**Parental refusal of consent for their child’s medical treatment: an ethical, professional and legal dilemma**

Gaining patient consent for medical treatment, including surgery, is an integral part of the modern day healthcare system in England and Wales. Without this consent, clinicians are liable to be accused of assault (Mayberry and Mayberry 2003 p9). The attainment of valid, informed consent is viewed as good practice in healthcare and ensures that the patient’s human right of deciding what happens to their own bodies is maintained (DH 2009). Consent is also important in the lawfulness of treatment and protects the patient from the civil wrong of ‘trespass to the person’ (F v West Berkshire Health Authority [1990]). The law recognises that an adult, who is deemed capable, has the right to refuse consent to medical treatment even if this decision results in the patient’s death (Griffith 2008). However, differences exist with gaining consent for medical treatment for children and young people, which can present ethical, legal and professional dilemmas for clinicians and the law courts.

One particular dilemma that does occur in practice, involves the refusal of consent to medical treatment by both parents of a child aged less than 16 years old. A real life example from practice is the parental refusal to consent to the heart surgery for their 9 year old child. This emotive example will now be reflected upon and critically examined from the view point of the parents, the child and the children’s nurse. An overview of clinical consent and children will also be presented in order to put this example into context.

Brief overview of consent to medical treatment and children in England and Wales

Young people aged 16 and 17 years old have a statutory right to give consent to medical treatment under the Family Law Reform Act 1969:

Section 8(1): ‘The consent of a minor who has attained the age of 16 years, to any surgical, medical or dental treatment, which in the absence of consent, would contribute a trespass to the 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’.

In the eyes of the law, this young person’s decision to consent to medical treatment should not be overridden by their parents (DH 2009) as there is a presumption that a young person over 16 years old has the appropriate mental capacity to give consent (Dimond 2008). However, certain situations including the consent to mental health treatment may require the parents to give the consent. In this scenario, The Mental Health Act 1983 (as amended by the Mental Health Act 2007) would then be referred for these young people.

In contrast, if a young person refuses to consent to life saving medical treatment, the medical team would call upon the courts to override the young person’s refusal. This process is echoed in the case of Re W (a minor) (medical treatment) [1992] whereby the Court of Appeal held that although a 16 year old girl had the statutory right to consent to treatment, the girl could not refuse essential treatment that could prevent her from dying from anorexia nervosa. The court overrode this refusal to consent and ruled in favour of her parents and the medical team by allowing the treatment to be given.

For children under the age of 16 years, the child’s ability to give consent to medical treatment is judged upon whether they can be deemed as ‘Gillick competent’ (Gillick v West Norfolk and Wisbech Area Health Authority and another [1985]). A child is considered competent if it is decided, by those taking consent, that the child has the emotional and intellectual maturity to understand the proposed treatment and can therefore give valid consent (Cornock 2007). The provision of contraceptive advice or treatment to a child aged less than 16 years can be given without parental consent if the child can satisfy the requirements of the Fraser guidelines, which also stem from the Gillick v West Norfolk and Wisbech AHA [1985] case. These guidelines also now extend to gaining a child’s consent to an abortion and treatment for sexually transmitted diseases without their parents’ knowledge.

Where a child aged less than 16 years old is not deemed ‘Gillick competent’, the persons with parental responsibility will give consent on behalf of the child (Griffith 2008). Parental responsibility is defined in the Children Act 1989.

Part 1 Section (3): ‘ In this Act “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 its property’.

Variations of people and bodies exist who can have parental responsibility for a child; but in the main, the biological mother and the married father (or the unmarried father named on the child’s birth certificate), have automatic parental responsibility. They therefore have the legal right to give consent for their child to receive medical treatment (Griffith 2004).

The parental point of view

*“Mother knows best”*

Before any medical treatment is consented to, open and honest discussions between parents and clinicians must be established in order for any given consent to be valid (Bristol Royal Infirmary Inquiry 2001). By law, all possible risks associated with the medical treatment must be made known to the parents too so that the consent can be informed. Recommendations derived from the cases of Sidaway v Board of Governors for the Bethlem Hospital [1985] and Chester v Ashfar [2004] both recommended that informed consent is a legal and ethical requirement when gaining consent to medical treatment. Clinicians should also acknowledge the parents’ autonomy with the decision making for their child’s treatment with a view to consent being given freely for the proposed treatment by both parents (O’Brien 2010).

So what happens if the parents refuse consent for their child’s medical treatment? In this situation, where the child is unable to give consent, the clinical team can involve the courts to help decide and or possibly invite the High Court to exercise its “inherent jurisdiction” (Cooke 2007 p295). If the court decides that the medical treatment is in the best interests of the child involved, the wishes of the parents are then overruled and the permission is given to provide the treatment (Dimond 2001).

This decision to overrule is demonstrated in the case of Re A (children) (conjoined twins: surgical separation) [2000] whereby the court decided to allow the separation of conjoined twins J and M which went against their parents’ wishes. Judge Walker reasoned that the operation would be in the best interests for both twins but acknowledged that the consequence of this surgery would result in M’s death. Another pertinent example is the case of Re D (a minor) (wardship: sterilization) [1976]. Mrs Justice Heilbron went against a mother’s wishes when ruling that a sterilisation operation was not in the best interests of her child and so ordered that the surgery should not take place. Although only the mother is involved in this particular case, it demonstrates the power to make a child a ward of court in order to protect them from potential harm.

However, it may also be argued that the medical team and courts overruling the parents’ wishes could be viewed as a violation of their human rights. This argument is reflected in the case of Glass v the United Kingdom [2004] which was taken before the European Court of Human Rights. The medical team involved administered diamorphine to a child against the mother’s wishes, and also put in place a ‘Do Not Resuscitate’ notice without her knowledge. The medical team were deemed in violation of Article 8 of The European Convention on Human Rights 1950 which is referred to in Section 1(1) in the Human Rights Act 1989. This is in reference to the team disrespecting the mother’s right to have a ‘private and family life’ and only interfering with this right ‘as in accordance with the law’. By not seeking advice from the courts when making these decisions, the court upheld that there had been a breach of the mother’s human rights.

When deciding upon medical treatment for children, the views of the parents should be listened to and respected; after all they often know their child very well and are legally responsible for their welfare. This can certainly be applicable when parents are the main carers of children with chronic health problems. Indeed, in the case of Re T (a minor) (wardship: medical treatment) [1997] it was ruled that the decisions regarding medical treatment should be left in the hands of the parents as they knew their child extremely well. These cases whereby the courts support the parents are rare especially if the treatment is recommended by a medical team. However, it does possibly suggest that the law opposing parental wishes is not always the ethical, right thing to do.

In the particular example being reflected upon in this assignment, the parents were adamant that their child would not have heart surgery for the correction of a congenital defect and could thus be potentially denying the child the chance to survive. The parents believed that God would heal their child and that the planned surgery was unnecessary. It was then in the child’s best interests for the courts to intervene and potentially overrule the parents’ refusal to consent.

This illustrates another issue with regards to the religious beliefs of the parents and refusal to consent to medical treatment for their child. Example cases in English and Welsh law exist which demonstrate the overruling of parents who hold certain religious beliefs. In the case of Re E (a minor) (wardship: medical treatment) [1993] Judge Ward ruled that notwithstanding the family and child being from the Jehovah Witness faith, a blood transfusion was essential for their child’s survival and therefore gave the medical team the permission to administer this treatment against the parents’ wishes.

Ideally, no conflict should occur between the parents and medical team during the clinical decision making process but unfortunately this does occur. In addition to the issues that have been discussed, Taylor (1999) suggests that although parents make decisions for their child’s welfare on a daily basis, consent for medical treatment can prove overwhelming. If legal involvement is necessary, the courts will always aim to act in the best interests of the child involved, but these important rulings are not decided upon lightly or without consideration of the parents’ views (Dimond 2001).

The child’s point of view

*“Children should be seen and heard and believed” (author unknown)*

As previously discussed, if a child is deemed ‘Gillick competent’ then consent can be obtained legally from the child. Governmental child-friendly literature is available for children and young people regarding the rights and procedures of giving consent, supporting the view that if capable, children should consent to medical treatment (DH 2001). Local information should also be provided for children by healthcare providers (NSF 2004) and clinicians are advised to provide sufficient information to the ‘Gillick competent’ child so that any consent given is informed (BMA 2001).

It is possible though that the children who are not seen as ‘Gillick competent’ can still have opinions about their healthcare. A moral viewpoint exists here that states that it is ethically irresponsible not to involve the child if they are capable of expressing these opinions (Dickey et al 2002). This right to expression is supported by the United Nations Convention on the Rights of the Child (1989)-

Article 13 (1): ‘The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child’s choice’.

Children of all ages should be able to express their opinions towards all aspects of their healthcare services, which include the consent and information giving processes. The National Service Framework guidelines (DH 2004) state that children should be encouraged to give their views on the planning and creation of these services, but research literature shows that children are still excluded from decision making in the healthcare setting (Coyne 2008). Further work is therefore required to ensure children’s involvement and that NSF guidelines, which include choice and consent, are adhered to in the healthcare setting (Glasper 2010; Coles et al 2007).

It is clear then that listening to children and offering appropriate choices is important in healthcare. However, ethical issues arise with certain situations, such as end of life decisions, which present ethical dilemmas for the clinicians involved. Ideally, the child’s wishes should dictate the care received, but if this conflicts with the child’s best interests, then the parents and medical team can intervene with decisions regarding any medical treatment (Whitty-Rogers et al 2009). This argument is echoed in the case of Re M (a child) (refusal of medical treatment) [1999] whereby the child’s refusal of a heart transplant was deemed to be not in the child’s best interests. Rightly, M’s maturity, intelligence and strong views on receiving the heart of someone else were acknowledged in the ruling of the case; But Judge Johnson stated that any future resentment from M with regards to going against M’s wishes outweighed the need to perform the life-saving surgery.

Farsides (in Tingle and Cribb 2007) suggests that, with regards to consent, “children benefit from closer attention and careful discrimination between individuals” (p143). Regardless of their age or cultural background, each child is unique and so should be respected and individually assessed when making medical treatment decisions. If appropriate, it is important that a child is permitted to express their valued opinions and be included in discussions with clinicians (Purssell 1995).

With regards to the example under discussion in this assignment, the views expressed by the 9 year old child were ascertained and listened to by the surgical, medical and nursing teams. However, the teams decided that the child was too young and lacked the maturity in order to understand the full impact of the proposed heart surgery. The children’s nurses involved with this example had a pivotal role to play when advocating for the child which will now be examined in the next section of this assignment.

The children’s nurse point of view

*“The* *people in your care must be able to trust you with their health and wellbeing” (NMC Code of Conduct, 2008)*

Consent for medical treatment is generally obtained by doctors or surgeons, but nurses have an important role to play within this process too. In particular, the children’s nurse can help obtain the child’s assent or informed consent which contributes towards establishing the child’s opinions about their healthcare (Harrington-Jacobs 2005). By participating in this obtainment, the children’s nurse is

acting as an advocate for the child by promoting the ‘Gillick competent’ child’s right to consent and also by facilitating the empowerment and involvement of any child with decisions about their treatment (Howlin 2008; Orr 1999). The importance of this advocating role is echoed by the Royal College of Nursing (RCN) (2003) who state that the children’s nurse should “listen to children and young people providing a means for them to convey their opinions and feelings and using these to guide decisions about the way their healthcare is delivered”.

Children’s nurses should also suspend any negative personal views they may have regarding children’s involvement with consent and ensure that they act in a professional manner throughout the consenting process (Pocock 2003). It is important that children’s nurses should be supportive and work closely with the child and family during this process, but they also need to stay objective and not become too emotionally involved in the situation thus obscuring their nursing role (Albuquerque-Queriroz 2008).

This can prove challenging if parents disagree to medical treatment. In this situation, it is expected that the children’s nurse will respect the parents’ decision and should strive to remain impartial. This could be especially difficult if the parents ask the advice of the children’s nurse but it is known that the healthcare professional should have no part in influencing any patient or parental decisions about medical treatment (Fullbrook 2007a).

If the refusal is based upon religious reasons, the children’s nurse must fully respect and understand the parents’ beliefs even if these conflict with their own views (Gibson 2008; NMC 2008). As previously discussed, the courts could now possibly intervene to make the child a ward of court and give permission for clinicians to carry out the proposed medical treatment; But before the law courts become involved, the local clinical team have a responsibility to persuade the parents that the treatment is essential for the well-being of their child.

Through involvement in family centred care, the children’s nurse is ideally placed in this situation to act as an ‘ethical mediator’ ensuring that the best interests of the child are maintained (Woods 2001). So, how does a children’s nurse ascertain that proposed medical treatment is ethically acceptable? The NMC Code of Conduct (2008) provides an essential overview of ethical guidance for nurses, but other bio-medical ethical frameworks exist that can be utilised by nurses effectively in practice to help assess ethical dilemmas.

The four principle based approach devised by Beauchamp and Childress (2001) is one framework that lends itself to assessing ethical decision making in nursing practice. Autonomy, beneficence, nonmaleficence and justice are listed as the four principles which can be used individually or in combination when applied to an ethical dilemma. When applying these principles to the refusal of parental consent, the children’s nurse would need to be satisfied that no unnecessary harm will come to the child (nonmaleficence) and that the family have been presented with the pros and cons of the recommended medical treatment (beneficence). The family should also be encouraged to vocalize what they think the child would want (McLeod 2005). This still remains an emotive and difficult scenario for the children’s nurse, but Wheat (2009) suggests that the nurse is acting ethically, purely by acknowledging the issues present and attempting to make a decent judgement on behalf of the child and family.

By ensuring that the best interests of the child are preserved, the children’s nurse is also upholding their duty of care to the patient. This duty relates to all clinicians, including nurses, taking reasonable care not to cause harm to their patients and links with professional accountability (Griffith and Tengnah 2010 p83). Cases exist in the English and Welsh legal system that demonstrate how failing to respond appropriately to the needs of a patient can result in a judgement of a breach of duty of care (Bolitho v City and Hackney HA [1989]) and also possible clinical negligence (Kent v Griffiths and Others [2000]).

By conserving a duty of care and being aware of the need to prevent unnecessary harm, children’s nurses are also preventing a breach of a child’s human rights. Sadly, this phenomenon does exist with incidences of these breaches towards children documented in medical research and healthcare literature. Charles-Edwards and Glasper (2002) strongly suggest that clinicians need to learn from these past experiences and take every step to ensure that children’s human rights are upheld at all times in the healthcare setting.

The welfare of the child in general is of the upmost importance to the children’s nurse, who also has a role in safeguarding this potentially vulnerable group of patients too. Children who are deemed as not being ‘Gillick competent’ are viewed as especially vulnerable as they can rely entirely on others to make decisions about their treatment (Fullbrook 2007b). Unfortunately, child protection issues would have to be considered in this particular situation of parental refusal to consent to medical treatment. If at any point, the children’s nurse felt that the parents’ reasons for refusing consent were suspicious or cruel, an explanation should be sought from the parents using an open, non-judgmental manner and would then be investigated further (Thornberry 2010). Any discussions should be documented fully and contemporaneously as too must the parents’ reason for refusal to consent (Griffith and Tengnah 2010 p184). All entries in the patient notes would of course be kept confidential and protected in line with the Data Protection Act 1988.

With reference to the real-life example from practice, the children’s nurses involved remained objective and supportive towards the child and family throughout the hospital admission. The planned surgery was viewed as an ethical option for the child and the family’s religious beliefs were acknowledged and respected. It was explained to the parents that the child would probably die if the heart surgery was not performed but the parents would still not consent. Both the nursing and medical team were concerned that the child’ best interests were not being considered fully by the parents and discussions then took place with regards to involvement of the law courts. At this point, the child’s ‘named’ nurses who had built a good relationship with the parents, suggested that the assistance from a minister associated with the family’s church could be useful in the decision making process. This decision was inspired as following liaison and reassurance from the minister, the parents consented to the heart surgery for their child. The courts were therefore not involved and the surgery went ahead as previously planned. The children’s nursing team involved are to be commended, as due to this effective family centred care approach, the parents were happy with their choice to consent and the child was now healthy.

Children’s nurses need to recognise that they have a pivotal role to play when gaining consent from parents, young people and children. Due to their unique position, they can liaise and mediate between the family, the child and the medical teams (O’Brien 2010). The nurse’s views can be very influential to all parties involved and will be listened to if necessary in a court of law (Delany in Tingle and Cribb 2007 p223). Where possible, parental autonomy should be preserved but as the Gillick v West Norfolk Area Health Authority and another [1985] and R (Axon) v Secretary of State for Health [2006] cases show, erosion of parental control will happen if their wishes are overruled by the court (Fullbrook 2007a). Whatever the outcome from a refusal of parental consent situation, the children’s nurse must strive to protect the child whilst providing a high standard of family centred care.

Finally, in conclusion, situations of parental refusal to consent to medical treatment can prove emotive and challenging for all clinicians involved. Legal, professional and ethical frameworks are in place to help guide and assist with the decision making processes which all aim to establish the best course of action for the child and family. Of equal importance is the consideration of the child and parents’ views which must be respected and considered in order to ensure the conservation of family centred care. Children’s nurses too must be aware of their essential role in this process where all parties involved are striving for the most important outcome- the welfare and best interests of the child.

*“The child- first and always”*

*(Motto of Great Ormond Street Hospital)*

**References**

Albuquerque-Queriroz A. (2008) Research report. *Nursing Ethics*. 15 (1) 125-130.

Beauchamp T, Childress J (2001) *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press.

Bristol Royal Infirmary Inquiry (Kennedy Report) (2001) Learning from Bristol: the report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995 [online]. Available:

http://www.bristol-inquiry.org.uk/final\_report/Summary.pdf

[accessed 14.07.11].

British Medical Association (BMA) (2001) *Consent, rights and concerns in healthcare* *for children and young people*. London: BMJ Books.

Charles-Edwards I, Glasper EA. (2002) Ethics and children’s rights: learning from past mistakes. *British Journal of Nursing*. 11 (17) 1134-1140.

Coles L, Glasper E A, Fitzgerald C, LeFluffy T, Turner S, Wilkes-Holmes C. (2007) Measuring compliance to the NSF for children and young people in one English strategic health authority. Journal of Children’s and Young People’s Nursing. 1 (1) 7-15.

Cooke J. (2007) *Law of tort.* 8th ed. England: Pearson Education Limited.

Cornock M A. (2007) Fraser guidelines or Gillick competence? *Journal of Children’s* *and Young People’s Nursing*. 1 (3) 142.

Coyne I. (2008) Children’s participation in consultations and decision making at health service level: a review of the literature*. International Journal of Nursing* *Studies.* 45 (11) 1682-1689.

Delany L. (2007) ‘The legal perspective’, in Tingle J, Cribb A (ed.) Nursing law and ethics. Great Britain: Blackwell Publishing, pp223.

Department of Health (DH) (2001) Consent- what you have the right to expect: a guide for children and young people. [online]. Available:

http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassests/@dh/@en/documents/digitalassest/dh\_4116903.pdf

[accessed 08.06.11].

Department of Health (DH) (2004) National service framework for children, young people and maternity services: Executive summary [online]. Available:

http:// www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassests/@dh/@en/documents/digitalasset/dh\_4090552.pdf

[accessed 15.05.11].

Department of Health (DH) (2009) Reference guide to consent for examination or treatment; second edition [on line]. Available:

http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/documents/digitalasset/dh\_103653.pdf

[accessed 13.07.11].

Dickey S B, Kiefner J, Beidler S M. (2002) Consent and confidentiality issues among school age children and adolescents*. Journal of School Nursing*. 18 (3) 179-186.

Dimond B. (2001) Legal aspects of consent: when parents are overruled. *British Journal of Nursing*. 10 (13) 880-881.

Dimond B. (2008) The mental capacity act 2005: children and young people. *British Journal of Nursing*. 17 (4) 248-250.

Farsides B. (2007) ‘An ethical perspective- consent and patient autonomy’, in Tingle J, Cribb A. (ed.) Nursing law and ethics. 2nd ed. UK: Blackwell Publishing, pp143.

Fullbrook S. (2007a) Consent: the issue of rights and responsibilities for the healthcare worker. *British Journal of Nursing*. 16 (5) 318-319.

Fullbrook S. (2007b) Best interests. A review of the legal principles involved: part 2(a). *British Journal of Nursing*. 16 (11) 682-683.

Gibson F. (2008) The cultural context of communicating complex information to parents of children with cancer- not just a linguistic obstacle (editorial). *European Journal of Oncology Nursing*. 12 (1) 2-3.

Glasper A. (2010) Encouraging young people to participate in their health services. *British Journal of Nursing*. 19 (11) 716-717.

Griffith R. (2004) The issue of consent and children: who decides? *British Journal of* *Community Nursing*. 9 (7) 298-301.

Griffith R. (2008) Consent and children: the law for children under sixteen. *British Journal of School Nursing*. 3 (6) 281-283.

Griffith R, Tengnah C. (2010) *Law and professional issues in nursing*. 2nd ed. England: Learning Matters Limited.

Harrington-Jacobs H. (2005) Ethics in paediatric end-of-life care: a nursing perspective. *Journal of Pediatric Nursing*. 20 (5) 360-369.

Howlin F. (2008) Understanding advocacy in children’s nursing: a Hermeneutic study. *Journal of Children’s and Young People’s Nursing*. 2 (3) 115-125.

Nursing and Midwifery Council (NMC) (2008) The code: standards of conduct, performance and ethics for nurses and midwives [online]. Available:

http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full/

[accessed 13.07.11].

Mayberry M, Mayberry J. (2003) *Consent in clinical practice*. UK: Radcliffe Medical Press.

McLeod A. (2005) The sources of ethical deliberation in neuroscience nursing: three case scenarios. *British Journal of Neuroscience Nursing*. 1 (5) 237-242.

O’Brien I, Duffy A, O’Shea E. (2010) Medical futility in children’s nursing: making end-of-life decisions. *British Journal of Nursing*. 19 (6) 352-356.

Orr F E. (1999) The role of the paediatric nurse in promoting paediatric right to consent*. Journal of Clinical Nursing*. 8 (3) 291-298.

Pocock M. (2003) A critical analysis of legal and ethical issues regarding consent in childhood. *Nurse Prescribing*. 1 (4) 180-185.

Purssell E. (1995) Listening to children: medical treatment and consent. *Journal of* *Advanced Nursing*. 21 (4) 623-624.

Royal College of Nursing (RCN). (2003) Children and young people's nursing: A philosophy of care. Guidance for nursing staff [online].

Available: http://www.rcn.org.uk/\_\_data/assets/pdf\_file/0003/78573/002012.pdf

[accessed 13.07.11].

Taylor B. (1999) Parental autonomy and consent to treatment. *Journal of Advanced* *Nursing*. 29 (3) 570-576.

Thornberry M. (2010) Safeguarding children: an essential guide. *Practice Nursing*. 21 (4) 178-183.

Wheat K. (2009) Applying ethical principles in healthcare practice. *British Journal of Nursing.* 18 (17) 1062-1063.

Whitty-Rogers J, Alex M, MacDonald C, Perrynowski Gallant D, Austin W. (2009) Working with children in end-of-life decision making. *Nursing Ethics*. 16 (6) 743-758.

**Table of Cases**

A (re) (children) (conjoined twins: surgical separation) [2001] 1 FLR 267

Bolitho v City and Hackney HA [1998] AC 232

Chester v Ashfar [2004] 3 WLR 927

D (re) (a minor) (wardship: sterilization) [1976] 1 AII ER 327

E (re) (a minor) (wardship: medical treatment) [1993] 1 FLR 386

F v West Berkshire Health Authority [1990] 2 AC 1

Gillick v West Norfolk and Wisbech Area Health Authority and another [1985] 2 BMLR 11

Glass v United Kingdom [2004] 39 EHRR 15

Kent v Griffiths and Others [2000] 3 CLL Rep 98

M (re) (a child) (refusal of medical treatment) [1999] 2 FLR 1097

R (Axon) v Secretary of State for Health [2006] EWHC 37

Sidaway v Bethlem Royal Hospital Govenors and Other [1985] 1 All ER 643

T (re) (a minor) (wardship: medical treatment) [1997] 1 WLR 242

W (re) (a minor) (medical treatment) [1992] 4 AII ER 627

**Table of Statutes and other legislation**

Children Act 1989

Data Protection Act 1988

European Convention of Human Rights 1950

Family Law Reform Act 1969

Human Rights Act 1989

The Mental Health Act 1983

United Nations Conventions on the Rights of the Child 1989