Consent to Treatment Policy for the Western Australian Health System

Department of Health 2009
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If you have a legal problem you should seek legal advice tailored to your specific circumstance from the Legal and Legislative Services Directorate of the Department of Health Western Australia (or the State Solicitor’s Office in the case of teaching hospitals only) before acting or relying on any of the legal information in this policy.

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Consent to Treatment Policy for the Western Australian Health System

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Foreword

In October 2000, the Department of Health issued guidelines on consent to treatment and disclosure of material risks. To assist health practitioners meet their obligations under the 2000 guidelines, the Department of Health also developed, in conjunction with specialists, procedure-specific consent forms for the most commonly performed procedures in public hospitals and made them available for use throughout the State.

Following feedback from health practitioners across the WA health system the Western Australian Council for Safety and Quality in Health Care (the Council) established the Informed Consent Advisory Committee in late 2004 (the Committee). The Committee, whose members are listed in the acknowledgements page, reviewed the 2000 Guidelines and made a number of recommendations to assist health practitioners comply with the consent process.

In November 2005, the Committee’s report and recommendations were forwarded to Dr Neale Fong, Director General of the Department of Health, for his consideration and endorsement. The Director General endorsed the Committee’s report and recommendations and tasked the Department of Health’s Office of Safety and Quality in Healthcare with implementation. The first edition of the Consent to Treatment Policy for the Western Australian Health System (Consent Policy) was released in October 2006.

On behalf of the Council and the Department of Health, I am delighted to present to you the second edition of the Consent Policy. This Consent Policy will continue to be used with the suite of procedure-specific information sheets available for use by clinicians for consumers in the WA public health system.

I look forward to working in partnership with consumers, clinicians and health service managers to ensure that this Consent Policy is fully implemented across the WA public health system.

In conclusion, I wish to personally acknowledge the input of all those who have contributed to the development of this policy.

Professor Bryant Stokes AM RFD

CHAIRMAN
WA COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

May 2009
# Consent to Treatment Policy for the Western Australian Health System

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*NOTE:* This Consent Policy may be updated at regular intervals. For the latest version of this document, please visit the Office of Safety and Quality in Healthcare website at: www.safetyandquality.health.wa.gov.au/
1. Purpose of the Consent to Treatment Policy for the Western Australian Health System

The Australian High Court case of Rogers v Whittaker (1992) was a landmark decision that clarified the legal obligations and requirements for health practitioners to obtain a patient’s consent to treatment.

The High Court held that the law ‘imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment and that the duty extends to the provision of information in an appropriate case’.

The High Court also held that the ‘patient’s consent to treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended’ but that ‘the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice’.

As the High Court pointed out ‘the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient’s apprehended capacity to understand that information’.

To assist health practitioners to meet their legal obligations with respect to consent, the WA Council for Safety and Quality in Health Care and the Office of Safety and Quality in Healthcare, Department of Health, have jointly developed and updated the Consent to Treatment Policy for the Western Australian Health System (Consent Policy).

An electronic copy of the Consent Policy and associated consent forms and procedure-specific information sheets are available from the Office of Safety and Quality in Healthcare website at: www.safetyandquality.health.wa.gov.au

The Consent Policy:
- requires a patient to be actively involved in the decision-making process
- requires WA Hospitals and Health Services to take a patient-centred view of the consent process on the basis that it is a patient’s right to determine what happens to his or her body
- provides guidance for health practitioners in relation to obtaining consent, including how to deal with emergencies, and children and adults who have reduced legal capacity
- outlines what information should be given to a patient to assist him or her to make informed decisions prior to deciding on a course of action
- provides valuable guidance for health practitioners in situations relevant to informed decision-making and gaining consent to treatment when statute law governs how consent should be obtained and how patients should be informed about risks
- provides model Consent to Treatment forms for competent adults, mature minors and patients incapable of consenting to the treatment (see Appendices 1 to 6).

Compliance with this Consent Policy is mandatory. In order to accommodate local variation in patients and practices, hospitals and health services will either adopt this Consent Policy in toto, or develop local operational consent policies that are aligned with this Departmental Consent Policy. Hospitals and health services will also provide health practitioners with access to this Consent Policy, the associated consent forms and the related Operational Directive.
2. What is Meant by Consent to Treatment?

Consent is a patient’s agreement for a health practitioner\(^a\) to provide treatment\(^b\). For the purposes of this Consent Policy, the consent process should be considered as a series of steps.

1. **Inform the patient**

   Provide the patient with all information that will assist him or her to reach an informed decision whether or not to consent to the proposed treatment. The information must include a description of the proposed treatment and any material risks\(^c\). It is essential to ensure the patient understands the information that has been given and the information that has been discussed.

2. **Gain consent**

   Gain the patient’s consent for the specific procedure.

3. **Record the consent**

   Record and document the consent process.

   Signing a consent form is the very last step in the consent process, and the absence of good dialogue and discussion is not good practice in gaining consent.

3. Why is it Necessary to Obtain Patient Consent?

Whether or not medical treatment is to take place is a decision for the patient, and as a matter of policy, no surgical operation, medical, anaesthetic, radiology or oncology procedure may be performed without the consent of the patient, if the patient is a competent adult.

A health practitioner’s obligation to obtain consent is distinct from the obligation to disclose information to a patient and warn him or her of material risks. Simply obtaining a patient’s written consent does not mean that the legal duty towards a patient to explain all material risks has been fulfilled.

In *Rogers v Whittaker (1992)*\(^c\), the High Court made it clear that a patient’s consent to medical treatment is meaningless unless it is made on the basis of relevant information and advice. A patient’s choice whether or not to undergo treatment requires a decision based upon information which is known to the medical practitioner but not to the patient, therefore it is up to the medical practitioner to disclose to that patient information as to the material risks inherent in the proposed treatment.

Therefore, in addition to obtaining a patient’s consent, whether verbally or in writing, a health practitioner also has a legal obligation to fully inform the patient of the potential benefits of the procedure and any material risks that are inherent in a procedure, including the risk of failure.

Failure to obtain a patient’s consent for a procedure may result in a criminal charge of assault or civil action for battery, whereas failure to disclose material risks to a patient may give rise to civil action for negligence.

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\(^a\) Health practitioner includes doctors, nurses and allied health professionals.

\(^b\) Treatment means the carrying out of an operation, administration of a drug or other like substance, or any other medical procedure.

\(^c\) Material risk: as defined by Rogers v Whittaker (1992) 175 CLR 479, means “a risk which, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it, or if the medical practitioner is or should reasonably be aware that a particular patient, if warned of the risk, would be likely to attach significance to it.”
3.1 When should consent be obtained in writing?

As stated in Section 3 of this Consent Policy, no surgical operation, medical, anaesthetic, radiology or oncology procedures may be performed without the consent of the patient, if the patient is a competent adult. Generally, the law does not require consent to be given in writing.

An exception to this rule includes consent required under the *Mental Health Act 1996* (see Section 4 of this Consent Policy). Section 110 of the *Mental Health Act 1996* requires the written approval of the Chief Psychiatrist for the provision of medical treatment to an involuntary patient or a mentally impaired accused.

It is however, the Department of Health’s policy that written consent, using an approved consent form, must be obtained for:

- surgical, medical, radiology, oncology and endoscopy treatments/procedures requiring general, regional or local anaesthesia, or intravenous sedation
- invasive procedures or treatment where there are known significant risks or complications\(^d\)
- sterilisation of a minor and the application of electroconvulsive therapy (special circumstances apply)
- administration of medications with known high risk complications or new unusual medications which may have risks
- drugs administered under the Special Access Scheme\(^e\)
- participation in clinical trials and medical research.\(^d\)

The absence of a completed consent form could lead to the conclusion that the procedure has not been discussed with the patient or that informed consent has not been obtained. Therefore, in all other cases, where a health practitioner does not complete a written consent form, documentation of the consent process must be made in the patient’s medical records (as per Section 5 and 9 of this Consent Policy).

Please note there are specific requirements in relation to the consent process for anaesthesia, open access procedures, obstetric procedures and blood products (see Section 4.7 of this Consent Policy).

The use of the recommended consent forms will assist health practitioners in providing adequate and appropriate information to patients under their care during the consent process in line with legal requirements and legal expectations.

Model Consent to Treatment forms for adults, minors and patients incapable of consenting to the procedure or treatment are provided at Appendices 1 to 6.

\(^d\) Procedural risk refers to a professionally recognised risk that a given procedure is likely to induce any of the following: a) functional impairment b) injury c) morbidity d) death.

\(^e\) The Special Access Scheme (SAS) allows medical practitioners, under certain circumstances, to prescribe drugs not yet approved for the Australian market for treatment of patients with serious medical conditions, with their informed consent. Approval to obtain such drugs is arranged through the Drug Safety Evaluation Branch of the Therapeutic Goods Administration (TGA). Further information about the SAS is available from the TGA website at [http://www.tga.gov.au/hp/index](http://www.tga.gov.au/hp/index).
4. When do Different Arrangements Apply When Obtaining Consent

The requirements for consent to be obtained prior to the commencement of treatment may vary depending on whether the patient is competent (an adult or a mature minor), or incompetent (a minor or an adult requiring a legally appointed guardian). The following situations may require different arrangements when:

- immediate treatment is required to save a person’s life or prevent serious harm (refer to Section 4.1 of this Consent Policy)
- treatment is provided under the Mental Health Act 1996 (refer to Section 4.2 of this Consent Policy)
- emergency psychiatric treatment is required (refer to Section 4.3 of this Consent Policy)
- medical treatment is provided under the Guardianship and Administration Act 1990 (refer to Sections 4.4(a) and (b) of this Consent Policy)
- treating a minor (refer to Section 4.5 of this Consent Policy)
- treatment is prohibited by law or is prohibited unless certain requirements are met (refer to Section 4.6 of this Consent Policy).

Please note that this Consent Policy does not deal with consent for use and transmission of confidential information, such as digital images taken as part of a surgical procedure. Refer to Operational Circular OP 2050/06 ‘Patient confidentiality and divulging patient information to third parties’ for further information.

4.1 Treatment in an emergency

The requirements for obtaining consent differ in the case of a medical emergency. Where urgent treatment is required to save a patient’s life or prevent serious harm to his or her health and the patient is not able to consent to the required treatment at the time, e.g., because the patient is unconscious, the patient is deemed by law to have consented to the treatment.

In the above instance, an ‘emergency’ is described as being a situation wherein the procedure is immediately necessary and not merely convenient.

The circumstances that constitute the emergency and the patient’s lack of competency must be clearly documented in the patient’s medical record and the hospital record.

Note in Section 4.3 of this Consent Policy that the law is slightly altered in relation to patients who require emergency psychiatric treatment under the terms of s119 of the Guardianship and Administration Act 1990.

4.1(a) Treatment of a patient with an advanced health care directive

Health practitioners should refer to Section 8 of this Consent Policy for guidance on treating a patient who refuses recommended diagnostic and/or therapeutic interventions, or on treating a patient with an advanced health care directive which prohibits certain forms of treatment in an emergency.

When the decision involves potentially life-threatening conditions, then the refusal should be clearly documented in the patient’s medical record.
4.2. Provision of medical treatment under the *Mental Health Act 1996*\(^5\)

Part 5 of the *Mental Health Act 1996*\(^3\) contains specific provisions relating to the medical treatment of patients and the consent requirements.

Under s109 of the *Mental Health Act 1996*\(^3\) an involuntary patient or a mentally impaired accused person, who is in an authorised hospital, may be given psychiatric treatment without consent. However, the psychiatric treatment must not involve deep sleep therapy, insulin coma or sub-coma therapy, psychosurgery or electroconvulsive therapy.

Under s110 of the *Mental Health Act 1996*\(^3\) an involuntary patient, or a mentally impaired accused person who is in an authorised hospital, may be given medical treatment, other than psychiatric treatment or deep sleep therapy, insulin coma or sub-coma therapy, psychosurgery if it has been approved in writing by the Chief Psychiatrist. (Refer to s108 of the *Mental Health Act 1996*\(^3\))

The power of the Chief Psychiatrist to provide his or her approval for medical treatment does not limit a power conferred by any other written law by which a person may consent to the medical treatment of another person, e.g., under the provisions of the *Guardianship and Administration Act 1990*.\(^7\)

Involuntary admission of a patient to an authorised hospital does “not limit a power conferred by any other written law by which a person may consent to the medical treatment of another person”.\(^3\)

Refer to Appendix 7 for further information on the *Mental Health Act 1996*.\(^8\) Contact the Office of the Chief Psychiatrist at the Department of Health for further information about the Chief Psychiatrist’s Guidelines for the use of Electroconvulsive Therapy (ECT) in WA and procedures for gaining consent for patients undergoing ECT. A consent form for ECT has been endorsed by the Chief Psychiatrist, Department of Health (Appendix 5, FORM E).

4.3. Provision of emergency psychiatric treatment

Sections 113-114 of the *Mental Health Act 1996*\(^3\) allows for emergency psychiatric treatment (which does not include psychosurgery) to be provided to a patient without any consent or approval in order "to:

a) save the person’s life; or
b) prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person."\(^3\)

When emergency psychiatric treatment is provided to a patient, as outlined above, a health practitioner must ensure that the documentation and reporting requirements, outlined in s115 of the *Mental Health Act 1996*\(^6\), are fulfilled.

Please refer to Operational Circular OP 2055/06\(^8\) or contact the Office of the Chief Psychiatrist for specific information relating to consent for emergency psychiatric treatment.

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\(^{1}\) Section 109 of the *Mental Health Act 1996*\(^3\) permits an involuntary patient, or a mentally impaired accused person who is in an authorised hospital, to be given psychiatric treatment without his or her consent.
4.4 Provision of medical treatment under the *Guardianship and Administration Act 1990*<sup>7</sup>

The *Guardianship and Administration Act 1990*<sup>7</sup> applies to the provision of medical and dental treatment to persons 18 years or over who are either represented by a guardian or are persons in relation to whom a guardian could be appointed.

**4.4(a) A person (18 years and over) who has had a guardian appointed for him or her with the authority to make decisions relating to medical treatment**

Under s43 of the *Guardianship and Administration Act 1990*<sup>7</sup> the State Administrative Tribunal may appoint a guardian for a person who is:

a) 18 years or over (that is, has attained the age of majority); and
b) incapable of looking after his or her own health and safety OR is unable to make reasonable judgements with respect to matters relating to his or her person OR in need of oversight, care or control in the interests of his or her own health and safety or for the protection of others; and
c) in need of a guardian.

The *Guardianship and Administration Act 1990*<sup>7</sup> provides, *inter alia*, that consent given by a guardian in the performance of the functions vested in him has effect as if it had been given by the represented person and he were of full legal capacity.<sup>7</sup>

Under the terms of the *Guardianship and Administration Act 1990*<sup>7</sup>, a guardian cannot consent to the sterilisation of a represented person unless the consent of the State Administrative Tribunal has first been obtained.

The relevant sections from the *Guardianship and Administration Act 1990*<sup>7</sup> that describe the appointment of a guardian and the functions of a guardian are included at Appendix 7.

**4.4(b) A person (18 years and over) who is incapable of consenting to medical treatment but who has not had a guardian appointed for him or her**

Where the patient is a person who is incapable of consenting to medical treatment and has not had a guardian appointed, then s119 of the *Guardianship and Administration Act 1990*<sup>7</sup> may apply. A health practitioner may provide ‘urgent treatment’ without consent if it is not practicable to obtain the consent of one of the people listed below (in order of priority):<sup>g</sup>

1. A guardian of the person needing the treatment
2. The spouse or de facto partner of the person needing the treatment
3. A person who, on a regular basis, provides or arranges for domestic services and support to the person needing the treatment but does not receive remuneration for doing so
4. A person who is the nearest relative (other than the spouse or de facto partner) of the person needing the treatment and who maintains a close personal relationship with the person needing the treatment
5. Any other person who maintains a close personal relationship with the person needing treatment
6. A person prescribed in the regulations

Refer to Appendix 7 for s119 of the *Guardianship and Administration Act 1990*<sup>7</sup>.

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<sup>g</sup> Refer to s119(3)(a to f) and s119(3a) of the *Guardianship and Administration Act 1990*<sup>7</sup>
4.5 Treatment of a minor

The parents of a patient who is a minor are usually the appropriate persons to give consent for the medical treatment of a child.

Under the Commonwealth *Family Law Act 1975*, parents, as a general rule, have full parental responsibility for any of their children who are under 18 years. Parental responsibility is not affected by changes to relationships, i.e., if the parents separate, divorce or remarry. However, where family relationships breakdown, such as separation or divorce, parental responsibility may be varied by a court order in which case consent to medical treatment for a child will have to be obtained in accordance with the court order.

Refer to Appendix 7 for the *Family Law Act 1975*.

4.5(a) Children and Community Services Act 2004

Protection orders made under the *Children and Community Services Act 2004* can vary parental responsibility depending on the type of protection order made. While responsibility for children placed in or taken into provisional protection and care, or subject to a negotiated placement agreement, generally remains with the parents, the Director General of the Department for Child Protection has statutory authority to make decisions on behalf of such children in specific circumstances.

If there is a conflict between two persons with parental responsibility over consent to medical treatment for a child, then attempts should be made to resolve the disagreement. Alternatively, it may be necessary to seek a court order. See below regarding * parens patriae* jurisdiction of the Supreme Court and Appendix 7 *Family Law Act 1975* for legal information.

4.5(b) Exceptions to parental consent to medical treatment on behalf of children/minors

(i) Emergencies

As stated in Section 4.1 of the Consent Policy, consent to treatment is implied where urgent treatment is required to save a patient’s life or prevent serious harm to his or her health. Consequently, in the case of an emergency, if a health practitioner believes that a child is not competent to consent to treatment, parental consent may not be required.

There are special legislative provisions in s19-21 of the *Human Tissue and Transplant Act 1982* to cover the administration of a blood transfusion to a child in the absence of parental consent. In such a situation, or where there is any uncertainty about a child’s capacity to consent to treatment, the treating health practitioner should seek advice from the hospital/health service executive or the Legal and Legislative Services Directorate at the Department of Health.

(ii) Mature Minor (competency of child to consent to medical treatment)

The law in Australia considers that a child under the age of 18 years of age is capable of giving effective consent to a medical procedure if he or she fully comprehends the nature and consequences of the procedure proposed, irrespective of whether a parent consents.
To determine whether a child is capable of providing consent, consideration should be given to the:

1. Age and maturity of the child
2. Child’s ability to understand fully the medical advice being given
3. Nature, consequences and implications of the proposed treatment
4. Potential risks to health
5. Emotional impact of either accepting or rejecting the advised treatment
6. Moral and family questions involved

The notion of ‘child’s best interests’ [Section 4.3b(iii)] also applies to mature minors, so that a court may override a decision of a mature minor with respect to medical treatment.

(iii) Child's best interests

In the case of children who are not capable of consenting on their own behalf, the law recognises the right of the children’s parents to consent on behalf of a particular child. However, the power of parents to consent, or withhold consent, to medical treatment is limited by the overriding criterion that they can only validly consent to treatment which is in the ‘child’s best interest’. (Refer to Appendix 7 for further information)

The Family Court of Australia has produced a guide entitled ‘A Question of Right Treatment: The Family Court and Special Medical Procedures for Children’, which outlines medical procedures that require court authorisation.13

(iv) Specific statutory provisions governing abortion and certain transfusions

There are specific statutory provisions dealing with consent to abortion in the Health Act 191114 and the removal of human tissue, including blood transfusions, in the Human Tissue and Transplant Act 198211 which apply to minors. (Refer to Appendix 7 for further information)

(v) Parens Patriae jurisdiction of the Supreme Court

Court authorisation for medical treatment of a minor is required when:

- both the parents and the minor lack the capacity to consent to medical treatment in a non-emergency situation
- or
- the parents refuse consent for a necessary procedure.

Such authorisation can be obtained by applying to the Supreme Court in its parens patriae jurisdiction requesting that the Court substitutes its consent to the treatment.

Hospitals/health services should liaise with Legal and Legislative Services Directorate at the Department of Health (or the State Solicitor’s Office in the case of teaching hospitals) for specific and relevant legal advice, and to establish agreed processes for obtaining legal advice or court authorisation out of office hours.

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h The power of parents to withhold consent does not equate to them having the power to issue orders that treatment must not go ahead.
4.6 Treatment which is prohibited by law or which is prohibited unless certain requirements are met

There are some forms of treatment which are prohibited by law. Examples of treatments which are prohibited by law include female genital mutilation, non-regenerative tissue removal from a child for the purpose of transplantation, deep sleep therapy, insulin coma or sub-coma therapy.

There are also some forms of treatment which are prohibited by law unless certain requirements are met. Examples of treatment which are prohibited by law unless certain requirements are met include abortion, regenerative tissue removal from a child for the purpose of transplantation, removal of blood from a child, psychosurgery, electroconvulsive therapy and sterilisation of a represented person.

4.7 Are there any other procedures where the usual process for obtaining consent may vary?

4.7(a) Anaesthesia

If a general, regional or local anaesthetic or intravenous sedation is to be administered to a patient as part of the patient’s planned treatment, the patient must be informed about any material risks associated with the anaesthesia. Where alternative treatment options exist, the advantages and disadvantages of each alternative treatment option should also be discussed. Preliminary information may be provided to a patient by a health practitioner at a pre-admission clinic. The anaesthetist must complete a detailed anaesthetic consent at the anaesthetic consultation.

Where a patient is referred to an anaesthetist for a separate anaesthetic consultation, it is his or her responsibility to inform the patient of the risks associated with alternative types of anaesthesia (e.g. regional, general or epidural), and to obtain the relevant consent from the patient. Information about anaesthesia should be provided to the patient in advance and he or she should be given an opportunity to discuss anaesthesia with the anaesthetist at the pre-operative assessment.

A written record of the patient’s consent, any information supplied and any relevant discussion with the patient, must be documented either in the anaesthetic record, the medical record or on an appropriate anaesthetic consent form [see Appendix 5, FORM D Patient Consent to Anaesthesia (General or Regional)].

4.7(b) Open-access procedures

The nature of open-access procedures such as endoscopy, interventional or radiological procedures may preclude the health practitioner from discussing the benefits, risks and likely outcomes of procedures with the patient on the day of the procedure.

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\(i\) s306 Criminal Code
\(j\) s12 Human Tissue and Transplant Act 1982
\(k\) s99 Mental Health Act 1996
\(l\) s199 Criminal Code
\(m\) s13 Human Tissue and Transplant Act 1982
\(n\) s19 Human Tissue and Transplant Act 1982
\(o\) s101 Mental Health Act 1996
\(p\) s104 and s107 Mental Health Act 1996
\(q\) s57 Guardianship and Administration Act 1990
Patients who attend open-access endoscopy units should therefore be provided with appropriate information pertaining to the risks of the procedure they are to undergo before they make a booking to have that procedure performed.\(^{16}\)

Doctors who refer patients (most commonly general practitioners) to an open-access endoscopy centre have a duty of care, at the time of referral, to provide information about the rare but possible complications of the procedure, including the risks associated with anaesthesia.

Hospitals and health services offering open-access endoscopy or other such procedures must ensure that:
- nursing staff in the pre-admission clinic are aware of patients who are booked for an open–access endoscopy who require sedation or anaesthesia from a specialist anaesthetist
- any endoscopist or anaesthetist who refers patients to the facility has informed the patient of the nature of the proposed treatment and appropriately disclosed any material risks
- the patient’s consent has been obtained and documented for the proposed procedure.

4.7(c) Obstetric procedures
Consent for obstetric procedures should be obtained in accordance with the requirements set out in Section 3 of the Consent Policy. However, where a blood transfusion is needed or a caesarean section is to be carried out in an emergency, the consent to treatment process outlined in Section 6 should be followed.

4.7(d) Blood products
"Informed consent for transfusion means a dialogue has occurred between the patient and the doctor. The significant risks, benefits and alternatives to transfusion including the patient’s right to refuse the transfusion will have been discussed".\(^{17}\)

A patient must be advised about the risks associated with receiving a blood transfusion in order to provide consent for the procedure. The risks of any adverse outcomes discussed with the patient should be recorded in the patient’s medical record.

Ideally, the health practitioner should also provide the patient with appropriate written information. Resources that have been developed by the Australian and New Zealand Society of Blood Transfusion\(^{17}\), National Health and Medical Research Council\(^{18}\) and the Australian Red Cross Blood Service\(^{19}\) may be useful information for patients.

Valid consent for blood transfusions or the administration of blood products during surgery can be documented on a Consent to Treatment form. However, where urgent treatment is required in the case of a medical emergency and the patient is not able to consent to the blood transfusion at the time, consent is implied.

See s19 to s21 of the Human and Tissue and Transplant Act 1982\(^{11}\) in Appendix 7 regarding medical practitioners performing a blood transfusion on a child (under 18 years) without consent.
5. How Should Consent be Obtained?

To secure valid consent, a health practitioner has two distinct obligations:

1. Inform the patient of the nature of the proposed treatment and disclose any material risks involved in it
2. Document the process

5.1. What are the requirements for valid consent?

Irrespective of whether or not written consent is obtained, a patient’s consent is only valid if various criteria have been met: 3, 20

1. The patient has received sufficient information to make the decision. The health practitioner should provide adequate information to enable the patient to make an informed decision to undergo the treatment.
2. The consent must be specific, and is valid only in relation to the treatment or procedure for which the patient has been informed and has agreed to.
3. The patient must not be acting under duress. The consent must be voluntary and given freely and a patient must not have been coerced or forced into making the decision. A patient who has been pressured into making a decision may consider that he or she has been coerced.
4. The patient is competent to make a decision. The patient must have the capacity to consent, which means he or she should understand the implications of having or not having treatment. An individual has the required capacity to make a decision about his or her treatment, if he or she has: 21
   - the capacity to understand and retain relevant information
   - the ability to manipulate the relevant information rationally
   - the ability to reflect and make a judgement based on personal values and the situation
   - the capacity to freely communicate a decision.

Examples of patients not being competent to give consent may include persons:

- sedated or temporarily unconscious
- with an altered mental state, e.g., through medication
- currently affected by a mental illness or persons with an intellectual disability.

Arrangements for obtaining consent from patients who are not competent to give consent are discussed in Section 4 of this Consent Policy, with relevant legislative extracts at Appendix 7 of this document.

5.2 What information should be given to a patient?

Information should be provided to a patient with the objective of helping him or her understand his or her illness and the available options for treatment. The information must be in terms that the patient can understand.

As a guide it is recommended that where the chance of an adverse outcome is greater than one case in every thousand (1:1000), such risks should be disclosed. However, any risks likely to be significant to a specific patient should be discussed. For reasons previously described these risks can only be determined through communication and a good understanding of the patient’s objectives, beliefs and attitudes.
The National Health and Medical Research Council’s Guidelines for Medical Practitioners\(^2\) set out the minimum level of information that should be provided to patients, and include:

- an explanation of the patient’s condition and diagnosis
- any degree of uncertainty in the diagnosis or prognosis
- the nature of the proposed treatment, including the time required for the treatment, the likely recovery period and the likely time that the patient will be off work
- the expected benefits of the treatment
- the potential risks involved in the treatment including:
  - any short or long term side effects of the treatment
  - any significant long term physical, emotional, mental, social, sexual or other risks
  - the risk that no benefit will be achieved
  - the risk that the condition will be worse after the treatment and/or procedure
- the likely outcomes of the treatment, including whether the treatment is irreversible
- outcomes which are inevitable if the treatment is performed, such as pain, altered bowel function after a cholecystectomy, removal of the umbilicus after repair of an umbilical hernia, or retrograde ejaculation after a prostatectomy
- the likely consequences of not choosing the proposed diagnostic procedure or treatment, or of not having any procedure or treatment at all
- alternative options for investigation, diagnosis and treatment and why they are not recommended
- any costs involved in the treatment
- any follow-up treatment or care which may be required.\(^r\)

Consent must be obtained separately for any additional expenses that may be incurred as a result of the treatment, including any ‘out of pocket’ expenses.

The patient must also be advised of the name of the health practitioner primarily responsible for his or her care, whether or not that health practitioner will be performing the procedure and whether health practitioners-in-training will be participating in the treatment. The names of the health practitioner performing the procedure and/or participating in the treatment must be recorded on the consent form.

\(^{r}\) Note: It MUST be made clear that the results of treatment can never be guaranteed.
5.3 How should a patient be informed about material risks?

To inform a patient of the risks associated with treatment is a very important part of the consent process. Any information provided to a patient must include general and specific risks of the treatment concerned, particularly material risks to the patient, if any, of the specific treatment.

The Department of Health strongly favours the guidance issued by the National Health and Medical Research Council (NHMRC) in relation to the provision of information to patients. The NHMRC’s Guidelines for Medical Practitioners state that the factors health practitioners should consider when determining how much information to provide to a patient about the risks of a proposed procedure include:

- the seriousness of the patient’s condition
- the nature of the intervention, for example, complex interventions require more information, as do interventions where the patient has no illness
- the likelihood of harm and the degree of possible harm - more information is required the greater the risk of harm and the more serious it is likely to be
- the questions the patient asks
- the patient’s temperament, attitude and level of understanding - every patient is entitled to information, but these characteristics may provide guidance to the form it takes
- current accepted medical practice.

Prior to the commencement of treatment, patients should be given the opportunity to discuss any concerns they may have with a senior member of the medical team, preferably the health practitioner who will perform the procedure. This may occur at the initial meeting, at a subsequent meeting or via alternative means such as telephone contact, where a face-to-face meeting is not possible before the commencement of an open-access procedure or other treatment. (Refer Section 4.7(b) of this Consent Policy)

The health practitioner must keep a record of his or her discussion with the patient in the patient’s medical record, and include a list of any material risks that have been discussed with the patient. Generic consent forms (Appendices 1 to 6) have been developed by the Department of Health to assist health practitioners to record and document the consent process.

5.3.1 What information should be provided to a patient from a culturally and/or linguistically diverse background or who has special needs?

Health practitioners should be aware that a patient from a culturally and/or linguistically diverse background or who has a physical impairment (such as blindness), or mental impairment, may need additional support to provide valid consent to treatment.

In the case of patients who are illiterate or vision impaired, appropriate communication methods or support must be employed and documented in the patient’s medical record.

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Note: In consent discussions with a patient, a doctor may consider the usual professional practice in the giving of information in a particular situation, but that is not conclusive evidence of providing full information. The doctor should take into account all of the circumstances in relation to the particular patient.
Every effort must be made to ensure that information about the advantages and disadvantages of each alternative treatment option and any material risk of having the specific treatment, is communicated in a manner that the patient can understand. This must occur before the patient is given a consent form for his or her signature.

Where a patient is identified as having special needs or language requirements, the health practitioner should engage the services of a Professional Interpreter to assist the patient to understand the procedure and the relevant implications.

Where an interpreter has been present he or she should sign the consent form to indicate he or she has interpreted the discussion between the health practitioner and the patient to the best of his or her abilities. If an interpreter is not confident of his or her competence to interpret a discussion between a health practitioner and a patient, he or she is obliged to advise the health practitioner accordingly and to decline or withdraw from the interpreting assignment.

In the event that an interpreter has expressed concerns about his or her performance that is serious enough to withdraw from the assignment, the services of an alternative interpreter should be retained. If the original interpreter has been asked to continue by the health practitioner this should be documented as a notation to the interpreter declaration.

Where possible interpreters should be given the opportunity to review relevant documentation related to the consent process and prepare for interpreting in advance of meetings between the health practitioner and the patient.

5.3.1(a) What is the role of the interpreter?

The Western Australian Language Services Policy 2008 sets out guidelines to help in obtaining assistance for patients who require language services.

If an interpreter is required during discussions with a patient, health practitioners must convey the essence of the information sheet and consent form to the patient, in the presence of the interpreter, and ensure that the patient understands what he or she is consenting to.

The role of the interpreter is solely to convey the information between the health practitioner and the non-English speaking patient. It is beyond the interpreter’s responsibility to complete forms or to provide other functions such as medical advice or the clarification of written medical information.

Professional Interpreters should be engaged wherever possible, in preference to other interpreters and/or family members. All attempts should be made to gain access to a Professional Interpreter before recourse to a non-accredited interpreter, family, friends or bilingual health workers.

If an interpreter is used during discussions with a patient, health practitioners are required to convey to the patient all vital information (including that on the consent form) such as risks, in the presence of an interpreter, to enable the practitioner to be confident that the patient understands what they are consenting to.

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\(^1\) See The Office of Multicultural Interests’ *The WA Language Services Policy (2008)* definition of “competent interpreters and translators”.\(^26\)
5.3.2 Can pre-prepared information be given to patients?

Informing patients of the benefits and risks of the procedure or treatment is a very important part of the consent process.

Where available, health practitioners should provide their patients with appropriate written or audiovisual information resource materials, which supplement their discussion of the benefits and risks of a proposed procedure. Written information brochures or pamphlets must not be used as a substitute for a face-to-face meeting.

When using pre-prepared information resources, health practitioners must be cognisant that pre-printed information sheets usually refer to the risks facing an “average” patient having the treatment, and that many patients (those who are older, sicker, have co-morbidities, etc.) will face much higher risks than shown in the information sheets. This must be stressed to patients when the pre-printed material is used during discussions between health practitioners and their patients.

The Department of Health has purchased a suite of Procedure Specific Information Sheets, which are available for use in all public hospitals/health services in WA. These information sheets are one source of information that health practitioners may provide to their patients and are available at: http://intranet.health.wa.gov.au/osqh/info_sheets/index.cfm.

In addition to these information sheets, several State and Territory Departments of Health and learned colleges (e.g., Royal Australasian College of Surgeons, Australian and New Zealand College of Anaesthetists and Royal Australian and New Zealand College of Obstetricians and Gynaecologists) have developed a range of printed patient information resources to assist health practitioners with the informed consent process. These resources may be obtained by contacting the relevant colleges.

It is Department of Health policy that where information resources, developed by individual health practitioners or external groups, such as the learned colleges are used, these resources must be endorsed by the hospital/health service executive to ensure that they are up to date, accurate, clear, concise and relevant to the patient’s needs.

Department of Health recommends that hospitals/health services establish a register of patient information resources. Appropriate audit processes should be maintained to ensure that these resources are continually reviewed and updated to meet new changes in clinical practice.

5.3.2(a) Can the old Department of Health procedure-specific consent forms be amended and used as information sheets?

Hospital/health services should note that the suite of Procedure Specific Consent Forms (PSCFs) previously developed by the Department of Health in 2002 are no longer updated or supported since the release of this Consent Policy in 2006. These PSCFs have been replaced by new Procedure Specific Information Sheets (PSIS) and model generic consent forms (see Appendices 1 to 6).

If it is necessary, health professionals may choose to amend the old PSCFs or other resources into patient information sheets. It is then the health professionals’ responsibility to ensure that any amendments to the forms are endorsed by the hospital/health service executive prior to use and are maintained, as per the criteria identified in Section 5.3.2 of this Consent Policy.
5.3.3 Can information be withheld from a patient?

If a health practitioner holds a reasonable belief that disclosure of a risk would prove damaging to the patient's health, he or she may exercise "therapeutic privilege" - that is, the health practitioner can withhold information. To withhold information in these circumstances, the health practitioner would need to make a judgment, on reasonable grounds, that the patient's physical or mental health might be seriously harmed by the information.20

Therapeutic privilege should only be used in very limited cases having regard to the basic legal rights of patients to make decisions about their own medical treatment.20 Any decision to withhold information from a patient on the grounds of therapeutic privilege should be documented in the patient's medical record.
6. Who is Responsible for Obtaining Consent?

Where a health practitioner recommends or advises a patient to undergo treatment, the health practitioner is responsible for providing sufficient, appropriate information and advice to the patient to enable the patient to make his or her own informed decision as to whether to undergo the treatment. As stated previously in Section 5.1, obtaining valid consent to treatment requires:

1. a detailed ‘consenting discussion’ to be held, during which the patient is informed of the nature of the proposed treatment, including a discussion of any material risk involved in it
2. the doctor undertaking the procedure to be satisfied that the patient has given his or her consent for the treatment
3. details of the ‘consenting discussion’ and the patient's consent to be appropriately documented.

6.1 Can another health practitioner obtain a patient’s consent to treatment?

This Consent Policy recognises that teamwork is a crucial part of how hospitals/health services operate and in some cases the person undertaking the ‘consenting discussion’ may not be the same person who will perform the procedure or treatment.

It may be necessary that other members of the treating team are delegated to obtain the patient’s consent to treatment. Any health practitioner who communicates information and risks to a patient must be sufficiently knowledgeable about the procedure to adequately communicate this to the patient. The name of the person responsible for obtaining consent must be documented in the patient’s medical record.

Irrespective of who undertakes the consenting process, the person performing the treatment, most likely the most senior medical practitioner on the treating team, is ultimately responsible for ensuring that consent to treatment has been adequately obtained.

6.1(a) Can the consent process be delegated to another ‘uninvolved’ medical practitioner or junior medical practitioner?

A senior medical practitioner may delegate the task of obtaining a patient’s consent to treatment to a junior medical practitioner or another ‘uninvolved’ medical practitioner. This delegation must be documented in the patient’s medical record. However, the senior medical practitioner must ensure that the junior practitioner to whom the task has been delegated is competent to undertake that task and take reasonable steps to ensure that the patient has been properly informed and that a consent form has been completed before the patient undergoes surgery or treatment.

The senior medical practitioner may be held responsible, where the task has not been appropriately carried out.

Any medical practitioner, including a junior medical practitioner who has been delegated to perform the consent task, must be aware that he or she will have legal and professional responsibilities to provide all necessary and proper information to assist the patient in making a decision and for obtaining a valid consent to treatment.
An ‘uninvolved’ medical practitioner or junior medical practitioner must therefore refuse to undertake the delegated task if he or she does not consider he or she has sufficient skill or experience. Where a junior medical practitioner refuses to undertake the consenting task, this decision should be documented in the patient’s medical record. Decisions made by an ‘uninvolved’ medical practitioner or junior medical practitioner in this regard must be respected by the hospital/health service and senior health practitioner.

6.1(b) Can nurses and other health professionals be involved in providing information and obtaining consent for procedures that are performed by medical staff?

Administrative and nursing staff (other than nurse practitioners, mentioned in Section 6.1(c) of this Consent Policy) cannot be delegated the task of informing a patient about the material risks of an operation, procedure or treatment and of obtaining consent, where consent is required to be documented in writing in accordance with this policy.

However in some cases, a senior health practitioner may inform the patient of the benefits and material risk of a procedure and obtain verbal consent and subsequently ask a hospital staff member to have the patient complete the consent form. In these situations the staff member is not seeking the consent - he or she is simply having the patient confirm his or her prior consent. Note, however that the senior practitioner must document the nature of his or her discussion in the patient’s medical record.

6.1(c) Can nurse practitioners obtain consent for the treatment they perform?

Nurse practitioners are registered nurses authorised to work at an advanced level of practice by the Nurses and Midwives Board of Western Australia. A nurse practitioner has the same obligations as a medical practitioner to obtain a patient’s consent for the procedure they are performing.
7. How Long is Consent Valid?

In principle, a health practitioner’s duty to disclose material risk and obtain a patient’s consent for treatment is a continuing obligation. The consent process should occur before the decision is made to proceed with treatment and as close as is reasonably practicable to the commencement of the treatment process and preferably prior to admission.

Consent is considered valid until a patient withdraws consent or there is a change in a patient’s circumstances, which may include:

- improvement or deterioration in the patient’s condition
- development of new treatment options since consent was given
- progression of the disease which may have changed the therapeutic goal from “cure” to “palliation”.

It is a requirement of this Consent Policy that a patient’s clinical condition and consent must be reviewed if his or her consent was obtained more than three months prior to the treatment being performed. Evidence of such a review should be documented in the patient’s medical record. The previously completed form may be revalidated if the patient’s circumstances have not altered, otherwise a new consent form should be completed. The consent process must be renewed if the period between the date of consent and the date of the procedure being performed exceeds six months.

If a patient consents to a procedure and then subsequently withdraws his or her consent, the date of withdrawal must be documented in the patient’s medical record. It is crucial that the patient is made aware that reconsideration of treatment or withdrawal of treatment is always an option and any changes should be documented in the patient’s medical record.

7.1 Consent for a course of treatment, e.g., chemotherapy

It is recognised that some treatments, such as chemotherapy, can involve more than one course of treatment. A single consent to treatment form is adequate to document consent for the entire course of treatment provided that the consent form clearly states that consent is given for the entire course of treatment. In such situations it is preferable to outline the elements of the course of treatment and any associated material risk, the alternatives, and the consequences of withdrawal at a future date.
8. What if a Patient Refuses to Consent to Treatment?

If a mentally-competent patient refuses to sign a written consent form for non-urgent treatment, then the practitioner should not proceed with treatment until consent has been validly obtained. The practitioner must check whether the patient’s refusal is related to the requirement to sign the form or to the nature of the treatment itself. In such circumstances further explanation of the patient’s condition, the proposed treatment or procedure and the consent form (with the aid of interpreting services if required) may alleviate the patient’s concerns. If necessary, a practitioner should suggest that the patient obtain a second opinion from another specialist.

If a patient refuses recommended diagnostic and therapeutic interventions, particularly when the decision involves potentially life-threatening conditions, then this refusal should be clearly documented. The patient should also be encouraged to inform his or her family and next-of-kin of this decision.

The WA Government introduced advanced healthcare planning legislation into the WA Parliament during 2006. Under the legislation:

- an adult who is of sound mind will be able to make an advanced health directive about all future health matters
- an adult who is of sound mind will be able to appoint an enduring guardian to make personal, life-style and medical decisions on his or her behalf in the event of future incapacity
- protection will be afforded to health professionals who carry out the directions contained in an advanced health directive or those of an enduring guardian.

This Consent Policy and Operational Directive will be updated if/when the legislation comes into force.
9. How Should the Consent Process be Documented?

The hospital/health service must verify that a health practitioner has completed the consent process for each patient and that the health practitioner has satisfied his or her obligations in relation to gaining valid consent.

It is the responsibility of the hospital/health service to ensure that a patient’s consent has been obtained by a health practitioner at each of the following stages:

1. At the pre-admission clinic (where possible)
2. At the patient’s admission to hospital (where possible)
3. Prior to the administration of the pre-operative medication
4. Prior to the patient’s transfer to operating theatre, diagnostic unit or medical imaging department

Evidence may include documentation in the patient’s medical record or production of a completed consent form.

9.1 What if the patient is admitted from the health practitioner’s private rooms?

It is Department of Health policy that any health practitioner who admits a patient to a public hospital from his or her private rooms must comply with the requirements for obtaining a patient’s consent, as outlined in this Consent Policy. This applies irrespective of whether the patient is to be admitted as a public or private patient.

When a patient is admitted to a public hospital, it is the responsibility of the health practitioner to provide documented evidence that the consent process has been completed. This evidence may include production of a completed consent form or a copy of documentation that is held in the patient’s medical record.

It is recommended that all hospitals and health services provide health practitioners with clear directions on procedures for documenting a patient’s consent to treatment prior to his or her admission to hospital. Copies of any relevant consent forms that are to be used for documenting written consent should also be provided to health practitioners for use in their private rooms.

9.2 What if a patient arrives in the operating theatre without valid or documented consent?

If a patient arrives in the operating theatre or treatment room without valid or documented consent, the clinical team must first determine whether the patient requires emergency treatment. If emergency treatment is necessary and must be provided without delay to save the life of the patient, to reduce pain, or for the patient’s ultimate wellbeing, then the patient is deemed by law to have consented to the treatment. (Refer to Section 4.1 of this Consent Policy)

All cases of patients arriving in the operating theatre or treatment room without valid or documented consent must be reported to a relevant Clinical Nurse Manager, Medical Director and other relevant health service administrators. Each case must also be documented in the patient’s medical record, reported as a clinical incident to the Advanced Incident Management System (AIMS) and investigated at the local level in accordance with the Department of Health’s Clinical Incident Management Policy for WA Health Services using the Advanced Incident Management System.26
9.2.1 Non-emergency treatment
If consent has not been obtained for non-emergency treatment, the admission clinic’s staff or relevant registered nurse must contact the first available officer, listed below in order of priority, and advise him or her that the patient cannot be given the pre-operative sedation:
1. Surgeon
2. Anaesthetist who ordered the pre-operative medication
3. The director of medical services and clinical nurse manager

The registered nurse must document in the patient’s medical record the reason for withholding the pre-operative medication. Essential non-sedative medication may be given to the patient at this time on instruction from a responsible medical practitioner.

9.2.1(a) Competent patients
If a patient has not been administered medication that may alter his or her mental state, he or she should be asked to consent to the scheduled treatment in the treatment room or operating theatre complex by the responsible medical practitioner.

As part of the consent process, health practitioners should confirm and document the following details with the patient, in accordance with the Department of Health’s Correct Patient, Correct Procedure and Correct Site Policy and Guidelines for WA Health Services:
- the patient’s full name and date of birth – the patient should be asked to state not confirm these details
- the type of treatment or procedure to be performed
- the reason for the treatment or procedure
- the side and site of the treatment or procedure.

The patient’s consent to treatment must be documented in the patient’s medical record. An approved consent form should also be used (See Appendices 1 to 6).

9.2.1(b) Incompetent patients
Where a patient has been administered medication that may alter his or her mental state or who may otherwise be incompetent, the surgeon and anaesthetist must BOTH:
- document in the patient’s medical record their actions and rationale for proceeding with the procedure
- sign an Authorisation to Proceed with Surgery on a Patient without a Valid Consent Form (See Appendix 6, FORM F).

The Authorisation to Proceed with Surgery on a Patient Without a Valid Consent Form is available from the Office of Safety and Quality in Healthcare website or the hospital or health service’s medical records department.

u www.safetyandquality.health.wa.gov.au
9.3 Generic consent to treatment forms

The Consent to Treatment form, stored on a patient’s medical record, represents a record of the minimum amount of information that is acceptable prior to the commencement of treatment or admission to a hospital/health service for treatment. The presence of a completed consent form does not preclude the fact that an appropriate record of the information provided to a patient and discussions with the patient (such as outlined earlier in Section 3 of the Consent Policy) should also be kept in the patient’s medical record.

The consent forms attached at Appendices 1 to 6 have been developed for use in the most commonly occurring situations, which are when:

- the patient is an adult or mature minor: FORM A Patient Consent to Treatment or Investigation should be completed and retained in the patient’s medical record
- a parent or guardian is consenting on behalf of a child or minor: FORM B Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation should be completed and retained in the patient’s medical record
- an authorised person is consenting on behalf of the patient who is unable to consent: FORM C Adults Unable to Consent to Treatment or Investigation should be completed by the authorised person and retained in the patient’s medical record
- where a patient is requiring anaesthesia: FORM D Patient Consent to Anaesthesia (General or Regional) should be completed by the authorised person and retained in the patient’s medical record.

A separate consent form for Electroconvulsive Therapy (ECT) (FORM E) has been endorsed by the Chief Psychiatrist, Department of Health for use in WA health services (See Appendix 5).

An additional consent form with respect to Authorisation to Proceed with Surgery on a Patient without a Valid Consent Form is provided at Appendix 6 (FORM F).

9.3.1 Development of specialty consent forms

There may be instances, due to local hospital/health service operational policies, where specific consent forms may need to be developed and used for treatment other than previously specified in this policy, for example, for use in:

- experimental treatment
- vaccination/immunisation
- other procedures that require specific written consent by law.

Hospitals/health services should clearly outline these requirements in local operational policies and make the specific consent forms available where these are required.
Where health practitioners or hospitals/health services develop consent forms for specific procedures, the hospitals/health services must ensure that they contain the minimum criteria that exist on the model generic consent forms provided in the Appendices 1 to 3. These are namely:

- type of consent form: standard or other
- communication needs identified
- procedure/s for which consent has been obtained
- the correct site and anatomical location on which the procedure is to be performed
- printed name/signature of patient
- printed name/signature of doctor
- printed name of responsible doctor and designation
- printed name/signature of interpreter
- acknowledgement of alternative treatment options
- acknowledgement of general risk disclosure
- material risk specific to the patient where appropriate
- record of any benefits, outcomes discussed with the patient
- a copy of any information resources provided to the patient.
10. What are the Governance Responsibilities of Hospitals in Relation to Implementation of the Consent Process?

Hospitals/health services should, as part of their clinical governance activities, undertake audits of patient medical records to measure compliance with the informed consent process specified in this Consent Policy. The focus of the audit is to verify the use of an appropriate consent form and the recording of discussions and/or dialogue between a health practitioner and patient in the patient’s medical records.

While the overall goal is to develop a standardised consent process across the WA health system, it is equally recognised that there needs to be some flexibility at the hospital/health service level to accommodate local variation in patients and practices.

Local hospital/health service operational policies should be developed and aligned with this Consent Policy. The operational policy should include:

1. information as to which procedures a health practitioner is required to obtain written consent (see procedural risk)
2. clear directions for obtaining a patient’s consent to treatment:
   a. where a patient is from a culturally and linguistically diverse background or has visual or hearing impairment
   b. where the patient is a minor (<18 years)
   c. where the patient is currently suffering from mental illness
   d. where the Guardianship and Administration Act 1990 applies to a patient
3. relevant consent forms that are to be used for documenting written consent and/or specify where consent should be recorded if this is not captured on a consent form (e.g., anaesthesia)
4. patient information that is specifically required by the hospital/health service
5. a process for the hospital/health service to audit compliance with the Consent Policy, clearly identifying:
   a. who is responsible for auditing the process
   b. what will be required of health practitioners whose clinical practice is audited.

With the increased mobility of medical practitioners and frequent use of agency or casual staff it is preferable that all WA public health services develop and maintain standardised policies across their respective hospitals, to minimise potential problems which commonly occur through highly variable protocols.
11. References

1. Rogers v Whittaker (1992) 175 CLR 479


25. Advice received from National Translation and Interpreter Service 2005.


For “professional interpreter” please see the below definitions from The Office of Multicultural Interests *WA Language Services Policy* (2008) regarding competent interpreters and translators.

**“Competent interpreters and translators:**

Those who adhere to a professional Code of Ethics for Practitioners incorporating the principles of impartiality and confidentiality, and performance that is accurate and faithful, and who meet at least one of the following criteria:

1. NAATI accredited, which can be achieved by passing a NAATI test; or by successfully completing a course of studies at an Australian institution approved by NAATI; or by providing evidence of specialised qualifications in translating and/or interpreting obtained from a recognised training institution outside Australia;
2. Obtained a formal qualification in interpreting or translating from an accredited tertiary institution

In languages where there is neither training nor NAATI accreditation:

3. NAATI recognised, which requires evidence of English proficiency, two referee reports and completion of a short training course.
4. Recognised by an approved or contracted service provider – such as the Translator and Interpreter Service (TIS), Deaf Interpreting Services (DIS), Kimberley Interpreting Service (KIS), or other private sector providers.
5. An employee of an organisation who is a Bilingual Language Aide with additional training in interpreting services e.g., completed a nationally accredited training module.

In interpreting, NAATI accreditation or a formal qualification from an accredited tertiary institution is available at a number of levels. The *WA Language Services Policy* (2008) refers to the paraprofessional and professional levels.

The level of competence of an Interpreter or a Translator is commensurate with their level of accreditation or training.”
## 12. Index

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<td><em>Family Law Act 1975</em></td>
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<td>4, 5, 6, 9, 25, 48</td>
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<td>Health Practitioner, definition of</td>
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<td><em>Human Tissue and Transplant Act 1982</em></td>
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<td><em>Rogers v Whittaker (1992)</em></td>
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# Appendix 1 (FORM A)

## Patient Consent to Treatment or Investigation

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<td>Suburb</td>
<td>Postcode</td>
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</table>

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”

### Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

**Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure**

- I have informed the patient of the treatment options available, and the likely outcomes of each treatment option, including known benefits and possible complications.
- I have recommended the treatment/procedures/investigations noted below on this form.
- I have explained the treatment/procedures/investigations, identified below, and what is entailed for the patient.
- I have provided the patient with information specific to the procedure identified. The patient has been asked to read information provided and ask the doctor/proceduralist questions about anything that is unclear. An identifiable copy of the information I have provided to the patient has been kept on the patient’s medical record.

Information provided to the patient includes:

- **Open access procedures**
  - I have given the patient opportunity to discuss the proposed procedure, benefits and risks, both general and specific and the risk of not having the procedure.

- **Other procedures**
  - I have discussed the proposed procedure, benefits and risks, both general and specific, and the risks of not having the procedure.

### Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires:  
- General and/or Regional Anaesthesia  
- Local Anaesthesia  
- Sedation

An Anaesthetist will explain the risk of general or regional anaesthesia to you.

### Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are:

### Signature of doctor/proceduralist obtaining consent

<table>
<thead>
<tr>
<th>Full name (please print)</th>
<th>Position/Title</th>
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</table>

### Signature of doctor/proceduralist with overall responsibility for treatment (if different)

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<th>Full name (please print)</th>
<th>Position/Title</th>
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</table>
### Patient Consent to Treatment or Investigation

**Patient’s declaration**

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure prior to signing the consent form.

- **The doctor/proceduralist** has explained my medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to me and associated risks, including the risks of not having the procedure.

- The risks of the procedure have been explained to me, including the risks that are specific to me and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.

- I understand that the result/outcome of the treatment/procedure cannot be guaranteed.

- I understand that if I am treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure, and that the doctor/proceduralist performing the procedure may be undergoing training.

- I understand that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.

- If a staff member is exposed to my blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

- I agree for my medical record to be accessed by staff involved in my clinical care and for it to be used for approved quality assurance activities, including clinical audit.

- I understand that if immediate life-threatening events happen during the procedure, I will be treated accordingly.

- I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform my doctor if this occurs.

- I consent to undergo the procedure/s or treatment/s as documented on this form.

- I consent to a blood transfusion, if needed  
  - Yes
  - No (please tick appropriate box)

**Patient’s full name**

<table>
<thead>
<tr>
<th>Patient's signature</th>
<th>Date/Time</th>
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**Parent/guardian signature**

<table>
<thead>
<tr>
<th>Parent/guardian signature</th>
<th>Date/Time (if desired for mature minor)</th>
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**Interpreter’s declaration**

Specific language requirements (if any) ____________________________

Interpreter services required:  

- Yes
- No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

<table>
<thead>
<tr>
<th>Interpreter’s signature</th>
<th>Date</th>
</tr>
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</table>

**Full name (please print)** ____________________________

**Confirmation of consent at pre-admission or admission to hospital**

I confirm that the request and consent for the operation/procedure/treatment above remains current.

<table>
<thead>
<tr>
<th>Patient’s signature</th>
<th>Date/Time (patient/person responsible)</th>
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</table>
## Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation

(1 of 2)

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<td>Suburb</td>
<td>Postcode</td>
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This form is to be completed giving due consideration to the "Consent to Treatment Policy for the Western Australian Health System"

### Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

**Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure**

- [ ] I have informed the parent/guardian of the child’s medical condition and prognosis. I have also explained the relevant diagnostic treatment options that are available for the child and associated benefits and risks.
- [ ] I have recommended the treatment/procedures/investigations noted below on this form. I have discussed the proposed procedure/s and outcomes (including irreversibility) with the parent/guardian. The benefits and risks, both general and specific, and the risks of not having the procedure have also been explained to the parent/guardian.
- [ ] The parent/guardian has been provided with information specific to the procedure identified. He or she has been asked to read information I have provided and to advise me or the doctor/proceduralist (if different person) if further information is required.
- [ ] An identifiable copy of the information I have provided to the parent/guardian has been kept on the patient's medical record.

### Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires:  
- [ ] General and/or Regional Anaesthesia  
- [ ] Local Anaesthesia  
- [ ] Sedation

An anaesthetist will explain the risk of general or regional anaesthesia to you.

### Disclosure of material risks

Material risk or specific risks particular to this patient that have arisen as a result of our discussions are:

### Signature of doctor/proceduralist obtaining consent

<table>
<thead>
<tr>
<th>Full name (please print)</th>
<th>Position/Title</th>
<th>Signature</th>
<th>Date</th>
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</thead>
</table>

### Signature of doctor/proceduralist with overall responsibility for treatment (If different)

<table>
<thead>
<tr>
<th>Full name (please print)</th>
<th>Position/Title</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Consent for a Minor Requiring Parental/Guardian Approval for Treatment or Investigation

(Parent/guardian's declaration)

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor/proceduralist performing the procedure prior to signing the consent form.

☐ The doctor has explained the child’s medical condition and prognosis to me. The doctor also explained the relevant diagnostic treatment options that are available to the child and their associated risks, including the risks of not having the procedure.

☐ The risks of the procedure have been explained to me, including the risks that are specific to the child and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor or proceduralist.

☐ I understand that the result/outcome of the treatment/procedure cannot be guaranteed.

☐ I understand that if immediate life-threatening events happen during the procedure, the child will be treated as necessary to save the child’s life or to prevent serious harm to the child’s health.

☐ I understand that if the child is treated as a public patient no guarantee can be provided that a particular doctor/proceduralist will perform the procedure and that the doctor/proceduralist performing the procedure may be undergoing training.

☐ I understand that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.

☐ I agree for my/this child’s medical record to be accessed by staff involved in the child’s clinical care and for it to be used for approved quality assurance activities, including clinical audit.

☐ If a staff member is exposed to my/this child’s blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

☐ I consent to the child having a blood transfusion ☐ Yes ☐ No (please tick relevant box)

☐ On behalf of the child, I give consent for my/this child to undergo the procedure/s or treatment/s as documented on this form.

☐ I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform the doctor if this occurs.

Parent/guardian’s full name __________________________ Date/Time __________________________

Relationship to patient __________________________ Date/Time __________________________

Interpreter’s declaration

Specific language requirements (if any)

Interpreter services required: ☐ Yes ☐ No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

Interpreter’s signature __________________________ Date __________________________

Full name (please print) __________________________

Confirmation of consent at pre-admission or admission to hospital

I confirm that the request and consent for the operation/procedure/treatment above remains current.

Signature __________________________ Date/Time ____________________________

(parent/guardian)
Appendix 3 (FORM C)

Affix hospital identification here

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Adults Unable to Consent to Treatment or Investigation

(Page 1 of 2)

This form is to be completed giving due consideration to the "Consent to Treatment Policy for the Western Australian Health System"

Reason for the adult being unable to consent

The patient is incapable of consenting to the procedure/treatment because:

☐ He/she lacks the legal capacity to be able to understand the nature and effect of the procedure/treatment.

☐ He/she is unconscious/suffers from dementia and cannot indicate whether or not he/she does consent to the procedure/treatment.

Declaration of doctor/proceduralist (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated procedure

☐ I have informed the person responsible of the patient’s medical condition and prognosis. I have also explained the relevant diagnostic treatment options that are available to the patient and the associated benefits and risks.

☐ I have recommended the treatment/procedures/investigations noted below on this form. I have discussed the proposed procedure/s and outcomes (including irreversibility) with the person responsible. The benefits and risks, both general and specific, and the risks of not having the procedure have also been explained to the person responsible.

☐ The person responsible has been provided with information specific to the procedure identified. He or she has been asked to read information I have provided and to advise me or the doctor/proceduralist (if different person) if further information is required.

☐ An identifiable copy of the information I have provided to the person responsible has been kept on the patient’s medical record.

Treatment/procedure/investigation

List the treatment/procedures/investigations to be performed, noting correct side/correct site

This procedure requires:

☐ General and/or Regional Anaesthesia  ☐ Local Anaesthesia  ☐ Sedation

An Anaesthetist will explain the risk of general or regional anaesthesia to you.

Disclosure of material risks

Material risk or specific risks particular to this patient that have arisen as a result of our discussions are:

Signature of doctor/proceduralist obtaining consent

Full name (please print) __________________________ Position/Title __________________________

Signature __________________________ Date __________________________

Signature of doctor/proceduralist with overall responsibility for treatment (If different)

Full name (please print) __________________________ Position/Title __________________________

Signature __________________________ Date __________________________
Adults Unable to Consent to Treatment or Investigation

Declaration of person responsible/consenting person

☐ The doctor/proceduralist has explained the patient’s medical condition and prognosis to me. The doctor/proceduralist also explained the relevant diagnostic treatment options that are available to the patient and the associated risks, including the risks of not having the procedure.

☐ The risks of the procedure have been explained to me, including the risks that are specific to the patient and the likely outcomes. I have had an opportunity to discuss and clarify any concerns with the doctor/proceduralist.

☐ I understand that the result/outcome of the treatment/procedure cannot be guaranteed.

☐ I understand that if immediate life-threatening events happen during the procedure, the patient will be treated as necessary to save the patient’s life or to prevent serious harm to his/her health.

☐ I understand that if the patient is treated as a public patient, no guarantee can be provided that a particular doctor/proceduralist will perform the procedure and that the doctor/proceduralist performing the procedure may be undergoing training.

☐ I understand that tissue samples and blood removed as part of the procedure or treatment will be used for diagnosis and common pathology practices (which may include audit, training, test development and research), and will be stored or disposed of sensitively by the hospital.

☐ I agree for the patient’s medical record to be accessed by staff involved in the patient’s clinical care and for it to be used for approved quality assurance activities, including clinical audit.

☐ If a staff member is exposed to the patient’s blood, I consent to a sample of blood being collected and tested for infectious diseases. I understand that I will be informed if the sample is tested, and that I will be given the results of the tests.

☐ I consent to the patient having a blood transfusion ☐ Yes ☐ No (please tick relevant box)

☐ On behalf of the patient, I give consent for the patient to undergo the procedure/s or treatment/s as documented on this form.

☐ I understand that I have the right to change my mind at any time before the procedure is undertaken, including after I have signed this form. I understand that I must inform the doctor if this occurs.

Signature of person responsible/consenting person

Consenting person’s full name ________________________________

Consenting person’s signature ______________________________ Date/Time ________

Relationship to patient ______________________________

Authority ____________________________

(Guardianship and Administration Act 1990, Mental Health Act 1996)
Appendix 4 (FORM D)

Affix hospital identification here

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<td>Sex</td>
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Address

Suburb Postcode

This form is to be completed giving due consideration to the "Consent to Treatment Policy for the Western Australian Health System"

Declaration of anaesthetist obtaining consent (to be completed by the clinician obtaining consent)

Tick the boxes or cross out and initial any changes or information not appropriate to the stated anaesthesia:

☐ I have informed the patient of the anaesthetic techniques for the proposed procedure noted below, including known benefits and possible complications.

☐ I have provided the patient with information specific to the anaesthetic techniques indicated below. The patient has been asked to read information provided and ask questions about anything that is unclear. An identifiable copy of the information I have provided to the patient has been kept on the patient’s medical record.

☐ I have informed the patient of specific anaesthetic risks particular to this patient, as noted below.

Proposed procedure

List the proposed procedure to be performed

Anaesthetic techniques

Tick the proposed anaesthetic technique/s discussed:

☐ General anaesthesia

☐ Spinal anaesthesia

☐ Epidural anaesthesia / analgesia

☐ Nerve blocks

☐ Blood transfusion

☐ Central lines

Disclosure of material risks

Material risks or specific risks particular to this patient that have arisen as a result of our discussions are documented below.

Signature of anaesthetist obtaining consent

Full name (please print) __________________________ Position/Title __________________________

Signature __________________________ Date __________________________

Signature of anaesthetist providing anaesthesia (if different to the anaesthetist who obtained consent)

Full name (please print) __________________________ Position/Title __________________________

Signature __________________________ Date __________________________
### Patient Consent to Anaesthesia (General or Regional)

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**Patient’s declaration**

Please read the information carefully and tick the following to indicate you have understood and agree with the information provided to you. Any specific concerns should be discussed with your doctor or proceduralist performing the procedure **prior to signing the consent form**.

- The anaesthetist has explained the anaesthetic techniques that may be used for the procedure which is proposed.
- The risks of the anaesthetic techniques that may be used, including the risks that are specific to me, have been explained.
- I have been given patient information sheets for my proposed anaesthetic technique.
- I have had the opportunity to discuss and clarify any concerns about the anaesthetic with an anaesthetist.
- I **understand** that a different anaesthetist may give the anaesthetic.
- I **understand** that the anaesthetic, in part or whole, may be given by a qualified doctor who is training in anaesthesia.
- I **understand** that the specific anaesthetic technique to be used will be confirmed only after I have had discussions with the anaesthetist who is giving the anaesthetic.

**Patient’s full name**

**Patient’s signature**

**Date/Time**

**Parent/guardian signature**

(if desired for mature minor)

**Date/Time**

**Interpreter’s declaration**

specific language requirements (if any)

Interpreter services required: ☐ Yes ☐ No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

**Interpreter’s signature**

**Date**

**Full name (please print)**

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**Consent to Treatment Policy for the Western Australian Health System**
Appendix 5 (FORM E)

<table>
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<th>Affix hospital identification here</th>
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</table>

Consent Form for Electroconvulsive Therapy (ECT) (Page 1 of 2)

This form is to be completed giving due consideration to the "Consent to Treatment Policy for the Western Australian Health System"

**Electroconvulsive therapy** is proposed for *(name of patient)*

for the following reasons *(doctor to list reasons)*:

**Electroconvulsive Therapy (ECT)**

ECT is given under a general anaesthetic, so the patient is asleep during the treatment and will not feel or remember anything. A muscle relaxing drug is given once the patient is asleep, to limit body spasms. During ECT, electrodes are put onto the scalp and an electric current is passed briefly through the electrodes to the brain, which causes a seizure (a 'fit'). Consent is given for a specified number of treatments in one course. Further courses require a new consent form to be completed.

**Risks**

These are the most common risks. There may be other unusual risks that have not been listed here. Please ask your psychiatrist if you have any general or specific concerns.

- I understand there are risks associated with any anaesthetic (see separate Anaesthetic Consent Form).
- I understand that I may have side effects from any of the drugs used. The most common side effects include light-headedness, nausea, skin rash and constipation.
- I understand the procedure has the following specific risks and limitations:
  - Immediately after treatment:
    - I may feel nauseated, have some muscle soreness and/or have a headache.
    - I will probably be somewhat confused.
    - With modern techniques, there is a very small risk of bone fractures or dislocations.
    - I may have heart rhythm or blood pressure changes, but these will be monitored closely during and after the procedure and treated if necessary.
  - Later consequences:
    - I may have short-term memory difficulties for some time after the procedure, and find it difficult, for example, to remember recent conversations or things I have just read.
    - I may also have some difficulty remembering past events, such as dates, names of friends, phone numbers. If this affects me, it may be mild and may last for an unpredictable length of time. In some people, memory loss may be severe and can even be permanent.
    - Some people complain of more severe memory loss, which is generally confined to the period around the time of the ECT treatment. There is no evidence that individuals' abilities to construct new memories are affected in the long term.
    - There is an extremely small risk of death from the procedure.
- I understand some of the above risks are more likely if I smoke, am overweight or have heart disease, high blood pressure or diabetes.

**Disclosure of material risk**

I understand the following are possible significant risks and complications specific to my personal circumstances and I have considered these in deciding to have this treatment:
Consent Form for Electroconvulsive Therapy (ECT) (Page 2 of 2)

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
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<tr>
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- I consent to a course of _____ treatments (patient to complete number of treatments: maximum 12)
- I acknowledge the psychiatrist has informed me and provided me with written information about the procedure, alternative treatments and answered my specific queries and concerns about this treatment.
- I acknowledge that I have discussed with the psychiatrist any significant risks and complications specific to my personal circumstances and I have considered these in deciding to have this treatment.
- I understand I can change my mind at any stage, even after a course of treatment has begun, without affecting my future health treatment, or any other treatment of the condition for which ECT has been proposed.
- I have not been guaranteed the treatment will be successful, and I understand the treatment is not a long-term cure for the condition, so I may relapse in the future.
- I understand that a doctor other than the specialist psychiatrist may perform the procedure. The doctor treating me will have been appropriately trained in the technique.
- I have received a copy of this form.
- If a needle stick/sharps injury occurs to staff during any procedure I give my permission for blood to be taken and tested for HIV and other blood borne disorders. I understand I will be advised and counselled as soon as practicable after the treatment if this has been necessary.

**Patient's full name**

Patient's signature __________ Date/Time __________

Witness to the patient’s signature: Name of witness __________

Signature of witness __________ Date/Time __________

Advocates/carer’s signature __________ Date/Time __________

Relationship to the patient __________

**Declaration of doctor**

- I declare that I have explained the nature and consequences of ECT, and discussed the risks that particularly concern the patient.
- I have given the patient, and the patient’s carer or advocate where involved, an opportunity to ask questions and I have answered these.

Full name (please print) __________ Position/Title __________

Signature __________ Date __________

**Involuntary patient or mentally impaired accused (where applicable)**

The treatment has been recommended by the treating psychiatrist and the recommendation is approved by:

Name and signature of psychiatrist __________ Date/Time __________

**Interpreter’s declaration**

Specific language requirements (if any) __________

Interpreter services required:  □ Yes  □ No

I declare that I have interpreted the dialogue between the patient and health practitioner to the best of my ability, and have advised the health practitioner of any concerns about my performance.

Interpreter’s signature __________ Date __________

Full name (please print) __________
### Authorisation to Proceed with Surgery on a Patient Without a Valid Consent Form

This form is to be completed giving due consideration to the “Consent to Treatment Policy for the Western Australian Health System”.

<table>
<thead>
<tr>
<th>Affix hospital identification here</th>
<th>Surname</th>
<th>UMRN</th>
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#### Reason for seeking authorisation to proceed with surgery on a patient without a valid consent form

A patient, who has been administered medication that may alter his/her mental state or who may otherwise be incompetent, has arrived at the Operating Theatre/Treatment Room: (Tick one of the boxes below)

- Without a valid consent form; or
- Information recorded on the patient’s consent form is incorrect and requires amendment.

**NOTE:** A Consent Form is valid if the information is correct in every detail (patient’s details, description of operation or procedure and side and site of procedure of operation), is signed by the patient (or person authorised to give consent in the case of an incompetent patient) and has been witnessed by an appropriate person.

#### Declaration of doctor/proceduralist/anaesthetist

Mr/Ms/Mrs (Insert name) is scheduled to undergo the following treatment/procedure/investigation (Insert): ____________________________________________________________

Mr/Ms/Mrs (Insert name) has arrived in the Operating Room without a valid consent form.

In consultation with (Insert name of doctor/proceduralist) it is considered that the proposed surgery/procedure is urgent and must proceed without a valid Consent Form being completed.

#### Reason for urgency/procedure proceeding

**NOTE:** Urgent can be defined as “treatment that, in the opinion of the health practitioners concerned, is necessary and must be provided without delay to save the life of the patient, to reduce pain or for the patient’s ultimate wellbeing”.

#### Documentation and notification (to be completed by doctor/proceduralist/anaesthetist)

Tick the relevant boxes below:

- I/We have documented the reason/s and rationale for proceeding with the procedure in the patient’s medical record.
- I/We have sought authorisation to proceed with the surgery/procedure from the following Clinical Nurse Manager, Medical Director or Health Service Administrator:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Position:</th>
<th>Date:</th>
<th>(Clinical Nurse Manager/Medical Director/Health Service Administrator)</th>
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</table>

#### Signature of doctor/proceduralist/anaesthetist (if different)

<table>
<thead>
<tr>
<th>Name of doctor/proceduralist</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
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</table>

<table>
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<tr>
<th>Name of anaesthetist</th>
<th>Signature:</th>
<th>Date:</th>
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Appendix 7 - Extracts From Relevant Legislation

Disclaimer
The information contained in this Appendix includes extracts from legislation relevant to this Consent Policy.

A  Criminal Code 1913
B  Family Law Act 1975 (Commonwealth)
C  Guardianship and Administration Act 1990
D  Mental Health Act 1996
E  Health Act 1911 – Abortion
F  Human Tissue and Transplant Act 1982 –
   Part II Donations of Tissue by Living Persons

Copies of the complete versions of each State Act can be accessed at www.slp.wa.gov.au.


The legal information is not intended to be comprehensive. Similarly, it is not intended to be, nor should it be relied upon as a substitute for legal advice.

If you have a legal problem you should seek legal advice tailored to your specific circumstances from the Legal and Legislative Services Directorate of the Department of Health (or the State Solicitor’s Office in the case of teaching hospitals only) before acting or relying on any of the legal information in this policy.
A. **Criminal Code 1913**

Part IV of the **Criminal Code 1913** refers to acts injurious to the public in general.

**Section 199 – Abortion**

1. It is unlawful to perform an abortion unless –
   - (a) the abortion is performed by a medical practitioner in good faith and with reasonable care and skill; and
   - (b) the performance of the abortion is justified under section 334 of the **Health Act 1911**.

2. A person who unlawfully performs an abortion is guilty of an offence. Penalty: $50,000.

3. Subject to section 259, if a person who is not a medical practitioner performs an abortion that person is guilty of a crime and is liable to imprisonment for 5 years.

4. In this section **medical practitioner** has the same meaning as it has in the **Health Act 1911**.

5. A reference in this section to performing an abortion includes a reference to –
   - (a) attempting to perform an abortion; and
   - (b) doing any act with intent to procure an abortion, whether or not the woman concerned is pregnant.

Part V of the **Criminal Code 1913** relates to offences against the person and relating to parental rights and duties and against the reputation of individuals.

**Section 306 – Female genital mutilation**

1. In this section –
   - **child** means a person under the age of 18 years;
   - **female genital mutilation** means –
     - (a) the excision or mutilation of the whole or a part of the clitoris, the labia minora, the labia majora, or any other part of the female genital organs;
     - (b) infibulation or any procedure that involves the sealing or suturing together of the labia minora or the labia majora; or
     - (c) any procedure to narrow or close the vaginal opening, but does not include –
       - (d) a reassignment procedure within the meaning of the **Gender Reassignment Act 2000** carried out on a person’s genitals by a medical practitioner within the meaning of the **Health Act 1911**; or a medical procedure carried out for proper medical purposes.

2. A person who performs female genital mutilation on another person is guilty of a crime and is liable to imprisonment for 20 years.

3. It is not a defence to a charge under subsection (2) that the other person, or a parent or guardian of the other person, consented to the mutilation.

4. A person who takes a child from Western Australia, or arranges for a child to be taken from Western Australia, with the intention of having the child subjected to female genital mutilation is guilty of a crime and is liable to imprisonment for 10 years.

5. In proceedings for an offence under subsection (4), proof that –
   - (a) the accused person took a child, or arranged for a child to be taken from Western Australia; and
   - (b) the child, while out of Western Australia, was subjected to female genital mutilation, is proof, in the absence of evidence to the contrary, that the accused person took the child, or arranged for the child to be taken, from Western Australia, as the case may be, with the intention of having the child subjected to female genital mutilation.
B. *Family Law Act 1975* (Commonwealth)

**Part VII – Children**

**Division 1 – Introductory**

**Subdivision A – What this Division does**

**Section 60A – What this Division does**

(a) a statement of the object of this Part and the principles underlying it, and an outline of this Part (Subdivision B); and

(b) provisions relevant to the interpretation and application of this Part (Subdivision C); and

(c) provisions relevant to how this Act applies to certain children (Subdivision D).

**Subdivision B – Objects, principles and outlines**

**Section 60B – Objects of Part and principles underlying it**

(1) The objects of this Part are to ensure that the best interests of children are met by:

(a) ensuring that children have the benefit of both of their parents having a meaningful involvement in their lives, to the maximum extent consistent with the best interests of the child; and

(b) protecting children from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence; and

(c) ensuring that children receive adequate and proper parenting to help them achieve their full potential; and

(d) ensuring that parents fulfil their duties, and meet their responsibilities, concerning the care, welfare and development of their children.

(2) The principles underlying these objects are that (except when it is or would be contrary to a child’s best interests):

(a) children have the right to know and be cared for by both their parents, regardless of whether their parents are married, separated, have never married or have never lived together; and

(b) children have a right to spend time on a regular basis with, and communicate on a regular basis with, both their parents and other people significant to their care, welfare and development (such as grandparents and other relatives); and

(c) parents jointly share duties and responsibilities concerning the care, welfare and development of their children; and

(d) parents should agree about the future parenting of their children; and

(e) children have a right to enjoy their culture (including the right to enjoy that culture with other people who share that culture).

(3) For the purposes of subparagraph (2)(e), an Aboriginal child’s or Torres Strait Islander child’s right to enjoy his or her Aboriginal or Torres Strait Islander culture includes the right:

(a) to maintain a connection with that culture; and

(b) to have the support, opportunity and encouragement necessary:

(i) to explore the full extent of that culture, consistent with the child’s age and developmental level and the child’s views; and

(ii) to develop a positive appreciation of that culture.
Division 2 – Parental responsibility

Section 61A – What this Division does
This Division deals with the concept of parental responsibility including, in particular:
(a) what parental responsibility is; and
(b) who has parental responsibility.

Section 61B – Meaning of parental responsibility
In this Part, parental responsibility, in relation to a child, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.

Section 61C – Each parent has parental responsibility (subject to court orders)
(1) Each of the parents of a child who is not 18 has parental responsibility for the child.
   Note 1: This section states the legal position that prevails in relation to parental responsibility to the extent to which it is not displaced by a parenting order made by the court. See subsection (3) of this section and subsection 61D(2) for the effect of a parenting order.
   Note 2: This section does not establish a presumption to be applied by the court when making a parenting order. See section 61DA for the presumption that the court does apply when making a parenting order.
   Note 3: Under section 63C, the parents of a child may make a parenting plan that deals with the allocation of parental responsibility for the child.
(2) Subsection (1) has effect despite any changes in the nature of the relationships of the child’s parents. It is not affected, for example, by the parents becoming separated or by either or both of them marrying or re-marrying.
(3) Subsection (1) has effect subject to any order of a court for the time being in force (whether or not made under this Act and whether made before or after the commencement of this section).
   Note: Section 111CS may affect the attribution of parental responsibility for a child.

Section 61D – Parenting orders and parental responsibility
(1) A parenting order confers parental responsibility for a child on a person, but only to the extent to which the order confers on the person duties, powers, responsibilities or authority in relation to the child.
(2) A parenting order in relation to a child does not take away or diminish any aspect of the parental responsibility of any person for the child except to the extent (if any):
   (a) expressly provided for in the order; or
   (b) necessary to give effect to the order.

Section 61E – Effect of adoption on parental responsibility
(1) This section applies if:
   (a) a child is adopted; and
   (b) immediately before the adoption, a person had parental responsibility for the child, whether in full or to a limited extent and whether because of section 61C or because of a parenting order.
(2) The person’s parental responsibility for the child ends on the adoption of the child, unless the adoption is by a prescribed adopting parent and leave was not granted under section 60G for the adoption proceedings to be commenced.

Division 5 – Parenting orders – what they are

Section 64B – Meaning of parenting order and related terms
(1) A parenting order is:
   (a) an order under this Part (including an order until further order) dealing with a matter mentioned in subsection (2); or
   (b) an order under this Part discharging, varying, suspending or reviving an order, or part of an order, described in paragraph (a).
(2) A parenting order may deal with one or more of the following:
   (a) the person or persons with whom a child is to live;
   (b) the time a child is to spend with another person or other persons;
   (c) the allocation of parental responsibility for a child;
   (d) if 2 or more persons are to share parental responsibility for a child – the form of consultations those persons are to have with one another about decisions to be made in the exercise of that responsibility;
   (e) the communication a child is to have with another person or other persons;
   (f) maintenance of a child;
   (g) the steps to be taken before an application is made to a court for a variation of the order to take account of the changing needs or circumstances of:
      (i) a child to whom the order relates; or
      (ii) the parties to the proceedings in which the order is made;
   (h) the process to be used for resolving disputes about the terms or operation of the order;
   (i) any aspect of the care, welfare or development of the child or any other aspect of parental responsibility for a child.

The person referred to in this subsection may be, or the persons referred to in this subsection may include, either a parent of the child or a person other than the parent of the child (including a grandparent or other relative of the child).

Note: Paragraph (f) – a parenting order cannot deal with the maintenance of a child if the Child Support (Assessment) Act 1989 applies.

(3) Without limiting paragraph (2)(c), the order may deal with the allocation of responsibility for making decisions about major long-term issues in relation to the child.

(4) The communication referred to in paragraph (2)(e) includes (but is not limited to) communication by:
   (a) letter; and
   (b) telephone, email or any other electronic means.

(4A) Without limiting paragraphs (2)(g) and (h), the parenting order may provide that the parties to the proceedings must consult with a family dispute resolution practitioner to assist with:
   (a) resolving any dispute about the terms or operation of the order; or
   (b) reaching agreement about changes to be made to the order.

(5) To the extent (if at all) that a parenting order deals with the matter mentioned in paragraph (2)(f), the order is a child maintenance order.

(6) For the purposes of this Act:
   (a) a parenting order that provides that a child is to live with a person is made in favour of that person; and
   (b) a parenting order that provides that a child is to spend time with a person is made in favour of that person; and
   (c) a parenting order that provides that a child is to have communication with a person is made in favour of that person; and
   (d) a parenting order that:
      (i) allocates parental responsibility for a child to a person; or
      (ii) provides that a person is to share parental responsibility for a child with another person; is made in favour of that person.

(9) In this section: “this Act” includes:
   (a) the standard Rules of Court; and
   (b) the related Federal Magistrates Rules.
Section 64C – Parenting orders may be made in favour of parents or other persons
A parenting order in relation to a child may be made in favour of a parent of the child or some other person.

Division 6 – Parenting orders other than child maintenance orders

Subdivision A – Introductory

Section 65A – What this Division does

(1) Division deals with:
(a) applying for and making parenting orders, other than child maintenance orders (Subdivision B); and
(b) the general obligations created by parenting orders, other than child maintenance orders (Subdivision C); and
(c) dealing with people who have been arrested (Subdivision D); and
(d) the obligations under parenting orders, other than child maintenance orders, relating to taking or sending children from Australia (Subdivision E).

Note: Paragraph (a) – section 60I provides that people with disputes about matters that may be dealt with in a Part VII order (which includes a parenting order) should generally make use of family dispute resolution before applying for the order.

(2) Measures designed to improve communication between separated parents and to educate parents about their respective responsibilities in relation to their children are contained in this Division (see section 65DA).

Note: Division 13A provides for the compliance regime for dealing with contraventions, and alleged contraventions, of parenting orders.

Section 65AA – Child’s best interests paramount consideration in making a parenting order

Section 60CA provides that in deciding whether to make a particular parenting order in relation to a child, a court must regard the best interests of the child as the paramount consideration.

Section 65B – Division does not apply to child maintenance orders

This Division does not apply to parenting orders to the extent that they consist of child maintenance orders. Child maintenance orders are dealt with in Division 7.

Subdivision B – Applying for and making parenting orders

Section 65C – Who may apply for a parenting order

A parenting order in relation to a child may be applied for by:
(a) either or both of the child’s parents; or
(b) the child; or
(ba) a grandparent of the child; or
(c) any other person concerned with the care, welfare or development of the child.

Section 65D – Court’s power to make parenting order

(1) In proceedings for a parenting order, the court may, subject to sections 61DA (presumption of equal shared parental responsibility when making parenting orders) and 65DAB (parenting plans) and this Division, make such parenting order as it thinks proper.

Note: Division 4 of Part XIII A (International protection of children) may affect the jurisdiction of a court to make a parenting order.

(2) Without limiting the generality of subsection (1) and subject to section 61DA (presumption of equal shared parental responsibility when making parenting orders) and 65DAB (parenting plans) and this Division, a court may make a parenting order that discharges, varies, suspends or revives some or all of an earlier parenting order.
(3) If the application for the parenting order was made as a result of the adjournment under paragraph 70NEB(1)(c) of proceedings under Subdivision E of Division 13A of Part VII:
   (a) the court must hear and determine the application as soon as practicable; and
   (b) if the court makes a parenting order on the application, the court may, if it thinks it is appropriate to do so, dismiss the proceedings under that Subdivision.

Note: The applicant may apply to the Family Court or to the Federal Magistrates Court for the application for the parenting order or for the proceedings under Subdivision E of Division 13A of Part VII, or both, to be transferred to the Federal Magistrates Court or to the Family Court, as the case requires (see section 33B of this Act and section 39 of the Federal Magistrates Act 1999).

Section 65DA – Parenting orders

(1) This section applies when a court makes a parenting order.

(2) It is the duty of the court to include in the order particulars of:
   (a) the obligations that the order creates; and
   (b) the consequences that may follow if a person contravenes the order.

(3) If any of the persons to whom the order is directed is not represented by a legal practitioner, it is also the duty of the court to explain to the person, or to each of the persons:
   (a) the availability of programs to help people to understand their responsibilities under parenting orders; and
   (b) the availability and use of location and recovery orders to ensure that parenting orders are complied with.

(4) The court may cause to be prepared, and given to persons to whom a parenting order is directed, a document setting out particulars of the matters mentioned in paragraphs (3)(a) and (b).

(5) If a person to whom the order is directed is represented by a legal practitioner, the court may request the practitioner:
   (a) to assist in explaining to the person the matters mentioned in paragraphs (2)(a) and (b); and
   (b) to explain to the person the matters mentioned in paragraphs (3)(a) and (b).

(6) If a request is made by the court to a legal practitioner under paragraph (5)(a) or (b), it is the duty of the practitioner to comply with the request.

(7) Failure to comply with a requirement of, or with a request made under, this section does not affect the validity of a parenting order.

(8) Any matter that is required by this section to be included in a parenting order or any explanation that is required by this section to be given to a person is to be expressed in language that is likely to be readily understood by the person to whom the order is directed or the explanation is given.
C. **Guardianship and Administration Act 1990**

**Division 1 – Appointment of a guardian**

The requirements for the appointment of a guardian are set out in section 43 of the *Guardianship and Administration Act 1990*.

**Section 43 – Making a guardianship order**

1. Subject to section 4, where the State Administrative Tribunal is satisfied that a person in respect of whom an application for a guardianship order is made under section 40 –
   - (a) has attained the age of 18 years;
   - (b) is –
     - (i) incapable of looking after his own health and safety;
     - (ii) unable to make reasonable judgments in respect of matters relating to his person; or
     - (iii) in need of oversight, care or control in the interests of his own health and safety or for the protection of others; and
   - (c) is in need of a guardian,

   the Tribunal may by order declare the person to be in need or a guardian, and if it does so shall appoint –
   - (d) a person to be a plenary guardian or a limited guardian and, if it is expedient, a person to be an alternate guardian; or
   - (e) persons to be joint plenary guardians or joint limited guardians,

   as the case may require, of the person in respect of whom the application is made.

2. Where under subsection (1) the State Administrative Tribunal declares that a person is in need of a guardian, it shall also declare the matter or matters set out in paragraph (b) of that subsection of which it is satisfied.

3. An appointment under subsection (1) may be made subject to such conditions and restrictions as the State Administrative Tribunal thinks fit.

4. An order appointing a limited guardian shall specify the functions that are vested in the limited guardian under section 46.

**Division 2 – Functions of guardians**

**Section 45 – Authority of plenary guardian**

1. Subject to section 43(3), where a person is appointed as a plenary guardian, or 2 or more persons are appointed as joint plenary guardians, he or they have all of the functions in respect of the person of the represented person that are, under the *Family Court Act 1997*, vested in a person in whose favour has been made –
   - (a) a specific issues order which confers responsibility for the long-term care, welfare and development of a child; and
   - (b) a specific issues order which confers responsibility for the day-to-day care, welfare and development of a child,

   as if the represented person were a child lacking in mature understanding, but a plenary guardian does not, and joint plenary guardians do not, have the right to chastise or punish a represented person.
(2) Without limiting subsection (1), a plenary guardian may –
(a) decide where the represented person is to live, whether permanently or temporarily;
(b) decide with whom the represented person is to live;
(c) decide whether the represented person should work and, if so, the nature or type of work, for whom he is to work and matters related thereto;
(d) subject to Division 3, consent to any treatment or Healthcare of the represented person;
(e) decide what education and training the represented person is to receive;
(f) decide with whom the represented person is to associate;
(g) as the next friend of the represented person, commence, conduct or settle any legal proceedings on behalf of the represented person, except proceedings relating to the estate of the represented person; and
(h) as the guardian ad litem of the represented person, defend or settle any legal proceedings taken against the represented person, except proceedings relating to the estate of the represented person.

(3) A plenary guardian may not:
(a) vote in any election;
[(b) deleted]
(c) consent, under section 17 of the Adoption Act 1994, to the adoption of a child or under section 69(1)(a)(ii) of that Act to the adoption of a represented person; or
(da) consent, under section 21(2)(d) of the Surrogacy Act 2008, to the making of a parentage order under that Act; or
(d) under the Marriage Act 1961 of the Commonwealth, give consent in relation to the marriage of a minor, sign a notice of intended marriage or take part in the solemnization of a marriage, on behalf of a represented person; or
(e) consent to the sterilization of a represented person except in accordance with Division 3.

Section 46 – Authority of limited guardian
Subject to section 43(3), where a person is appointed as a limited guardian, or 2 or more persons are appointed as joint limited guardians, he or they have, in respect of the person of the represented person, such of the functions mentioned in section 45 as the State Administrative Tribunal vests in him or them in the guardianship order.

Section 47 – Guardian may apply for directions
(1) A guardian may apply to the State Administrative Tribunal for directions concerning the performance of any function vested in him, and the Tribunal may on any such application give to the guardian any direction not inconsistent with this Act.
(2) A guardian shall comply with any direction given to him under subsection (1).
(3) The executive officer shall, at least 14 days before the day on which an application under subsection (1) is to be heard, cause notice of the hearing to be given to the applicant, the represented person, and such of the persons referred to in section 41(1)(a) and (b) as the State Administrative Tribunal may specify.
(4) The State Administrative Tribunal may, where exceptional circumstances so require, shorten the time for giving notice under subsection (3) to any person.
Division 3 – Limitations on sterilization of persons under guardianship or where application for guardianship made

Section 57 – Prerequisites for sterilization of persons to whom this Division applies
(1) A person shall not carry out or take part in any procedure for the sterilization of a represented person unless –
   (a) both the guardian of the represented person and the State Administrative Tribunal have consented in writing to the sterilization;
   (b) all rights of appeal in respect of a determination under section 63 have lapsed or been exhausted; and
   (c) the sterilization is carried out in accordance with any condition imposed under this Act.

(2) Notwithstanding section 259 of The Criminal Code, a person who knows that an application has been made for a guardianship order in respect of a person shall not carry out or take part in any procedure for the sterilization of that person before:
   (a) the application has been finally dealt with by the State Administrative Tribunal; and
   (b) all rights of appeal in respect of a determination under section 43 have lapsed or been exhausted.

Penalty applicable to subsections (1) and (2): $4 000 and imprisonment for 2 years.

Section 58 – Restriction on guardian’s consent
(1) A guardian shall not consent to the sterilization of a represented person unless the consent of the State Administrative Tribunal has been first obtained.

(2) The consent of the guardian may be given subject to compliance with any condition.

Section 59 – Application for consent
(1) A represented person, his guardian or the Public Advocate may apply to the State Administrative Tribunal for its consent to the carrying out of a procedure for the sterilization of the represented person.

Part 10 – Miscellaneous provisions
Section 119 – Medical and dental treatment
(1) If in the opinion of a practitioner a person presented to him for treatment –
   (a) is in need of urgent treatment;
   (b) is incapable of consenting to the proposed treatment; and
   (c) is at the time of presentation a person for whom a guardian could be appointed under this Act, the practitioner may provide the treatment if the person referred to in subsection (3) consents to it.

(1a) A practitioner may provide treatment under subsection (1) without the consent of the person referred to in subsection (3) if in the opinion of the practitioner it is not practicable to obtain that consent.

(2) If in the opinion of a practitioner a person presented to him for treatment –
   (a) is in need of treatment that is not urgent treatment;
   (b) is incapable of consenting to the proposed treatment; and
   (c) is at the time of presentation a person for whom a guardian could be appointed under this Act, the practitioner may provide the treatment if the person referred to in subsection (3) consents to it.
For the purposes of subsections (1) and (2), the person who may consent to treatment is the first in order of priority of the following persons –

(a) a guardian of the person needing the treatment;
(b) the spouse or de facto partner of the person needing the treatment;
(c) a person who, on a regular basis, provides or arranges for domestic services and support to the person needing the treatment but does not receive remuneration for doing so;
(d) a person who is the nearest relative (other than the spouse or de facto partner) of the person needing the treatment and who maintains a close personal relationship with the person needing the treatment;
(e) any other person who maintains a close personal relationship with the person needing treatment; or
(f) a person prescribed in the regulations.

For the purposes of subsection (3) a person is to be regarded as maintaining a close personal relationship with the person needing the treatment if the relationship is maintained through frequent personal contact and a personal interest in the welfare of the person needing the treatment.

In this section –

**practitioner** in relation to medical treatment means a medical practitioner within the meaning of the *Medical Practitioners Act 2008* section 4, and in relation to dental treatment means a dentist registered under the *Dental Act 1939*; and

**urgent treatment** means treatment that in the opinion of the practitioner concerned is urgently needed –

(a) to save the life of the person needing the treatment;
(b) to prevent serious damage to the health of the person needing the treatment; or
(c) to prevent the person needing the treatment from suffering or continuing to suffer significant pain or distress.
**D. Mental Health Act 1996**

Part 5 of the *Mental Health Act 1996* contains specific provisions relating to the medical treatment of patients and consent requirements.

**Division 2 – Informed consent**

**Section 95 – Requirements for informed consent**

(1) For the purposes of this Division a patient gives informed consent to treatment only if –
   (a) the requirements of this Division have been complied with; and
   (b) the consent was freely and voluntarily given.

(2) A failure to offer resistance to treatment does not of itself constitute consent to treatment.

**Section 96 – Capacity to give informed consent**

A patient is incapable of giving informed consent unless he or she is capable of understanding –
   (a) the things that are required by this Division to be communicated to him or her;
   (b) the matters involved in the decision; and
   (c) the effect of giving consent.

**Section 97 – Explanation to be given**

(1) Before an informed consent is given the patient is to be given a clear explanation of the proposed treatment –
   (a) containing sufficient information to enable the patient to make a balanced judgment about the treatment;
   (b) identifying and explaining any medication or technique about which there is insufficient knowledge to justify its being recommended or to enable its effect to be reliably predicted; and
   (c) warning the patient of any risks inherent in the treatment.

(2) The extent of the information that a patient is required to be given under this section is limited to information that a reasonable person in the patient’s position would be likely to regard as significant unless it is, or reasonably should be, known that the patient would be likely to regard other information as significant.

(3) The requirements of subsection (1) apply irrespective of any privilege that a person may assert.

(4) Anything that is required by this section to be communicated to a patient is not to be considered to have been effectively communicated unless –
   (a) it is in a language or form that is readily understood by the patient using a competent interpreter if necessary; and
   (b) it is so expressed as to facilitate his or her understanding of what is required to be communicated.

**Section 98 – Sufficient time to be given**

Informed consent is not to be considered to have been given unless the patient has been allowed sufficient time to consider the matters involved in the decision and obtain such advice and assistance as may be desired.

**Division 3 – Prohibited treatment**

**Section 99 – Offence to administer certain treatment**

(1) A person is not to administer to or perform on another person –
   (a) deep sleep therapy; or
   (b) insulin coma or sub-coma therapy.

(2) A person who contravenes subsection (1) commits a crime.

Penalty: Imprisonment for 5 years.
Section 100 – Meaning of “psychosurgery”

(1) In this Division –

psychosurgery means –

(a) the use of a surgical technique or procedure, or of intracerebral electrodes, to create in a person’s brain a lesion that, by itself or together with any other lesion created at the same time or any other time, is intended to permanently alter the thoughts, emotions, or certain behaviour of the person; or

(b) the use of intracerebral electrodes to stimulate a person’s brain, without creating a lesion, with the intent that, by itself or together with any other such stimulation at the same time or any other time, the stimulation will, temporarily, influence or alter the thoughts, emotions, or certain behaviour of the person.

(2) The behaviour referred to in subsection (1)(a) and (b) does not include behaviour considered to be secondary to a paroxysmal cerebral dysrhythmia.

Section 101 – Prerequisites to psychosurgery

(1) A person is not to perform psychosurgery on another person unless –

(a) that other person has given informed consent to it; and

(b) it has been approved by the Mental Health Review Board constituted as required by section 130.

(2) A person who contravenes subsection (1) commits a crime.

Penalty: Imprisonment for 5 years.

(3) It is no defence to a charge of an offence against this section that the person on whom psychosurgery was performed refused to give, or was incapable of giving, informed consent.

Section 102 – Applications for approval to perform psychosurgery

(1) An application for the Mental Health Review Board to approve of the performance of psychosurgery is to be made in writing.

(2) For the purposes of proceedings before the Board to consider the application –

(a) the applicant and the person on whom the psychosurgery is proposed to be performed are parties to the proceedings; and

(b) the Board may also treat as a party any other person who the Board is satisfied has a sufficient interest in the matter.

Division 5 – Electroconvulsive therapy

Subdivision 1 – Involuntary patients and mentally impaired accused

Section 104 – Prerequisites

(1) A person is not to perform electroconvulsive therapy on –

(a) an involuntary patient; or

(b) a mentally impaired accused who is in an authorised hospital, unless –

(c) it has been recommended by the treating psychiatrist; and

(d) the recommendation is approved by another psychiatrist.

Penalty: $10 000 and imprisonment for 2 years.

(2) Subsection (1) does not apply if the electroconvulsive therapy is given as emergency psychiatric treatment and the requirements of Division 7 have been fulfilled.
Section 105 – Matters for consideration by psychiatrist

Before a psychiatrist approves a recommendation for the purposes of 104(1)(d), the psychiatrist is required –

(a) to be satisfied that the proposed therapy has clinical merit and would be appropriate in the circumstances;
(b) to decide whether or not the person concerned has the capacity to give informed consent to the proposed therapy;
(c) if the person has the capacity –
   (i) to ascertain whether or not that consent has been given; and
   (ii) to have regard to whether or not that consent has been given.

Subdivision 2 – Other patients

Section 107 – Informed consent required

(1) A person is not to perform electroconvulsive therapy on a person who is neither –
   (a) an involuntary patient; nor
   (b) a mentally impaired accused who is in an authorised hospital,
       unless the person on whom the therapy is performed has given informed consent to it.
Penalty: $10 000 and imprisonment for 2 years.
(2) Subsection (1) does not apply if the electroconvulsive therapy is given as emergency psychiatric treatment and the requirements of Division 7 have been fulfilled.
(3) It is no defense to a charge of an offence against subsection (1) of having performed electroconvulsive therapy on a person without the person having given informed consent to it that the person refused to give, or was incapable of giving, informed consent.

Division 6 – Other treatment, involuntary patients and mentally impaired accused

Section 108 – Meaning of “psychiatric treatment” in this Division

References in this Division to psychiatric treatment are to psychiatric treatment that does not involve –

(a) treatment that is prohibited by section 99;
(b) psychosurgery; or
(c) electroconvulsive therapy.

Section 109 – Consent not required for psychiatric treatment

An involuntary patient, or a mentally impaired accused who is in an authorised hospital, may be given psychiatric treatment without his or her consent.

Section 110 – Medical treatment may be approved by the Chief Psychiatrist

(1) A person who is in an authorised hospital as –
   (a) an involuntary patient; or
   (b) a mentally impaired accused,
       may be given medical treatment, other than psychiatric treatment or treatment referred to in section 108, if it has been approved in writing by the Chief Psychiatrist.
(2) Subsection (1) does not limit a power conferred by any other written law by which a person may consent to the medical treatment of another person.
Division 7 — Emergency psychiatric treatment

Section 113 – Definition
(1) In this Division –

_**emergency psychiatric treatment**_ means psychiatric treatment that it is necessary to give to a person –

(a) to save the person’s life; or

(b) to prevent the person from behaving in a way that can be expected to result in serious physical harm to the person or any other person.

(2) Psychosurgery is not permissible as an emergency psychiatric treatment.

Section 114 – Consent or approval dispensed with
Treatment that is emergency psychiatric treatment may be given without any consent or approval that would be required if it were not emergency psychiatric treatment.

Section 115 – Duties of person giving emergency treatment
A person who under section 114 gives treatment without any consent or approval that would have been required had the treatment not been emergency psychiatric treatment, is to –

(a) ensure that a record is made of the treatment including –

(i) particulars of the treatment;

(ii) the time and place at which, and the circumstances in which, the treatment was given; and

(iii) the names of the person given treatment and the persons involved in giving the treatment; and

(b) send to the Mental Health Review Board a report of the giving of the treatment including the information that is required by paragraph (a) to be recorded.
E. **Health Act 1911 – Abortion**

In addition to section 199 of *The Criminal Code 1913*, Lawful abortions and requirement of informed consent, section 334 of the *Health Act 1911* ("the Health Act") relevantly provides:

1. A reference in this section to performing an abortion includes a reference to —
   - (a) attempting to perform an abortion; and
   - (b) doing any act with intent to procure an abortion, whether or not the woman concerned is pregnant.

2. No person, hospital, health institution, other institution or service is under a duty, whether by contract or by statutory or other legal requirement, to participate in the performance of an abortion.

3. Subject to subsections (4) and (7), the performance of an abortion is justified for the purposes of section 199(1) of *The Criminal Code* if, and only if:
   - (a) the woman concerned has given informed consent; or
   - (b) the woman concerned will suffer serious personal, family or social consequences if the abortion is not performed; or
   - (c) serious danger to the physical or mental health of the woman concerned will result if the abortion is not performed; or
   - (d) the pregnancy of the woman concerned is causing serious danger to her physical or mental health.

4. Subsection (3)(b), (c) or (d) do not apply unless the woman has given informed consent or in the case of paragraphs (c) or (d) it is impracticable for her to do so.

5. In this section— "informed consent" means consent freely given by the woman where—
   - (a) a medical practitioner has properly, appropriately and adequately provided her with counselling about the medical risk of termination of pregnancy and of carrying a pregnancy to term;
   - (b) a medical practitioner has offered her the opportunity of referral to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying a pregnancy to term; and
   - (c) a medical practitioner has informed her that appropriate and adequate counselling with be available to her should she wish it upon termination of pregnancy or after carrying the pregnancy to term.

6. A reference in subsection (5) to a medical practitioner does not include a reference to—
   - (a) the medical practitioner who performs the abortion; nor
   - (b) any medical practitioner who assists in the performance of the abortion.

7. If at least 20 weeks of the woman’s pregnancy have been completed when the abortion is performed, the performance of the abortion is not justified unless —
   - (a) 2 medical practitioners who are members of a panel of at least 6 medical practitioners appointed by the Minister for the purposes of this section have agreed that the mother, or the unborn child, has a severe medical condition that, in the clinical judgment of those 2 medical practitioners, justifies the procedure; and
   - (b) the abortion is performed in a facility approved by the Minister for the purposes of this section.

8. For the purposes of this section—
   - (a) subject to subsection (11), a woman who is a dependent minor shall not be regarded as having given informed consent unless a custodial parent of the woman has been informed that the performance of an abortion is being considered and has been given the opportunity to participate in a counselling process and in consultations between the woman and her medical practitioner as to whether the abortion is to be performed.
   - (b) a woman is a dependent minor if she has not reached the age of 16 years and is being supported by a custodial parent or parents; and
   - (c) a reference to a parent includes a reference to a legal guardian.

9. A woman who is a dependent minor may apply to the Children’s Court for an order that a person specified in the application, being a custodial parent of the woman, should not be given the information and opportunity referred to in subsection (8)(a) and the court may, on being satisfied that the application should be granted, make an order in those terms.
(10) An order made under subsection (9) has effect according to its terms and is not liable to be challenged, appealed against, reviewed, quashed or called in question in or by any court.

(11) If the effect of an order under subsection (9) is that no custodial parent of the woman can be given the information and opportunity referred to in subsection (8)(a), subsection (8) does not apply in relation to the woman."

Section 335 – Reports to be furnished
(1) It shall be the duty of every midwife to furnish to the Executive Director, Public Health and to the medical officer of health of the district in which she practices a report in writing in the manner and at the time and in the form prescribed of every case attended by her, whether of living, premature or full-time birth, or stillbirth, or abortion.

(2) A report furnished under subsection (1) shall state the name and address of the mother, and shall be furnished to the Executive Director, Public Health and to the medical officer of health within 48 hours of the event.

(3) A midwife who contravenes subsection (1) as read with subsection (2) commits an offence.

(4) The occupier of any house at which a female not usually resident in any such house, is attended, whether for gain or not, during childbirth or abortion or miscarriage, shall forthwith notify to the medical officer of health that such female is being so attended.

(5) (a) When a medical practitioner attends on the happening of any premature birth, stillbirth or abortion (other than an abortion to which paragraph (d), he shall send to the Executive Director, Public Health within 48 hours of the happening a report in the prescribed form.

(b) A medical practitioner, or where a medical practitioner is not in attendance, a midwife, who attends a woman at the delivery of a foetus at any time after the 20th week of pregnancy shall notify the Executive Director, Public Health of the attendance in the prescribed form.

(c) A medical practitioner who, for the purposes of section 44 of the Births, Deaths and Marriages Registration Act 1998, certifies the cause of a neonatal death shall notify the Executive Director, Public Health of the fact in the prescribed form within 48 hours of the certification.

(d) When a medical practitioner performs an abortion, the medical practitioner shall notify the Executive Director, Public Health of the fact in the prescribed form within 14 days of the abortion being performed.

(e) A notification under paragraph (d) must not contain any particulars from which it may be possible to ascertain the identity of the patient.

(6) (a) The Governor may from time to time proclaim that the provisions of this subsection shall apply in respect of any district or part of a district and may from time to time proclaim that those provisions shall cease to apply in respect of, or having ceased to apply shall again apply in respect of any district or part of a district.

(b) The provisions of this subsection shall apply in respect of a district and part of a district so long as those provisions remain the subject of a proclamation to that effect under the provisions of the last preceding paragraph.

(c) The Executive Director, Public Health shall appoint medical practitioners upon such terms and conditions as he considers fit to conduct a post mortem examination upon the body of every stillborn child where the still birth happens in any district or part of a district to which the provisions of this subsection apply.

(d) The Executive Director, Public Health shall notify in the prescribed manner all medical practitioners and midwives of the name and address of every medical practitioner appointed under the provisions of the last preceding paragraph and acting under the appointment.

(e) When a stillbirth happens in any district or part of a district to which the provisions of this subsection apply, the medical practitioner attending or, if there is no medical practitioner attending, the midwife attending, shall, so soon as reasonably possible after the happening, report it in the manner and form prescribed, to a medical practitioner appointed under paragraph (c) and acting under the appointment, who shall, unless otherwise authorised or directed by the Executive Director, Public Health, thereupon conduct a post mortem examination on the body of the stillborn child.
F. Human Tissue and Transplant Act 1982 – Part II Donations of Tissue by Living Persons

Division 3 – Donations from children

Section 10 Blood transfusions not subject to this Division
Nothing in this Division prevents the removal in accordance with Division 5 of blood from the body of a child.

Section 11 References to parents
In this Division, a reference to the parent of a child shall not be read as including a reference to the guardian of a child or to another person standing in loco parentis to the child.

Section 12 General prohibition of removal of tissue from children
(1) It is not lawful, except as provided by this Part, to remove regenerative tissue from the body of a living child for the purpose of the transplantation of the tissue to the body of another living person.

(2) It is not lawful to remove non-regenerative tissue from the body of a living child for the purpose of the transplantation of the tissue to the body of another living person.

Section 13 Parent may consent to removal of regenerative tissue from a child
(1) A parent of a child may, in the circumstances specified in subsection (2), consent in writing to the removal from the body of the child of specified regenerative tissue for the purpose of the transplantation of the tissue to the body of another member of the family of the child or to the body of a relative of the child.

(2) The circumstances specified for the purposes of subsection (1) are that -
   (a) medical advice has been furnished to the parent and the child regarding the nature and effect of the removal and the nature of the transplantation;
   (b) the child has the mental capacity to understand the nature and effect of the removal and the nature of the transplantation; and
   (c) the child has agreed to the removal of the regenerative tissue for the purpose of its transplantation to the body of the person referred to in subsection (1).

Section 14 Revocation of consent
A parent who has given a consent under this Division, or a child who has under this Division agreed to the removal of tissue from his body, may, at any time before the removal of the tissue to which the consent or agreement applies, revoke, either orally or in writing, his consent or agreement, as the case requires, to the removal.

Division 5 – Blood Transfusions

Section 19 - Parent may consent to removal of blood from child
The parent of a child may consent to a removal of blood from the body of the child for a use referred to in section 18 if:
   (a) a medical practitioner advises that the removal should not be prejudicial to the health of the child; and
   (b) the child agrees to the removal.

Section 20 - Consent is sufficient authority for removal of blood
A consent under this Division is sufficient authority for the removal of blood from the body of the person who has given the consent, or from the body of the child of the person who has given the consent, as the case requires.
Section 21 - Blood transfusions upon children without parental consent

(1) A medical practitioner may perform a blood transfusion upon a child without the consent of any person who is legally entitled to authorise the blood transfusion if -
   (a) such person -
      (i) fails or refuses to authorise the blood transfusion when requested to do so; or
      (ii) cannot be found after such search and enquiry as is reasonably practicable in the circumstances of the case;
   and
   (b) the medical practitioner and another medical practitioner agree -
      (i) as to the condition from which the child is suffering;
      (ii) that the blood transfusion is a reasonable and proper treatment for that condition; and
      (iii) that without a blood transfusion the child is likely to die;
   and
   (c) the medical practitioner who performs the blood transfusion on the child -
      (i) has had previous experience in performing blood transfusions; and
      (ii) has, before commencing the transfusion, assured himself that the blood to be transfused is suitable for the child.

(2) When a medical practitioner has performed a blood transfusion on a child without the consent of any person legally entitled to authorise it and in respect of that transfusion the requirements and conditions of this section have been complied with, the transfusion shall be deemed for all purposes to have been performed with the authority of a person legally entitled to authorise it.

(3) Where a medical practitioner other than the medical practitioner who is to perform the blood transfusion on the child cannot be found after search or enquiry for such time as the last-mentioned medical practitioner considers reasonable in the circumstances of the case, having regard to the emergency arising from the condition of the child, it is sufficient compliance with subsection (1)(b) if the last-mentioned practitioner satisfies himself -
   (a) as to the condition from which the child is suffering;
   (b) that a blood transfusion is a reasonable and proper treatment for that condition;
   (c) that to delay the blood transfusion until that other medical practitioner can be found and be available for consultation would cause a serious deterioration in the child’s condition; and
   (d) that without a blood transfusion the child is likely to die."

(4) In this section –
   blood transfusion means the transfusion of human blood, any constituent of human blood or saline solution or other liquid, into a child and includes the exchange of the whole or any part of the blood of a child and all medical and surgical procedures necessary to perform the transfusion or exchange; and
   child means a person who is or appears to be under the age of 18 years.

(5) Nothing in this section relieves a medical practitioner from liability in respect of the administration of a blood transfusion to a child being a liability to which he would have been subject if the transfusion had been administered with the consent of a parent of the child or a person having authority to consent to the administration of the transfusion.