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Child Consent – Part II

Children and Consent – the key issues Part II

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Summary

Working within legal frameworks is a must for all nurses and integral to practice (NMC, 2015a). As such, all healthcare practitioners must have an understanding of the law of consent and what it means in practice when they are providing care and treatment to children and young persons under the age of 18. This second article moves discussions on from children of tender years as discussed by Angela Smith in Part I. It considers what is meant by *Gillick* competence in terms of the law of consent as it applies in England and Wales to children under the age of 16. It discusses the legal framework that applies to young persons aged 16 and 17 years. It will also provide an overview of the extent of adolescent autonomy, what happens when competent children and young people refuse treatment, what happens when there is a conflict between a child and their parent or guardian relating to treatment and the potential for recourse to the court in complex situations.

Keywords

Consent, Autonomy, Refusal

Key Points

1. Children under 16 years of age can consent to treatment providing they have sufficient maturity and intelligence to understand the implications of the proposed treatment.
2. Children aged 16 and 17 years have a statutory right to consent to medical examination and treatment.
3. No child under the age of 18 is a wholly autonomous being and the law provides for those with parental responsibility to also consent to medical examination and treatment where competence is an issue.

4. Whilst children under 16 years and children aged 16 and 17 may consent to treatment if they meet the criteria, this autonomy does not extend to the right to refuse treatment which can be vetoed by those with parental responsibility and the court.

Consent to treatment and children under 16 years of age

When treating children and young people, healthcare practitioners need to obtain valid consent; it provides them with the fully informed confirmation they need to proceed with the proposed treatment. Consent respects patient autonomy and it can offset any potential action against the practitioner. For children of tender years this means gaining the consent of the person(s) with parental responsibility (Smith, 2018), but what about those children who are growing and developing, evidencing understanding and maturity?

The United Nations Convention on the Rights a Child (UNCRC, 1989) recognises parents have rights. This is to fulfil their responsibilities and duties to ensure their child receives adequate healthcare and this includes making decisions in relation to care and treatment which is subject to them acting in their child's best interests. However, the Convention also recognises a child will mature as they develop into adulthood. As such, the parents' right to make such decisions as the child progresses through the stages of childhood should be made "*in a manner consistent with the evolving capacities of the child*" (Article 5, UNCRC, 1989; Kennedy & Grubb, 1998). Essentially this means that as children develop and mature, they may be able to make certain decisions for themselves and this includes decisions about care and treatment. In any event, regardless of competence, children have the right to participate in decisions that relate to them (Article 12, UNCRC, 1989).

To assist healthcare practitioners with their understanding of the evolving capacities of the child and what it means in practice, guidance can be found in legal principles derived from decisions of the court and legislation. It is the well-known case of *Gillick v West Norfolk and*

Wisbech Area Health Authority [1985] 3 All ER 402, HL that sets down the relevant guidance and test to establish adolescent maturity to make a treatment decision. In order to protect her daughters and parental rights, Mrs Gillick challenged the Department of Health's guidance to doctors that contraceptive advice and treatment could be provided to children under the age of 16 without the consent of their parent (although doctors were to make every effort to gain the child's agreement to involve the parent). Mrs Gillick also put forward the argument that providing contraception to girls under 16 constituted an offence and that they could not consent to such treatment as they were legally below the age where they could consent to sex. In this case Lord Scarman stated "*the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed*" (p 424). The House of Lords held that a child under 16 years, in certain circumstances, may have the competency in law to consent irrespective of any parental objection. It will ultimately be a question of fact as to whether the child has sufficient understanding and intelligence, and, although this case dealt with a specific issue it is now applied widely in healthcare settings when dealing with the consent to treatment of children under the age of 16. This facilitates (at least to a certain extent) autonomy in competent children under 16 years of age.

When it comes to consenting to more complex treatment with possible serious consequences then healthcare practitioners need to be aware that the child will need to evidence deeper understanding of the proposed treatment (*Re R (A Minor) (Wardship: Medical Treatment)* [1991] 4 All ER 177, CA). In this case, R, a 15 year old girl, was receiving care and treatment for an acute psychotic illness which included episodes of aggressive and suicidal behaviour. R, was considered able to consent to treatment (in the form of medication) however on occasions she would refuse treatment therein risking an exacerbation of her

psychosis. The intervention of the court was sought for authorisation to administer anti-psychotic medication absent consent. Lord Donaldson stated that “*the Court has the right and, in appropriate cases, duty to override the decision of parents or other guardians. If it can override such consents, as it undoubtedly can, I see no reason why it would not be able, and in an appropriate case, willing to override decisions by Gillick competent children.*”

However, whilst the Court of Appeal agreed to the administration of the medication, they did not in effect veto R’s refusal which was within their powers, it was on the basis that R, in this instance, did not have sufficient maturity and understanding and therefore was not *Gillick* competent. The court found R’s illness impacted on her ability to understand the need for medication to treat her illness; R was unable to evidence the understanding necessary to the decision.

Where a child does not have sufficient intelligence and maturity to make a decision and parental consent is absent (for example in the case of “*an emergency, parental neglect, abandonment of child or inability to find parent*” (p 424, *Gillick v West Norfolk and Wisbech Area Health Authority*), healthcare practitioners can act in the child’s best interest. It is worthy of note at this stage that the principles derived from court decisions, such as the *Gillick* principle outlined above, are reflected in relevant and professional guidelines as well as policies and procedures drafted by care and treatment providers including health boards.

In the event of any issues or conflict between parent and child and/or professionals and child the court will intervene in the same way as if the child was of tender years as set out in the previous article in this series by Angela Smith. The matter will be determined with the welfare of the child being the court’s paramount consideration (s1(1) Children Act 1989). In the case of *Re B (A Minor) (Wardship: Abortion)* [1991] 2 FLR 226, a 12 year old girl expressed a wish to have her pregnancy terminated. This decision was supported by her grandparents who she lived with and the 16 year old putative father. Following a referral by

the GP to the Local Authority, an application to the court was made for leave to have the pregnancy terminated and this was opposed by the child's mother who was against abortion. In this instance the Judge deemed the child was not sufficiently mature to make such a decision and authorised termination was in the child's best interests. In the 2014 case of *An NHS Trust v A, B, C and a Local Authority* [2014] EWHC 1445, a 13 year old girl expressed a wish to have a termination after her pregnancy was discovered at 21 weeks gestation. The hospital was concerned and applied to the court for declarations in relation to the girl's competency to consent to the termination of the pregnancy and, in the event she lacked this competence, a declaration that a termination would be in the child's best interests. In this instance the girl was held to have sufficient maturity and understanding to decide whether to terminate or continue with her pregnancy and therefore 'best interests' was not an issue as she was *Gillick* competent.

Consent to treatment and children aged 16 and 17 years

The Family Law Reform Act 1969 defines a child as any person under the age of 18 years. However, healthcare practitioners need to be aware that section 8(1) of this Act provides the legal basis on which those children aged 16 and 17 years may consent to medical treatment. Essentially it provides for children of this age to be treated the same as a person aged 18 or over; the starting point therefore for 16 and 17 year olds is a presumption of capacity which is rebuttable. Whilst there is this presumption, healthcare professionals should note that section 8(3) of this Act ensures parental consent to treatment on behalf of their child is not fully extinguished and equally it also maintains the ability of the court to intervene to protect children. This was evidenced in the case of *Re W (A Minor) (Medical Treatment: Court Jurisdiction)* [1992] 3 WLR. In this case a 16 year girl was in a critical condition suffering from anorexia nervosa. The issue before the court was whether the girl could be transferred to a specialist unit and force fed, if necessary, absent her consent to such care and treatment.

Although competence is assumed by virtue of section 8(1), the Court of Appeal held section 8(3) maintains parental consent and protects the court's power to intervene. In this case, in light of the seriousness of her condition, the court ordered transfer and treatment was in her best interests, vetoing her refusal. This decision was upheld on appeal to the House of Lords who held s 8(1) does not confer an absolute right to determine a treatment decision either way and that such refusal could not veto any consent provided by the court. However when exercising that power the court would take account of the child's wishes (in accordance with age and maturity) but would override same when it is in their best interest as whilst important, they were not decisive.

Healthcare practitioners should also be aware that when a 16 or 17 year old lacks the mental capacity to give consent in accordance with section 2(1) of the Mental Capacity Act (MCA) 2005 (i.e because of *an impairment of, or a disturbance in the mind or brain*) as opposed to not having the maturity or understanding or is overwhelmed by the decision), then treatment may be provided on a best interests basis and the principles of the MCA must be followed by healthcare practitioners.

Refusal to consent to treatment and children under 16 years and 16 and 17 year olds

As alluded to above, whilst both categories of adolescents can consent to treatment (if *Gillick* competent and by reason of a presumption of capacity), this recognition of their ability to consent and respect for autonomy is more complex when it relates to refusing treatment.

Ultimately, whilst competent consent cannot be overridden, the law provides for competent refusal to be overridden in two ways, by those with parental responsibility and the court. In the case of *Re R*, discussed above, Lord Donaldson stated "*in a case in which the 'Gillick competent' child refuses treatment, but the parents consent, that consent enables treatment to be undertaken lawfully...in a case in which the positions are reversed, it is the child's consent*

*which is the **enabling** (my emphasis) factor*” (p 185, e-f). What this means is a parent has the right to consent where a competent child refuses treatment but they do not have the right to veto the child’s consent to treatment. In *Re W*, discussed above, Lord Balcombe stated that no minor (referring to a child under 18 years of age) is a wholly autonomous individual. (Healthcare practitioners should note, there is an exception to this principle when a child aged 16 or 17 refuses informal admission into hospital for a mental disorder. In these circumstances a person with parental responsibility cannot consent to the admission (Mental Health Act 1983, s 131)).

There is no doubt that the most difficult cases for healthcare practitioners are those where children (with competence to consent to treatment or presumed competence) refuse life-saving treatment. The fact is children do refuse treatment and these are the most complex of cases. In the case of *Re E*, a 15 year boy of the Jehovah Witness faith refused potentially life-saving transfusions. These were to be administered together with on-going chemotherapy to maximise possible recovery from Leukaemia. Although considered well informed, highly intelligent and mature, the court found he was not Gillick competent on the grounds that he was unable to consider the way in which he would die or the impact his death would have upon his family (*Re E (A Minor)* (1990) 9 BMLR 1). Brazier and Cave (2017) suggest that the level of competence as that expected in the aforementioned case is unattainable whilst noting that the court will seek to protect children when their lives are at risk.

In *An NHS Foundation Hospital v P* [2014] EWHC 1650, a 17 year old girl refused treatment for an overdose. In this instance P’s mother consented to the treatment however the hospital were reluctant to proceed on this basis and in the absence of a court order. Even though there was a presumption of capacity in relation to P (and she was assessed as having capacity under the Mental Capacity Act 2005), treatment was authorised on the basis of *Re W*, that is, given

the seriousness of P's condition, treatment was deemed to be in P's best interests therein vetoing her refusal.

In these very difficult circumstances of refusal, guidance is available. The 2009 Department of Health Guidance provides *"it would be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful"* and this was probably the situation in the last case. Similarly there is guidance from the GMC (0-18 Guidance for Doctors, 2007). Paragraph 31 provides *"you should seek legal advice if you think treatment is in the best interests of a competent young person who refuses."* Further, paragraph 32 of this guidance provides that the harm caused to children as a result of their refusal must be carefully weighed up and legal advice sought. This guidance may have been relied upon by Hereford Hospital who instigated legal proceedings in relation to 13 year old Hannah Jones. In this case Hannah was successful in offsetting these legal proceedings which may have seen her forced into having a potentially life-saving heart transplant against her wishes after years of being in and out of hospital. Hannah was able to evidence her competence to decide (which would have been to a high standard given the gravity of the outcome) when she convinced a child protection officer that she fully understood the options. This decision was relayed by the appointed protection officer to the lawyers involved in the matter who then brought the proceedings to an end (The Guardian, 11 November 2008). This case also evidences there are occasions when a child's refusal has been respected.

Conclusion

Ultimately a child under the age of 16 years may be able to consent to treatment. However, it is limited to the extent that such autonomy applies to the right to consent to treatment and not to the right to refuse treatment which can be overridden by parental consent and the

intervention of the court. It is the responsibility of the healthcare practitioner to assess and determine whether a child under 16 years of age has the requisite maturity and intelligence to make treatment decisions. With regards to children aged 16 and 17 years, section 8(1) of the Family Law Reform Act 1969 provides the legal basis on which these children may consent to medical treatment. This rebuttable presumption of competency essentially means 16 and 17 year olds are treated like adults in terms of their consent to treatment. The presumption does not extend to any refusal to treatment which can be overridden. In this respect the law is clear with section 8(3) of the Act ensuring parental consent is not extinguished. This allows for a person with parental responsibility to override any refusal although it appears from the case of *An NHS Foundation Hospital v P* above not to be the case with the hospital refusing to proceed with parental consent only. Section 8(3) also preserves the ability of the court to intervene to protect 16 and 17 year olds. It is clear from all the discussions above that, to a significant degree, the autonomy of a child with sufficient maturity and understanding to consent to treatment is respected as is that of the child aged 16 and 17 years although as noted in the case of *Re W*, no minor is wholly autonomous. It is perhaps understandable that the court will do its utmost to protect children when their lives are at risk however they do so whilst giving weight to the wishes and beliefs of the child even if these are not determinative in themselves.

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