Feidhmeannacht na Seirbhíse Sláinte
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Quality and
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Tús Áite do
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National Consent Advisory Group

National Consent Policy

Part One – General Principles

Part Two – Children and Adolescents

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Part One – General Principles

Glossary

Adoption

Adoption in Ireland provides for the permanent transfer of parental rights and duties from the birth parents to the adoptive parents. An adopted child is considered to be the child of the adopters as if born to them in lawful wedlock.

Adult

A person over the age of 18 years

Advance care planning

A process of discussion between a service user and his/her care providers about future medical and social care preferences in the event that the service user is unable to speak for him/herself due to an emergency or serious illness.

Advocate

An advocate refers to an individual tasked with supporting or promoting the interests of others.

Autonomy

The capacity to make decisions and take actions that are in keeping with one's values and beliefs.

Bioethics

A multidisciplinary activity dealing with the ethical implications of biological research and medicine.

Braille

A system of reading and writing using raised dots. Braille is reading by touch.

Capacity

The ability to make a decision.

Child

A person under the age of 18 years, unless that person has attained full age through marriage

Coercion

Forcing someone to behave in a particular way by use of threats or intimidation or some other form of pressure or force.

Cognitive impairment

A cognitive decline greater than that expected for a person's age and education level.

Family

May include the immediate biological family and/or other relatives, spouses, partners (including same sex and de facto partners) or friends.

Foster care

Foster care is caring for someone else's child in one's own home – providing family life for a child who, for one reason or another, cannot live with his or her own parents, either on a short or a long term basis

Health and social care

The HSE provides health and social services to everyone living in Ireland. Services are delivered to young and old, in hospitals, health facilities and in communities across the country.

Interpreter

A person who facilitates communication between users of different languages by use of oral translation or sign-language methods, either simultaneously or consecutively.

Legal guardian

A person with rights and responsibilities in respect of someone who lacks legal capacity, such as a child.

Major procedure

A significant medical intervention, usually complex and high-risk.

Minor

A person who is less than 18 years of age, who is not or has not been married.

Personal data

Data relating to a living individual who is or can be identified either from the data or from the data in conjunction with other information that is in, or is likely to come into, the possession of the data controller.

Service user

The term ‘service user’ includes:

- People who use health and social care services as patients.
- Carers, parents and guardians.
- Organisations and communities that represent the interests of people who use health and social care services.
- Members of the public and communities who are potential users of health services and social care interventions.

Third party

A person or entity who is not involved in the particular interaction or relationship.

1 Introduction

Consent must be obtained before starting treatment or investigation, or providing personal or social care for a service user[1] or involving a service user in teaching and research (all defined as 'interventions' for the purpose of this policy). This requirement is consistent with fundamental ethical principles, with good practice in communication and decision-making and with national health and social care policy. In the case of medical examination, treatment, investigation or social care service, the need for consent is recognised in Irish and international law.

1.1 Scope of this policy

The need for consent, and the application of the general principles in this policy, extends to all interventions on service users in all locations. Thus, it includes social as well as health care interventions and applies to those receiving care and treatment in hospitals, in the community and in residential care settings. How the principles are applied, such as the amount of information provided and the degree of discussion needed to obtain valid consent, will vary with the particular situation. In some situations, permission, as matter of common courtesy and of respect for the service user, rather than consent may be required e.g. to enter a person's home, and should be obtained in keeping with relevant HSE codes of conduct[2]. Knowledge of the importance of obtaining consent is expected of all staff employed or contracted by the HSE.

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[1] The term service user includes:
- People who use health and social care services as patients.
- Carers, parents and guardians.
- Organisations and communities that represent the interests of people who use health and social care services.
- Members of the public and communities who are potential users of health services and social care interventions

[2] HSE Doc 2.1: Code of Standards and Behaviour (V3) (2009)

1.2 Ethical issues regarding consent

The ethical rationale behind the importance of consent is the need to respect the service user's right to self-determination (or autonomy) – their right to control their own life and to decide what happens to their own body. Those providing health and social care can often claim greater expertise in decisions regarding the 'means' to achieve the 'end' of better health, such as what medication will best treat blood pressure or whether admission to long-term care is advisable, although service users retain ultimate decision-making authority and must consent to the intervention. However, service users are the experts in determining what 'ends' matter to them, including how they should live their everyday lives, decisions about risk-taking and preference for privacy or non-interference.

While respect for autonomy is very important, it is not the only ethical principle relevant to consent. Health and social care professionals also have a responsibility to try and maximise the health and well-being of, and to minimize harm to, service users. Ultimately, however, the competent service user's right to make their own decisions applies even when their decision seems unwise to the health and social care professional.

1.3 Health and social care decision-making

The relationship between those who provide health and social care and the service user should be a partnership based on openness, trust and good communication. Almost every health and social care intervention involves decisions made by service users and those providing their care. Good decision making requires a dialogue between parties that recognises and acknowledges the service user's goals, values and preferences as well as the specialist knowledge, experience and clinical judgment of health and social care professionals.

1.4 Consent in Irish law

It is a basic rule at common law that consent must be obtained for medical examination, treatment, service or investigation. This is well established in Irish case law and ethical standards. The requirement for consent is also recognised in international and European human rights law and under the Irish Constitution. Therefore, other than in exceptional circumstances,[3] treating service users without their consent is a violation of their legal and constitutional rights and may result in civil or criminal proceedings being taken by the service user. Health and social care professionals have a responsibility to keep themselves informed of legal developments which may have a bearing on their practice. Likewise, the employer or service provider has a responsibility to staff to provide access to legal information which may have a bearing on the service provided.

1.5 Role of the family

No other person such as a family member or carer can give or refuse consent on behalf of an adult service user.[4] However, in recognition of the prominent role played by the family in Irish culture and society, it may be appropriate in some circumstances to include family members in the discussion and decision-making process pertaining to health and social care interventions.[5] The role of the family in such situations is not to make the final decision, but rather to support the service user in reaching a decision in conjunction with health/social care providers; or in the case of a service user lacking capacity to help provide greater insight into his/her previously expressed views and preferences and to outline what they believe the individual would have wanted.

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[3] For discussion of these exceptional circumstances see chapter one paragraph 6

[4] Unless the service user has been made a Ward of Court, see para 5.7

[5] The term family as used here may include the immediate biological family and/or other relatives, partners (including same sex and de facto partners) or friends. They may have a close, ongoing, personal relationship with the service user, be chosen by the service user to be involved in treatment decisions, and have themselves indicated that they are ready to be involved in such decisions.

1.6 Complaints

In health and social care, sometimes a family member may make a complaint regarding the care a family member received. Where this happens and the complaint is investigated/reviewed it is essential to ensure that the service user has consented to their personal information being made available for such internal investigations/reviews.

This also applies in cases where the service user has died and the service users' family request an investigation or review of the care received prior to death. Difficulties may arise where the service users' husband/wife does not wish the investigation or review to proceed or where the couple were estranged prior to the service user's death. In all such instances consent must be sought from the husband/wife and advice should be sought in relation to access by family members to records under the Freedom of Information Acts.

1.7 Age of consent in Irish law

The age of consent in Ireland is outlined in the following Acts:

- The Non-Fatal Offences against the Persons Act, 1997 states that persons over the age of 16 years can give consent for surgical, medical and dental procedures.
- The Child Care Act 1991, the Children Act 2001 and the Mental Health Act 2001 define a “child” as a service user under the age of 18 years, “other than a service user who is or who has been married”.

This is discussed further in Part Two of this policy.

2. What is valid and genuine consent?

Consent is based on the principle that individuals are entitled to choose freely whether or not to receive a medical intervention, use a service or participate in research and it endorses the concept of personal autonomy (i.e. the right to make decisions without external influence). It is also associated with the ethical principle of respect for persons, which requires that people's beliefs and opinions be valued and, where feasible, adhered to. These principles, however, are not absolute and must be balanced against other values such as justice, integrity and solidarity, thereby recognising the interdependence and the interconnection of individuals within society.

Consent should be regarded as a process of communication that begins with the initial contact and continues through to the end of the individual's involvement in the treatment process, provision of social care or research study. In order for consent to be deemed valid, informed and genuine, there are five criteria that must be met, namely: voluntariness; the provision of information; understanding; competence; and the accurate recording of the individual's decision.

Seeking consent is not merely getting a consent form signed; the consent form is just one means of documenting that a process of communication has occurred.

For the consent to be valid, the service user must:

- Have received sufficient information in a comprehensible manner about the nature, purpose, benefits and risks of an intervention/service or research project.
- Not be acting under duress; and
- Be competent to take the particular decision.

These criteria are discussed further in the next section.

3. Providing information and discussing treatment options

The exchange of information between those who provide health and social care and the service user is central to consent. As stated above, for consent to be valid, the service user ‘must have received sufficient information in a comprehensible manner about the nature, purpose, benefits and risks of an intervention’. The meaning of ‘sufficient information’ will depend both on the individual circumstances of the service user and on the nature and extent of the intervention. Ensuring that information is provided in a ‘comprehensible manner’ requires consideration of the quality of the communication between those who provide health and social care and the service user both in terms of the content of the information to be provided and of how that information should be provided. This will be explained in further detail in sections 3.1 - 3.3.

3.1 Importance of individual circumstances

How much information service users want and require will vary depending on their individual circumstances. Discussions with service users should as much as possible be tailored according to:

- Their needs, wishes and priorities.
- Their level of knowledge about, and understanding of, their condition, prognosis and the treatment options.
- Their ability to understand the information provided/language used.
- The nature of their condition.

3.2 What information should be provided about interventions?

The amount of information to be provided about an intervention will depend on the urgency, complexity, nature and level of risk associated with the intervention.

Choosing whether to undergo or to forego medical investigation and treatment or whether to agree or not to a major lifestyle change such as admission to residential care often requires the service user to balance the potential risks and benefits of both approaches. In these circumstances, service users require adequate information about:

- Their diagnosis and prognosis including any uncertainties about the diagnosis or prognosis.
- Options for treating or managing the condition, including the option not to treat.
- The purpose of any proposed intervention and what it will involve.
- The potential benefits, risks and the likelihood of success of a proposed intervention, as well as that of any available alternative.
- Whether a proposed investigation or treatment is experimental or part of a research project.
- If relevant, the costs they will have to pay related to an intervention.

By contrast, the nature and effect of some interventions, such as removal of a dressing or provision of assisted personal care in the home, are often self-evident and relatively risk-free. In these circumstances, it is usually enough for staff to seek consent to proceed after a brief description of the intervention. Refusal of permission, especially if it may be harmful to the service user, or a request for additional information should trigger additional discussion.

Although service users may be provided with standardised informational material, they should be told if their particular circumstances might modify the risks or benefits as stated in such material.

Service users should be asked if they have understood the information they have been given, and whether or not they would like more information before making a decision. Questions should be answered honestly and, as far as practical, as fully as the service users wishes.

3.3 What information about risks and side effects of an intervention should be provided?

The amount of information about risk that staff should share with service users will depend on the individual service user and what they want or need to know. Although most service users will be aware that no physical procedure or medication is entirely risk free, they may not be as familiar with the potential risks of administration of blood products or of radiographic procedures. Factors such as service users' occupations or lifestyles may influence those risks that they consider significant or particularly undesirable.

A general rule is to provide information that a reasonable person in the service user's situation would expect to be told. This is in line with ethical and professional standards as well as the legal standard applied by the Irish courts. Such information includes the likelihood of:
(a) side effects or complications of an intervention;
(b) failure of an intervention to achieve the desired aim; and
(c) the risks associated with taking no action or with taking an alternative approach.

Common, even if minor, side effects should be disclosed as should rare but serious adverse outcomes. The latter, sometimes called 'material' or significant' risks, include death, permanent disability (such as paralysis or blindness), permanent disfigurement and chronic pain.

Information about risk should be given in a balanced way. Service users may understand information about risk differently from those providing health and social care. This is particularly true when using descriptive terms such as 'often' or 'uncommon'. Potential biases related to how risks are 'framed' are important: a 1 in a thousand risk of a complication also means that 999 out of a thousand service users will not experience that complication. In order to best support service users in assessing the risks and benefits of various interventions/course of action consideration should be given to:

- Designing and employing communications that use plain language
- Avoid explaining risks in purely descriptive terms (such as low risk), try to supplement with numerical data
- Use absolute numbers; avoid using relative risk or percentage improvements
- Use visual aids e.g. pictographs wherever possible, to maximise understanding.

3.4 How and when information should be provided

The manner in which the health and social care options are discussed with a service user is as important as the information itself. Service users should be given the time and support they need to maximise their ability to make decisions for themselves. It is particularly important to ensure this is the case for those who may have difficulty making decisions including those with communication difficulties or intellectual disability or cognitive impairment.

It must not be assumed that a service user lacks capacity to make a decision solely because of communication difficulties, intellectual disability or cognitive impairment.
The following measures are often helpful:

- Discussing treatment options in a place and at a time when the service user is best able to understand and retain the information.

- Providing adequate time and support, including, if necessary, repeating information.
- Use of simple, clear and concise English and avoidance of medical terminology.
- Supplementing written or verbal information with visual depictions.
- Asking the service user if there is anything that would help them remember information, or make it easier to make a decision; such as bringing a relative, partner, friend, carer or advocate to consultations.
- Speaking to those close to the service user and to other health and social care staff about the best ways of communicating with the service user, taking account of confidentiality issues.

Additional measures may be required in specific circumstances:

- <u>Provision for service users when English is not their first language</u>

Except in emergency situations, an interpreter proficient in the service user's language is required to facilitate the service user giving consent for interventions that may have a significant impact on his or her health and well-being. In most cases, this is best achieved by using a professional interpreter, and the service user should be informed that an interpreter will be arranged at no cost to them to assist in communication. The use of family and friends is not recommended as the accuracy of the interpretation, especially with regards to medical terminology, cannot be guaranteed and the family member's own views may influence the interpretation or lead to filtering of the necessary information. The use of children as interpreters should be avoided as this may have an adverse impact on the child's welfare. Additional time will always be required for discussions involving an interpreter, and this should be planned for in advance[6].

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[6] On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services (2009)

- <u>Deaf and hard of hearing service users</u>

Deaf and hard of hearing service users should be asked how they would like information to be provided. Some individuals with impaired hearing can lip read, some use hearing aids and others may require sign language interpreters. If required, a Sign Language interpreter should be obtained. In relation to the use of children, family and friends as interpreters see paragraph above.

- <u>Blind and visually impaired service users</u>

People with a visual impairment should be asked how they would like information to be provided. There are a range of formats that can be used to make written information accessible to people with visual impairments. These include large print, Braille, writing in thick black marker pen and use of audio tapes. Information can also be made more accessible using text and email applications.

4. Ensuring consent is voluntary

For consent to be valid the service user must not be acting under duress and their agreement should be given freely, in other words they must understand that they have a choice. Duress refers to pressures or threats imposed by others; illness itself may bring pressures to bear on service users, who may feel they have little choice regarding treatment as a result.

It is not uncommon for health and social care professionals to make strong recommendations to service users, such as to stop smoking or drinking as this generally reflects a genuine concern for the service user's welfare. However, coercion invalidates consent and care must be taken to ensure that the service user makes a decision freely.

Coercion should be distinguished from providing the service user with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for the service user's health. Use of threats to induce consent such as withdrawal of any privileges is not acceptable.

Service users may also be subject to pressure from family and friends to accept or reject a particular intervention, such as, for example, to enter a nursing home if they are perceived to be at risk of harm at home. Staff should take particular care in these circumstances to ensure as far as practical that the service user's decision has not been made under undue pressure, for example by having private discussions with the service user so that ultimately he or she makes their own decision.

5 Has the service user the capacity to make the decision?

5.1 General principles

Best practice favours a 'functional' or decision-specific approach to defining decision-making capacity: that capacity is to be judged in relation to a particular decision to be made, at the time it is to be made - in other words it should be issue specific and time specific – and depends upon the ability of an individual to comprehend, reason with and express a choice with regard to information about the specific decision. The "functional" approach recognises that there is a hierarchy of complexity in decisions and also that cognitive deficits are only relevant if they actually impact on decision making.

5.2 Duty to maximise capacity

Best practice and international human rights standards favour "supported decision-making" where possible. This requires that efforts must be made to support individuals in making decisions for themselves where this is possible. A service user's ability to make decisions may depend on the nature and severity of their condition, or the difficulty or complexity of the decision. Some service users will always be able to make simple decisions, but may have difficulty if the decision is complex or involves a number of options. Other service users may be able to make decisions at certain times but not at other times, because of fluctuations in their condition or because factors such as confusion, panic, shock, fatigue, pain or medication temporarily affect their ability to understand, retain or weigh up information, or communicate their wishes.

It is important to give those who may have difficulty making decisions the time and support they need to maximise their ability to make decisions for themselves. Approaches that may be helpful in this regard include:

- Discussing treatment options in a place and at a time when the service user is best able to understand and retain the information.
- Providing adequate time and support, including, if necessary, repeating information.
- Use of simple, clear and concise English and avoidance of medical terminology.
- Supplementing written or verbal information with visual depictions.
- Asking the service user if there is anything that would help them remember information, or make it easier to make a decision; such as bringing a relative, partner, friend, carer or advocate to consultations.
- Speaking to those close to the service user and to other health and social care staff about the best ways of communicating with the service user, taking account of confidentiality issues.

5.3 Presumption of capacity

Those who provide health and social care services must work on the presumption that every adult service user has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. It must not be assumed that a service user lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including intellectual disability, mental illness, dementia or scores on tests of cognitive function), their beliefs, their apparent inability to communicate, or the fact that they make a decision that seems unwise to the health and social care professional. Capacity should not be confused with a health and social care professional's assessment of the reasonableness of the service user's decision. Similarly, the fact that a service user has been found to lack capacity to make a decision on a particular occasion does not mean that they lack capacity to make any decisions at all, or that they will not be able to make similar or other decisions in the future.

5.4 When to consider incapacity

An important implication of the presumption of capacity is that this presumption should not be challenged unless an adequate "trigger" exists. The possibility of incapacity and the need to assess capacity formally should only be considered, if, having been given all appropriate help and support, a service user:

- Is unable to communicate a clear and consistent choice;
- Is obviously unable to understand the information and choices provided; or
- Makes a choice that seems to be based on a misperception of reality or one that doesn't seem consistent with that person's known beliefs and values insofar as they are known.

5.5 Assessing capacity to consent

Capacity to consent should be assessed if there is sufficient reason to question the presumption of capacity. This involves assessing whether:

- The service user understands in broad terms the reasons for and nature of the decision to be made.
- The service user has sufficient understanding of the principal benefits and risks of an intervention and relevant alternative options after these have been explained to them in a manner and in a language appropriate to their individual level of cognitive functioning.
- The service user understands the relevance of the decision, appreciates the advantages and disadvantages in relation to the choices open to them and is able to retain this knowledge long enough to make a voluntary choice.

5.6 Making decisions if capacity is absent

There is currently no legislative framework to govern how decisions about treatment and care should be made for those who lack capacity. However, Irish case law, national and international guidelines suggest that in making decisions for those who lack capacity, the health and social care professional should determine what is in their best interests, which is decided by reference to their values and preferences if known. The health and social care professional should:

- Consider whether the service user's lack of capacity is temporary or permanent. In those with fluctuating cognitive impairment, it may be possible to make use of lucid periods to obtain consent.
- Consider which options for treatment would provide overall clinical benefit for the service user.
- Consider which option, including the option not to treat, would be least restrictive of the service user's future choices.

- Support and encourage service users to be involved, as far as they want to and are able, in decisions about their treatment and care.
- Seek any evidence of the service user's previously expressed preferences, such as an advance statement or decision, and of the service user’s previous wishes and beliefs.
- Consider the views of anyone the service user asks you to consult.
- Consider the views of people close to the service user.

Those close to the service user may have insight into the service user's previously expressed preferences, wishes and beliefs. They may also have their own views as to the appropriateness or otherwise of interventions, based on their knowledge of the service user’s circumstances. In general, the closer the relationship to the service user, the greater weight should attach to such views. **However, it is important to note that no other person such as a family member/carer can give or refuse consent on behalf of an adult service user** unless they have specific legal authority to do so.[7]

5.6.1 Emergency situations involving service users who lack capacity

As with all service users, in emergency situations where a service user is deemed to lack capacity the health and social care professional should treat the service user without their consent, provided the treatment is immediately necessary to save their life or to prevent a serious deterioration of their condition and that there is no valid advance refusal of treatment. The treatment provided should be the least restrictive of the service user’s future choices. While it is good practice to inform those close to the service user – and they may be able to provide insight into the service user’s likely preferences - nobody else can consent on behalf of the service user in this situation.

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[7] See further paragraph 5.7

In non-emergency situations, a distinction can be made between those service users who, depending on the nature of their incapacity, may or may not be able to express an opinion regarding the proposed intervention. Even in the presence of incapacity, the expressed view of the service user carries great weight.

- Cannot express opinion: This includes service users who are in a coma or have severe dementia or have sufficient clouding of consciousness to impair effective communication. Decisions should be made in the best interests of the service user, bearing in mind the principles outlined above. It is good practice to inform those close to the service user of planned interventions and to seek their agreement if possible. However, it is important to remember that the primary duty of the health and social care professional is to the service user.

- Can express opinion: Many service users who lack capacity will have opinions in respect of their treatment. Most health and social care decisions regarding those who lack capacity arise in the community, and, except in emergencies, it may often be impractical or undesirable to try to impose care, treatment or investigation on someone who refuses it. Legal advice should be sought in respect of refusal of any major intervention including surgery, prolonged detention or other restrictions on liberty.

5.7 Wards of court

Where a service user has been made a ward of court, consent for minor procedures may be given by the service user's Wardship Committee (usually one person). For major procedures the consent of the President of the High Court must be obtained. If in doubt regarding whether or not court consent is required, the Office of Wards of Court should be contacted[8].

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[8] www.courts.ie/offices

6 Is it always necessary to seek service user consent?

The general principles of consent apply to all decisions about care: from the treatment of minor and self-limiting conditions, to major interventions with significant risks or side effects. However, while the agreement of the service user should always be sought, there are a number of situations where the amount of information provided about an intervention may legitimately be abbreviated. These include:

- Emergency situations.
- Where the service user declines information.
- When information would be harmful to the service user.

6.1 Emergency situations

In an emergency life-threatening situation where the service user is unable to consent or to appreciate what treatment is required, the necessary treatment may be administered in the absence of the expressed consent of the service user in his or her best interests. The application of this exception is limited to situations where the treatment is immediately necessary to save the life or preserve the health of the service user.

6.2 Where the service user declines information

Some service users do not want to know in detail about their condition or the treatment. While this should be respected if possible, it is important that some basic information be provided about major interventions in order that consent can be obtained and the service user has been advised of what is involved. If a service user refuses to receive detailed information about their condition, this should be documented.[9]

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[9] Further details on the documentation of consent are provided at 7.6

6.3 When information would be harmful to the service user

In very rare and exceptional circumstances health and social care professionals may withhold information from the service user where they believe that providing the information would have a serious adverse effect on the health of the service user e.g. by causing significant psychological distress to a very vulnerable service user. However, the fact that a service user might be upset or refuse treatment or services as a result of receiving information as part of the consent process is not a valid reason for withholding information that they need or are entitled to know.

The decision to withhold information from a service user should be discussed with a senior healthcare colleague or line manager and the justification for the decision should be documented clearly in the service users healthcare record.

7. Specific Issues relating to consent

7.1 Scope of consent

The need for consent, and the application of the principles in this policy, extends to all health and social care interventions involving service users in both acute and non-acute settings. A non- exhaustive list includes:

- Physical examination.
- Blood tests.
- Radiological examinations.
- Screening tests.
- Surgical procedures.
- Anaesthetic procedures.
- Chemotherapy and radiotherapy treatment.

- Prescription of medications.
- Use of blood products.
- Clinical photography.
- Provision of social care.
- Psychological interventions.

Provision of health and social care to a service user during a single episode often involves a number of interventions. This is particularly true during acute hospital admissions. While seeking broad or general consent to encompass all such interventions may not be in keeping with the service user's autonomy, seeking consent for each separate decision in this context might be unduly burdensome for service users and staff. A useful approach is to consider what a reasonable person in the service user's situation would consider appropriate. Thus, for example, it might be judged that someone facing potentially hazardous surgery would more likely prefer to focus on the risks of the surgical procedure than on the much smaller risks associated with the ancillary antibiotic treatment. However, individual preferences remain important in these circumstances: if service users have a strong preference for detailed information and for involvement in all aspects of decision-making, this should be respected as far as possible.

Those who provide health and social care services should discuss with service users the possibility of additional problems arising during an intervention or treatment when they may not be in a position to make a decision about how to proceed. If there is a significant risk of a particular problem arising, the service user should be asked in advance what they would like the health and social care professional to do if the difficulty occurs. It is important that service users understand the scope of any decisions to be made, especially if:

- Treatment will be provided in stages, with the possibility that changes or adjustments might be needed.
- Different professionals will provide particular parts of an investigation or treatment, such as anaesthesia and surgery.
- A number of different investigations or treatments are involved.

The service user should be asked if there are any particular procedures they object to in the context of their proposed treatment and this should be clearly documented on their record. If they agree only to parts of the proposed intervention/treatment, there should be a clear process through which they can be involved in making decisions at a later stage. Those who provide health and social care must not exceed the scope of the authority given by a service user, except in an emergency.

7.2 Involvement of students

Most service users support the importance of education and training of health and social care professionals and understand why such students may be involved in the care of the service user. However, service providers should ensure that service users are not burdened by excessive contact with students. Where it is proposed to involve students in providing care, the service user should be informed and the role of the student should be clearly outlined. If the service user has any objections, these should be respected as far as possible. Students should clearly identify themselves as students in any interaction with service users and must never represent themselves as qualified professionals.

7.3 Who should seek consent from a service user?

The person who is providing the health and social care service is ultimately responsible for ensuring that the service user is consenting to what is being done. The task of providing information and seeking consent may be delegated to another professional, as long as that professional is suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed intervention and of the benefits and in order to be able to provide the information the service user requires. Inappropriate delegation (for example where the seeking of consent is assigned to a junior health and social care professional with inadequate knowledge of the procedure) may mean that the "consent" obtained is not valid.

7.4 When should consent be sought?

The provision of information and the seeking and giving of consent should involve a continuing process of keeping service users up to date with any changes in their condition and the interventions proposed. It should not be a once-off, sometimes 'eleventh hour' event, exemplified by getting a hurried signature on a consent form.

While there are no legal provisions relating to the duration of consent, for major interventions it is good practice where possible to seek the service user's consent to the proposed procedure well in advance, when there is time to respond to the service user's questions and provide adequate information. Clinicians should then check, before the procedure starts, that the service user has no questions or concerns and still consents to proceed. If the service user has cognitive difficulties that might interfere with his or her recollection of the earlier discussion or there is a change in the service users condition which may result in a change in the nature, purpose or risks associated with the procedure, a fresh consent following provision of appropriate information should be sought.

Asking a service user to provide consent just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, or seeking consent from someone who is sedated, in pain or anxious, creates doubt as to the validity of the consent. In particular, service users should not be given routine pre-operative medication before being asked for their consent to proceed with a treatment.

7.5 Types of consent

Service users may indicate consent orally, in writing or in certain limited circumstances (such as where a service user holds out their arm for a blood pressure reading) non-verbally. However, the criteria for a valid consent do not depend on the form in which it is given. Before accepting a service user's consent, those who provide health and social care services must consider whether the service user has been given the information they want or need, and how well they understand what is proposed.

7.6 How should consent be documented?

It is essential for those who provide health and social care to document clearly both the service users' agreement to the intervention and the discussions that led up to that agreement if

(a) the intervention is invasive, complex or involves significant risks;
(b) there may be significant consequences for the service user's employment, or social or personal life;
(c) providing clinical care is not the primary purpose of the intervention e.g. clinical photographs or video clip to be used for teaching purposes or blood testing following needle stick injury to staff;
(d) the intervention is innovative or experimental.

This may be done either through the use of a consent form or through documenting in the service user's notes that they have given verbal consent.

If it is not possible to get written consent, for example, in an emergency or if the service user needs treatment to relieve serious pain or distress, oral consent will suffice but should be carefully documented. If the service user is unable to write, a mark on the form to indicate consent is sufficient. It is good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the service user has chosen to make their mark in this way to be recorded in the case notes.

7.7 Confidentiality and data protection

Service users have a right to expect that information about them will be held in confidence by those who provide health and social care services to them. Confidentiality is central to trust in this relationship. Staff are expected to comply with the provisions of the Data Protection Acts 1998 and 2003 which state that personal information obtained from service users for the purposes of informing care, treatment or service provision should not be disclosed to a third party unless it will support or progress the purpose for which it was collected.

Sharing of information on a 'need to know' basis between staff involved in a service user's care is essential to the provision of safe and effective care. Consent from the service user is not sought in these circumstances.

An integral component of modern health and social care is the use of audit and quality assurance programmes to ensure that the care provided is of the highest quality when benchmarked against national and international standards. Many such programmes involve the use of medical records or blood samples from which individual service users cannot be identified. It is not common practice to seek consent before engaging in such activities. The Data Protection Acts do not require explicit consent to be obtained where the data to be used has been truly anonymised.

7.8 When consent is refused

If an adult with capacity to make an informed decision makes a voluntary and appropriately informed decision to refuse treatment or service, this decision must be respected, even where the service user's decision may result in his or her death. In such cases it is particularly important to accurately document the discussions with the service user, including the procedure that has been offered, the service user's decision to decline and the fact that the implications of this decision have been fully outlined.

Those who provide health and social care services should also consider and discuss with the service user whether an alternative treatment/measure is acceptable to the service user. For example in the case of a service user who is refusing a blood transfusion for religious reasons, the service user should be referred for a haematology consultation to ascertain whether any alternative treatment would be acceptable. In the context of social care, for example, where a frail older person is assessed to require home supports in order to keep them safe refuses these services, alternative measures should be discussed with the service user.

If there is uncertainty about the service user's capacity to make a decision, the guidance in Section 5.5 should be followed.

There are some circumstances in which a valid refusal of consent raises additional issues:

7.8.1 Refusal of treatment in pregnancy

The consent of a pregnant woman is required for all health and social care interventions. However, because of the constitutional provisions on the right to life of the "unborn"[10], there is legal uncertainty regarding whether a pregnant woman's right to refuse treatment extends to the refusal of treatment which puts the life of the foetus at serious risk. This matter can ultimately only be determined by the courts. Thus, where a pregnant woman refuses treatment and this refusal may impact on the life of the foetus, it is essential that the consequences of the refusal are fully and clearly explained to the woman, and legal advice should be sought if she persists in the refusal.

7.8.2 Refusal of isolation for infectious disease

The consent of service users with infectious diseases is required for all health and social care interventions, including treatment of the infection. The refusal of a competent person to receive treatment for an infection, even if medically unwise, should be respected. However, under the provisions of the Health Act 1947 such a person may be isolated in order to prevent the spread of the disease.[11]

In practice, detention and isolation is most likely to occur when someone with an infectious disease, such as tuberculosis, refuses treatment that would render them non-infectious and, hence, no longer a risk to others. In these circumstances, while treatment cannot be provided without the consent of the service user, the health and social care professional should explain the possible consequences of the refusal of treatment, including potential detention and isolation.

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[10] Article 40.3.3 of the Irish Constitution 1937

[11] Section 38 of the Health Act (1947): 'Where a chief medical officer is of opinion.....that such person is a probable source of infection with an infectious disease and that his isolation is necessary as a safeguard against the spread of infection, and that such person cannot be effectively isolated in his home, such medical officer may order in writing the detention and isolation of such person in a specified hospital or other place until such medical officer gives a certificate…..that such person is no longer a probable source of infection.'

7.8.3 Refusal of treatment by a service user formally admitted under the Mental Health Act 2001

Where the service user has been formally admitted to an approved centre under the Mental Health Act 2001, the procedures in respect of treatment must comply with the provisions of that Act. In some limited cases, the Act allows treatment to be provided even if the service user is unwilling or unable to consent. However, this does not remove the ethical imperative to seek the consent of the service user and to make every effort to ensure that the treatment is acceptable to the service user. Nor does the Mental Health Act 2001 remove the ethical obligation to maximise service user capacity and to involve service users lacking capacity in the decision-making process to the greatest extent possible.

7.8.4 Refusal of the taking of blood and urine samples for the purposes of Garda investigations into driving under the influence of alcohol and/or drugs.

The general principles regarding consent apply when testing for intoxicants. When such testing is clinically indicated, the urgency of the situation in which such testing commonly occurs means that explicit discussion of the pros and cons of the particular test is not required.

However, specific legal rules apply to the taking of blood and urine samples for the purposes of Garda investigations into driving under the influence of alcohol and/or drugs. Section 14 of the Road Traffic Act 2010 applies where an "event"[12] has occurred and, as a result, a person is injured and is admitted to or attends at a hospital. In such a situation, where a Garda is of the opinion that, at the time of the event, the person was driving or attempting to drive, the Garda may require the person to permit a doctor or nurse who has been specifically designated by the Garda Siochána to take a sample of

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[12] As specified in the Act

blood or (at the person's option) to provide a sample of urine. The Garda must first consult with the designated doctor or nurse in order to ensure that this requirement would not be prejudicial to the health of the person. The Act does not provide for the forcible taking of a sample without the consent of the person. However, the person's refusal to comply with the requirement to provide a sample is a criminal offence. Refusal is not an offence where the person is under the care of a doctor or nurse and the doctor or nurse refuses on medical grounds to permit the taking of the sample.

7.9 Advance refusal of treatment

Sometimes service users may wish to plan for their medical treatment in the event of future incapacity, including advance refusal of medical treatment. There is no Irish legislation confirming the enforceability of such advance refusals. However, such an advance plan should be respected on condition that:

- The decision was an informed choice, according to the principles discussed in sections 2-5;
- The decision specifically covers the situation that has arisen, and
- There is no evidence that the service user has changed their mind since the advance plan was made.

If there is reasonable doubt about the existence of an advance treatment plan, the service user's capacity at the time of making the treatment plan or whether it still applies in the present circumstances, treatment decisions should be made according to the principles discussed in Section 5.6.

7.10 Withdrawal of consent

A service user with capacity is entitled to withdraw consent at any time, including during the performance of a procedure. Where a service user does object during treatment, it is good practice for the practitioner, unless this would genuinely put the life of the service user at risk, to stop the procedure, establish the service user's concerns, and explain the consequences of not completing the procedure and respect the withdrawal of consent.

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National Consent Advisory Group

National Consent Policy

Part Two – Children and Adolescents

1. Introduction

As with adult service users, consent must be obtained before providing any health or social care intervention to children. The requirement to obtain consent in this context is consistent with fundamental ethical principles, with good practice in communication and decision-making and with national health care policy. Obtaining consent in this context may be different from obtaining consent in the adult context due to the age or capacity of the child to understand and participate in the decision and the role of the parents in decision-making. However, even where children are unable to give a valid consent for themselves, they should nonetheless be as involved as possible in decision-making as even young children may have opinions about their healthcare and have the right to have their views taken into consideration. This principle is consistent with legal and international human rights standards and ethical guidance.

2. Role of parent(s) and legal guardian(s)

Parents are generally considered best placed to safeguard the health and wellbeing of their children. Parents and health and social care professionals have a responsibility to act in the best interests of children and to care for them in a manner that respects their dignity and wellbeing.

Legal guardianship refers to the right of a parent to be involved in all major decisions affecting the welfare and upbringing of a child including decisions relating to education, health, religious, moral and monetary concerns. Under current Irish law, the following guardianship rules apply:

- Where parents are married, the child's mother and father are legal guardians;
- Where a child has been jointly adopted, the adoptive parents are the child's legal guardians;

- Following a separation or divorce, both parents remain the child's legal guardian, even if the child is not living with them and they have not been awarded custody of the child.
- Where the child's parents are not married, the child's mother is the only automatic legal guardian.
- Where the children's parents are not married, the mother of the child and the child's father may enter into an agreement which has the effect of making the father the guardian of the child.
- Where the child's parents are not married, the child's father may apply to court to be appointed legal guardian; this application will be determined on the basis of the best interests of the child.

For children below the age of 16, parent(s) or legal guardian(s) can consent to the treatment of the child (and for a child below the age of 18 for psychiatric treatment under the Mental Health Act, 2001). The age of consent is discussed further at paragraph 3.

Currently, there is some discussion in health and social care practice as to whether one or both parents/legal guardians' consent is required prior to commencement of medical treatment and/or social care intervention.

It may be argued that the consent of both parents/legal guardians is required prior to treatment of the child on the basis of the rights of the parents/guardians in keeping with Article 41 of the Constitution which recognises the family as the natural primary and fundamental unit group of society and the Guardianship of Infants Act, 1964. However, seeking joint parental consent may cause delays in children receiving services and potential logistical difficulties in ensuring that all forms are co-signed e.g. parents/legal guardians working abroad. In addition the requirement for joint consent may be perceived by those parents/legal guardians not in dispute to be bureaucratic.

Conversely, it may be argued that seeking the consent of only one parent/legal guardian is widely recognised in health and social care practice and is considered to be more practical for safe, timely and effective service provision. It is generally accepted in other jurisdictions from a legal perspective that, in protecting health professionals from an action in battery, the consent of one parent (or in their absence, that of the court) is sufficient. The acceptance of consent of one parent/legal guardian assumes that the child's welfare is paramount, which is in line with the Child Care Acts 1991 and 2001, and that the Health and Social Care professional is proposing treatment/intervention in the child's best interests. It also assumes that both of the parents/legal guardians are concerned with the child's welfare.

This draft policy proposes that, in keeping with the prioritisation of the best interests of the child, in general the consent of one parent will provide sufficient authority in respect of any health or social care intervention in relation to a child.

However, in relation to a decision which will have profound and irreversible consequences for the child, the consent of both parents/guardians should be sought unless any of the circumstances listed below apply. In addition, the providers of health and social care services should accommodate a request from either parent that the consent of both parents should be required for health or social care interventions. Such a request should be communicated by the parent/guardian in writing to the service provider or otherwise documented in writing. The request must contain full contact details of the parent/guardian. It is the responsibility of the parent/guardian to ensure that these details are updated as necessary. Bearing in mind the presumption that parents/guardians have the right to be involved in decision-making in respect of their children other than where it is not in the best interests of the child, the service provider must comply with such a request unless a court has directed to the contrary or it is reasonably believed not to be in the child's best interests.

The requirement to seek consent from both parents as outlined above will not apply:

- Where one of the parents/guardians is not contactable following reasonable efforts to contact him/her, or
- Where one of the parents/guardians has indicated that they do not wish to be consulted, or
- Where one of the parents/guardians state that they wish the custodial guardian to make any necessary decisions on their behalf, or
- In emergency situations. [1]

3. Age of consent

The Child Care Act 1991, the Children Act 2001 and the Mental Health Act 2001 define a child as a service user under the age of 18 years of age, other than a service user who is or has been married.

Section 23 of the Non-Fatal Offences against the Person Act 1997 provides that a person over the age of 16 years can give consent to surgical, medical or dental treatment and it is not necessary to obtain consent for it from his or her parent or guardian. The section covers any procedure undertaken for the purposes of diagnosis and any procedure, such as administration of anaesthetic, which is ancillary to treatment.

This means that, in the context of criminal law, consent to medical treatment by a 16 and 17 year old has the same status as if he or she were an 18 year old. While currently there are no legal provisions in Ireland for minors under 16 years to give consent on their own behalf, it is nonetheless good practice to involve the minor in decisions relating to them and listen to their wishes and concerns in terms of their treatment and care.

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[1] See further Chapter one paragraph 6.1

In many jurisdictions a minor is capable of giving informed consent when he or she achieves a sufficient understanding and intelligence to enable him/her to understand fully what is proposed. For example, in England the 1985 Gillick case[2] established that a doctor had discretion to give contraceptive advice or treatment to a girl under the age of 16 years without her parents' knowledge or consent provided the girl had reached an age where she had a sufficient understanding to enable her to understand fully what was proposed. Hence, the concept of a mature minor is dependent on the child's level of maturity, with no lower age limit defined. In addition, the gravity and nature of the treatment are also taken into account when assessing a minor's capacity to fully understand all aspects of the situation and to objectively weigh up treatment options. This concept of the mature minor has been accepted in other jurisdictions including Northern Ireland, Scotland, New Zealand, Australia and some provinces in Canada.

In Ireland, the courts place great emphasis on the rights of the family and the rights of parents to decide what is in the best interests of their children. It is possible that the Irish courts may interpret the provisions of the Constitution in such as way as to require parental consent to be obtained before providing a health or social care service to any minor under the age of 16 years. However, as against this, it should be noted that children and minors also have significant personal rights of their own under the Constitution, the European Convention of Human Rights, and the United Nations Convention on the Rights of the Child. These rights include rights to liberty, bodily integrity, the freedom to communicate with others and to follow their own conscience.

This draft policy acknowledges that in health and social care practice it is usual to involve parent(s)/guardian(s) and seek their consent when providing a service or treatment to a minor under 16. However, the minor may seek to make a decision on their own without parental involvement or consent. In such circumstances it is best practice to encourage and advise the minor to communicate with and involve their

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[2] *Gillick v Western Norfolk and Wisbech Area Health Authority and another* [1985] 3 AER 402

parents or guardians. It is only in exceptional circumstances that, having regard to the need to take account of an objective assessment of both the rights and the best interests of the person under 16, health and social care interventions would be provided for those under 16 without the knowledge or consent of parent(s) or guardian(s).

In those circumstances, an assessment must be made as to whether:

(a) the minor has sufficient maturity to understand the information relevant to making the decision and to appreciate its potential consequences;
(b) the minor's views are stable and a true reflection of his or her core values and beliefs, taking into account his or her physical and mental health and any other factors that affect his or her ability to exercise independent judgement;
(c) the nature, purpose and usefulness of the treatment or social care intervention;
(d) the risks and benefits involved in the treatment or social care intervention, and
(e) any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the Children First: *National Guidelines for the Protection and Welfare of Children 2011* (or any equivalent replacement document) must be applied.

4. Refusal of treatment or social care intervention by a person under 18 years

The position relating to refusal of treatment or social care by a person under the age of 18 years is unclear. It may be argued that consent and refusal are opposite sides of the same coin and should be regarded in the same way. This would mean that a young person between the age of 16 and 18 years who is recognised as having the legal capacity to consent must also have the capacity to refuse. However, courts in other jurisdictions have held that there is a clear practical distinction to be made between consent to and refusal of medical treatment in that consent involves acceptance of what is an experienced medical view whereas refusal rejects that experience from a position of comparatively limited knowledge. Consequently, it is argued that the implications of refusal may be more serious and, in extreme cases, may even result in death.

Section 23 of the Non-Fatal Offences Against the Person Act 1997, while it allows the young person aged 16-18 to give consent to medical treatment, does not include an express entitlement to refuse such treatment.

This draft policy proposes that in cases where an individual under the age of 18 refuses life sustaining treatment, or other decisions which may have profound, irreversible consequences for him or her, an application should be made to the High Court to adjudicate on the refusal. In such a case, the High Court could intervene to order treatment that is necessary to save life and where this is in the best interests of the young person. In the event of such an application, the person under 18 should be separately represented.

5. Refusal of health and social care intervention by parents

Decisions by parents or guardians concerning their children will usually be respected even if this is in conflict with the views of health and social care professionals. However, in exceptional circumstances if parents or guardians refuse medical treatment on behalf of a child, an application may be made to the court to have the parents' refusal overruled in the best interests of the child. This is provided for by Article 42(5) of the Constitution which states that where a child's parents have failed in their duty to the child the State may intervene to safeguard the welfare of the child.

6. The minor parent

Parent(s)/guardian(s) are presumed to be the best decision-makers for their children and to act in their best interests. This presumption holds even if the parent(s)/guardian(s) is under 16 years. As with all decisions made by parent(s), if the decision is not considered to be in the best interests of the child then the health and social care professional should engage in dialogue with the parent(s)/guardian(s) about the decision they are making in relation to their child. Failing resolution, it is recommended that legal advice is sought.

7. Children in the care of the HSE

In respect of children who are in voluntary care, consent is required from the child's parent or guardian unless a court order has been made dispensing with that person's consent. If there is no parent/guardian, or that person is unavailable, the HSE must make an application to the District Court under section 47 of the Child Care Act 1991 authorising the relevant social worker to give consent.

In relation to children who are subject to interim and emergency care orders, an application can be made to the District Court pursuant to the Child Care Act 1991 in regard to medical treatment. In relation to children who are subject to a full care order, although it is good practice to seek the consent of the parent/guardian, the HSE is authorised pursuant to Section 18 of the 1991 Childcare Act to consent to any necessary medical or psychiatric treatment, assessment or examination. However, different procedures apply to admission and treatment under the Mental Health Act 2001 as set out below.

For children who are in foster care for five years or more, in accordance with Section 43A of the Child Care Act 1991[3] a foster carer or relative may make an application, and be granted an Order, giving them like control over the child as if they were the child's parent provided that:

- The child has been formally placed in their care for five years or more.
- The granting of the Order is in the child's best interest.
- The HSE consents to the making of such an Order.
- Parental consent is obtained for children in voluntary care or on temporary Orders.
- Parents are given notice of the application in the case of children who are subject of full Care Orders.
- The wishes of the child have been given due consideration, as appropriate.

The effect of such an Order will be to grant such foster parents/carers the right to do all that is reasonable to safeguard and promote the child's welfare, health and development. This includes the giving of consent to any necessary medical or psychiatric assessment, examination or treatment; and to the issuing of a passport.

In the case of any child in an emergency life-threatening situation, the welfare of the child is the paramount consideration and the doctrine of necessity will apply whereby a medical practitioner may dispense with the requirement for consent.

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[3] As inserted by section 4 of the Child Care (Amendment) Act 2007

8. Children and mental health services

The Mental Health Act 2001 applies to treatment for a mental disorder in an "approved centre". The MHA distinguishes between voluntary and involuntary patients and the measures in the Act in respect of treatment apply only to involuntary patients. At present, a child or young person who has been admitted by his or her parents is classified as a "voluntary" admission under the MHA.

The MHA defines a "child" as a person under 18 years of age unless they are or have been married. There is legal uncertainty in respect to consent to treatment regarding the position of a voluntary patient who is a young person aged between 16 and 18 and in particular whether the age of consent of 16 in the Non-Fatal Offences Against the Person Act 1997 Act applies to young people in this situation. In its "Headspace Toolkit", the Mental Health Commission advises that a person under the age of 18 years does not have a right to decide whether to consent to mental health treatment. It has been recognised that this is an anomalous position given the capacity for 16 and 17 year old young people to consent to medical and other treatments and that the MHA specifically only applies to treatment in an inpatient (approved) setting.

Where a child has been admitted involuntarily, the MHA measures on treatment apply. This requires the consent of the District Court to be obtained before psychosurgery or electro-convulsive therapy may be given to a person under the age of 18 years. It also requires that a second opinion must be obtained before medication, which has been prescribed to a child for a continuous period of three months, may be continued.
Regardless of whether a child or young person has been admitted voluntarily or involuntarily, a underlying principle of the MHA is that in respect of any treatment decision, the person must, so far as reasonably practicable, be notified of the proposal and be entitled to make representations about it and to have these taken into account.

The general principles of consent apply where any other treatment or intervention in health and social care is required to be provided to the child or young person.

9. Sexual health services

Under Irish law it is a criminal offence to engage or attempt to engage in a sexual act with a child under 17 years of age. [4] It is not a defence to show that the child consented to the sexual act. The consent of the Director of Public Prosecutions is required for any prosecution of a child under the age of 17 years for this offence. A girl under the age of 17 who has sexual intercourse may not be convicted of an offence on that ground alone.

There is no set minimum age for contraceptive advice and sexual health services.[5] In keeping with section 23 of the Non-Fatal Offences Against the Person Act 1997, a young person aged over 16 years can give their own consent to contraceptive/ sexual health advice or interventions. However, in light of the fact that the activity may constitute a criminal offence, efforts should be made to involve the parent(s)/guardian(s) in this consultation and decision making.

In relation to the Criminal Law (Sexual Offences) Act 2006 and child protection guidelines, it is critical that the heath or social care professional rules out any possibility or suspicion that any aspect of sexual intercourse was abusive, exploitative, or non-consensual. Health professionals need to be mindful of the risks involved in providing medical treatment to this age group. They should therefore:

i) Document the result of an assessment (to see if there is suspicion or evidence of abuse) and actions taken,

ii) Document efforts to encourage the patient to involve his/her parents.

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[4] Section 3 of the Criminal Law (Sex Offences) Act 2006 as amended by Section 5 of the Criminal Law (Sexual Offences) (Amendment) Act 2007

[5] See paragraph 3 above

In addition, the health and social care professional must be aware of any legal requirements to report sexual activity of a minor under 17 years to either the Gardai or to the HSE under the Children First Guidelines (2011) or any other relevant legislation or national guidelines. A minor under 17 must be informed of this requirement to report when requesting contraception advice or sexual health interventions.

Prior to obtaining consent, the 16 year old minor must be informed by the health or social care provider that confidentiality cannot be assured due to the potential obligation to report the sexual activity due to their age. The minor should also be informed that his/her parent(s)/guardian(s) may have rights to access their medical records under the Freedom of Information Act 1997.

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