Regional Claims Forum – Midlands and East Learning from Claims

Samantha Thomas, Safety & Learning Lead
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@NHSResolution

Advise / Resolve / Learn

Session overview

1. Learning from consent claims data - NHS Resolution
2. Induction of labour: Improving the consent process – Birmingham Women's and Children's NHS Foundation Trust
3. Consent and decision making for intimate examination: Action plan pilot– NHS England- East of England.
4. Consent- the pitfalls, the problems and the right to make a poor decision- Weightmans
5. Q&A
6. Close and survey

Learning objective: To provide an awareness of the Safety and Learning team offer, the purpose of GIRFT Litigation packs, Scorecards and Factsheet 5, and how to use the learning from claims to improve services.

NHS Resolution

Failed to Warn-Informed Consent CNST claims 2020/21 to 2024/25

National & regional overview (Midlands & East of England)

Safety & Learning Team

Presentation Overview

1. Introduction
2. National - Volume and value of Failed to Warn-Informed Consent CNST claims per year.
3. National & Regional – Status of Failed to Warn-Informed Consent CNST claims 2020/21 to 2024/25.
4. National & Regional – Top specialities for Failed to Warn-Informed Consent CNST claims volume
5. National & Regional – Top 5 Cause codes for Failed to Warn-Informed Consent CNST claims volume.

Learning Objectives: To provide an overview of the national and regional themes seen in Failed to Warn-Informed Consent claims brought under the CNST scheme.

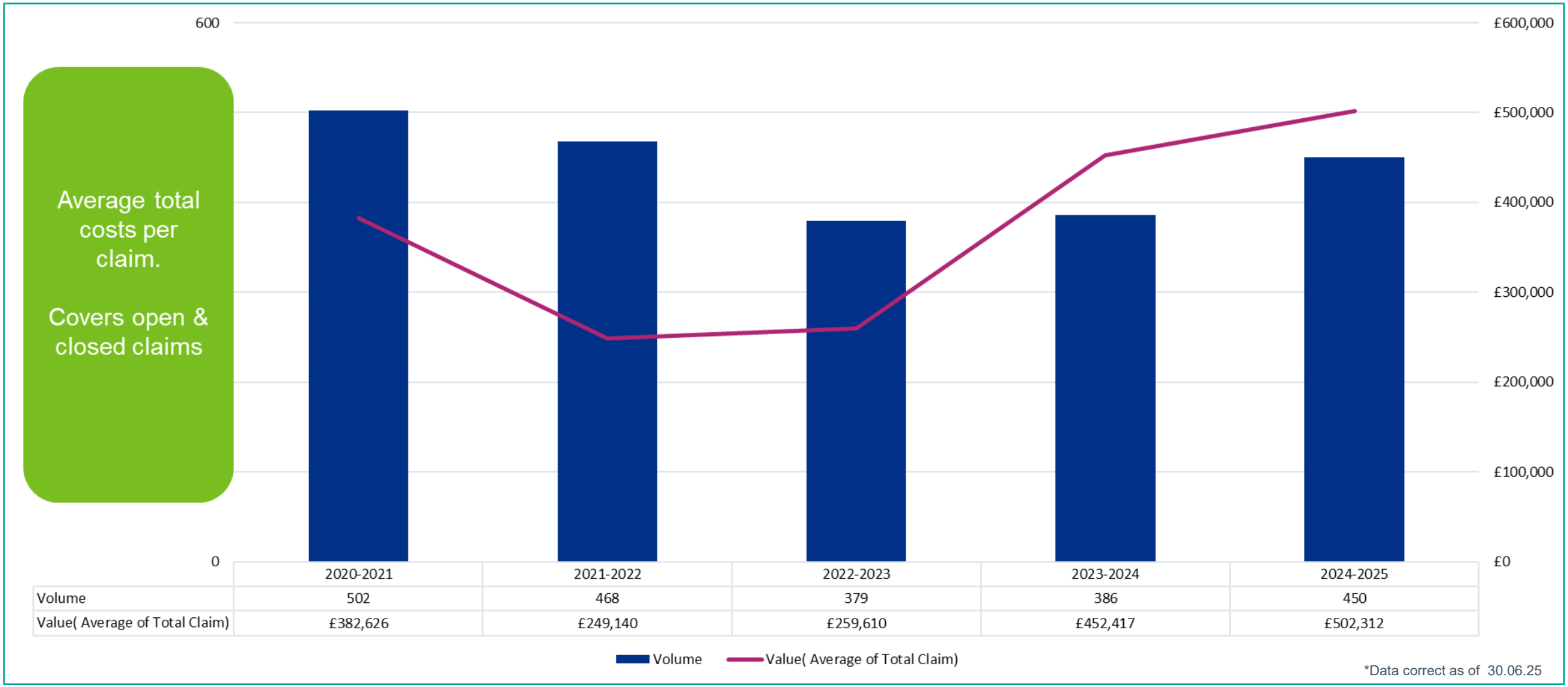
- How does these themes compare with what you see in your local claims via the Trust scorecard?
- Do they align with your current quality metrics, e.g. complaints and patient safety events data?
- How can this help you formulate priorities for future patient safety improvement?

Introduction

- Supporting decision making (consent) is a vital part of patient care.
- Consent claims often centre on the information, or insufficient information, provided to patients to make informed decisions about their healthcare.
- Supported decision making ensures that risks are not omitted (including the risk that treatment may not achieve its intended aims).
- Between April 2020 and March 2025, 2185, claims were reported with a cause code of ‘Fail To Warn-Informed Consent’. The estimated value of these claims is £807.7 Million.

https://resolution.nhs.uk/resources/the-benefits-of-supported-decision-making-consent/
https://resolution.nhs.uk/resource-fol-module/consent/

National - Failed to Warn-Informed Consent CNST claims per year 2020/21 to 2024/25 via claims notification date

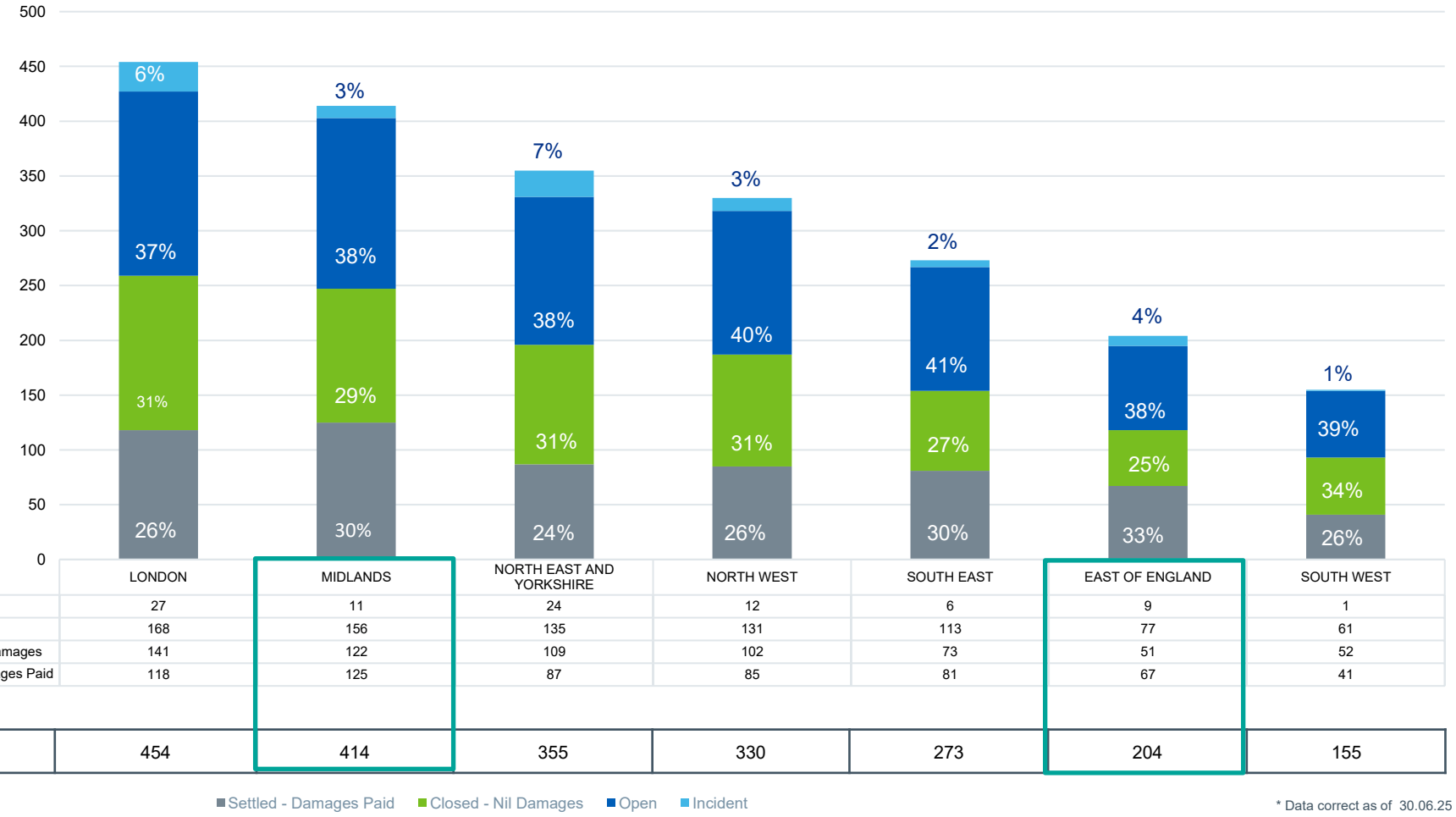


	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
Volume	502	468	379	386	450
Value(Average of Total Claim)	£382,626	£249,140	£259,610	£452,417	£502,312

Status of National & Regional Failed to Warn-Informed Consent CNST claims 2020/21 to 2024/25 via claims notification date

NHS Resolution

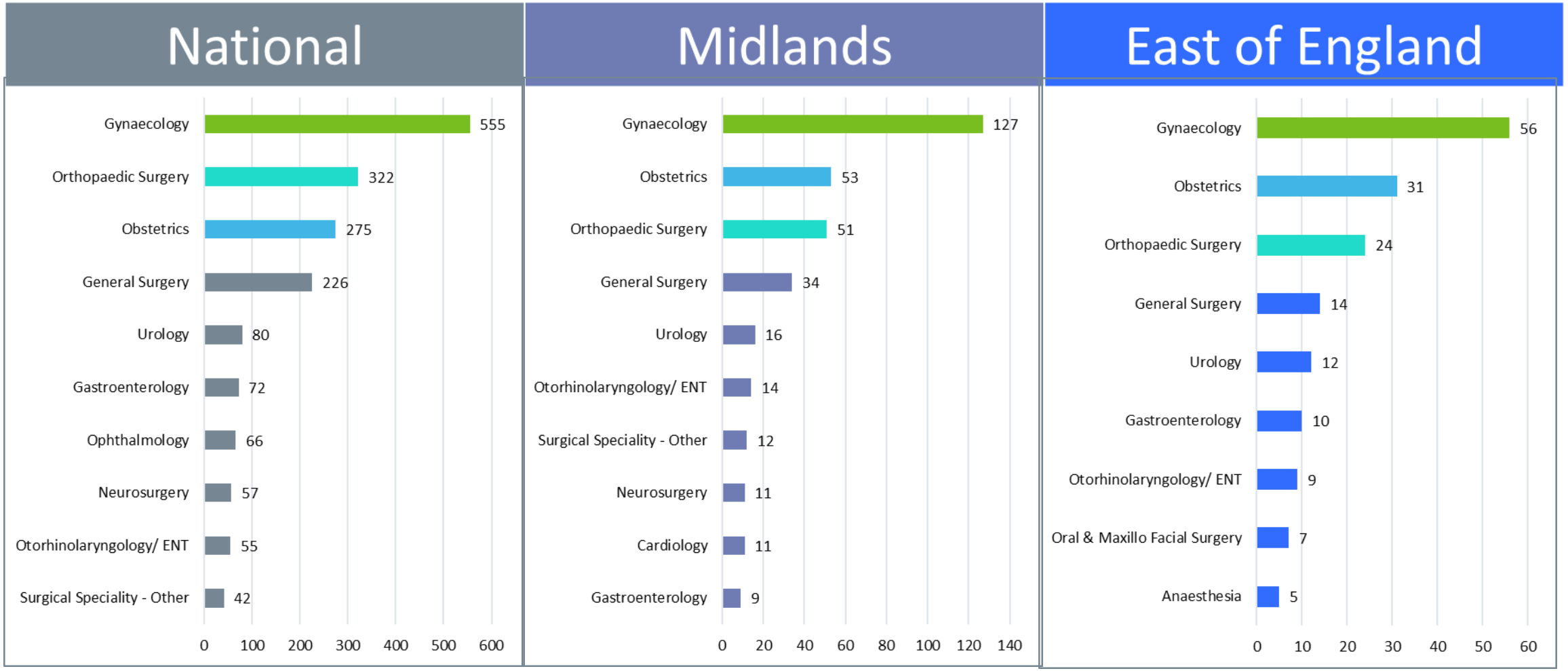
National	Volume
Incident	90 (4%)
Open	841 (38%)
Closed - Nil Damages	650 (30%)
Settled - Damages Paid	604 (28%)
Grand Total	2185



	LONDON	MIDLANDS	NORTH EAST AND YORKSHIRE	NORTH WEST	SOUTH EAST	EAST OF ENGLAND	SOUTH WEST
Incident	27	11	24	12	6	9	1
Open	168	156	135	131	113	77	61
Closed - Nil Damages	141	122	109	102	73	51	52
Settled - Damages Paid	118	125	87	85	81	67	41
Grand Total	454	414	355	330	273	204	155

* Data correct as of 30.06.25

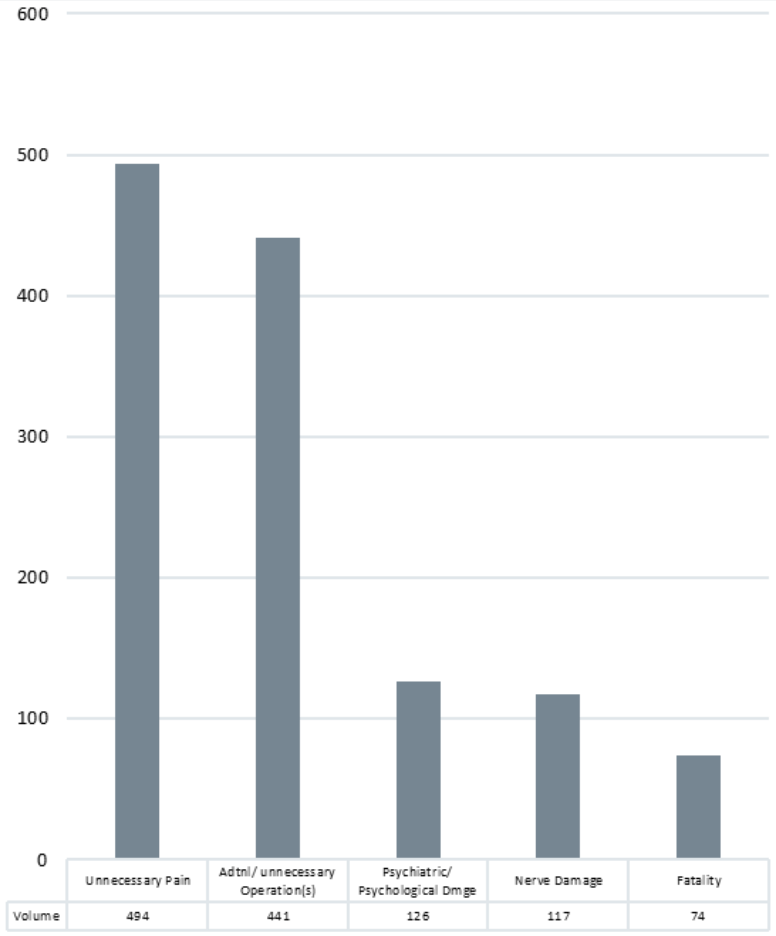
Failed to Warn-Informed Consent CNST claims by specialities & volume 2020/21 to 2024/25 via claims notification date



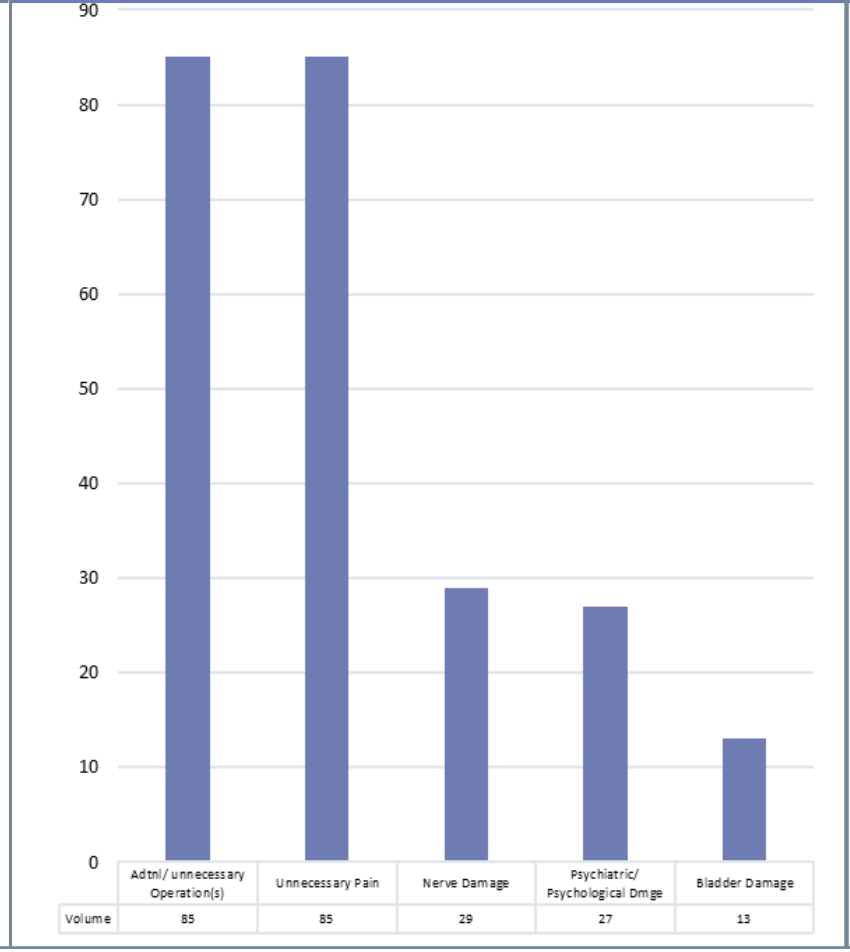
Specialities with <5 claims have been supressed, Data correct as of 30.06.25

Volume of Failed to Warn-Informed Consent CNST claims by injury code 2020/21 to 2024/25 via claims notification date

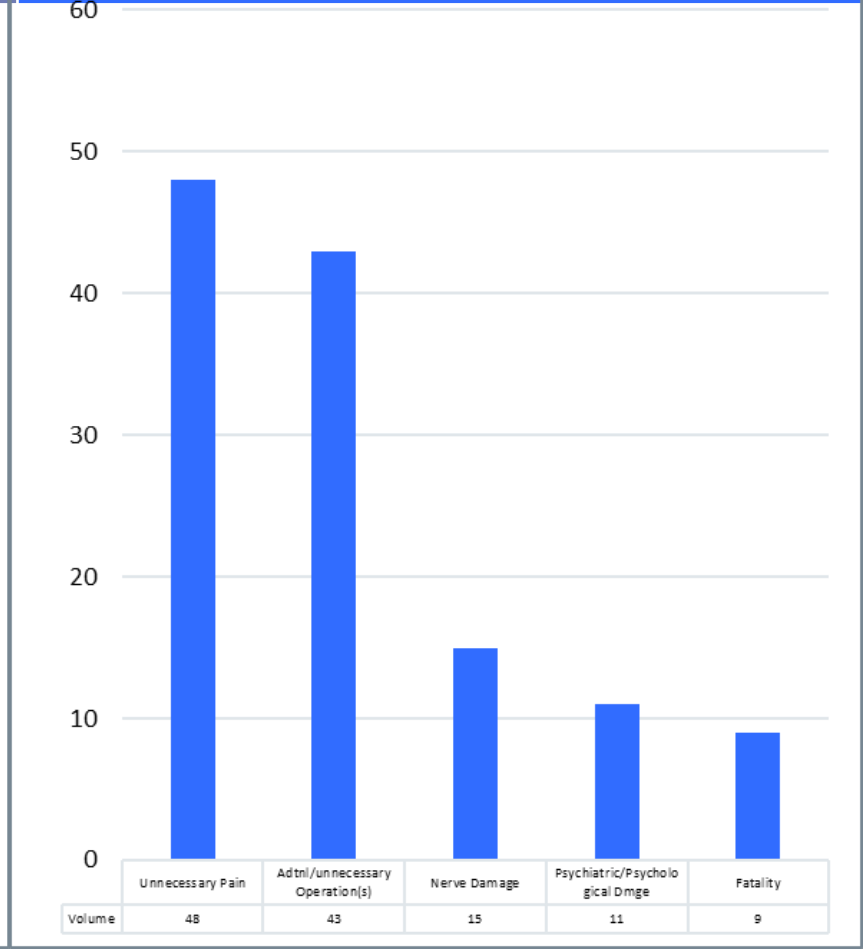
National



Midlands



East of England



Induction of Labour: Improving the Consent Process

Kookie Salt

Consultant Midwife

Birmingham Women's and Children's NHS Foundation Trust

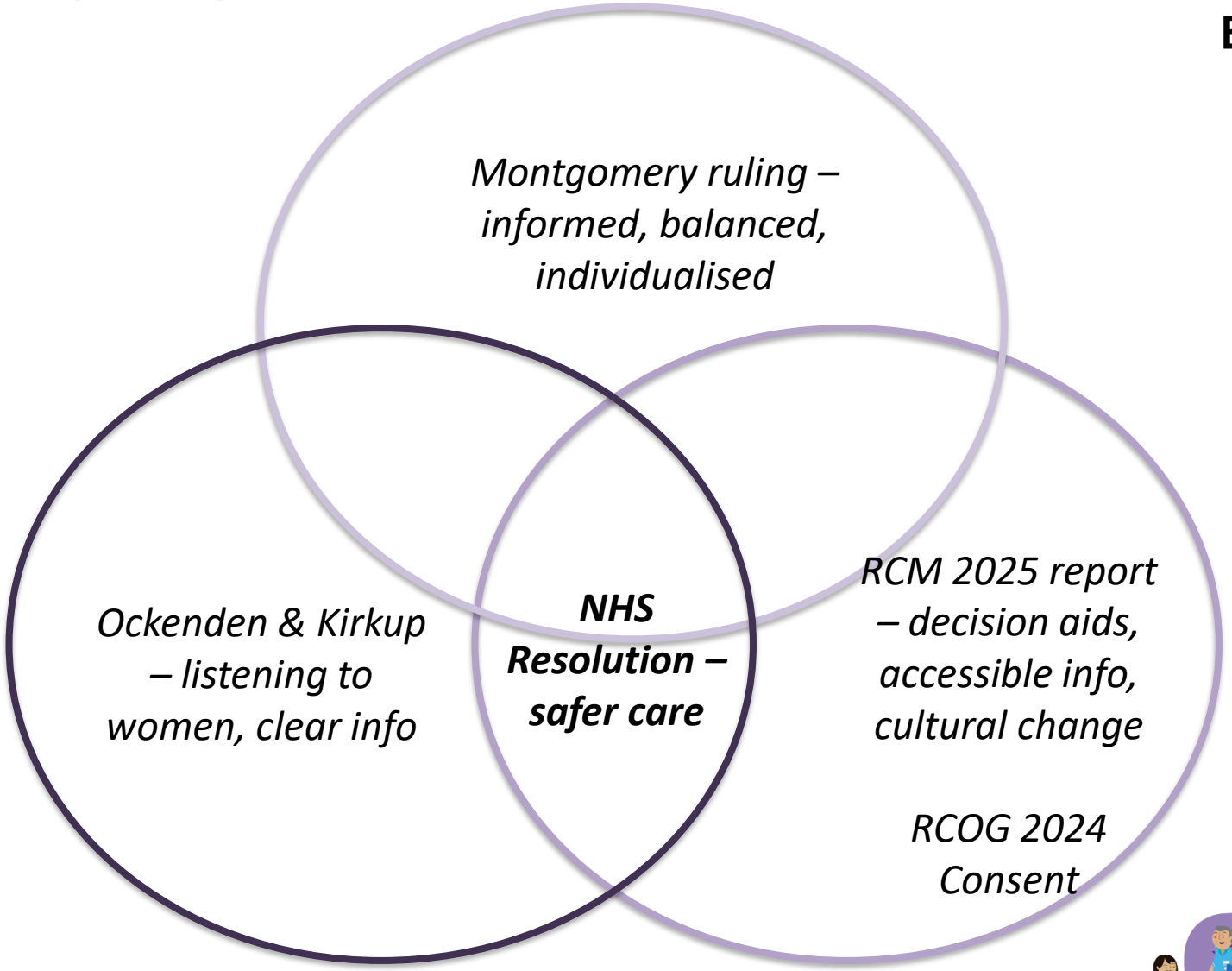
By your side

Aim

- Why consent matters for safety, trust and birthing experience
- Show how BWC improved the Induction of Labour (IOL) consent process.

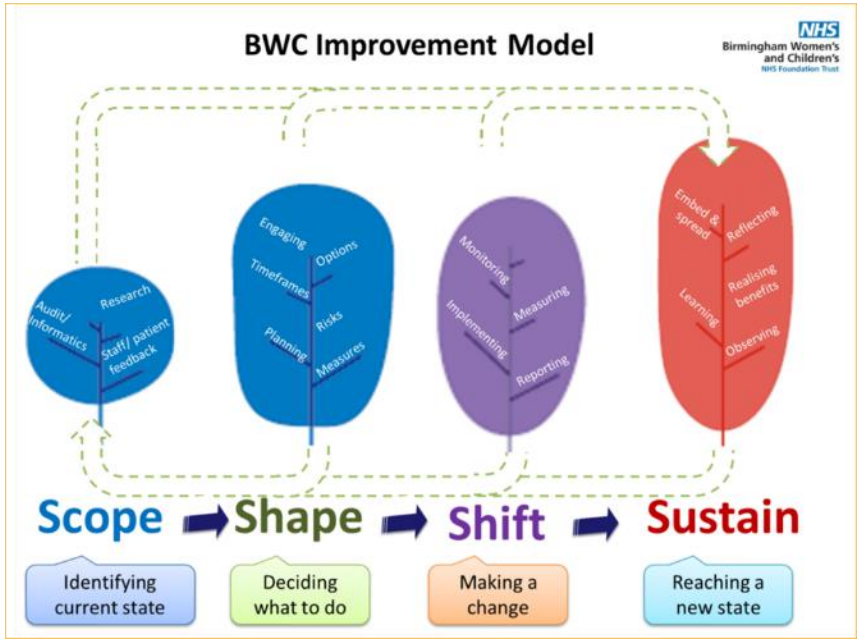
National Context

Birmingham Women's and Children's NHS Foundation Trust



Background

- Induction of Labour Working Group formed in 2019
- Aim: improve women's experience, flow and capacity



Women's Experience

- One woman told us she was offered induction after a growth scan, but wasn't given clear reasons, risks or alternatives.
- She felt pressured into a sweep without information, anc only later learned from her community midwife that she had options.
- She also wasn't told about place of birth restrictions unti late in labour.

- Experiences like this showed us just how important it was to improve the way we do consent.

Image by pch.vector on Freepik

Before

- Women often described the information given:
  - Inconsistent
  - Pressured
  - Lacking clarity
  - Coerced

After

- Most recent feedback:
  - Structured tools to support decision making
  - Clearer understanding
  - More meaningful conversations
  - Greater confidence in their choices

What We Did

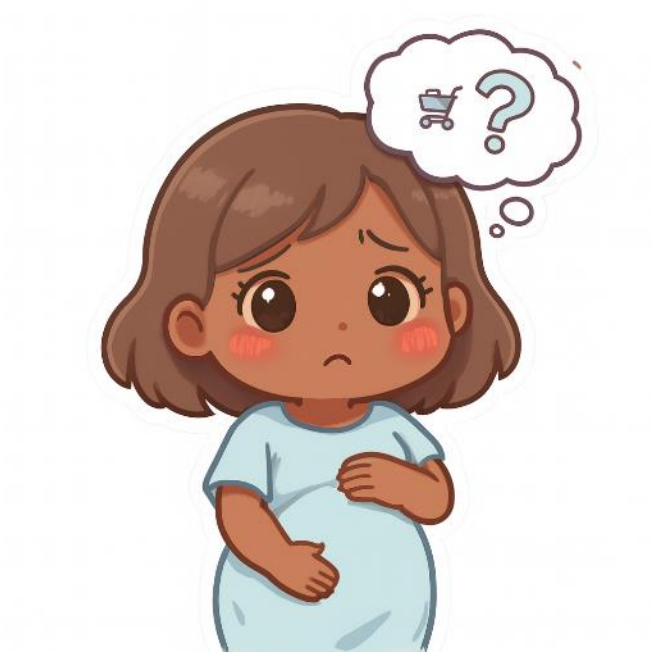
Consent Training for Specialist Midwives

Decision-Making Tool

IOL Workshop

Women's Information Leaflet

Decision Making Tool



Freepik AI Image Generator, 23 Sept. 2025

NHS
Birmingham Women's and Children's

Woman's Name: _____
Date of Birth: _____
Hospital Number: _____

Documentation of Induction of Labour Decision Making
Reason for offering induction of labour:

Safe Gestational Range to start IOL: ____+__ to ____+___

Date: _____
Clinician Name: _____
Signature: _____
Role: _____

☐ **Benefit:** To achieve birth earlier than waiting for spontaneous labour, reduce risk of stillbirth, reduce risk of harms due to maternal medical condition

☐ **Risks:** Typically, more vaginal examinations than spontaneous labour. Failure to establish labour, hyperstimulation, increase duration of labour and length of time in hospital, increased reports of pain and request for epidural, APH/PPH, OASI. No increase in the likelihood of emergency caesarean section (24%), possible increase in risk of instrumental birth (22%).

☐ **Length of induction process:** variable duration depending on response to medication, potentially up to 5 days, sometimes there can be significant delays in the process (particularly waiting for transfer to delivery suite for ARM). In most cases, IOL requires women to birth on the main delivery suite, CEFM is required, and waterbirth is usually not appropriate.

Methods of induction:	Advantages / benefits	Disadvantages / risks	Individual plan
☐ Cervical Sweeps	• Increases the likelihood of spontaneous labour • Can be carried out from 38 weeks gestation if the membranes are intact	• May be uncomfortable • May not be possible if the cervix is closed • May cause spotting or cramping	
☐ Prostaglandins Propess – 24 hours Prostin – 6 hours (max 3)	• More likely to cause a woman to go into labour without requiring ARM and/or oxytocin. (In our hospital 29% of women will go into active labour after prostaglandins alone).	• May cause pain requiring opiate analgesia • May cause hyperstimulation (frequent contractions causing fetal heart rate abnormalities) • Higher risk of uterine rupture in women at risk	
☐ Dilapan (12-24 hours)	• Low risk of uterine rupture • Low risk of hyperstimulation	• May be uncomfortable during insertion. • Almost always requires ARM and oxytocin.	
☐ ARM (amniotomy)	• Done prior to starting oxytocin to help the contractions become more effective at opening the cervix.	• May be uncomfortable. • If the baby's head is very high there is a risk of cord prolapse	
☐ Oxytocin	• Produces contractions that help the cervix to dilate and the baby to descend	• Contractions may be painful – increased request for epidural • Continuous CTG is required due to risk of fetal hypoxia • Need for regular blood tests to check on sodium levels • Increased risk of PPH –active management of 3rd stage	

Indication specific information provided: ☐ Postdates ☐ RFM ☐ PROM/PPROM ☐ Diabetes ☐ LGA ☐ SGA/FGR ☐ VBAC IOL ☐ PET ☐ OC ☐ APH ☐ Twins ☐ Fetal Med ☐ Maternal Med

☐ **Alternatives to IOL:** Expectant management, caesarean section

☐ **Top tips leaflet** and ☐ **IOL leaflet** provided (Paper or Badgernet)

To be completed by the woman: ***I am in agreement with the plan to have induction of labour.*** Signature: _____ Date: _____

Planned date for IOL: _____

Call your planned location at 10AM on the day of your induction and you will be advised when to come in.
☐ **IOL suite:** 0121 335 8219 ☐ **Ward 1: 0**121 335 8110

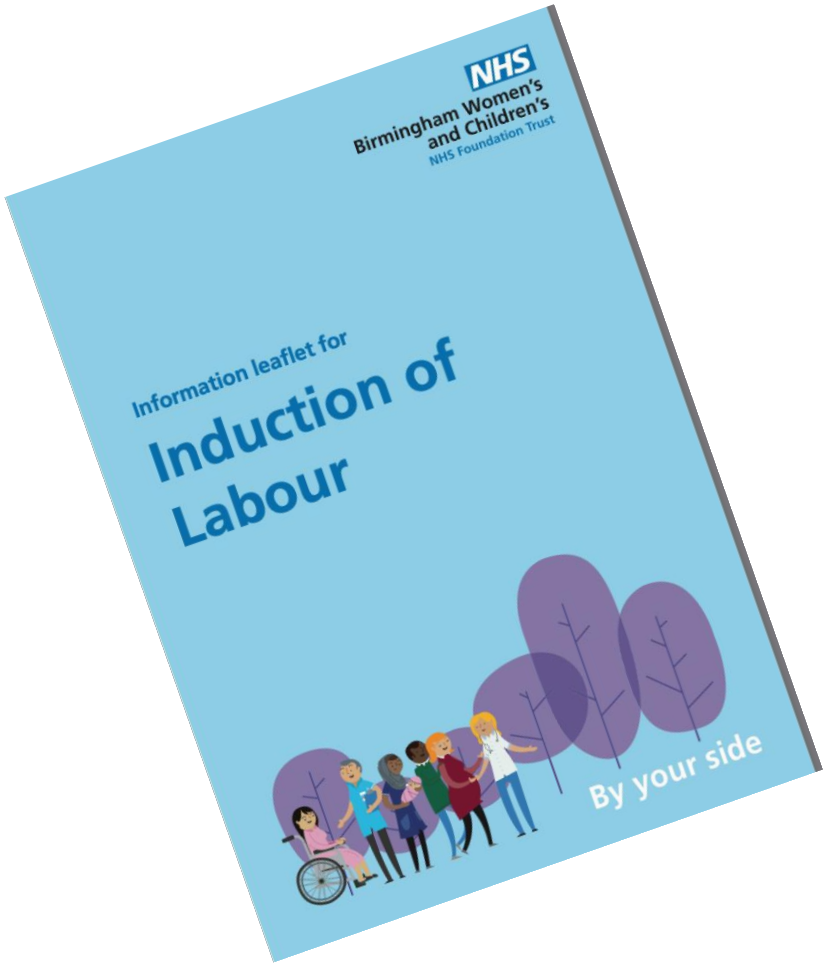
Uncommonly, if the hospital is very busy with emergencies, it may be necessary to defer the start of the IOL to a later date within the safe gestational range. If there is a delay – would you be happy to be called to come in at any time a bed becomes available (e.g. in the middle of the night)? **Yes / No** (Please circle)

Specific questions or concerns?

If you have concerns before IOL, including feeling unwell, pain, suspected labour, reduced fetal movements, bleeding or liquor from the vagina, please call triage. **03000 201 201**

Induction of Labour Information Leaflet

Birmingham Women's and Children's
NHS Foundation Trust



You have been given this booklet because you have been offered an induction of labour (IOL) or because it is likely that you could be offered an IOL at a later stage of your pregnancy.

This may be because of a concern or risk factor in your current pregnancy, your medical history or due to events in a previous pregnancy or birth.

This booklet explains what will happen when your labour is induced and contains lots of helpful tips for you during your IOL and birth.

Induction discussed by: .....

Date of discussion: .....

Indication for induction: .....

Gestational range to commence Induction of labour;

Earliest date to start your IOL: .....

Latest date to start your IOL: .....

Date IOL provisionally booked: .....

Contents Page

Lessons Learned

- Challenges
- Successes

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NHS
Birmingham Women's and Children's
Foundation Trust

What women have told us…

I changed my mind several times — from withholding consent, to requesting a caesarean, to finally choosing induction — but I felt supported throughout.

The IOL workshop meant I already knew what was being discussed with me, it made me feel confident and reassured.

The leaflet was clear and really helpful when considering my options… discussions with my healthcare professional felt more meaningful.

The Homebirth team are absolutely excellent… I chose a homebirth again despite a previous PPH because I knew my choices would be respected.

I opted for an elective caesarean due to PTSD. My consultant midwife supported me, and I felt my mental health was fully considered.

Evaluation

- Leaflet: clear, helpful, improved conversations
- Women are able to change minds with support
- Workshops: ~14 attendees weekly, fewer complaints
- Specialist midwives: timely, trauma-informed support

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Plans for the future

- Translate the leaflet to be more accessible
- Record voice-overs for the workshop so that it can be accessed at any time – make it available in alternative languages
- Continue evaluation (audit complaints data, feedback)

Image from Freepik.com

Consent & decision-making for intimate examination: Action plan pilots

Rachael Bickley
SUV Lead East of England Maternity Team

Listening to women across the East of England

Context

Ockenden assurance visits of 2022 and CQC feedback survey, Maternity & Neonatal Voices Partnerships (MNVPs) across the region the East of England regions support a survey about parents about choice & decision making in maternity care - 813 parent responses across all LMNSs within the region.

Best Practice

Good decision making facilitated with quality information, time to digest, discuss and decide.

Challenges

Poor facilitation of decision-making, paternalistic care, and parents describing care and intimate examinations without consent.

A collaborative beginning…

- Regional task group set up to include midwifery, obstetric, service user and safeguarding stakeholders.
- Facilitated to discuss survey feedback and experiences from all aspects
- Group discussions framed in a paper illustrating:
  - Intimate Examinations not being facilitated well regarding Mental Capacity and Human Rights Acts.
  - Valid Legal Consent as a construct is being compromised as a result.

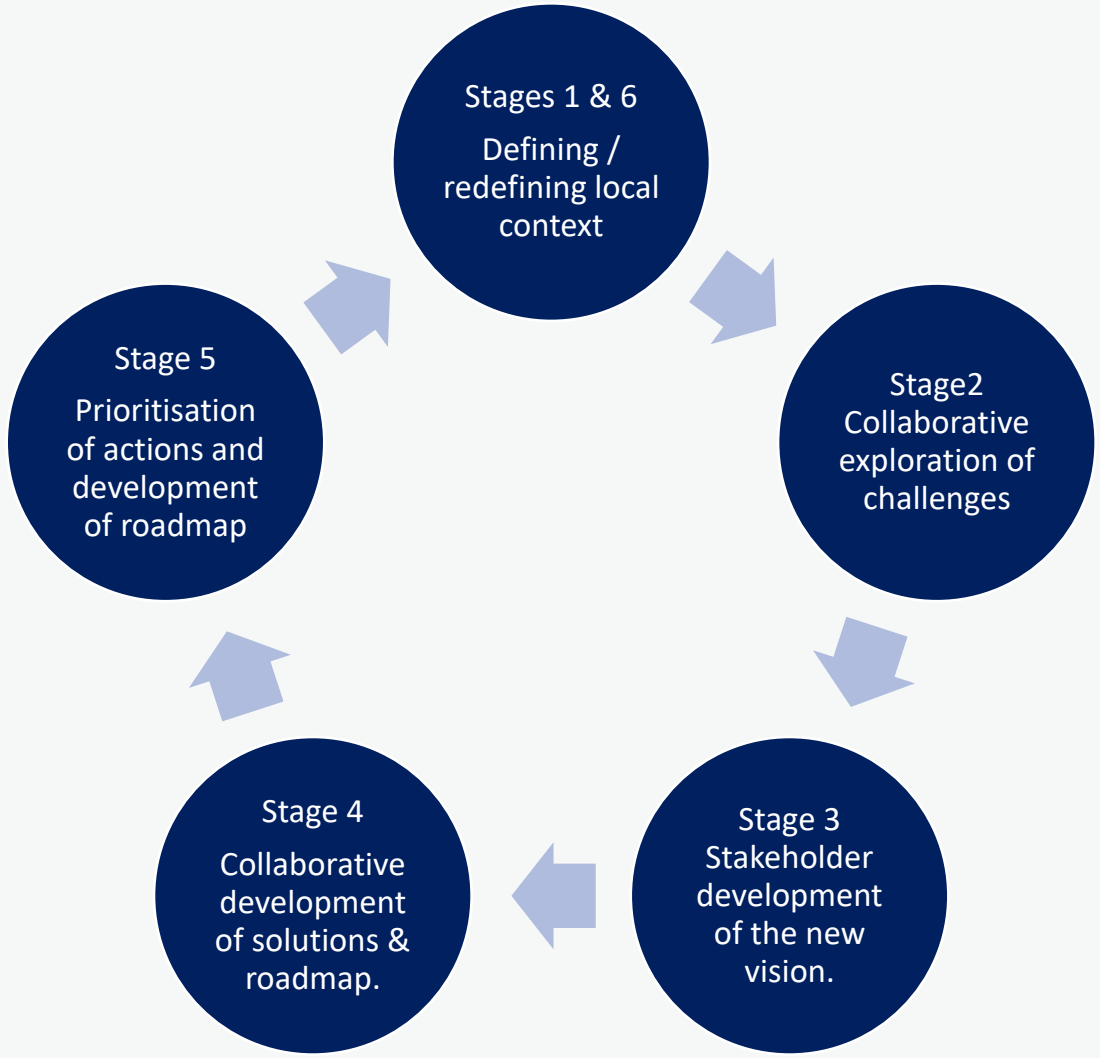
Pilot project aim:

- To develop local collaborative roadmaps for positive change to how consent for intimate examination is facilitated by health care staff and experienced by women and birthing people.

A collaborative approach

Our approach supports:

- Exploration of consent and decision making for intimate examination within the UK legal framework for consent from the perspective of all stakeholders including consideration of Mental Capacity & Human Right Act.
- Developing an approach to evaluation at the start of the process, ensuring capacity to re-evaluate and assess impact.
- Collaborative innovation of solutions using structured evidenced based tools



Stage 1

Defining context

- Facilitated by anonymous questionnaire developed by using Theoretical Domains Framework *(Michie et al. 2005, 2012).*
- Triangulation of local SUV experience data.
- Validated change implementation tool used successfully to support change in other healthcare settings.
- Supports exploration of behavioural attributes contributing to induvial and system challenges/facilitation of required changes.

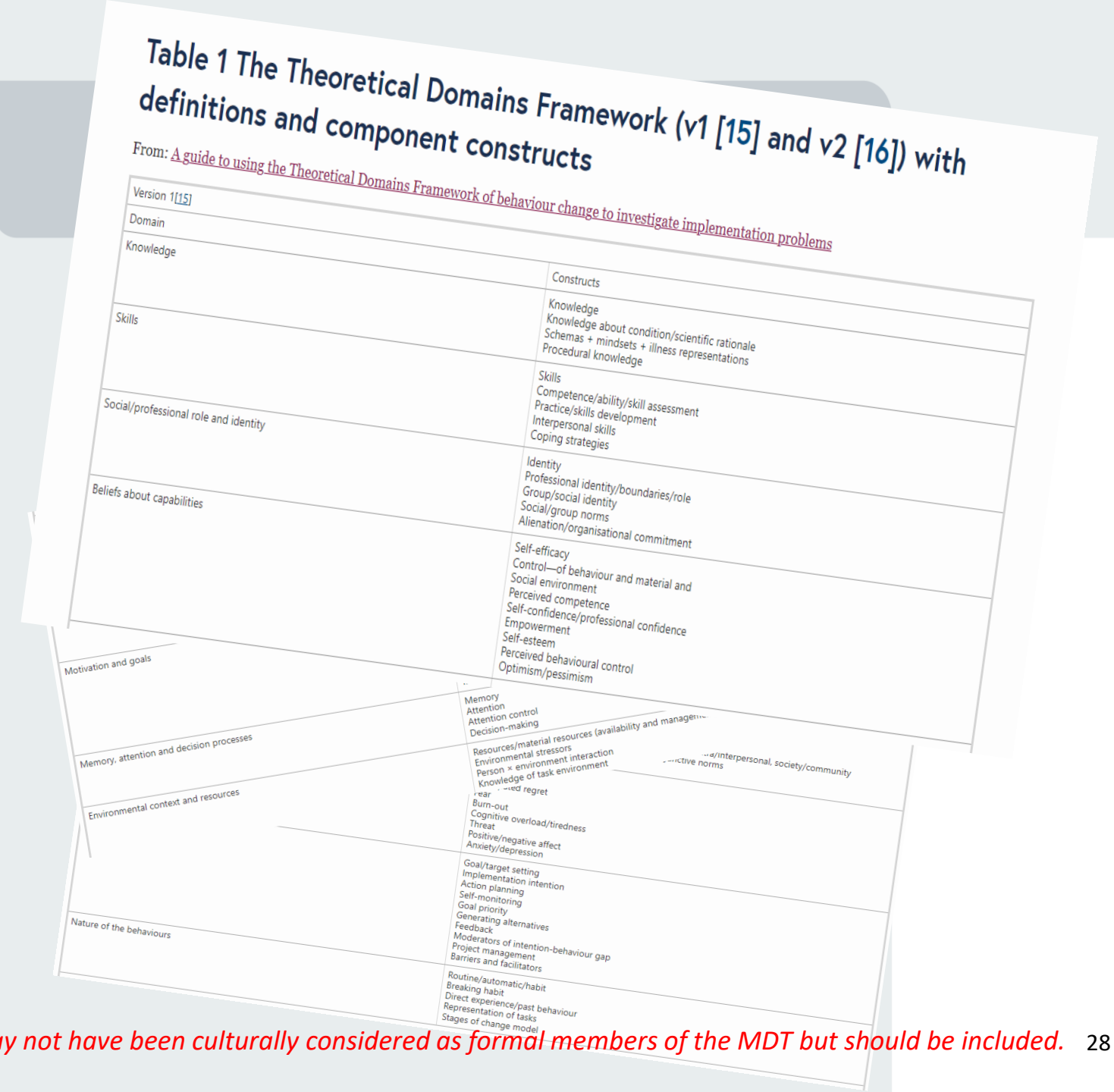


Table 1 The Theoretical Domains Framework (v1 [15] and v2 [16]) with definitions and component constructs

From: A guide to using the Theoretical Domains Framework of behaviour change to investigate implementation problems

Version 1[15]	
Domain	
Knowledge	Knowledge Knowledge about condition/scientific rationale Schemas + mindsets + illness representations Procedural knowledge
Skills	Skills Competence/ability/skill assessment Practice/skills development Interpersonal skills Coping strategies
Social/professional role and identity	Identity Professional identity/boundaries/role Group/social identity Social/group norms Alienation/organisational commitment
Beliefs about capabilities	Self-efficacy Control—of behaviour and material and Social environment Perceived competence Self-confidence/professional confidence Empowerment Self-esteem Perceived behavioural control Optimism/pessimism
Motivation and goals	
Memory, attention and decision processes	Memory Attention Attention control Decision-making
Environmental context and resources	Resources/material resources (availability and manage Environmental stressors Person × environment interaction Knowledge of task environment Burn-out Cognitive overload/tiredness Threat Positive/negative affect Anxiety/depression
Nature of the behaviours	Goal/target setting Implementation intention Action planning Self-monitoring Goal priority Generating alternatives Feedback Moderators of intention-behaviour gap Project management Barriers and facilitators
	Routine/automatic/habit Breaking habit Direct experience/past behaviour Representation of tasks Stages of change model

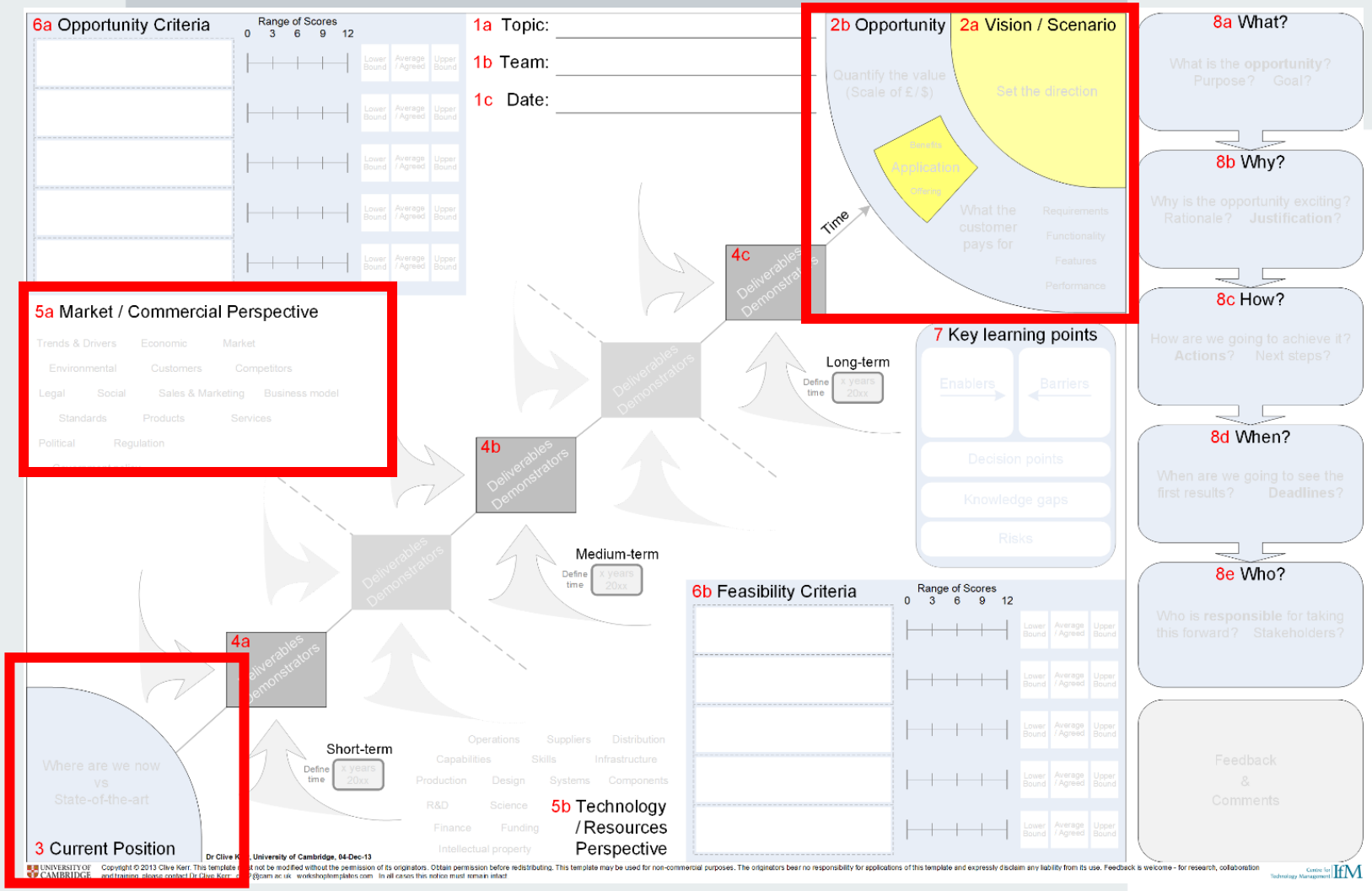
**Midwifery support workers and other unregistered staff may not have been culturally considered as formal members of the MDT but should be included.*

Stages 2 & 3

Agreeing the local context &

Collaborative exploration of vision & challenges

- **Workshop Parts 1 & 2**
  - Introducing “Road mapping” (as developed in this template by Clive Kerr. (Kerr, C 2020)
  - Agreement of local context and current position using data from the TDF questionnaire & SUV experiences to facilitate.
  - Development of a new vision including a legal context for valid consent using the Mental Capacity and Human Rights Acts

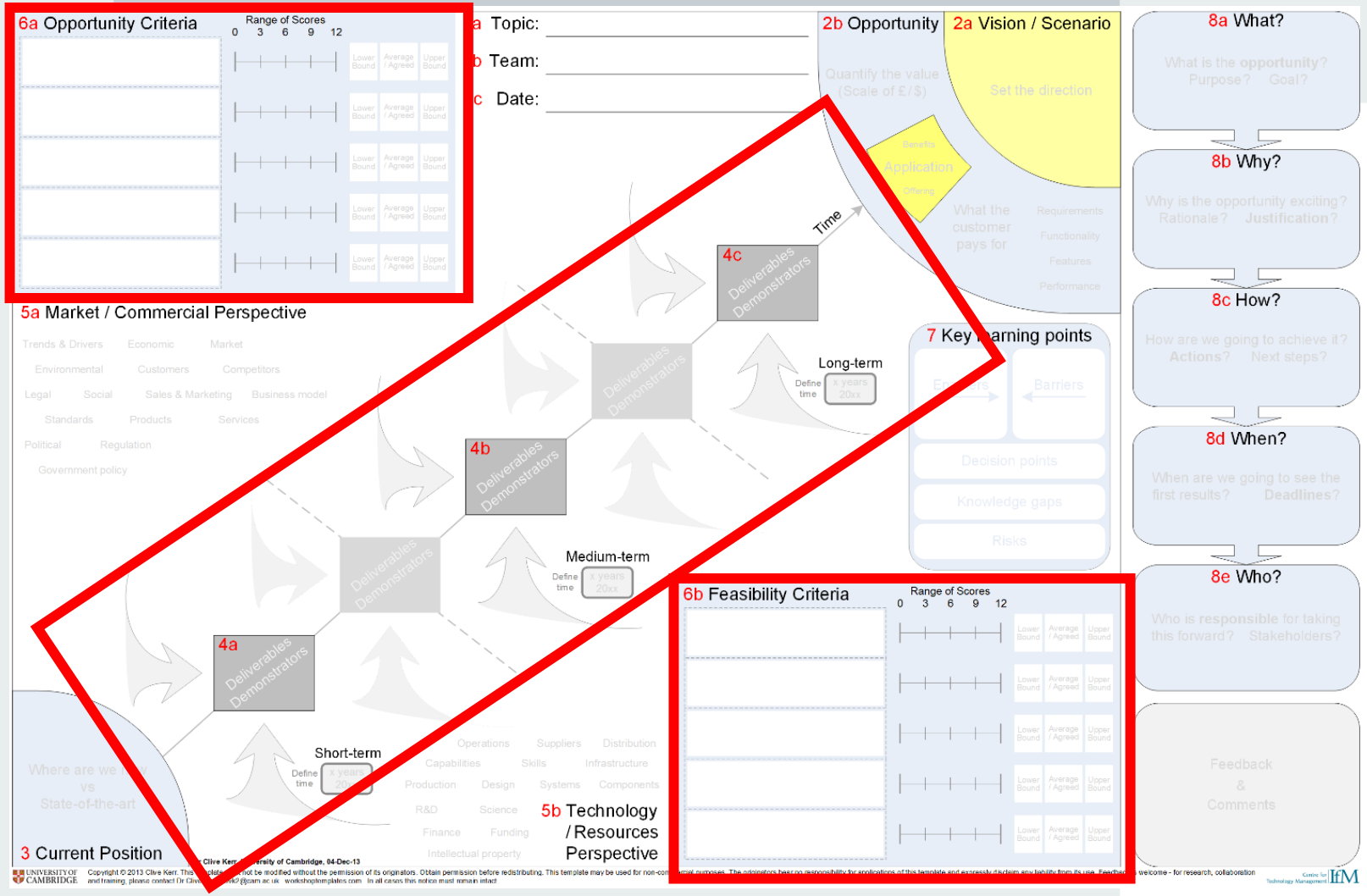


collaborative development of actions through consideration of the opportunities and feasibility of presenting options.

Stages 4 & 5

Solution development & prioritisation

- **Workshop Part 3**
  - Identifying potential solutions & local system and personal challenges
  - Continuing a structured and validated approach to creating solutions. Supporting stakeholders to develop evidenced based actions for change
  - Returning to create individual and system “roadmapping” in prioritising the identified actions in personal & system, short, medium and long-term change *(Kerr, C 2020)*.



Two workshops held to facilitate local agreement of context and develop roadmaps.

Consent for IE Action Plan Pilot Workshops

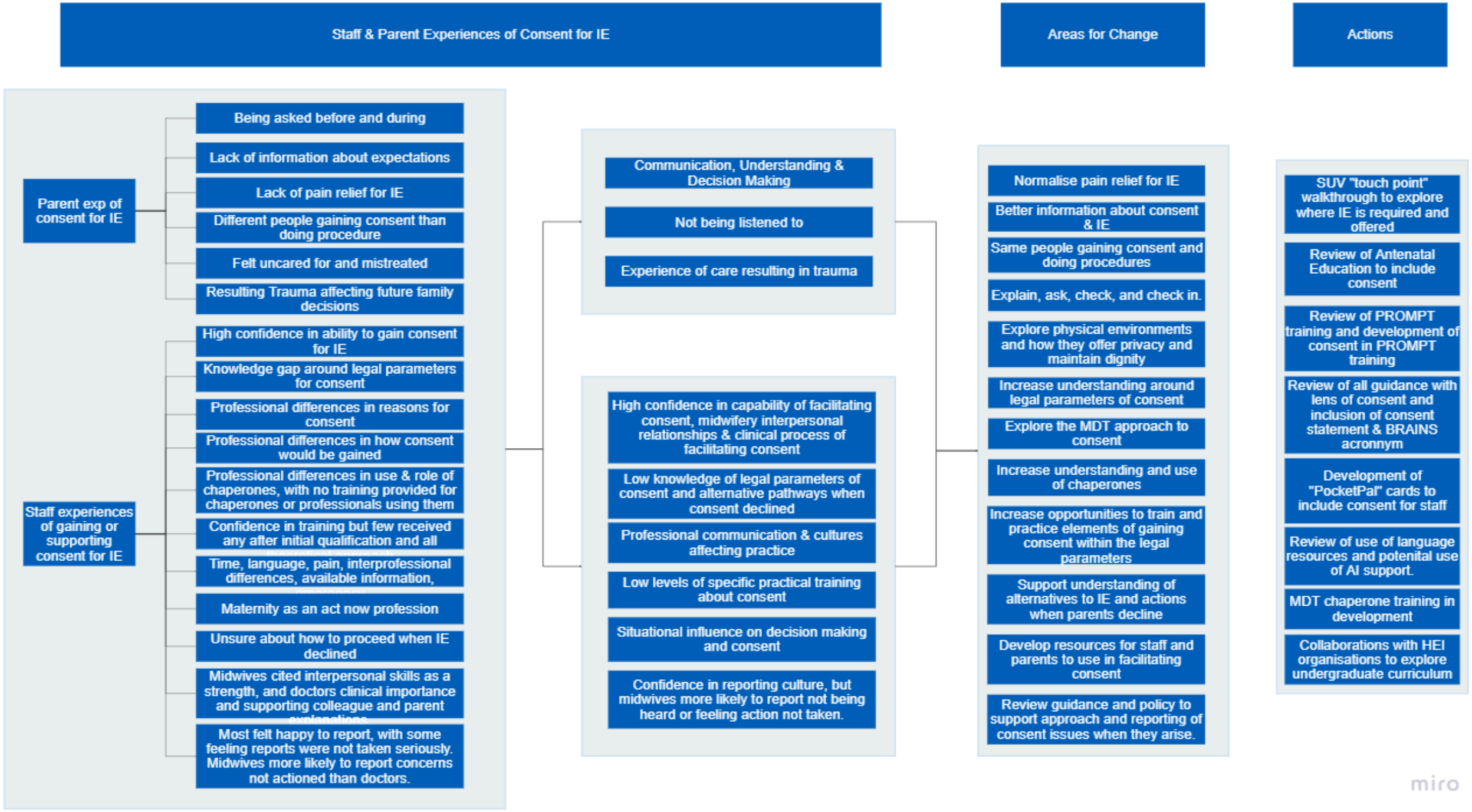
Total Session time: 2hrs

Time	Item	Lead
00:00	Welcome & Introductions	Whole Group
00:15	Setting group dynamic • To include: Acknowledgement of the difficult subject. Safety & confidentiality. Open and honest interactions. • Format for the session – Using the templates	Lead Team
00:30	Presentation of Local results	Lead team
00:50	Section 1: Acknowledging the starting point. Through group discussion around the presentation of results and using their own summary points complete the baseline section of the template as a whole group.	Group
1:10	Section 2: Solution Building Either in stakeholder groups/as a whole group Collate themes from the evidence into possible solution themes and add to mapping template	Group
1:30	Possible challenges and prioritising	Group
1:45	Summary and Close & Post session evaluation opportunity	Lead Team

NHS England and NHS Improvement

Principles for today's session

- Everyone here is welcome, and we all want safe, effective and respectful care.
- Some of the things we hear may be difficult, but everyone's experience is valid.
- We are all here to work together.

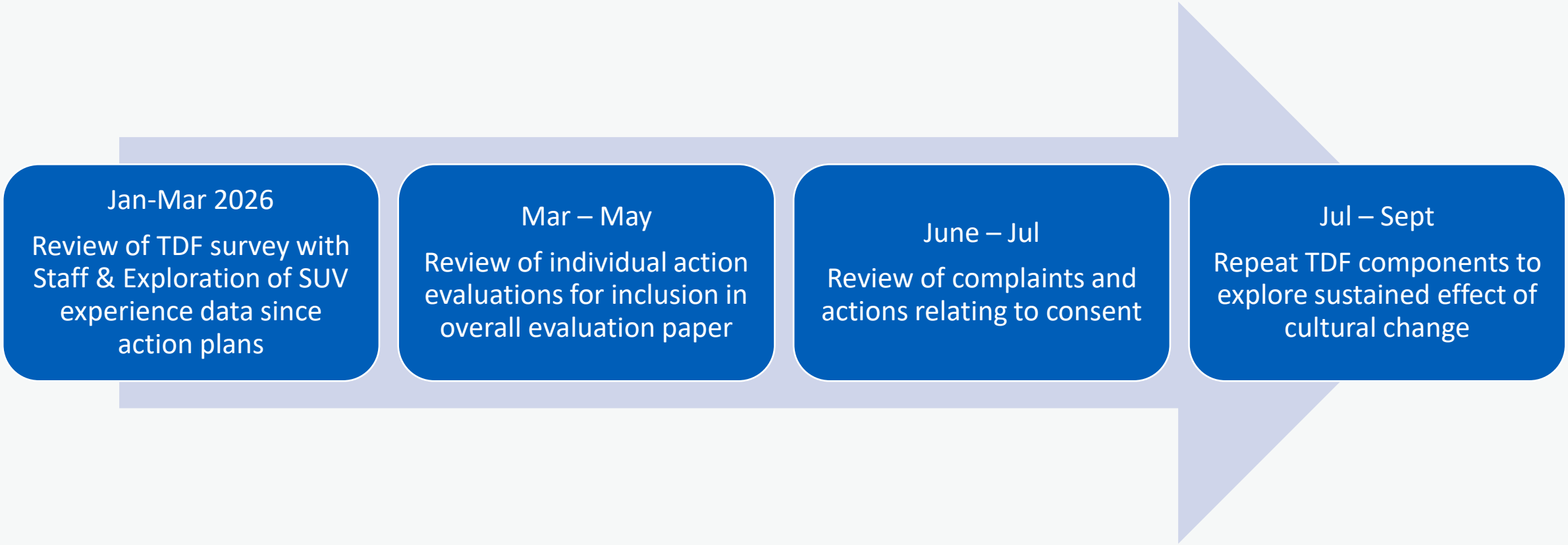

Staff & Parent Experiences of Consent for IE
Areas for Change
Actions
Parent exp of consent for IE
Being asked before and during
Lack of information about expectations
Lack of pain relief for IE
Different people gaining consent than doing procedure
Felt uncared for and mistreated
Resulting Trauma affecting future family decisions
Staff experiences of gaining or supporting consent for IE
High confidence in ability to gain consent for IE
Knowledge gap around legal parameters for consent
Professional differences in reasons for consent
Professional differences in how consent would be gained
Professional differences in use & role of chaperones, with no training provided for chaperones or professionals using them
Confidence in training but few received any after initial qualification and all
Time, language, pain, interprofessional differences, available information,
Maternity as an act now profession
Unsure about how to proceed when IE declined
Midwives cited interpersonal skills as a strength, and doctors clinical importance and supporting colleague and parent
Most felt happy to report, with some feeling reports were not taken seriously. Midwives more likely to report concerns not actioned than doctors.
Communication, Understanding & Decision Making
Not being listened to
Experience of care resulting in trauma
High confidence in capability of facilitating consent, midwifery interpersonal relationships & clinical process of facilitating consent
Low knowledge of legal parameters of consent and alternative pathways when consent declined
Professional communication & cultures affecting practice
Low levels of specific practical training about consent
Situational influence on decision making and consent
Confidence in reporting culture, but midwives more likely to report not being heard or feeling action not taken.
Normalise pain relief for IE
Better information about consent & IE
Same people gaining consent and doing procedures
Explain, ask, check, and check in.
Explore physical environments and how they offer privacy and maintain dignity
Increase understanding around legal parameters of consent
Explore the MDT approach to consent
Increase understanding and use of chaperones
Increase opportunities to train and practice elements of gaining consent within the legal parameters
Support understanding of alternatives to IE and actions when parents decline
Develop resources for staff and parents to use in facilitating consent
Review guidance and policy to support approach and reporting of consent issues when they arise.
SUV "touch point" walkthrough to explore where IE is required and offered
Review of Antenatal Education to include consent
Review of PROMPT training and development of consent in PROMPT training
Review of all guidance with lens of consent and inclusion of consent statement & BRAINS acronnym
Development of "PocketPal" cards to include consent for staff
Review of use of language resources and potenital use of AI support.
MDT chaperone training in development
Collaborations with HEI organisations to explore undergraduate curriculum

Session feedback and pledges

- Sessions could have been longer
- Format helpful to guide discussions at local levels
- Valued discussions which were constructive and useful
- Wanted to see more workshops and greater presence from obstetric teams.

- Interim information to be prepared for MSWs around chaperone role.
- Will think more about consent and help colleagues to consider validity of consent
- Discuss consent on ward rounds
- Feel more confident to challenge poor practice
- Remember there are alternatives.

Consent Roadmap Evaluation Plan



Thank You

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Weightmans

See the Possibility

Consent – the pitfalls, problems & the right to make a poor decision

30 September 2025

Sarah Skinner
Legal Director

Weightmans

See the Possibility

Consent. Why bother? Is it really that important?

No consent at all = Trespass, Battery, or GBH

Treatment outside scope of consent

Deficiency in the obtaining of informed consent = negligence

Weightmans

See the Possibility

"Personally, I wouldn't have signed it."

The duty of medical professionals to obtain informed consent for treatment and disclose risks concerning treatment

The evolution of the consenting expectations and duty of care through cases of Bolam, Sidaway, Chester, Birch and Montgomery;

Consenting headaches!

We see the following:

- – partially complete consent forms
- – lack of detail in relation to risks specific to the type of surgery being performed
- – consent forms not dated/unclear who consented the patient
- – consent process undertaken immediately prior to surgery even where no emergency
- – junior staff consenting the patient for complex surgery
- – no documentation of the alternatives to surgery or the less risky surgical options
- – no clear documentation of the risks of surgery that were explained to the patient and any concerns raised and discussed with the patient
- – where circumstances change, such as in obstetric cases, a failure to review the mode of delivery during labour and advise/consent the patient for c-section.

The key principles of consent

Consent will only be valid if :-

(1) capacity issues have been addressed;
(2) the consent covers the treatment in question;
(3) consent is voluntarily given;
(4) the patient gave consent having been informed
- in an appropriate time and manner;
- about the pros & cons and risks of the proposed and reasonable alternative treatment (including option of no treatment)
- to a level of detail appropriate to the circumstances

Sidaway (1994) Lord Scarman

"English law must recognise a duty of the doctor to warn his patient of risk inherent in the treatment which he is proposing: and especially so, if the treatment be surgery. The critical limitation is that the duty is confined to material risk. The test of materiality is whether in the circumstances of the particular case the court is satisfied that a reasonable person in the patient's position would be likely to attach significance to the risk."

Chester v Afshar (2004)

- Neurosurgeon advised a patient to undergo spinal surgery, which carried a risk of causing *cauda equina* syndrome. The neurosurgeon did not warn the patient of this risk. The patient reluctantly had the operation and the risk occurred.
- The judge allowed the claim finding that, had the warning been made, Ms Chester would not have undergone the surgery **at the time** she did, but he did not find she would never have undergone the surgery
- The judge awarded damages as there was a sufficient causal link between the failure to warn and the damage

The evolution of consent

The rationale behind the duty to warn is to enable adult patients of sound mind to make their own decisions as to what is done with their bodies.

The fundamental importance of the right to decide, and that the function of the law is to protect the patient's right to choose.

Personal autonomy had become more important in the 20 years since *Sidaway* was decided

MONTGOMERY V LANARKSHIRE HEALTH BOARD, SC 2015

Distinction between the doctor's role

(1) in considering investigatory or treatment options, and

(2) in discussing with the patient any recommended treatment and alternatives.

The first is an exercise of professional skill and judgment, and so negligence there is to be judged by reference to the expertise of members of the medical profession (i.e., the Bolam test).

The latter, is not. The patient is entitled to decide which risks to health he or she is willing to run, and that may sometimes depend on non-medical considerations, or on value judgments which the patient herself must make.

Montgomery consent

An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and consent must be obtained before treatment interfering with bodily integrity is undertaken.

The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any **material** risks involved in any recommended treatment, and of any reasonable alternative or variant treatments.

What is material?

- The test

  *In the circumstances of the particular case, a **reasonable person in the patient's position** would be likely to attach significance to the risk, or the doctor **is or should reasonably be aware that the particular patient** would be likely to attach significance to it.*

What is material?

The assessment is therefore fact-sensitive, and sensitive also to the characteristics of the patient

Considerations:

- *the nature of the risk*
- *the effect which its occurrence would have on the life of the patient*
- *the importance to the patient of the benefits sought to be achieved by the treatment*
- *the alternatives available and the risks involved in those alternatives.*

Examples

A v East Kent Hospital University NHS Foundation Trust [2015] EWHC 1038 (QB)

- *"the evidence did not show that there was a material risk to which Mrs A should have been alerted that B was suffering from a chromosomal abnormality. If the risk had been at the level indicated by either Dr Taylor and agreed by Dr Reardon (namely somewhere between 1% or 3 %), or anywhere approaching that level, then I would have concluded that [the doctors] should have raised it with Mrs A. However, in my judgment the evidence given to the effect that the risk was 1 in 1,000 or, as [the doctors] put it, theoretical, negligible or background, was much to be preferred and I accept that evidence."*

Tasmin v Barts Health NHS Trust [2015] EWHC 3135

- *A risk of 1:1,000 is an immaterial risk for the purposes of paragraph 87 of Montgomery.*

- *But it is not entirely that clear…*

"in the context of defining the borderline between materiality and immateriality. Here, I am quite satisfied that the relevant risk was so low that it was below that borderline. I am not to be understood as saying exactly where the threshold should be defined"

Ollosson v Lee [2019] EWHC 784

The materiality of the risk of chronic post vasectomy pain

Judgment – in summary the risk of chronic [post vasectomy] pain appears to be about 5%. Once one tries to evaluate pain there is always difficulty, as there is a considerable subjective element in the appreciation of pain, and substantial variation in patients who try to describe or score levels of pain.
In the light of all that evidence, was it adequate to describe the risk as 'small'? In my judgment it was. Of course, 'small' may mean different things to different people, but the word 'small' is clearly an everyday word which encompasses and satisfactorily conveys the level of risk involved …. a patient told of a 'small' risk can ask for further clarification.

The importance of dialogue

- *The doctor's advisory role involves **dialogue**, the aim of which is to ensure that the patient understands the seriousness of her condition, and the anticipated benefits and risks of the proposed treatment and any reasonable alternatives, so that she is then in a position to make an informed decision..*

DOCTOR'S DUTY WILL NOT BE DISCHARGED BY

- OTT information
- Confusing detail
- Lengthy unexplained information sheets
- Lack of opportunity for dialogue
- Failure to check that patient understands
- A mere signature on a consent form

Consenting requirements

- Consent will only be valid if
- (1) capacity issues have been addressed;
- (2) the consent covers the treatment in question;
- (3) consent is voluntarily given;
- (4) the patient gave consent having been informed
- a) in an appropriate time and manner;
- b) about the pros & cons and risks of the proposed and reasonable alternative treatment (including no treatment)
- c) to a level of detail appropriate to the circumstances

Exceptions

Patients lacking capacity to give informed consent

- children (parents/ guardians decide, or *Gillick* competent children decide)
- mentally incapacitated adults

"True"Emergency situations [88]

- e.g. patient requires emergency treatment but is unconscious or unable to make a decision

Patient decides that they do not want to be informed

- no obligation on doctor to force discussion of risks

Exceptions continued

No obligation on doctor to explain risks if doctor decides that would be seriously detrimental to the patient's health

- This decision would be made *in the reasonable exercise of medical judgment* (i.e. subject to *Bolam* test)
- BUT a warning to doctors: *it is important that the therapeutic exception should not be abused. It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.*

Examples

- **Border v Lewisham & Greenwich NHS Trust [2015] EWCA Civ 8 – urgent care**

The claimant was brought into A & E with a suspected broken right humerus. The SHO on duty was unable to put an IV into her injured right arm. He proposed to put an IV line into the left arm, as would be the normal practice in that situation; but the claimant asked him not to explaining that she had recently had a left mammectomy and axillary node clearance'.

Insertion of an IV line into the left arm carried a risk of provoking oedema. The SHO gave consideration to that risk but decided to put an IV line into the left arm despite the claimant's warning on the basis that it was a standard and important practice when working in the resuscitation room to do this in order to gain control of any situation which may develop

The judge held that "it would be a brave decision for a Senior House Officer not to follow the standard practice ... that an IV line should, if possible, be inserted in the early stage. The logic is clear: in an uncertain and potentially dangerous situation it is better to be ready, even if there is a slight risk of an adverse known side effect."

Urgent care scenario

In a medical emergency, when the patient is incapable of giving consent, a doctor may proceed without consent provided that he or she is acting in the patient's best interests

"…[but] to fall within the principle, not only (1) must there be a necessity to act when it is not practicable to communicate with the assisted person, but also (2) the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person."

In an emergency a doctor has little time to ponder the choices available. He must act in the best interests of his patient, as he sees them, but he can be more readily forgiven if he errs in his judgment."

BUT

"…….On the evidence, however, this was not such a case of medical emergency. The claimant was in the emergency room – the resuscitation room – but she was fully conscious and capable of giving or withholding her consent. The judge was therefore wrong to regard the issue of consent as unimportant".

Bilal v St George's University Hospitals NHS Trust (2023) EWCA Civ 606

- Case involved a poor outcome from two spinal surgeons
- Issues included diagnosis of post operative pain and failure to discuss or recommend alternative treatment to surgery such as pain management or injections.
- Claimant lost on all issues.

Judgement" a responsible and respectable body of skilled spinal surgeons would have concluded that there were no reasonable alternatives available"

It was found that the claimant would have proceeded to surgery even if he had been advised of other treatment options.

Claimant appealed….

Appeal court concluded…"it is for the doctor to assess what the reasonable alternatives are; it is for the court to judge the materiality of the risk inherent in any proposed treatment, applying the test

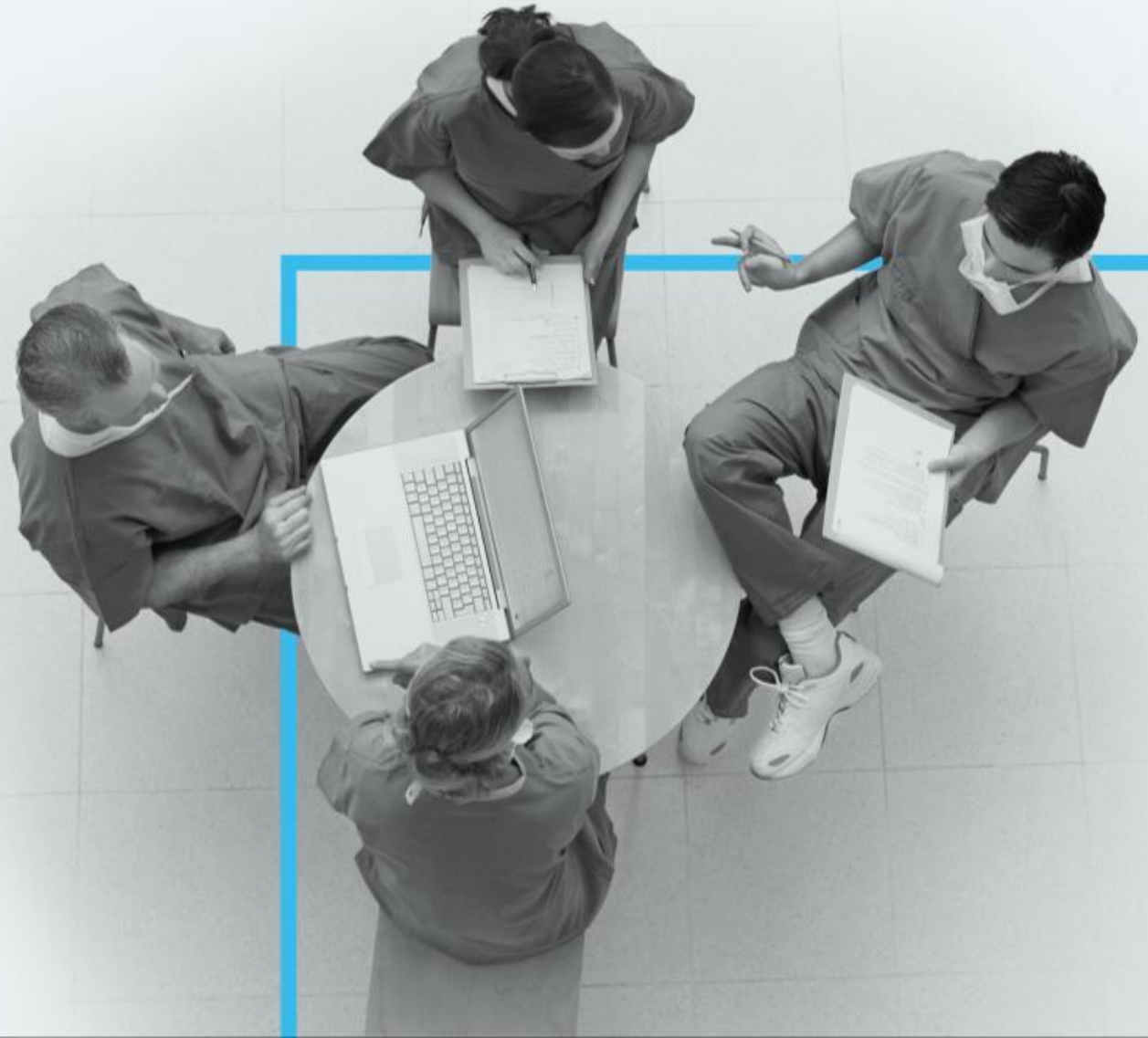
of whether a reasonable person in patient's position would be likely to attach significance to the risk"

Own examples

- Urogynecology – prolapse and stress incontinence surgery with poor outcome
- Fetoscopic laser ablation in twin-to-twin transfusion syndrome leading to death of one twin and brain injury in the other
- Obstetric case: consent for method of delivery and the need to review the same as labour progresses. Mother wanted vaginal birth but then faced with need for an emergency c-section when CTG deteriorated. However, there was delay leading to rupture of the uterus and instrumental delivery leading to injury to mother and urinary and faecal incontinence.

Questions and discussion

NHS Resolution



Feedback survey

https://forms.office.com/e/R1JU01HQcR

- Please hold the date- the next Midlands and East network webinar is on November 26th 2025 on VTE

Thank you for listening

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