



National Consent Policy

Part Two

Children and Minors



Part Two—Children and Minors

1. Introduction

In any matter relating to children, the child's best interests are of paramount importance. This policy advocates for a child-centred approach to be taken in relation to any decision in the area of health and social care services as they relate to children. Such an approach involves putting the interests and wellbeing of the child at the centre of all decisions and ensuring that the child's own voice is heard and respected as far as possible.

All service users have the right to participate in decision-making in relation to their care. In the provision of health and social care to children, it is important that respect for their autonomy is integrated into decision-making in the same way as for adults. This does not mean that the interests and views of parents or legal guardians will be displaced, as in most instances the child's interests will be best represented by its parents or legal guardians, although their interests are not the same. However, respect for the autonomy of the child entails the facilitation, wherever possible, of the child's right to make his/her own decisions.

Involving children in decision-making 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 and/or legal guardians 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 by giving their assent to the proposed treatment or service. This principle is in keeping with legal and international human rights standards and ethical guidance which provide that the child's wishes should be taken into account and, as the child grows towards maturity, given more weight accordingly.

Children with disabilities have the right to express their views freely on all matters affecting them, on an equal basis with other children, with their views being given due weight according to their age and maturity. In order to realize this right, children with disabilities must be provided with disability and age-appropriate assistance (see further Part One Section 3.4).

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

Parents and legal guardians are generally considered best placed to safeguard the health and wellbeing of their children. Parents, legal guardians 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.

Reference to ‘parent’ in this policy is intended to mean a parent as defined by Section 2 of the Guardianship of Infants Act 1964 as amended by the Status of Children Act 1987. These provisions mean that only a person who is a legal guardian may give consent in respect of his/her child. legal guardianship is described below.

2.1 What is legal guardianship?

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 the 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 joint guardian of the child. This agreement must be made by way of a statutory declaration by both parents under the Guardianship of Children (Statutory Declaration) Regulations 1998¹⁵; and
- where the child’s parents are not married and have not made an agreement under the Guardianship of Children (Statutory Declaration) Regulations 1998, 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.

¹⁵ S.I no. 5 of 1998

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2.2 Who can give consent for a child?

For children below the age of 16, a parent(s) or legal guardian(s) can consent to the treatment of the child (and for a child below the age of 18 being treated for a mental disorder covered by the Mental Health Act, 2001). The age of consent is discussed further at Section 3.

Where a child accesses a health or social care service in the company of an adult, the adult should be asked to confirm that they are the child's parent and/or legal guardian and this should be documented in the child's healthcare record. In the event that they indicate that they are not the child's parent and/or legal guardian, contact must be made with the child's parent and/or legal guardian in order to seek appropriate consent.

Consent obtained from parents or legal guardians by telephone, or otherwise than in person, is acceptable in circumstances where the parent and/or legal guardian is unable to attend and is willing to provide consent by telephone. The same standards and principles of informed consent set out in Part One of this policy apply to consent obtained by these means and the consent should be clearly documented in the healthcare records.

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.

On the one hand, 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/legal 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 battery¹⁶, the consent of one parent or legal guardian (or in their absence, that of the court) is sufficient.

¹⁶ Battery is a form of trespass to the person resulting from proof of contact with the body without consent

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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 a treatment or intervention in the child's best interests. It also assumes that both of the parents/legal guardians are concerned with the child's welfare.

The provisions of the Irish Constitution 1937 acknowledge the important role and responsibility that all parents and legal guardians have to safeguard the welfare of their children in relation to decisions in many different contexts, including health, social development, education and so on.

As a corollary to the rights given to parents as legal guardians of their children, there are also duties imposed on them to act in the best interests of their children. In the health and social care context this requires parents and legal guardians to engage with health and social care service providers to ensure that the child receives the best possible care and services. Such involvement by parents and legal guardians should be encouraged and facilitated by service providers as much as possible.

Where both parents/legal guardians have indicated a wish and willingness to participate fully in decision making for their child, this must be accommodated as far as possible by the service provider. This also imposes a responsibility on the parents/legal guardians to be contactable and available at relevant times when decisions may have to be made for the child.

Even where both parents/legal guardians have not clearly indicated their wish to be involved in decision making, if the decision will have profound and irreversible consequences for the child, both parents/legal guardians should be consulted if possible. However if urgent care is required and the second parent/legal guardian cannot be contacted despite reasonable efforts to do so, the service provider has a paramount duty to act in the best interests of the child.

Apart from the circumstances outlined above and in keeping with the prioritisation of the best interests of the child, the consent of one parent/legal guardian will provide sufficient authority in respect of any health or social care intervention in relation to a child.

In emergency circumstances where neither parent/legal guardian is contactable, the general doctrine of necessity applies¹⁷ and the service provider is obliged to act in the best interests of the child.

¹⁷ See Part One section 6.1

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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(s) or legal guardian(s). The section covers any procedure undertaken for the purposes of diagnosis and any procedure, such as administration of anaesthetic, which is ancillary to treatment¹⁸.

This means that consent to surgical, medical or dental treatment by a 16 and 17 year old has the same status under this Act 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.

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 case¹⁹ established that a doctor had discretion to give contraceptive advice or treatment to a girl under the age of 16 years without her parents' or legal guardians' 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. However, the Gillick case and other similar cases elsewhere do not have any application in Ireland although they may be of persuasive authority in the event of a judicial determination on this issue.

¹⁸ For detailed information about the assessment of capacity please refer to Part 1: underpinning principles, section 5.5

¹⁹ *Gillick v Western Norfolk and Wisbech Area Health Authority and another* [1985] 3 AER 402

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In Ireland, the courts place great emphasis on the rights of the family and the rights of parent(s)/ legal guardian(s) 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 a 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 policy acknowledges that in health and social care practice it is usual to involve parent(s)/ legal 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 parent(s) or legal guardian(s). 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 legal guardian(s).

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

- the minor has sufficient maturity to understand the information relevant to making the decision and to appreciate its potential consequences;
- 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;
- the nature, purpose and usefulness of the treatment or social care intervention;
- the risks and benefits involved in the treatment or social care intervention, and
- any other specific welfare, protection or public health considerations, in respect of which relevant guidance and protocols such as the 2011 Children First: National Guidelines *for the Protection and Welfare of Children* (or any equivalent replacement document) must be applied.

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This same assessment of maturity is relevant for all minors under 16 including those who have been diagnosed with intellectual disability.

3.1 Confidentiality and the minor

Prior to giving consent for a health or social care intervention, the minor should be informed by the health or social care provider that confidentiality cannot be assured as his/her parent(s)/legal guardian(s) may have rights to access the minor's medical/other records under the Freedom of Information Act 1997²⁰.

In certain circumstances there may also be a legal obligation on the health or social care provider to report sexual activity due to the age of the minor (see further Section 10). The minor should be informed of the health and social care provider's intention to report such activity to the HSE or the Garda Síochána.

4. Refusal of health or social care services by children and minors

In the case of young children who are not assessed as falling within the mature minor category described in Section 3 above, consent from the child's parent(s)/ legal guardian(s) is required for every intervention. If the child refuses despite parental consent, the child should be given the opportunity to explain the reasons for their refusal and reasonable attempts should be made to give the child sufficient time, explanation and reassurance to try to address the child's fears or concerns about the intervention.

Where a mature minor refuses a health or social care service the service provider should, as a first step, encourage the minor to involve their parent(s)/legal guardian(s) in the decision. If the minor does not want to involve their parent(s)/legal guardian(s) and the service is deemed to be in best interests of the minor, then the parent(s)/legal guardian(s) must be informed despite the minor's refusal.

²⁰ Freedom of Information Act, 1997 (Section 28(6)) Regulations 2009

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Consultation should take place involving the minor and the parent(s)/legal guardian(s), with the assistance of the HSE Advocacy service and/or a third party mediator where appropriate, in order to try to reach a consensus if possible. If this is unsuccessful legal advice should be sought as to whether an application to court is required to resolve the matter, particularly if a physical intervention is envisaged.

5. Refusal of treatment or social care intervention by a person between 16 and 18 years

The legal position relating to refusal of treatment or social care by a person between the age of 16 and 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 policy proposes that in cases where an individual between the age of 16 and 18 refuses a treatment or service, in general such refusal should be respected in the same way as for adults. However, if the refusal relates to life sustaining treatment, or other decisions which may have profound, irreversible consequences for him or her, reasonable efforts must be made to discuss the young person's refusal with all the relevant parties, including the involvement of the HSE Advocacy services and/or a third party mediator where appropriate, in an attempt to reach consensus. Failing agreement, an application should be made to the High Court to adjudicate on the refusal.

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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, it would be best practice that the young person would be separately represented.

6. Refusal of health and social care intervention by parent(s)/legal guardian(s)

As noted in Section 2, parent(s)/legal guardian(s) are generally considered best placed to safeguard the health and wellbeing of their children. Service providers should recognise the caring relationship between parent and child in which parent(s)/legal guardian(s) act as advocates and care providers for children and have expertise in the particular needs of their child. Parent(s)/legal guardian(s) are entitled to be treated with courtesy and respect and to be provided with adequate information and support in relation to the provision of health and social care services to their children (see further Part One Section 3).

It is important for service providers to recognise the role of the parent(s)/legal guardian(s) in deciding together with health and social care professionals what is in the best interests of the child. Case conferences involving the parent(s)/legal guardian(s) and all relevant care providers are often a useful way of ensuring that parent(s)/legal guardian(s) and professionals work in partnership in decision-making for the child.

Where a second opinion is sought by parent(s)/legal guardian(s) in order to assist their decision-making, this should be facilitated as far as possible by the service-provider.

In exceptional circumstances where there is disagreement between parent(s)/legal guardian(s) and the health and social care professionals, or where parent(s)/legal guardian(s) refuse medical treatment on behalf of a child, the service provider may consider applying to the court to have such 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. The parent(s)/legal guardian(s) have the right to seek legal representation and to be heard in relation to any such application.

In circumstances where parent(s)/legal guardian(s) disagree between themselves about the provision of a health or social care service to their child, they should be advised that they have a responsibility to discuss the matter and reach an agreement between themselves as quickly as possible, with the assistance of the HSE advocacy services and a third party mediator if required.

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If agreement is not possible then the service should generally not be provided to the child unless it is deemed by the health and social care professional to be necessary to safeguard the child's best interests. In such circumstances legal advice should be sought as to whether an application to court is required.

7. The minor parent

Parent(s)/legal 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/legal guardian is under 16 years.

As with all decisions made by parent(s)/legal guardian(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)/legal guardian(s) about the decision they are making in relation to their child and carry out an assessment of the minor as outlined in Section 3 above. If appropriate, the maternal grandparents might also be asked to participate in this discussion with the consent of the minor parent/legal guardian. Failing resolution, it is recommended that legal advice is sought.

8. Children in the care of the HSE

It is the responsibility of the HSE to ensure that there is an appropriate care order in place for a child in respect of whom consent is required to be given for the provision of health or social care services. In respect of children who are in voluntary care, consent is required from the child's parent/legal guardian unless a court order has been made dispensing with that person's consent. If there is no parent/legal 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. This also applies to children who are in foster care for less than five years or in respect of whom an application has not been made under Section 43A of the 1991 Act described below.

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.

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In relation to children who are subject to a full care order, although it is good practice to seek the consent of the parent/legal 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 (see Section 9).

For children who are in foster care for five years or more, in accordance with Section 43A of the Child Care Act 1991²¹ 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/legal guardian 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/legal guardian consent is obtained for children in voluntary care or on temporary Orders
- Parent(s)/legal guardian(s) 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. This Order should be produced by the foster parent to the service provider on request.

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.

As with all children and minors, children in care have the right to express their views freely on all matters affecting them with their views being given due weight according to their age and maturity.

²¹ As inserted by section 4 of the Child Care (Amendment) Act 2007

9. Mental health services

The provision of mental health services to children follows the same general principles as for other health and social care services. This means that for children below the age of 16 years, consent from the child's parent/legal guardian is required. For minors between 16 and 18 years who access mental health treatment on an outpatient basis through Child and Mental Health Services, general practitioners or other counselling services, the provisions in Section 3 of this policy apply.

The Mental Health Act 2001 sets out some additional provisions in respect of admission and treatment of a child in an approved centre i.e. an inpatient mental health service. The Mental Health Act 2001 defines a child as a person under 18 years of age unless they are or have been married.

Most children are admitted to an approved centre on a 'voluntary basis'. A child is considered a voluntary patient where their parent(s)/legal guardian(s) consent(s) to the admission. Parental/legal guardian consent is also required to treat the child. Regardless of age, an underlying principle of the 2001 Act (Section 4) is that when it is proposed to give treatment to a person, the person should be consulted and their views listened to and taken into consideration before any treatment is given to them.

It is particularly important that information is provided in a form and language that the child or young person can understand.

Occasionally, a child may need to be detained in an approved centre. This can occur where it appears to the HSE that the child is suffering from a mental disorder and the child requires treatment which he or she is unlikely to receive without formal admission. Such situations may arise, for example, where the parent(s)/legal guardian(s) of a child do not wish to have their child admitted, contrary to the advice of the treating consultant psychiatrist. In such instances, the HSE must make an application to the District Court for a Section 25 order authorising the admission and detention for treatment of the child in a specified approved centre.

Where a young person is the subject of a Statutory Care Order, it is also necessary to seek a Section 25 order for assessment, admission and treatment in an approved centre. It is considered best practice in such situations for the child or young person to have separate legal representation.

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The 2001 Act also contains certain provisions in relation to the treatment of a detained child. Section 61 requires the approval of the consultant psychiatrist responsible for the care and treatment of the child and the authorisation of a second consultant psychiatrist before medication which has been prescribed to a child for a continuous period of three months can be continued. Electroconvulsive therapy or psychosurgery cannot be given to a detained child without the approval of the District Court.

There is an uncertain relationship between the 2001 Act and the Non-Fatal Offences against the Person Act 1997. This has created confusion over the capacity of 16 and 17 year olds who have been admitted under the 2001 Act to make mental healthcare decisions and it remains unclear whether 16 and 17 year olds in this situation can consent to treatment without parental/legal guardian consent. Where the young person who has been admitted under the 2001 Act requires any other treatment or intervention not related to their mental health, the general principles of consent apply as discussed in this policy.

10. 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 age²². 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. Under the law, a girl under the age of 17 who has sexual intercourse may not be convicted of an offence on that ground alone. This exemption from prosecution does not apply to boys of the same age.

There is no specific provision in law regarding the age at which contraceptive advice and treatment and sexual health services can be provided to a young person and therefore the provision of such advice, treatment or service should follow the same general principles as for any other health and social care service²³. 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 (see Section 3). However, in light of the fact that the activity may constitute a criminal offence for a person under the age of 17, efforts should be made to involve the parent(s)/legal guardian(s) in this consultation and decision making.

²² Section 3 of the Criminal Law (Sex Offences) Act 2006 as amended by Section 5 of the Criminal Law (Sexual Offences) (Amendment) Act 2007

²³ See section 3 above

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In relation to the Criminal Law (Sexual Offences) Act 2006 and child protection guidelines, it is critical that the health 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:

- document the result of an assessment (to see if there is suspicion or evidence of abuse) and actions taken; and
- document efforts to encourage the minor to involve his/her parent(s)/legal guardian(s).

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)²⁴.

²⁴ or any other relevant legislation or national guidelines