Review of the Guardianship Act 1987

Question Paper 5

Medical and dental treatment and restrictive practices

The following comments are provided by Sexual Assault Services within Nepean Blue Mountains and Western Sydney Local Health Districts and the Forensic Medical Service that sits across both Districts.

These services are responsible for the provision of crisis and ongoing counselling and forensic and medical services for victims of recent and past sexual assault.

There are occasions where a victim of sexual assault whom has experienced sexual assault within the past five days cannot consent for treatment in response to sexual assault. This includes where the client could present as unconscious, drug and/or alcohol affected, has an intellectual disability or mental health issue. Due to the need to respond to sexual assault in a forensic context urgently, the Sexual Assault Service Counsellor is often required to seek consent for treatment for sexual assault through the Guardianship Board.

Consent in this context relates to seeking consent for a forensic examination which can include various swabs (anus, penis and vagina), bloods, urine, skin swabs and forensic photography.

The timeframes for responding to sexual assault need to be considered by the Guardianship Act and will be noted in this feedback.

Section 3 TYPES OF MEDICAL AND DENTAL TREATMENT

3.25 Treatment by someone other than a medical or dental practitioner

- Question 3.3 Treatment by a registered health practitioner – 'should the definition of medical and dental treatment in Part 5 of the Guardianship Act 1987 (NSW) include treatment by a registered health practitioner?'

ANSWER

Yes. In the field of Forensic Medicine there are forensic nurses increasingly responsible for the assessments of patients and for the gaining of consents for the examination, release to police and photography.

Patients should have the same protection regardless of who the health professional is.

Section 4 CONSENT TO MEDICAL AND DENTAL TREATMENT

4.13 Major Treatment - What is major treatment?

- Question 4.2: Major Treatment

1. Is the definition of major treatment appropriate? Should anything be added? Should anything be taken out?
2. Who should be able to consent to major treatment and in what circumstances?
3. How should a patient's objection be taken into account?
4. In what circumstances could major treatment be carried out without consent?

ANSWER

The definition is not appropriate.

There should be a clear, broad based definition at the beginning of each category of treatment. For example:

Special: *The most invasive and risky kinds of treatment. Treatments that are likely to result in a permanent change e.g. sterilisation. Where the risk of death, with said treatment, is considered high e.g. removal of brain tumour / surgery for abdominal aneurysm etc.*

Major: *Where there is a risk of permanent harm e.g. operations / general anaesthetic / chronic administration of addictive medication etc. Where the risk of death is not high e.g. appendectomy / reduction of dislocated shoulder*

The HIV test is not considered a major medical treatment.

The oral contraceptive pill or injectable contraception or implanted contraception, which can be used to stop menstruation, is not considered a major medical treatment.

This category as a whole is poorly defined.

In regards to 'minor treatment', by definition, a sexual assault examination would be considered a minor treatment and is only ever completed where there is a reasonable concern that a sexual assault has occurred. This is established through a thorough assessment by a Sexual Assault Counsellor in consultation with the Forensic Medical Unit.

4.27 Person Responsible

- Question 4.6 Person Responsible
  1. Is the 'person responsible' hierarchy appropriate and clear? If not, what changes should be made?
  2. Does the hierarchy operate effectively? If not, how could its operation be improved

ANSWER

This section is considered very clear and appropriate for seeking consent when a victim of sexual assault is unable to consent. Use of this hierarchy is easy to use and effective in being able to respond in a timely way for victims of sexual assault.

When the 'person responsible' is unable to be contacted, the next option is to seek consent through the Guardianship Board however, this has been difficult when needing to respond to timeframes for sexual assault forensic collection.

4.35 Requirement that consent requests and consents be in writing

- Question 4.8 Requirement that consent requests and consents be in writing
  Is the requirement that consent requests and consents must be in writing appropriate? If not, what arrangements should be in place?

ANSWER

There are various timeframes for different types of sexual assault. For example, digital penetration of the vagina/anus provides a timeframe of twelve hours for the possible collection of forensic evidence. However, it is often the case that victims of sexual assault do not present immediately after the sexual assault but do present within the timeframe for forensic collection.

There have been occasions whereby the process of seeking consent for forensic collection through the Guardianship Board at NCAT has resulted in a wait of beyond 3-4 hours for this consent to be granted. This includes writing the request on the relevant paperwork, referring this to NCAT and waiting for a tribunal to form.

This is not timely and impacts on the capacity of forensic collection and is not conducive to victim care whom often wants to complete the forensic, wash and be cared for by family etc.

Hospital systems have medico legal responsibilities to document the treatment of patients regardless of their presentation. In a sexual assault context, this is carefully and thoroughly documented given the type of presentation and possible legal action thereafter.

There is also a business hours requirement to complete paperwork with NCAT however this is not required after hours whereby only a phone call is required and verbal consent is provided which is then documented in the health record.

An appropriate and timely response to sexual assault would include that consent is verbal and documented within the clients health record thereafter.

It should also be noted that when consent is required through NCAT, consent is documented in the 'sexual assault protocol' as 'consent granted by Guardianship'. This paperwork is either stored in electronic medical records systems or paper based health records across health settings in NSW.