Gillick competence – researchers need to recalibrate

Dr Michael B. Lewis, Reader in Psychology at Cardiff University, considers a Court of Appeal ruling that will affect how research is carried out on children in England and Wales.

Ask a clinician what 'Gillick competence' means and you may hear a confident definition: a child under 16 can make their own decision if they demonstrate 'sufficient understanding and intelligence to enable him or her to understand fully what is proposed' By extension, those who are 16 and 17 can also make their own decisions without reference to Gillick competence. That familiar formula comes from the House of Lords decision in a 1985 case, Gillick v West Norfolk and Wisbech Area Health Authority. Since this ruling, there has been a quiet assumption that Gillick competence can also be employed as a convenient test for consent to research participation. In July 2025, the Court of Appeal pressed pause on that assumption.

In Re S (Wardship: Removal to Ghana) [2025] EWCA Civ 1011, the Court delivered an important clarification: Gillick is not a universal test and only applies to consent for medical treatment. For researchers, the implication is stark: while Gillick remains foundational in clinics, it does not automatically authorise under-16s to self-consent to research. This ruling also has consequences for research with 16- and 17-year-olds.

The UK laws governing minor consent

The discussion here concerns the laws in England and Wales, although the situation in Northern Ireland is similar. In Scotland, a person aged 16 or over has full legal capacity to enter into transactions, including consent to research. Further, under 16s may consent to procedures if they have sufficient understanding of what is involved, like Gillick principles, but this is explicitly recognised in statute and applies to the research context.

The main law in England and Wales governing consent for minors is the Children Act 1989. This states that only those with parental responsibility are able to make decisions about people aged under 18. However, that is caveated by two further legal provisions.

The first caveat is that young people aged 16 and 17 have the capacity to consent to medical, surgical, or dental treatment. This is set in law by Section 8 of the Family Law Reform Act 1969. As a statutory right, their consent is legally presumed to be as valid as an adult's for treatment purposes.

The second caveat is the *Gillick Competence* doctrine, established by the 1985 House of Lords ruling. This provides a mechanism for a child under 16 to consent to medical treatment if they demonstrate 'sufficient understanding and intelligence'. This common law principle establishes that consent for medical treatment can be assessed by maturity and understanding rather than focusing on a fixed age.

The focus of both of these rulings is therapeutic consent. Research is different. The ethical purpose of clinical treatment is to promote the best interests of a particular patient. The purpose of research is to generate generalisable knowledge, with any direct benefit to an individual participant uncertain or incidental. This difference is baked into international and UK research ethics frameworks including that of the British Psychological Society: risk-benefit assessments, independent review, and consent standards are calibrated to protect participants where benefits may be indirect.

What is the current advice for research consent for minors?

There are multiple sources of information on research consent from children, and the interpretation of the legal situation has varied. The NHS HRA's (Health Research Authority) page on research involving children is widely consulted by research ethics committees and investigators within the NHS and outside of it. It draws a firm line for CTIMPs (Clinical Trials of Investigational Medicinal Products): under the Medicines for Human Use (Clinical Trials) Regulations, children under 16 cannot self-consent to a CTIMP; consent must come from a parent or legally authorised representative. For non-CTIMP research, however, the HRA notes that it is commonly assumed that Gillick can be applied to research consent. This is based on a claimed lack of case law on the topic.

The BPS acknowledges the uncertainties that flow from the HRA guidance regarding Gillick competence. The BPS Code of Human Research Ethics signals that age 16 may be acceptable for sole consent to low-risk research, but pragmatically advises: if in doubt, seek parental consent too. The Code thereby reflects the diversity of institutional practice (especially within NHS RECs) while avoiding an overly legalistic stance that could be out of step with case law.

Without unambiguous guidelines, it is easy to see why researchers have pushed the boundaries. Requiring parental consent can exclude under-18s from studies where topics are sensitive (sexual health, mental health, identity), where parental involvement may be a barrier, or where recruitment is online and anonymous. Ethics arguments here are strong: promoting autonomy, widening access, and giving voice to young people's experiences. The move to allow children to self-consent is a well-meaning attempt to provide autonomy to individuals, but does expose researchers to potential litigation.

What the Court of Appeal's decision on what Gillick competence means

The legal challenge to common research practice stems from the judicial rulings that restrict the scope of the *Gillick* doctrine to the consent for medical treatment, for which it was originally developed. The Court of Appeal has confirmed that Gillick competence is not a mandate for universal adolescent autonomy based on understanding by the minor. It was stated that 'in terms of its legal impact, the decision in *Gillick* is limited to the ability of a young person to give autonomous valid consent to medical treatment.' This ruling is clear: Gillick competence was created to facilitate necessary medical treatment and research is, by definition, non-therapeutic.

The Court of Appeal's clarification effectively isolates Gillick competence to its originating, therapeutic purpose. This means that an ethical consent process in a research context (using an in-depth Gillick competence assessment) may be deemed legally invalid because the activity itself (non-therapeutic research) falls outside the narrow, judicially sanctioned scope of the Gillick principle.

The BPS 16-year rule: A convention, not a legal mandate

This is where the British Psychological Society's guidance, while pragmatic, becomes legally vulnerable. The BPS Code of Human Research Ethics suggests: 'On balance, the age of 16 should be acceptable for sole consent on the part of the young person for low-risk research, but if in doubt parental consent should be sought as well.'

This advice, setting the cutoff for sole consent at 16, could potentially conflict directly with the law in England, Wales and Northern Ireland on childhood authority. The age of majority is 18 years, and, critically, Parental Responsibility, defined by the Children Act 1989, persists until a child reaches 18. Parental responsibility holders are the legal gatekeepers for non-statutory decisions affecting the child's welfare. The Family Law Reform Act 1969 provides an exception to this such that 16- and 17-year-olds can consent to medical treatment. The recent Court of Appeal ruling suggests that such an exception does not automatically translate to consent for other non-therapeutic situations and so puts an end to 16- and 17-year-olds self-consenting to research participation in England and Wales.

The suggestion in the BPS Code that the law can be circumvented for low-risk research is a dangerous one. What research carried out on children could be low risk? A simple question about a child's gender could, if not handled with care, lead to mental distress or worse. The reputational damage to a university from litigation from a parent of a child who was allegedly coerced into taking part in research would be immense. If a young person aged 16 or 17 suffers harm in a research study, or if data are misused, a claim of negligence could successfully argue that the researcher failed to secure legally sound consent because the person with legal parental responsibility had not consented to the non-therapeutic activity. There is no low-risk research when dealing with children.

By setting the age of sole consent for research at 16, the BPS effectively attempts to terminate the requirement for parental responsibility involvement two years prematurely. This is a *professional convention* adopted to mitigate barriers to participation, but it lacks firm statutory backing. While well-intentioned, the BPS advice could lead researchers or institutions open to potential litigation.

What about research in schools?

According to the BPS Code, in some circumstances 'the consent of the head teacher may be sufficient in addition to child consent'. This presumably comes from the common law doctrine of *in loco parentis* and the Children Act 1989, which both establish the responsibilities of professionals for a duty of care towards children. This duty of care extends to consenting to

emergency medical care but does not extend to routine medical care, for which the standard rules for medical consent apply. It is a long stretch to apply a duty of care that can mean consenting to emergency medical treatment to the right to consent for a child to take part in research.

The circumstances that the BPS Code provide as being suitable for teacher consent are those where the research is very similar to standard curriculum practice. Such situations will be vanishingly rare. In order for an activity to be research then a participant must be free to withdraw and data must be collected. Students typically do not have the right to withdraw from standard curriculum practice.

If a researcher is involved in reviewing or evaluating a school activity that is compulsory and part of the standard curriculum practice, then this might be better termed service evaluation (akin to the HRA definition) rather than research. Service evaluation is an expected part of schooling and so it is appropriate that a senior member of school staff can provide permission for it to take place. This permission, however, is not research consent and so long as data on individual students are not being recorded, then parental consent would not be necessary.

Within research conducted via schools, there has been a creep towards applying the *in loco parentis* doctrine and opt-out consent to bypass the need to acquire consent from the person with parental responsibility. This practice can expedite important research on children, but it is not consistent with the current legal situation in England and Wales and so carries risks for researchers and institutions.

So where does this leave psychology?

The BPS Code of Ethics and Conduct establishes the principle of *Respect*, which gives rise to the ethical objective of protecting the autonomy of children to choose to participate in research. Simultaneously, the foundational principle of *Integrity* obligates psychologists to ensure that their professional conduct is lawful. The BPS Codes set the minimum ethical standard for all practitioners. These are principle-based documents designed to support decision making and should be applied within any legal jurisdiction. The BPS Code of Human Research Ethics states that researchers should ensure their protocol for taking consent is appropriate for the legal frameworks they are working within. In England and Wales, this legal adherence must be maintained even when it exceeds the requirements set forth in the BPS Code of Human Research Ethics.

Ultimately, achieving a complete alignment between the law and the ethical goals of promoting participant autonomy requires new legislation or further clarification of the current legislation. Laws that allow minors to consent to medical treatments do not generalize beyond those settings to research situations that carry no medical benefit to the individual. It is the professional duty of researchers to ensure their practices are legally sound, thereby protecting both the young participants and the integrity of the psychology profession.

Conclusion

Gillick competence is great for treatment: a flexible, child-centred test that has modernised clinical consent. But as a basis for research consent, it was always a legal stretch. With the Court of Appeal now stating that Gillick is not a universal test, psychology needs to recalibrate.

For under-18s, parental responsibility should again be seen as the default legal anchor; children can consent for medical treatment, but the legal position is that consent for research is different. There are no low-risk research studies when dealing with children and research must be carried out lawfully. Assent and comprehension remain central to research ethical practice, even when consent must be obtained from someone else. Ideally, a change to the law in the rest of the UK would allow sole-consent from competent children – as is the case in Scotland. This would allow researchers to maximise the autonomy of participants but also stay within the law.