the patient is informed what has been done, and why, as soon as the patient is sufficiently recovered to understand.

Northern Ireland

Although the *Mental Capacity Act (Northern Ireland)*, received Royal Assent in May 2016, it has not been enacted in its entirety, and may not be, until 2020. It applies to those aged 16 years and over. Although its contents are seen as best practice, forensic clinicians should regularly check the progress of its enactment, including the progress of The Mental Capacity (Suitably Qualified Person) Regulations (Northern Ireland) 2017, which are currently in draft form.

Scotland

The *Adults with Incapacity (Scotland) Act, 2000*, applies to those aged 16 years and over. Many of its principles are echoed in the MCA, 2005. Medical treatment decisions are covered in section 5. As part of the information gathering process, the clinician should establish whether there is a certificate of incapacity (under s47), which allows practitioners to carry out treatment, under part 5 of the Act. Such a certificate specifies the period of time which it covers.

Children

FPs should be familiar with the GMC publication: *0-18 years: guidance for doctors* (2007).[8]

The *Family Law Reform Act, 1969*, (s8), allows persons aged 16 years or over to give informed consent to surgical or dental treatment. Although there is no decided legal authority it is presumed that this applies to examinations and assessments undertaken for forensic purposes.

The Law Lords have determined that 'the ability of a child under the age of 16 to make his own medical decisions is evaluated according to chronological age, considered in conjunction with the child's mental and emotional maturity, intelligence and comprehension'[9], this concept is known colloquially as Gillick competence.

If the child/young person (under 18 years) lacks competence to consent to the forensic assessment, then consent is required from a person who holds parental responsibility for the child/young person.

If there is no one with parental responsibility available then there are a number of possible alternatives, namely:

1. The local authority may use the Children Act, 1989 to seek a court order to give them parental responsibility for the child (e.g. an Emergency Protection Order or Section 31 of the Children Act).
2. A relative or other person may seek a residence order and parental responsibility for the child or any person may seek a specific issue order with the leave of the Court.
3. There is the provision under Section 3(5) of the *Children Act, 1989* for:

   'A person who –

   a. does not have parental responsibility for a particular child; but

   b. has care of the child to do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'.

However, lawyers advise caution with regard to using this section of the Act when the case is not urgent.

In all cases where the examination is carried out under the auspices of a court order the doctor should ask to see a copy of the order before conducting the assessment. This is because the order can contain details regarding the place and time of an examination, the person(s) to be present, the person(s) to conduct the examination, and the person(s) or authorities to whom the results should be given.

'In England, Wales and Northern Ireland the law on parents overriding young people's competent refusal is complex' and the General Medical Council advises doctors to 'seek legal advice if they think that treatment is in the best interests of a competent young person who refuses'.[8]

In practice it would be very difficult to undertake a forensic assessment without the co-operation of the child/young person and the Faculty of Forensic & Legal Medicine does not support the use of sedation to ensure compliance unless there are concurrent medical needs which require an examination under anaesthetic/sedation.

Doctors must always act in the best interests of the child and they cannot be compelled, by a parent, court or other person, to undertake an examination.

Northern Ireland

As noted, the Mental Capacity Act (Northern Ireland), 2016, applies to those aged 16 years and over. Article 2 of the *Children (Northern Ireland) Order 1995*, states that a child *'...means a person under the age of 18'*. As described above, if a young person is deemed 'Gillick' competent, even if under the age of 16 years, they can consent to treatment. A parent (or someone with parental responsibility) cannot overrule such a decision, but can do so if a child refuses treatment. A Court can overrule a child or young person's refusal.

Scotland

Here, legislation has gone somewhat beyond Gillick; the Age of Legal Capacity (Scotland) Act 1991, clearly states in section 2(4) that children under the age of 16 have legal capacity to consent to any surgical, medical or dental treatment or procedure so long as that child is capable of understanding the nature and consequences of the proposed treatment or procedure.

Importantly, this section protects the child's rights to refuse examination or treatment (presuming he has capacity under the legislation), even when a Sheriff's warrant has been granted or a children's hearing makes a supervision requirement that the child submits to such an examination or treatment.

Under section 55 of the *Children (Scotland) Act 1995*, there is provision for a Child Assessment Order (CAO) to determine whether the local authority's suspicion of abuse or neglect is justified. This may be used, for example, to authorise the medical examination of the child in the face of parental opposition. However, the 1995 Act preserves the right of a child to consent to medication examination (s.90). Thus, as stated above, the wishes of a child who has the capacity to refuse cannot be overridden.

Release of information and forensic samples to police

Following a forensic medical examination of a person who lacks capacity the forensic clinician will need to consider whether to release details of the examination findings to the police or other appropriate agencies (e.g. social services). In addition, they will also need to decide if they are going to give the samples to the police for analysis or store them securely (normally only possible in Sexual Assault Referral Centres) until the patient is able to consent to their release for analysis, or the police obtain a court order compelling the forensic clinician to release the samples. Again, each decision will need to be made on a case-by-case basis and the forensic clinician must be prepared to justify their decisions. Although all clinicians owe their patients a duty of confidence, they can disclose information to appropriate persons or authorities in the public interest, if the benefits which are likely to arise from the release of information outweigh the patient's interest in keeping the information confidential and society's interest in maintaining trust between doctors and patients.

The GMC updated its guidance on Confidentiality in 2017.[10] It contains several references to disclosures in relation to 'crime', and it behoves all FPs to study this carefully; *'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.'*[10]

The guidance further states: *'Such a situation might arise, for example, if a disclosure would be likely to be necessary for the prevention, detection or prosecution of serious crime, especially crimes against the person. When victims of violence refuse police assistance, disclosure may still be justified if others remain at risk, for example from someone who is prepared to use weapons, or from domestic violence when children or others may be at risk'*.[10]

The GMC has a useful flowchart developed in conjunction with the 2017 guidance on confidentiality.

References

1. General Medical Council
Consent: patients and doctors making decisions together (June 2008), London
2. Mitchels B, Prince A (1992).
The Children Act and Medical Practice. Family Law
3. *Montgomery v Lanarkshire Health Board (Scotland)* [2015] UKSC 11
4. General Medical Council
Decision making and consent. Supporting patient choices about health and care Draft 2018
5. *Mental Capacity Act, 2005*
6. *Mental Capacity Act 2005 Code of Practice* 2007
7. Department of Health (DH)
Reference guide to consent for examination or treatment (2009). DH, London.
8. General Medical Council
0-18 years: guidance for all doctors (2007)
9. *Gillick v West Norfolk and Wisbech Area Health Authority and Another* (1986) AC 112, [1986] 1 FLR 224
10. General Medical Council
Confidentiality: good practice in handling patient information (2017), London

Useful resources

Rogers JE, Odell MS, Schreiber JR
Sexual Assault Examination of the Unconscious Patient: A Legal, Ethical and Professional Grey-area for the Forensic Physician
JLM. 2018; 26 (1): 265-72

British Medical Association (BMA)
employment/ethics/mental-capacity

Department of Health (DH)
Consent form 4

Mental Capacity Act Resources

Church M, Watts S.
Assessment of mental capacity: a flow chart guide
Psychiatric Bulletin 2007, 31:304-307

Northern Ireland: Harper C, et al
No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016
International Journal of Mental Health and Capacity Law, 2016

Scotland: Adults with Incapacity Act Guide

* Law of delict in Scotland

** The clinician must be mindful that it in some cases, it may be a member of the family or 'close' friend who is the perpetrator. In other cases there may be sensitive information about an incident which the patient would not wish to be disclosed to friends and/or family. Therefore, the clinician must decide whether it is in the patient's best interests to speak to the available family etc.

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