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How to cite:

Cornock, Marc (2015). The child and consent. *Orthopaedic & Trauma Times*(27) pp. 13–15.

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Version: Accepted Manuscript

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The child and consent
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Word count: 2839 excluding abstract and reference list

Abstract

Having previously discussed the legal principles of consent and refusal of treatment in previous articles (Cornock 2015a & 2015b), this article turns its attention to how a child can consent to treatment on their own behalf and whether a child has the ability to refuse treatment. It will also consider the role of the parent or guardian in the consent process. The article is based on the law of England and Wales.

Introduction

A child, in the eyes of the law, is someone under the age of eighteen (Children Act 1989 at section 105). The distinction between child and adult is important from a legal perspective because on reaching adulthood certain rights and privileges are granted that are not available to those under eighteen. For instance, in English law it is only those over eighteen who are able to vote in a general election. The rights and protections offered by the law of consent only apply to those aged eighteen and over. Therefore the child does not have the automatic rights with regard to consent and their bodily determination discussed in Cornock 2015a.

However, as we will see, the fact that the law does not automatically provide the child with rights in regard to their ability to consent does not mean that the child has no legal rights, or that they can be treated by a health care practitioner in a paternalistic manner.

How the law develops

The law develops through a process of reform and amendment. There are two forms of law in the United Kingdom, statute law and common law. Statute law is the more senior of the two and if there is conflict between statute and common law, statute law takes precedence. This is because statutes originate from Parliament, as Acts of Parliament, as part of a democratic process. Common law, on the other hand, originates from cases that are heard in the courts. If a court is hearing a case where the law is unclear or where there is no statute providing authority or where no previous judgment applies, then the outcome of that case, the judgment, can be used as authority in other similar cases.

Development of the law relating to the child and consent

Until 1969 a child had no right to consent, this was a right reserved for those eighteen and over. This position changed with the introduction of the Family Law Reform Act 1969. Section 8 of the Act is headed 'Consent by persons over 16 to surgical, medical and dental treatment' and states:

'The consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian.'

The effect of this Act is to put the child who has reached the age of sixteen in the same position as someone who is eighteen: that they can consent on their own behalf.

However, it is important to note that the wording of the Act specifically relates to the provision of consent by a child. It says nothing about the child being able to refuse to give their consent. Thus, if the child decided that they did not want a specific procedure, their refusal could be overridden by someone with parental responsibility giving consent on their behalf (this is discussed further below). So although the law developed to allow children sixteen and over to consent, it did not do anything for their ability to withhold or refuse their consent, or anything at all for those under sixteen.

The next development in the law occurred in a case in 1986. In *Gillick v. West Norfolk & Wisbech Area Health Authority* [1986] the court considered the position of children under sixteen in relation to consent. They held that, whilst there is no automatic right of a child under sixteen to consent on their own behalf, those children who were able to demonstrate sufficient maturity and competence should be able to provide their own consent.

One of the Law Lords hearing the case, Lord Scarman, stated that in deciding if a particular child is competent to consent, it is necessary to determine if the child has

'sufficient discretion to enable him or her to exercise a wise choice in his or her own interests' and whether 'the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed' (Gillick v. West Norfolk & Wisbech Area Health Authority [1986] at page 188).

Other legal developments since, such as the Axon case in 2006, have merely reinforced the position in the Family Law Reform Act 1969 and the Gillick case.

Gillick competence

As a result of the Gillick case, a child who is able to demonstrate that they have the necessary competence to be able to provide their own consent is often referred to as being 'Gillick competent'. To be 'Gillick competent' the child would have to have the intellectual and emotional maturity to understand the nature and degree of their condition, what is being proposed regarding their treatment, including the nature and purpose of the treatment including any possible complications and side effects and the expected outcome, as well as the consequences of not having the proposed treatment. They would also have to be able to make a decision based on this information. If they are not able to arrive at a decision they would not be deemed to be 'Gillick competent'.

Refusing treatment

At the current time the position with regard to consent is that an adult, someone aged eighteen or over, who is competent (see Cornock M 2015a for a discussion of competence) has the legal right to consent on their own behalf AND to refuse to give that consent, that is to refuse treatment. A child aged sixteen and over, who is competent, has the legal right to provide consent on their own behalf but there is no legal provision that specifically allows them to refuse their consent and if they decide not to give their consent this can be overridden by someone with parental responsibility. A child under sixteen has no automatic right to either give their consent or to refuse their consent. In order for a child under sixteen to be able to give consent on their own behalf they have to prove that they are Gillick competent, only then will any consent they give be legally valid. With regard to any refusal of consent by a child under sixteen, the legal position is the same as for a child over sixteen, that it can be overridden by someone with parental responsibility. This means that for all

children, both those sixteen and over and those under sixteen, a refusal of treatment is not legally valid as it can be overridden by someone else and the treatment can proceed against the child's wishes. Further a court can, in certain circumstances order that a treatment be performed on a child against their wishes.

Parental responsibility

Although a commonly used term, 'parental responsibility' is in fact a legal term. It is defined in the Children Act 1989 where Section 3(1) states that parental responsibility 'means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property'.

It is important to note that parental responsibility is a legal duty and it exists not for the benefit of the person having the responsibility but for the child over whom they have that responsibility. Exercise of parental responsibility is a balancing act between the rights of a parent to raise their child according to their beliefs and values and the need to exercise their duties to act in the best interests of the child.

One area in which this balance between the rights of the person with parental responsibility and their duties in relation to the best interests of the child can be seen in the area of health care. Someone with parental responsibility can provide consent for a child who is either unable to consent or refusing to provide their consent. However, in making their decision, they have to consider all the relevant factors such as the need for treatment, the benefits of the treatment, any possible complications, any alternative treatments, any possible consequences of not having the treatment including how the child's condition would be managed, and the wishes of the child in order to make a decision that is grounded in the child's best interests.

Who has parental responsibility for a child?

Legally, the natural mother of a child has parental responsibility for that child. Fathers have parental responsibility for the child if they were married to the natural mother at the time of conception or birth of the child. Since 1st December 2003 (England and Wales) [15th April 2002 (Northern Ireland) or 4th May 2006 (Scotland)] both of a child's legal parents have parental responsibility if they are registered on the child's birth certificate.

Before these dates, a father who was not married to the mother of the child could only acquire parental responsibility through a parental responsibility agreement with the mother or through a specific court order.

Despite the use of the word parent in the term, parental responsibility does not necessarily have to be exercised by a parent. Normally it is the parents of the child who will exercise parental responsibility over the child but others who may have the right include legally appointed guardians.

Parents share parental responsibility, but the responsibility can also be shared between parents and legally appointed guardians. Where responsibility is shared, as with parents, one person can exercise their parent responsibility without prior approval of anyone else with parental responsibility, except where this is legally prohibited (see below). Therefore when seeking consent for a child from someone with parental responsibility, generally only one person's consent is needed.

Parental responsibility is not affected by divorce of the parents, or if the child is placed in care (where it may be shared between the parents and the Local Authority, or any court appointed guardian). However, parental responsibility can be removed by the courts or when the child is adopted.

Where parents disagree

As parental responsibility can be exercised by one person alone without any prior agreement or discussion with anyone else who also has parental responsibility for the child, there may be situations where there are disagreements about the treatment for the child.

In these situations, the legal position is that provided consent has been obtained from one person with parental responsibility, the proposed treatment can proceed. However, it would be advisable, and best practice, to discuss treatment options with all those holding parental responsibility where possible and to seek their agreement to the proposed treatment.

The exceptions to the rule that only one person can exercise their parental responsibility in relation to consent for a child relate to situations where a treatment is being provided for a non-therapeutic reason, such as religious circumcision of a male baby. In these cases the consent of both parents is required and without consent from both it would not be legal to proceed.

Obtaining consent from/for a child

It is best practice for the person who is planning to perform the proposed treatment to obtain the consent. If this is not possible then they need to ensure that they are satisfied that appropriate consent has been obtained and check with the person who provided the consent that it is still valid.

As can be seen from the above discussion, there are two possible situations with regard to consent and the child. The first is where the child is sixteen or over and the second where they are under sixteen.

Where the child is over sixteen, the child themselves can provide their own consent. In this situation the three general principles of consent need to be followed, essentially the consent has to be given by a competent person, who has been given adequate information and the consent has to be given voluntarily (see Cornock 2015a for further discussion).

If the child over sixteen is unable or unwilling to provide their consent then someone with parental responsibility can be approached for their consent to the treatment. When approaching someone with parental responsibility for their consent, the three principles above still need to be satisfied.

Where the child is under sixteen they are not automatically able to provide their own consent. It is necessary to determine if they are Gillick competent: essentially the child's competence to consent is assessed (see above for a discussion of what is needed to determine if a child is Gillick competent). If they are able to demonstrate this then they are most likely to be Gillick competent.

Whether a child is Gillick competent or not is a decision for the person proposing to undertake the treatment. If there is any doubt then seeking the advice of another practitioner or a more senior colleague is considered best practice.

Once a child is deemed to be Gillick competent then they are able to provide consent on their own behalf. Consent by a child aged sixteen or over, or by a child deemed to be Gillick competent, cannot be overridden by anyone else.

If a Gillick competent child refuses to give their consent, the situation is the same as that of a child aged sixteen or over and someone with parental responsibility can be approached for their consent.

It is important to note that determining whether a child is Gillick competent is not an all or nothing situation. Once a child is declared to be Gillick competent for a particular treatment, it does not mean that they are then considered to be Gillick competent for any subsequent treatments. Each time the child needs to have a treatment their ability to be Gillick competent needs to be assessed. Indeed a child can be deemed to be Gillick competent for one treatment but at the same time not deemed to be Gillick competent for another because the latter requires a higher degree of emotional and intellectual ability.

Treatment of a child in an emergency

Where a child needs treatment in an emergency, consent can be obtained from the child themselves if they are either over sixteen or are Gillick competent. If the child is not able to give consent then someone with parental responsibility can provide consent on their behalf. If it is not possible to contact someone with parental responsibility, then the condition of the child and the immediacy of the treatment becomes a vital factor. Where the condition is life threatening and/or the procedure is needed immediately, it is the best interests of the child that are paramount and the treatment can proceed on the basis of the principle of necessity to save or preserve the life of the child (see Cornock 2015b for further discussion re this principle).

The position in Northern Ireland and Scotland

Whilst this article has considered the position of the child in relation to English Law, that is the law of England and Wales, it is important to note the position in Northern Ireland and Scotland.

Northern Ireland adopts the same legal position as England and Wales with regard to the rights of the child to consent to treatment on their own behalf. However, the position in Scotland is legally different.

With regards to a child under sixteen, the Gillick case does not apply to Scotland. However, Scotland has an equivalent provision to Gillick competence but instead of originating in a case, this is enshrined in legislation, the Age of Capacity (Scotland) Act 1991. Here in Section 2(4) it states that:

‘A person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.’

For the child over sixteen it is the Age of Capacity (Scotland) Act 1991 that applies and not the Family Law Reform Act 1969. However, again the Age of Capacity (Scotland) Act 1991 goes further than the provisions in the Family Law Reform Act 1969 as it provides that ‘a person of or over the age of 16 years shall have legal capacity to enter into any transaction’ (section 1(1b)). This means that as well as the right to consent to treatment on their own behalf, a child over sixteen in Scotland has the legal right to refuse to consent and this refusal cannot be overridden, even by someone with parental responsibility.

Conclusion

When obtaining consent from someone under the age of eighteen, it is vital to consider whether the child is under the age of sixteen. If aged sixteen to eighteen, the child can legally consent to treatment but a refusal to be treated can be overridden by a person with parental responsibility. If aged under sixteen, an assessment of whether the child is Gillick competent must be made. Again, even in the Gillick competent child, their refusal can be overridden by a person with parental responsibility.

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Children Act 1989

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