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Life Without *Gillick*: Adolescent Sexual and Reproductive Healthcare in Ireland

Abstract

The decision of the House of Lords in *Gillick v West Norfolk Area Health Authority* carved out a safe space for competent minors to confidentially access sexual and reproductive health care and advice in the UK. Ireland is one of the few common law jurisdictions that has not endorsed *Gillick* or a similar mature minor doctrine, nor has it securely legislated for the right to consent of those aged 16 and 17 years. The legal lacuna created by this deficiency has left young persons in Ireland seeking sexual and reproductive healthcare, and the clinicians who provide this, in a challenging place. While this void has been partially filled with policy statements by bodies such as the Irish College of General Practitioners and the Health Service Executive, nonetheless the legal shortcomings leave both a sense of insecurity, and real world difficulties for adolescents seeking to access to sexual and reproductive healthcare.

Introduction

Gillick v West Norfolk Area Health Authority[1] is a generally regarded as a landmark decision, one that recognised competent minors as independent rights-holders in a particular health domain. The House of Lords held that young people aged 16 and 17 years were presumed competent to consent on their own behalf under s.8 of the Family Law Reform Act 1969, and that those under the age of 16 could seek contraceptive advice and treatment in their own right, if they were of "sufficient understanding and intelligence to enable [them] to understand fully what is proposed".[2] This has provided the basis for what has become known as '*Gillick* competence'. Further detail on the application of this standard to contraception was outlined as a set of 'rules' by Lord Fraser which provided a measure of reassurance to doctors in respect of their obligations in assessing *Gillick* competence in such circumstances.

Gillick has been applied in a variety of settings that, while still relating to the healthcare of competent minors, are removed from the original circumstances that obtained in *Gillick* itself.[3] The most contentious has been treatment refusal where the standard for *Gillick* competence was elevated to almost unattainable levels in some cases[4] with the Court of Appeal ultimately restricting its scope,[5] a position which has not always met with the approval of children's rights advocates.[6] As Emma Cave has stated, "(A)s the test has been applied and interpreted in increasingly wider contexts … it has shown signs of strain".[7] However, issues of the wider applicability of *Gillick* do not concern us in this paper. Rather, our interest is in the way in which *Gillick* successfully carved out a safe space for competent minors to confidentially access sexual and reproductive health care and advice. In so doing, *Gillick* provided a framework which has helped the UK to meet its subsequent obligations under the United Nations Convention on the Rights of the Child (UNCRC),[8] particularly in

respect of access to confidential counselling and advice (including HIV services, and sexual and reproductive services) without parental or legal guardian consent, where this is in the child's best interests.[9]

Ireland is one of the few common law jurisdictions that has not endorsed *Gillick* or a similar mature minor doctrine. [10] The purpose of this paper is to argue that the legal lacuna created by this deficiency has left young persons in Ireland seeking reproductive healthcare, and their clinicians, in a difficult place. While this void has been partially filled with policy statements by, amongst others, the Irish College of General Practitioners (ICGP)[11] and, more recently, the Health Service Executive (HSE)[12] (the Irish equivalent of the NHS), we contend that the lack of legal certainty is an ongoing impediment to the realisation of the child's right to the highest attainable standard of health under Art. 24 of the UNCRC. In advocating for this broad right, the Committee on the Rights of the Child (CtRC) has urged states to "ensure universal access to a comprehensive package of sexual and reproductive health interventions." This entails the adoption of child-sensitive health approaches, including "adolescent-friendly health services" that provide access to a broad variety of "reproductive health services, which … respect confidentiality and … deliver services that are acceptable to adolescents."[68]

This paper will proceed by outlining the impact of *Gillick* on the sexual and reproductive health rights of minors in the UK, and the reassurance provided by subsequent judgments in this sphere of healthcare provision. It will follow by identifying the absence of clarification of the corresponding legal territory in Ireland by the Oireachtas (Irish legislature) or the courts, and the difficulties that this creates for the realisation of children's rights in respect of sexual and reproductive health.

Gillick and Reproductive Healthcare

The origins of *Gillick* lie in the National Health Service (Family Planning) Act 1967, s.1 of which empowered Local Health Authorities (LHAs) (and subsequently the Secretary of State) to issue birth control advice. In May 1974, the Department of Health and Social Security issued an explanatory circular with an attached Memorandum of Guidance, section G of which stated:

> "(1) that in the light of the fact that there were 1,490 births and 2,804 induced abortions among girls under 16 there was a clear need for contraceptive services to be available for and accessible to young people at risk of pregnancy irrespective of age. (2) That it was for the doctor to decide whether to provide contraceptive advice and treatment. (3) That the Medical Defence Union had advised that the parents of a child, of whatever age, should not be contacted by any staff without his or her permission".[13]

Given the extent to which this Guidance departed from traditional views of parental rights, it is unsurprising that it "provoked much concern"[14] and in December 1980 the Department reissued section G which encompassed changes indicating that, as a general principle, healthcare professionals should seek to persuade the child to involve their parent, and that "it would be most unusual to provide advice about contraception without parental consent".

Although this seemed conciliatory language aimed at appeasing concerned individuals it was followed by a robust assertion in respect of the importance of confidentiality:

> "To abandon this principle for children under 16 might cause some not to seek professional advice at all. They could then be exposed to the immediate risks of pregnancy and of sexually-transmitted disease, as well as other long-term physical, psychological and emotional consequences which are equally a threat to stable family life … in such exceptional cases the nature of any counselling must be a matter for the doctor or other professional worker concerned and that the decision whether or not to prescribe contraception must be for the clinical judgment of a doctor."[15]

Following on from the issuance of this circular, Mrs. Gillick, a Catholic mother, sought a written assurance that none of her five daughters, while under the age of 16 years, would be prescribed contraceptives or given abortion care without her prior knowledge and consent. Not satisfied with the response from the LHA, which stated that in accordance with the guidance the ultimate decision lay with the doctor's clinical judgement, she brought proceedings seeking a declaration that the guidance gave advice which was unlawful. Her claim failed at first instance, but was successful in the Court of Appeal which both endorsed parental rights, and rejected the notion that a girl under 16 was capable either of consenting to treatment, or of validly requiring a doctor not to seek the consent of her parents.

The findings of the Appeal court were overturned by a majority (Lord Fraser, Lord Scarman and Lord Bridge; with Lord Brandon and Lord Templeman dissenting) in the House of Lords, which essentially entrusted clinicians to act in the interests of their adolescent patients. Lord Scarman clarified that section 8 of the Family Law Reform Act 1969 entitled those over 16 to consent independently to contraception, as to any other medical treatment, and that this could not be nullified by any parental right or intrusion. Attention then turned to those under the age of 16, with Lord Scarman identifying that those of "sufficient understanding and intelligence" could lawfully consent. In respect of the provision of contraceptive care and confidentiality, Lord Fraser set out more explicit guidance:

> "the doctor will ... be justified in proceeding without the parents' consent or even knowledge provided he is satisfied on the following matters: (1) that the girl (although under 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents …; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent."[16]

Although Lords Scarman and Fraser offered slightly different tests for competence,[17] the variation between the two versions is not of relevance to our discussion here.

After Gillick

While *Gillick* was followed by a series of 'life and death' hard cases, it was 20 years before its original and specific declarations in respect of sexual and reproductive healthcare came under further scrutiny in *R (Axon) v Secretary of State for Health*.[18] As pointed out by Rachel

Taylor in her commentary on the case, the facts in *Axon* bore significant similarities to those of *Gillick*.[19] As before, there were public concerns around the rates of teenage pregnancies with fears about confidentiality identified as one of the major deterrents to adolescents seeking reproductive healthcare.[20] Again, the state sought to allay those concerns by issuing specific guidance.[21] Akin to Mrs. Gillick, Ms. Axon was concerned that on foot of the promulgated guidance, her daughters (aged under 16) could potentially access contraceptive, or particularly abortion, advice or care without her knowledge and guidance. She had undergone an abortion in the past which she still regretted and she was concerned that neither of her daughters should undergo a similar experience without her being there to advise and guide them.[22]

By this time, the UK had introduced the Human Rights Act 1998 and so Ms. Axon relied on the right to private and family life protected under Article 8 of the European Convention on Human Rights. She contended that the 2004 Guidance misrepresented the decision of the House of Lords in *Gillick* by making health professionals the sole arbiters of what is in the best interests of a child, thus excluding parents from making important decisions about their child's welfare in breach of parental rights. Ms. Axon sought a declaration that health professionals, in most circumstances, have a duty to consult the parents of a young person under 16, and parents the right to be consulted, before reproductive health advice and/or treatment is provided.[23] Silber J considered Ms. Axon's arguments separately with regard to contraception and abortion, as he deemed there were matters of information, understanding and moral seriousness that distinguished decision-making in the two situations. However, he ultimately dismissed all of her claims, noting that it had been established by the jurisprudence of the European Court of Human Rights that, in the event of a conflict in respect of Article 8 rights, the child's rights should be prioritised over those of the parents.[24] He robustly adhered to the principles established by the House of Lords in *Gillick*, which he deemed to be binding on the court.[25]

Gillick subsequently was engaged in decisions around approving the capacity of children to choose whether or not to undergo an abortion,[26] or take hormonal blockers as part of treatment for gender dysphoria.[27] In respect of the second of these, the judgment by the Court of Appeal in *Bell Tavistock and Portman NHS Foundation Trust* addressed the first meaningful post-*Gillick* challenge to the capacity of adolescents to consent to (rather than refuse) specific treatment. In respect of hormonal treatment, the Divisional Court in *Bell* had come to the

> "factual conclusion that under 14s were 'highly unlikely' to give valid consent and that it was improbable that 14 or 15 year olds could do so. The court continued by indicating that even in respect of 16 and 17 year olds an application to the court would be appropriate if there were any doubt about the long-term best interests of the child in question".[28]

On appeal the Tavistock Clinic submitted that in making this declaration, the Divisional Court had departed from the established standards laid down in *Gillick*, and "intruded into the realm of decisions agreed upon by doctors, patients and their parents, where the court had not previously gone".[29] The Court of Appeal agreed, endorsing the principles of *Gillick* and finding that they encompassed gender health: "Nothing about the nature or implications of

the treatment with puberty blockers allows for a real distinction to be made between the consideration of contraception in *Gillick* and of puberty blockers in this case".[30] In both cases, the medical profession were recognised by the courts as the most appropriate gatekeeper to determine the competence of minors to access potentially controversial treatments.

In sum, *Gillick*, and the vigorous defence of its articulated principles in subsequent cases, has provided a robust legal platform for two related but distinct matters; first, adolescent access to sexual and reproductive healthcare subject to standard assessments of competence and safeguarding; and second, the obligation on doctors to observe complete confidentiality in cases where *Gillick* competent minors do not wish to involve their parents or guardians. These elements are regarded as important in encouraging adolescents to seek medical advice with a consequent reduction in the possibility of unplanned pregnancy and sexually transmitted infections.[31] This approach recognises the importance of the relationship between the minor and the healthcare professional, with regulators emphasising the duty of professionals to meet the needs of adolescents seeking sexual or reproductive healthcare or, if unwilling to do so, to refer to someone who will as a matter of urgency.

The Irish Position

The legal position in Ireland is in notable contrast to that described above. Before looking in more detail at the relevant legislation, a brief consideration of the role of the Constitution of Ireland 1937 (Bunreacht na hÉireann) is required. The Constitution affords a special protection to the "family" based on marriage (Art. 41) and "parents" are stated to have an "inalienable right and duty" to provide for their children's "religious, moral, intellectual, physical and social education" (Art. 42). In articulating this, the Constitution reflected the prevailing societal view at the time it came into force, that children were "objects of parental rights and duties rather than autonomous rights holders".[32] Although as citizens children were rights holders, the effect of the constitutional weighting was to favour parental over children's rights.[33] In light of ongoing criticism by the CtRC of this situation,[34] the Constitution was amended following a referendum in 2012 to include a specific reference to children's rights (Art. 42A).[35] The Supreme Court has described Art. 42A as "an emphatic statement of the rights of the child" clarifying that it provides a counterweight to the elevation of family and parental rights.[36]

Legislative Framework

The only relevant Irish legislation on consent is the Non-Fatal Offences Against the Person Act 1993. Section 23(1) states that:

> [T]he 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 constitute a trespass to his or her person, shall be as effective as it would be if he or she 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 or her parent or guardian.

Although the wording of this section is identical to that in s.8 of the Family Law Reform Act 1969, s.23 is contained in a criminal law statute. This has given rise to uncertainty as to scope of the authority or protection provided by s.23, with the Law Reform Commission (LRC) arguing that the section protects clinicians from criminal liability only and does not apply to civil liability, such as litigation by aggrieved parents.[37]

Section 23 applies to those aged 16 and 17 years, and is silent on the validity of consent of those who are younger than 16 years. There has been very limited judicial consideration of this space. The only relevant case is *HSE v JM*, a case which involved the refusal of anti-psychotic medication and blood tests by JM, a girl aged 15 years and 11 months who was an inpatient in a Child and Adolescent Mental Healthcare Unit and who had made several suicide attempts.[38] Specialist medical evidence to the court was that JM understood the information regarding her diagnosis and treatment and had the ability and maturity to retain this information and communicate her views. However, her current mental state was such that she felt worthless and she was so hopeless about her future that she could not make clear decisions regarding her treatment.[39]

Despite the fact that "[I]n the course of the argument there has been extensive reference to the case of Gillick", in authorising treatment the High Court carefully avoided making any finding regarding the status of *Gillick* competence in Ireland. While it did note the importance of the minor's views,[40] it proceeded on the basis that even if "the concept of '*Gillick* competent' forms part of Irish law, it is clear that [the girl] is not in fact '*Gillick* competent'."[41] The Court did endorse the position of the England and Wales Court of Appeal that refusal of treatment is distinct from consent, and that judicial and parental authority to consent on behalf of the minor continued in this respect. But the matter of whether *Gillick* competence is, or is not, relevant in Irish law remained unresolved. Although one may understand judicial caution about making a definitive statement of the legal position in such an important area when not required to do so on the facts of the case, it is regrettable that the opportunity was not taken to provide greater clarity.

There is no specific Irish legislation regarding confidentiality although the Irish courts have strongly endorsed the importance of medical confidentiality, including in respect of adolescents.[42] However, the picture becomes more complicated where an adolescent's parent seeks information about their healthcare. In *McK v The Information Commissioner*, a father sought hospital notes relating to his estranged daughter. The Supreme Court found that the constitutional protection of the family meant that, "[i]t would only be in exceptional circumstances that medical information about a child would not be given to a parent/guardian".[43] The case in question was ultimately found to be exceptional due to the strong resistance to disclosure voiced by the girl, who at that stage was almost 18. The reference to the status of the family in *McK* preceded the children's rights amendment to the Constitution, and so its status as precedent is unclear. A Court today might well take a different view on the Constituional position of the family should, for example, a case similar to *Axon* now occur.

Despite the LRC recommending that the position described above should be clarified through legislation,[44] the legal gaps identified above have not been addressed by the

Oireachtas. In this legislative vacuum, policy documents have had to assume a level of authority beyond that which such measures should normally be expected to bear. The HSE National Consent Policy, which was originally published in 2013, provides the most detailed policy engagement.[45] The current version (2022) affirms that, as a matter of policy, the age of consent is 16 years, stating that this is in line with established medical practice, Irish Medical Council guidance,[46] and a "reasonable interpretation" of s.23 of the *Non-Fatal Offences Against the Person Act* 1997.[47] As regards those under 16, in the absence of a ruling on *Gillick* competence, the Policy states that "as a general rule" parental consent should be obtained before providing treatment.[48] On this basis, the Policy states that where someone under 16 wishes to access healthcare without parental involvement or consent, they should be encouraged and advised to involve their parents. The Policy does recognise however that there may be "unusual" circumstances where a child does not consent to parental involvement in their healthcare decisions, and states that in such situations a healthcare worker should act in the child's best interests. In deciding whether the circumstances are "unusual", so as to allow the healthcare worker to proceed without parental knowledge or consent, the Policy lists factors to be taken into account, including: the child's maturity and ability to understand the consequences of the decision; whether the child's views are stable; the nature, purpose and usefulness and the risks and benefits of the treatment and any other relevant welfare, protection or public health considerations.[49] These statements in the National Consent Policy may provide some degree of comfort for clinicians in responding to minors seeking reproductive healthcare, who can at least point to compliance with a recognised Policy in the event of litigation or a complaint to their regulatory authority. However, the Policy clearly lacks the robustness of a legislative or judicial statement, and can provide no reassurance on the matter of confidentiality in respect of minors

Consequences of Legal Uncertainty

While the legal uncertainty described above has consequences across the healthcare system, the context in which sexual and reproductive healthcare is sought means that this presents particular challenges. The most obvious issue here is that some minors do not want their parents to know that they are sexually active. Data from the Economic and Social Research Institute in 2020 indicated that 55% of Irish teenagers not discuss sex or sexual relationships with parents at the age of 13, that figure falling to a still sizeable 40% at 17.[50]

There is a paucity of hard data regarding the lived impact of the legal uncertainty, and so any picture must be constructed from incomplete sources. A 2010 study by the Irish Family Planning Association (IFPA) of client profile in their clinics gives some indication of the scale of the problem at that time.[51] Of the 251 consultations with young people aged between 13 and 17 and carried out in one of the IFPA clinics between 2006 and 2010, a total of 65% attended on their own and, in the under 16 age group, 54% were unaccompanied.[52] Most young people were "acutely conscious" of the risks they were running in seeking the service, with the IFPA noting that sexually active young people would prefer to avoid sexual health services altogether rather than risk parental involvement. Of those who attended the IFPA clinic, almost half attended for contraceptive services, 32% for emergency contraception and 9% for pregnancy services. In these cases, clinicians had decided to provide care based

on an evaluation of maturity, notwithstanding that the providers involved reasonably believed that they were assuming legal risks in providing this service.

The IFPA provides services in Dublin only. For minors outside of Dublin, access to sexual and reproductive health will most typically be through their General Practitioner. A study of GP prescribing practices, also from 2010, found that a majority of GPs (53.8%) felt legally exposed when prescribing contraception to under 16s.[53] Over 20% of GPs had refused to prescribe emergency contraception to a girl under 16 with 58% of these citing a lack of parental consent as the reason. Almost one third of the GPs surveyed had refused to prescribe oral contraception to a girl under 16 with, again, over half citing the absence of parental consent as the reason. A slightly more recent study in a mixed urban/rural environment identified that approximately one-fifth of GPs would always require parental consent before prescribing contraception for a minor.[54] Almost two-thirds of GPs in this study expressed significant concern about potential medico-legal repercussions of prescribing to minors without parental consent in the absence of specific legislation to govern the area.

There are likely to be additional problems for young people in state care. A study of the sexual health of young people in care found that almost all had had sex before the legal age of consent (17 years). Of these, virtually none had had sexual relationships characterised by a high degree of sexual competence (defined as consistent use of contraception; autonomy in decision-making; both partners being equally willing; and the absence of regret).[55] There are multiple reasons for these, including disrupted family and substitute carer relationships, reduced educational attainment, and lower levels of support around sexual health and relationships.[56] Adolescents in care also face a "range of practical and psychological barriers to accessing contraceptive and sexual health services".[57] While many of these difficulties are structural, children in State care are unlikely to be advantaged by a system where access is impacted by

The ongoing legal uncertainty also has consequences for access to abortion services which recently became lawful in Ireland in a number of circumstances, including where the pregnancy has not exceeded 12 weeks gestation.[58] However, the *Health (Regulation of the Termination of Pregnancy) Act* 2018 does not address the outstanding issues around the age of consent, simply stating that nothing in the Act affects the existing legal position regarding consent.[59] A review of the operation of the 2018 Act found that access to abortion care is a problem for many women, especially for those living outside of major urban centres.[60] Unfortunately, the issue of access by adolescents was not addressed in the review and so we lack concrete data on the additional impediments to access experienced by them.[61] Nonetheless, it is reasonable to conclude that such challenges exist and that these are especially problematic given that access to abortion care is so time limited under the provisions of the 2018 Act.[62]

As part of the policy package accompanying the introduction of abortion care, the Irish Government introduced a free contraception scheme, initially covering those aged 17 to 25 years, with a subsequent extension to apply up to the age of 30.[63] Funds have been made available to extend the Scheme to 16-year-olds although this is described as being "subject to consultation across Government, legal advice and legislative amendment".[64] There are

no discernible plans to extend the Scheme to under 16s. The effect of this is that the most vulnerable young people, some of whom will most need access to free contraception, are left outside of the ambit of the Scheme.

Conclusion: Time for Clarity

It is fifty years since the publication of guidance in the UK to address the need for confidential access to contraceptive services to be available for young people based on maturity, and almost forty since the House of Lords judgment in *Gillick*. In contrast, in Ireland there has been a failure to legally support similar endeavours. This has continued notwithstanding that the Constitution of Ireland has been amended to include an explicit recognition of children's rights. Even before this amendment, the Law Reform Commission issued a *Draft Health (Children and Consent to Health Care Treatment) Bill 2011* which broadly reflected the model of *Gillick* competence.[65]

The absence of clarifying legislation leaves Ireland falling well short of the recommendations of the CtRC in respect of reproductive healthcare. The CtRC has repeatedly criticised Ireland for its failures in this regard, expressing its concerns at the "severe lack of access to sexual and reproductive health education and emergency contraception for adolescents"[66] and, more recently, identifying the need to ensure that adolescent girls have access to "age-appropriate reproductive health services, including free and safe abortion and post-abortion services".[67] The cost of this failure to meet human rights obligations is likely to fall most heavily on the most vulnerable individuals who, for whatever reason, cannot rely on family support to help them negotiate the complex world of adolescent sexuality.

We are fully aware that the law cannot solve all the problems that young people encounter in this domain. However, legal clarity could achieve a number of goals. First, it would establish a legal space for the competent minor to access essential sexual and reproductive healthcare and reassure them that their information would be kept confidential; secondly, it would provide doctors with an assurance that their medical activity in this regard is lawful and thus possibly expand access opportunities; and, thirdly, it would allow for the development of policies which could enhance "health-seeking behaviour" among young people.[68] We contend that the ongoing lack of action by the Oireachtas to address these needs is indefensible.

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[1] [1986] AC 112.
[2] Ibid, 188-89.
[3] Fortin J. The *Gillick* decision – not just a high-water mark. In: Gilmore S, Herring J, Probert R (eds) *Landmark Cases in Family Law.* Oxford: Hart Publishing, 2011.
[4] See for example, *Re E (A Minor) (Medical Treatment)* [1993] 1 FLR 386; *Re L (Medical Treatment) (Gillick Competency)* [1998] 2 FLR 810.
[5] *Re R (A Minor) (Wardship: Consent to Treatment)* [1992] Fam 11; *Re W (A Minor) (Medical Treatment: Court's Jurisdiction)* [1993] 3 WLR 758.

[6] Gilmore S, Herring J. No is the hardest word: consent and children's autonomy. *Child & Fam L Q* 2011; 23(1): 3-25; Lyons B. Dying to be Responsible: Adolescence, Autonomy and Responsibility. *Legal Studies* 2014; 30: 257-78.
[7] Cave E. Goodbye *Gillick*? Identifying and resolving problems with the concept of child competence. *Legal Studies* 2014; 34: 103-22.
[8] E/CN.4/RES/1990/74.
[9] General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15, para. 31.
[10] See for example, *Secretary of the Department of Health and Community Services v JWB and SMB* [1992] HCA 15 (Australia); *AC v Manitoba* [2009] SCC 30 (Canada).
[11] Ni Riain A. *Consent in under 16's – the issues for Irish General Practice*. Dublin: 2005.
[12] HSE. *National Consent Policy*. Dublin, 2022.
[13] As cited in *Gillick* v *West Norfolk & Wisbech HA* [1985] 2 WLR 413 per Parker LJ at [417].
[14] Ibid.
[15] Ibid at [418].
[16] [1986] AC 112 at [174].
[17] Grimwood T. *Gillick* and the consent of minors: contraceptive advice and treatment in New Zealand. *Victoria U Wellington L Rev* 2009;40:743-59.
[18] [2006] EWHC 37 (Admin).
[19] Taylor R. Reversing the Retreat from *Gillick*? *R (Axon) v Secretary of State for Health*. *Child & Fam L Q* 2007;19:81-97.
[20] Department of Health. *Teenage Pregnancy* Cm 4342. London: 1999.
[21] Department of Health. *Best Practice Guidance For Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health*. London: 2004.
[22] *Axon* at [16].
[23] *Axon* at [8].
[24] *Axon* at [144]-[146].
[25] *Axon* at [154].
[26] *An NHS Trust v A. B. C and A Local Authority* [2014] EWHC 1445 (Fam).
[27] *Bell v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363.
[28] *Bell* (CA) at [10], per Burnett LCJ.
[29] *Bell* (CA) at [66].
[30] *Bell* (CA) at [76].
[31] Conception rates for under 18s in England have been decreasing steadily (although this is likely due to a range of factors and not attributable solely to the legal position). England saw a 60% decrease in such pregnancies between 1998 and 2016 while the decrease in Scotland over a similar period was 58% and in Wales was 62%. See Baxter A, Dundas R, Popham F, Craig, P. How Effective was England's Teenage Pregnancy Strategy? A Comparative Analysis of High Income Countries. *Soc Sci Med* 2021; 270: 113685.
[32] Nolan, A. The Battle(s) Over Children's Rights in the Irish Constitution. *IPS* 2007; 22: 495-516.
[33] This was perhaps most evident in *N v HSE* [2006] 4 IR 375 where a two year old child was removed from her prospective adoptive parents with whom she had lived and returned to her natural parents (who had now married) notwithstanding expert evidence that this would lead to psychological or emotional damage for the child. See Kilkelly U, O'Mahony C. The Proposed Children's Rights Amendment: Running to Stand Still? *Ir J Fam Law* 2007; 10(2): 19-25.
[34] United Nations Committee on the Rights of the Child. *Concluding Observations: Ireland (CRC/C/IRL/CO/2)*. Geneva: 2006, paragraph 9.
[35] See O'Mahony C. Falling Short of Expectations: The 2012 Children Amendment, from Drafting to Referendum. *IPS* 2016, 31(2): 252-281.
[36] *In the Matter of JJ* [2021] IESC 1, at [131].
[37] Law Reform Commission. *Children and the Law: Medical Treatment*. Dublin: 2011, pp. 39-42.
[38] [2013] IEHC 12.
[39] [2013] IEHC 12 at [7].
[40] [2013] IEHC 12 at [29].
[41] [2013] IEHC 12 at [28].
[42] *The Child and Family Agency v AA* [2018] IEHC 112.
[43] [2006] IESC 2, [15.1].

[44] Law Reform Commission *Children and the Law: Medical Treatment* [LRC 103-2011].
[45] HSE. National Consent Policy (v 1.1). Dublin: 2022. Available at https://www.hse.ie/nationalconsentpolicy/ Accessed 21 July 2023.
[46] *Guide to Professional Conduct and Ethics for Registered Medical Practitioners*. Dublin: 2019, 8th Ed.
[47] National Consent Policy, p. 45.
[48] National Consent Policy, p. 47.
[49] National Consent Policy, p. 48.
[50] Nolan A, Smyth E. *Talking About Sex and Sexual Behaviour of Young people in Ireland*. Dublin: ESRI, 2020.
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[52] *Ibid*, 6.
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[58] *Health (Regulation of the Termination of Pregnancy) Act* 2018, s.12.
[59] Health (Regulation of Termination of Pregnancy) Act 2018, s.21. This reflects the conservatism of the legislation which had been published in advance of a referendum to amend the Constitution to allow for abortion, when the scale of public support for this change had not yet become apparent. See Donnelly M, Murray, C. Abortion Care in Ireland: Developing Legal and Ethics Frameworks for Conscientious Provision. *Int J Gynecol Obstet* 2020, 148(1): 127-132.
[60] O'Shea. M. *Report of the Independent Review of the Operation of the Health (Regulation of Termination of Pregnancy) Act 2018.* Dublin: Department of Health, 2023.
[61] Although the legislation requires the collection of certain data, this does not include the age of the person accessing the service and so a composite picture is not available. The service user study which underpins the Report involves only service users over the age of 18 years. See Conlon C, Antosik-Parsons K, Butler E. *Unplanned Pregnancy and Abortion Care (UnPAC) Study*. Dublin: HSE, 2022.
[62] After 12 weeks, termination of pregnancy is available only in situations of risk to the woman's life or health or where the foetus has a life limiting condition. For various reasons, the rollout of this aspect of the legislation has been much less successful and so most women who cannot access within the 12 week window still end up travelling for abortion care.
[63] https://www.gov.ie/en/press-release/95b1b-expansion-of-the-free-contraception-scheme-to-include-women-aged-26-from-1-january-2023/.
[64] https://www.gov.ie/en/press-release/95b1b-expansion-of-the-free-contraception-scheme-to-include-women-aged-26-from-1-january-2023/.
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