8. Minors

8.1. Can I treat a Minor without consent in an emergency?

Yes. Section 174 of the *Children and Young Person's (Care and Protection) Act* allows a Medical Practitioner to carry out medical treatment on a child (15 or under) or young person (aged 16 or 17) without the consent of the child or young person, or a parent of the child or young person, if the Medical Practitioner is of the opinion that it is necessary, as a matter of urgency, to carry out the treatment on the child or young person to save their life or to prevent serious damage to their health.

8.2. Can I treat a Minor in an emergency if they or their parents previously objected and refused the treatment?

Section 174 the *Children and Young Person's (Care and Protection) Act* provides a Medical Practitioner with authority to treat a minor in an emergency without consent.

However, where the various treatment options are known well before the treatment becomes urgent, treatment options should be discussed with the Minor and/or the parent(s) before the situation becomes an emergency. This would apply in situations such as where a family has a known objection to blood products and it is known that their child will require heart surgery. Where consensus cannot be reached between the treating team and the family, it may be necessary to obtain a court order to provide guidance as to whether the treatment can proceed before the situation deteriorates into an emergency. Legal advice can be sought from the Ministry of Health's Legal Branch if necessary.

8.3. What is a Mature Minor and when can they consent to non-emergency treatment?

Generally, a Minor is capable of independently consenting to or refusing their medical treatment when they achieve a sufficient level of understanding and intelligence to enable them to understand **fully** what is proposed. This means that there is no set age at which a child or young person is capable of giving consent.

Health Practitioners must decide on a case-by-case basis whether a Minor has sufficient understanding and intelligence to enable them to fully understand what is proposed.

The legal position relating to a Minor's capacity to consent was established by an English case known as *Gillick. Gillick was* approved by the High Court of Australia in a case known as *Marion's* case. The *Gillick* case holds that a child's capacity increases as they approach maturity or in other words, the authority of a parent decreases as their child's capacity increases.

The significance of the proposed treatment will be a relevant factor in assessing whether a Minor has capacity to consent. For example, it may be likely that a 15-year-old would be assessed as having the capacity to consent to receive contraceptive treatment, but less likely that she would be assessed as having the capacity to consent to a heart transplant. The child's capacity to consent will need to be assessed carefully in relation to each decision to be made. If a Medical Practitioner assesses a Minor as *Gillick* competent (also known as a Mature Minor) and the Minor can give valid consent, then the consent of the parent or guardian will not be required. However, where the Minor agrees, it is good practice to involve the family in the decision-making process where appropriate.

Where a practitioner assesses a Minor to be a Mature Minor, the *Consent to Medical Treatment (Adults and Mature Minors)* form should be used.

Where a Minor is not considered to be a Mature Minor, the consent of a parent or guardian is required and the *Consent to Medical Treatment (Minors)* form should be used. Depending on the age and understanding of the minor, effort should be made to include the Minor in the decision-making and consent processes.

Pursuant to the *Minors (Property and Contracts) Act 1970*, if a Minor aged 14 and above consents to their own medical treatment the Medical Practitioner may rely on that consent as a defence to a claim against the Medical Practitioner for assault or battery. Also, where medical treatment of a Minor aged less than 16 years is carried out with the consent of a parent or guardian of the Minor, the Minor cannot make a claim against the Medical Practitioner for assault or battery. Health Practitioners relying on consent from a Mature Minor aged 13 and under should be especially diligent when assessing the patient's capacity to consent, as these legal protections will not apply.

Example

Peter is a 14 year old who presents to emergency with a deep laceration to his arm after falling off his bike. The Health Practitioner explains that the cut requires stitches and that this will require a local anaesthetic. Further, that the consequences of not performing the stitches would be possible scarring and infection.

The Health Practitioner forms the view, in speaking with Peter, that he fully understands the proposed treatment, and the risks and consequences of not undertaking the treatment, and as such deems him to be a Mature Minor able to consent to his own treatment. When time allows and with Peter's consent, the Health Practitioner calls Peter's mother to confirm the consent.

The following is suggested as a **general guide** only and will not apply to all Minors in all circumstances. When considering the table below, Health Practitioners should be aware that when applied, the doctrine of *Gillick* competence or the Mature Minor may necessitate variations to these recommendations.

Table 1: Maturity Guide for Minor's Capacity to Consent to Medical Treatment

Level of maturity & understanding	Recommendation for Obtaining Consent
Immature and insufficient understanding (may be 13 and under)	Consent from a parent or guardian must be obtained (Attachment B)
Intermediate understanding (may be 14 and 15)	Consent from the young person may be sufficient. However, the consent of a parent or guardian should also be obtained, unless the young person objects to this (refer discussion above on *Gillick* Competence) (Attachment A or B, depending on the young person's capacity)
Mature understanding (may be 16 and 17)	Consent of the young person will be sufficient in most cases (refer discussion above on *Gillick* Competence) (Attachment A)

Further guidance

- *Gillick v West Norfolk and Wisbech AHA* [1986] AC 112
- *Secretary of the Department of Health and Community Services v JWB and SMB* [1992] HCA 15 (Marion's case)

8.4. Can a Minor refuse treatment?

A Minor who has capacity to consent to their own treatment may also refuse treatment.

A parent or guardian may also refuse treatment on behalf of a Minor who does not have capacity provided such refusal is in the best interests of the child.

However, a court can potentially override a decision of a Minor with capacity, or the decision of a parent or guardian, to avoid serious consequences for the Minor. In this situation, the court would consider the Minor's age and maturity, and make a decision in the Minor's best interests.

There is no State Form to document the refusal of treatment by or on behalf of a Minor. Where a Minor with capacity, or the parent/guardian of a Minor, refuses treatment, the procedure below should be followed and documented in the Health Record.

8.5. Non-emergency treatment in case of refusal of consent or conflict between the parent and the Minor

The following is the suggested procedure to follow where clinically indicated treatment is not emergency treatment and consent is refused by either the parents of a Minor, or Minor with capacity or there is conflict between the parent(s) and the Minor:

- Establish that there is no suitable alternative treatment available to which consent would be forthcoming.
- If there is doubt about the Minor's capacity to consent or refuse in their own right, consider obtaining a specialist opinion on capacity.
- Where there is a dispute about the appropriateness of the treatment plan, obtain a second medical opinion and discuss this with the parent(s) or guardian and/or patient.
- Attempt to reach agreement by counselling and repeat discussion with the family. These efforts should be documented.
- If applicable, explain to the parent(s) and patient that although the treatment is not urgent at this stage, if it is not provided in a timely manner, the situation may become urgent. Explain how the delay would affect the patient.
- In circumstances where the parents do not consent to treatment on behalf of their child, consider whether the refusal of treatment means that there are reasonable grounds to suspect that the Minor is 'at risk of significant harm' to the degree that a report must be made pursuant to the mandatory reporting requirement under section 27, *Children and Young Persons (Care and Protection) Act 1998*. When a report is made to the Child Protection Helpline or the Child Wellbeing Unit because the parent or guardian(s) have refused to consent to treatment, parents should generally be told before the report is made that the Health Service intends to notify the Department of Communities and Justice, unless doing so would place the child or any other person at risk. Making a suspected risk of significant harm report to the Department of Communities and Justice may ultimately lead to a guardian being appointed to consent to the treatment in place of the parents.
- As a last resort, a court order may be sought authorising the treatment. In such cases, support may also need to be given to the family to assist them to obtain legal advice. The matter should be escalated within the Health Service and advice can be sought from the Ministry of Health Legal Branch.
- All discussions and statements and wishes about treatment should be documented in the Minor's Health Care Record.

Example

Sarah is a 17-year-old patient who has Hodgkin's disease and is about to start her third round of chemotherapy following a relapse of the disease. Sarah and her family are followers of the Jehovah's Witness faith and object to having a blood or platelet transfusion. Sarah and her parents have provided a written, signed document to her Medical Practitioner refusing blood or platelet transfusions. Sarah's Medical Practitioner has over 20 years' experience with patients in similar situations and has advised that Sarah will die without chemotherapy treatment. Sarah has a 70% chance of being cured of the disease with chemotherapy treatment, but this treatment will necessitate a blood transfusion, without which Sarah is likely to die from anaemia.

Sarah and her parents seek to have the chemotherapy treatment but refuse to consent to a blood or blood product transfusion. Sarah has been assessed by expert Medical Practitioners as a Mature Minor. She is fully supported by her parents in her decision.

As Sarah is a minor, her refusal of treatment may potentially be overridden by her parents or the court, notwithstanding the fact she is both intelligent and mature. However, before approaching the court, the Medical Practitioner should consider following the procedures set out in this Consent Manual and:

(a) consider any alternative appropriate treatment for which consent would be forthcoming

(b) consider obtaining a second opinion from a suitably qualified Medical Practitioner to confirm the prognosis and treatment plan

(c) attempt to reach agreement with Sarah and her family by repeat discussions and counselling

(d) if no agreement can be reached, consider whether the refusal of treatment means that there are reasonable grounds to suspect that Sarah is 'at risk of significant harm' to the degree that a suspected risk of significant harm report must be made to the Department of Communities and Justice pursuant to the mandatory reporting requirement under section 27, *Children and Young Persons (Care and Protection) Act 1998.*

Finally, the Medical Practitioner should escalate the issue within the Health Service and urgently seek advice from Ministry of Health Legal Branch to obtain an appropriate court order for guidance on a treatment plan. In this situation, the court may invoke its' *parens patriae* jurisdiction to make an order based on the best interests of Sarah. In making its decision the court is likely to take into account the nature of the disease, the nature of the treatment, the reasons for the treatment, the desirability of the treatment, the risks to Sarah's health with and without the proposed blood transfusions, the faith and views of Sarah and her parents, and the views of the attending Medical Practitioners.

8.6. When can a Minor consent to sexual health treatment?

As for all medical treatments, to provide sexual health treatment, a Health Practitioner must be satisfied that the Minor has sufficient understanding and intelligence to enable them to fully understand what is proposed, taking into account the significance of the treatment. The Health Practitioner should document in the Health Record the assessment of the Minor as having sufficient understanding and intelligence to consent to sexual health treatment.

It is generally established that a Mature Minor may consent to the prescription of hormonal contraception (including the oral contraceptive pill, injectable and implantable hormones and long-term reversible contraception including intrauterine devices) and treatment for sexually transmitted infections provided the Health Practitioner assesses the patient as having capacity to give informed consent. Such assessments must be made on a case-by-case basis and are dependent on professional judgement.

In circumstances where a Health Practitioner decides that a Minor seeking sexual health treatment is not sufficiently mature to consent to the treatment, the Health Practitioner should talk to the minor indicating there is a need for parental or guardian involvement in the consent process and discuss consent options with the minor.

Health Practitioners who have reasonable grounds to suspect that a child is at risk of significant harm (for example, where it is apparent that the patient's sexual partner(s) is/are more than two years older than the patient) are required to make a report to the Department of Communities and Justice pursuant to the mandatory reporting provisions of the *Children and Young Persons (Care and Protection) Act 1998*. However, the making of such a report does not preclude the Mature Minor from consenting to the medical treatment nor does it preclude that treatment being provided.

8.7. Who is able to consent on behalf of a Minor if their parents have separated?

The consent of either parent to their child's medical treatment is usually enough, as the law makes it clear that each parent has full responsibility for each of their children who are under 18 and parental responsibility is not affected by changes to relationships (that is, if the parents separate or are divorced).

There are two circumstances where the consent of either parent may not be enough:

- Where no formal court orders have been made, and one parent consents to treatment and the other refuses. The recommended way of handling this situation is by counselling the parents and trying to reach agreement on what is in the child's best interests.
- Where a court has made an order stipulating that a particular parent has particular responsibilities, that is, for health care decisions. In this case, consent must be obtained in accordance with that order.

The court can make a number of different types of parenting orders which may set out matters such as who the child will live with, how much time they will spend with the other parent or the allocation of parental responsibility.

Health Practitioners should assume that either parent can consent (alone) unless a court order stipulating something different is brought to their attention.

Health Services may develop local level policies and procedures for establishing the existence or otherwise of court orders where the parents of a Minor have separated. Legal advice from Ministry of Health Legal Branch can be sought if there is uncertainty.

8.8. Can a parent or guardian of a minor delegate their responsibility for providing consent to another adult?

Occasionally, a parent delegates their responsibility for consenting to medical treatment on behalf of their Minor child to another adult. This may occur more often in certain cultures, for example, in relation to Aboriginal children, where an extended family member, rather than the child's mother or father, might be responsible for giving consent on their behalf.

Ideally, this delegation would be in writing. If a written delegation exists, a copy of it should be placed on the Minor's Health Record. If the delegation was given verbally, it should be confirmed with the parent or guardian and documented in the Minor's Health Record.

If a Minor presents with an adult other than a parent, the Health Practitioner should attempt to ascertain the adult's relationship to the child and whether the adult is the child's guardian.

Where the adult does not appear to be the child's guardian, but bears some relationship to the child, and confirms that the parent/guardian is aware that they are accompanying the child, it is reasonable to assume that the parent or guardian has delegated responsibility to that person, unless there is any indication to the contrary (that is, a previous objection by the parent to that person exercising any authority in relation to the child). This does not apply to children in statutory out-of-home care or detention who have an appointed authorised carer (see below).

8.9. What if the Minor is in out-of-home care or in detention?

Children in statutory out-of-home care or detention are in the parental responsibility of the Minister for Families, Communities and Disability Services and day-to-day care responsibility lies with the authorised carer. The term 'authorised carer' is defined in section 137 of the *Children and Young Persons (Care and Protection) Act 1998.*

The authorised carer has authority under the *Children and Young Persons (Care and Protection) Act 1998* to consent to medical treatment not involving surgery on the advice of a Medical Practitioner. This ensures that children and young people in out-of-home care can receive appropriate and timely day to day medical and dental treatments. The authorised carer is not able to delegate their responsibility for consenting to medical treatment to anther adult.

Minors detained in a detention centre can be treated in the absence of consent in certain circumstances under section 27 of the *Children (Detention Centres) Act 1987.*

Further guidance

- NSW Health Guidelines *Health Assessment of Children and Young People in Out-of-Home Care (Clinical Practice Guidelines)* (GL2013_013)
- Department of Communities and Justice Factsheet *Consent for Medical and Dental Treatment of Children and Young Persons in out-of-home care*
- Department of Communities and Justice *Medical and Dental Consent Tool*

8.10. Can a Mature Minor make a valid Advance Care Directive?

Unlike an ACD written by an adult with capacity, an ACD written by a Mature Minor will not necessarily be legally binding. An ACD written by a Mature Minor will be treated in the same way that a Mature Minor's consent or refusal is treated – that is, it may be overridden by parents, or the court, if to do so would be in the best interests of the Minor.

In some circumstances, where a Mature Minor has prepared a written ACD, it may be appropriate to obtain a court order specifying whether the ACD must be followed.

8.11. What are the legal requirements for Special Medical Treatment in relation to children?

The *Children and Young Persons (Care and Protection) Act 1998* classes some procedures as Special Medical Treatment. It is an offence to carry out these procedures/treatments on a child less than 16-years-old unless:

- the treatment is required as a matter of urgency to save the child's life or to prevent serious damage to the child's health, or
- the treatment is described in paragraphs (a) or (b) below, and the Guardianship Division of NCAT has consented to the treatment.

The definition of Special Medical Treatment under the *Children and Young Persons (Care and Protection) Act 1998* is different from that which is used under the *Guardianship Act*. The definition of Special Medical Treatment under the *Children and Young Persons (Care and Protection) Act 1998* includes the following:

(a) any procedure or treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person unless the treatment is intended to remediate a life-threatening condition and from which permanent infertility, or the likelihood of permanent infertility, is an unwanted consequence
(b) any medical treatment in the nature of a vasectomy or tubal occlusion
(c) any medical treatment that involves the administration of a drug of addiction within the meaning of the *Poisons and Therapeutic Goods Act 1966* over a period or periods totalling more than 10 days in any period of 30 days, except for medical treatment in circumstances where the drug is administered in accordance with a written exemption granted, either generally or in a particular case, by the Secretary of the Department of Communities and Justice on the written request of the Secretary of the Ministry of Health
(d) any medical treatment that involves an experimental procedure that does not conform to the document entitled *National Statement on Ethical Conduct in Human Research 2007* published by the National Health and Medical Research Council in 2007 and updated in 2018.

Further guidance

- Department of Communities and Justice *General Exemption*
- NSW Civil and Administrative Tribunal Guardianship Division Special Medical Treatment for people under 16 years