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Children's Developmental (Im)maturity: Aligning Conflicting Decisional Capacity Assessment Approaches in Australia

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Abstract: Children's decision-making is complex. There are many factors that contribute to children's decisional capacity including cognitive reasoning, developmental maturity, upbringing and circumstances. For healthcare decisions, Australian law acknowledges children's autonomy, and permits mature children to consent to beneficial healthcare. Yet, it also protects them from making life-changing decisions that could contravene their best interests. The criminal law approaches to children's decision-making in Australia's jurisdictions involves holding older children fully responsible for their decision-making, regardless of circumstances or maturity. The two approaches conflict because health law offers a protective mechanism for children yet criminal law imposes a punitive approach to children's decision-making. This article considers whether the dichotomous approaches for children's capacity assessments in Australian law can be reconciled.

Keywords: children; decision-making; capacity; criminal responsibility; health law; criminal law

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1. Introduction

Children's decision-making is complex. Because children mature at different rates, their ability to make rational and mature decisions depends on a range of factors including, for example, maturity, intelligence and psychological state (Re Alex 2004). The type of decision can also affect how a child might respond; a child may be able to understand the need for pain relief but not refusing life-saving medical treatment, for example (Hunter and New England Area Health Services v A 2009). It is difficult, then, to assign an age for children's decision-making because of the various factors that can affect their understanding. However, preventing a child from making decisions for themselves until they become an adult is also problematic because it then overrides a child's autonomy on the assumption they lack decision-making ability and imposes an arbitrary age for when decision-making should engage.[1] Yet, that is what Australian law attempts to do in some areas. When the law prevents children from expressing their views or their views are not given the appropriate weight according to their maturity, the law is inconsistent with human rights obligations (Convention on the Rights of the Child 1990). Children's decision-making, then, is a complicated concept and one which causes challenges for policy makers and courts.

Health law attempts to balance children's autonomy and vulnerability. It sometimes accounts for children's differing maturity in relation to decision-making. The mature minor principle, also known as the Gillick competency, is a United Kingdom common law decision-making framework adopted in Australia which acknowledges children's developmental differences and permits children's involvement in, and responsibilities for, decision-making in some circumstances. The common law test can be invoked where a child has the maturity to understand the nature and effect of healthcare decisions and allows them to consent to beneficial healthcare decisions (Gillick v West Norfolk and Wisbech

[1] The age of majority in Australia is 18: Age of Majority Act 1974 (ACT); Minors (Property and Contracts) Act 1970 (NSW); Age of Majority Act 1981 (NT); Law Reform Act 1995 (Qld) s 17; Age of Majority (Reduction) Act 1970 (SA); Age of Majority Act 1973 (Tas); Age of Majority Act 1977 (Vic); Age of Majority Act 1972 (WA).

Area Health Authority 1986 "Gillick's case"). Such a framework reflects a child's autonomy and acknowledges complexities in children's decision-making although there are some clear limitations which will be addressed in this paper.

The Australian jurisdictions' criminal law on the other hand, to be discussed in this paper, assumes older children are fully capable of making decisions. It applies an adult's level of decisional capacity from the age of 14 and allows for a rebuttable presumption of criminal incapacity before age 14. The criminal law, then, fails to consider the intricacies of children's decision-making including developmental maturity and 'hot' and 'cold' contexts to be discussed further in this paper.

This paper will critique the Australian jurisdictions' approaches to children's decisional capacity from a socio-legal perspective (See, e.g., O'Donovan 2016; Freckelton 2013), an interdisciplinary perspective, and highlight how the law needs to resolve the opposing positions taken to assigning decision-making responsibility to children between criminal law and health law. Other areas of law which affect children's decision-making are not addressed in this article; health law and criminal law have been chosen because of their dichotomous approaches to children's interactions within them. While Australian law is applied in this article, reference to law in other international jurisdictions such as the United Kingdom have been made to show similar legal trends, for comparison, or to demonstrate the applicability of this article's scope beyond Australian law. As such, despite the domestic focus of this paper, it has broader application to international jurisdictions.

This paper is structured into five sections. This paper considers the mature minor decision-making framework in Section 2, highlighting the major themes arising from health law and literature including the many factors influencing children's decision-making; arbitrariness of prescribing a decision-making age; and best interests decisions for children overriding autonomous decisions. This section emphasises that despite an acknowledgment of children's maturity and the importance of autonomy, children still cannot make life-changing decisions which contravene their best interests even where those decisions have been carefully considered. Section 3 considers the criminal law's approaches to criminal responsibility including the options proposed in the literature to address the challenges of the criminal law for children. Importantly, criminal law holds older children to an adult's level of decisional capacity despite the potentially reactive nature of criminal offending. Section 4 identifies conflicts in the health law and criminal law decision-making models from a socio-legal perspective and argues how Australian law should not refuse mature children's decision-making for healthcare yet hold all children criminally accountable for their decision-making. Section 5 concludes whether the dichotomous approaches for children's capacity assessments in Australian law can be reconciled.

2. Healthcare Decision-Making

Children's decision-making, in relation to healthcare, relies upon parental responsibility. The law has seen a substantial shift in parents' roles, responsibilities and rights in recent decades. While children were once considered property of their parents in the past (Freeman 1992), they are now considered persons and individuals with their own enforceable rights. A parent's role, now, relates to protecting their child's rights rather than exercising a right to control their child. Further, it is a shift from parental rights, which are parent-centric, towards parental responsibility, which encompasses a broader understanding of children's wellbeing (Bridgeman 2007).

Parents are primarily responsible for making all personal and health decisions for children until they reach adulthood. Specifically, parental responsibility in Australia relates to all 'duties, powers, responsibility and authority which the law provides' (Family Law Act 1975 (Cth) s 61B). Parents must exercise their decision-making authority in the best interests of their children because children are presumed to lack capacity to make decisions for themselves (Secretary, Department of Health and Community Services v JWB and SMB 1992 "Marion's case"). Determining what is in a child's best interests relates to 'protection and care as is necessary for [their] wellbeing' (Convention on the Rights of the

Child 1990, art 3). Scoping parental decision-making from a best interests perspective is paternalistic because it assumes parents know what is best for their children; Mullin argues that contravening a child's autonomy might not be in their best interests and so paternalism can be counter-productive (Mullin 2014).

Autonomy, then, is very relevant for children's decision-making despite parental responsibility. In fact, human rights law enshrines the important concept of autonomy for children. The United Nations *Convention on the Rights of the Child* identifies that the views of a child should be considered in decisions affecting them where the child is capable of forming their own views; specifically, article 12 states that children need to be able to 'freely' express their views and for their views to be given 'due weight in accordance with the age and maturity of the child' (United Nation Convention on the Rights of the Child 1990). Determining the weight of a child's contribution depends upon a child's understanding of the issue but even very young children are capable of expressing their views (Krappman 2010). Whether or not a person has capacity, their wishes should be considered when decisions are made about them; children's wishes are important but not overriding to their best interests (Royal Alexandra Hospital for Children v J 2005; Minister for Health v AS 2004). The extent to which a child's wishes about a decision should be considered will depend upon the age of a child and the law that applies but even very young children can be involved in decisions being made about them (See, e.g., Alderson et al. 2022).

Broadly, children are subject to a 'presumptive decisional incapacity' in relation to healthcare treatment; children are presumed to lack capacity for decision-making unless their competence has been established (Harvey 2003). Capacity has no consistent definition across jurisdictions or between common law, statute and area of law (Eckstein and Kim 2017). Capacity generally relates to being able to understand the nature and effect of their decision as well as weigh up the risks and benefits (Re C 1994). Adults are generally presumed to have capacity for decision-making (Re MB 1997) whereas children are required to establish they possess decision-making capacity (Gillick's case 1986). While children are presumed to lack capacity and therefore need parental consent for decisions, that presumption can be rebuttable where the mature minor principle engages. The mature minor principle is an English doctrine developed in response to a dispute about the extent of children's involvement in healthcare decisions (Ibid.). It has set a strong precedent for acknowledging children's decision-making autonomy for some healthcare decisions.

The landmark United Kingdom case establishing the mature minor principle is *Gillick v West Norfolk and Wisbech Area Health Authority*. In that case, a Department of Health and Social Security (DHSS) memorandum, at the time, instructed medical practitioners to provide confidential medical advice to children of all ages, even without a parent present. The memorandum acknowledged that to waive a child's confidentiality might dissuade them from seeking medical advice but that children under 16 should be encouraged to include parents or guardians in the decision-making process. Mrs Gillick sought an assurance to have medical practitioners refuse to provide medical advice to her daughters, aged under 16, in relation to contraception without her consent in contravention of the DHSS memorandum. Mrs Gillick argued that providing contraception advice to children promoted sexual activity and she, as a parent, was entitled to refuse that treatment or advice for her daughters in advance of them seeking that advice. The DHSS refused Mrs Gillick's request, emphasising that the final decision must rest with a medical practitioner exercising their clinical judgment. Consequently, Mrs Gillick sought a court declaration that the DHSS' memorandum contravened a parent's rights and duties and was therefore unlawful. The House of Lords ultimately found there were circumstances when a child could consent to their own medical treatment without seeking parental consent. Mrs Gillick was unsuccessful in seeking her declaration. These circumstances for children to consent to medical treatment became known as the 'Gillick competency' or the 'mature minor' principle (See, e.g., Wheeler 2006).

The mature minor principle allows medical practitioners to assess a child's capacity to determine their decision-making ability. Specifically, where a child can reach 'a sufficient

understanding and intelligence to enable him or her to understand fully what is proposed', they can consent to that treatment independently and without parental input (Gillick's case 1986). As a child matures, parental responsibility for healthcare decision-making decreases because the child possesses a 'higher legal status than [other] minors generally' (Lennings 2015). Parental duty is, therefore, a 'dwindling right' (Gillick's case 1986). Such a determination puts decision-making on a continuum when children can consent to treatment according to their understanding: more serious treatment would require a higher level of understanding. Maturity rather than age is reflected and allows for decisions appropriate for a child's stage of development. The mature minor principle was adopted into Australian law in *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* and is a common law capacity assessment standard for Australian children's healthcare decisions.

Marion's case considered the lawful circumstances to sterilise a child with an intellectual disability. Marion (a pseudonym) had severe deafness, epilepsy and behavioural problems, among other things. Because of her disability, she was unable to look after herself physically nor understand the 'nature and implications of sexuality, pregnancy and motherhood' (ibid., p. 221). Her parents sought clarification about whether they could lawfully authorise a hysterectomy and ovarienectomy and, if not, sought court authorisation for the procedures. The High Court of Australia, by majority, found there to be two pathways to sterilisation:

1. Where the child is Gillick competent and capable of providing informed consent themselves; or
2. Where the Family Court of Australia permits it to occur.

Significantly, from this case, Mason CJ, Dawson, Toohey and Gaudron JJ endorse the mature minor approach that a child with sufficient intelligence to fully understand the medical treatment is capable of giving consent, stating that it 'accords with experience and with psychology' and that '[i]t should be followed in this country as part of the common law' (ibid., pp. 237–38). Importantly, children's capability for decision-making varies according to their understanding and maturity (ibid., p. 293); the full extent of decision-making capacity will be explored further below. Their Honours then acknowledged the complexities of capacity for children with intellectual disabilities, highlighting that there are 'varying kinds and consequences of intellectual disability' and that it would be incorrect to hold that all children with disability would be incapable of achieving maturity for decision-making (ibid, p. 238). In that way, the mature minor principle involves an individual assessment of the child's unique circumstances and understanding to determine their level of maturity to make decisions.

In addition to the *common law* approach to children's decision-making, entrenching capacity presumptions for children in legislation has also occurred in some jurisdictions. The United Kingdom's (UK) *Family Law Reform Act 1969*, for example, presumes capacity for children from age 16 in relation to 'surgical, medical or dental treatment' (s 8). Such an authority is not absolute (Re W (a minor) 1993). *Bell v Tavistock* (2020) affirmed that courts can still exercise their protective jurisdiction despite this provision if treatment is not in a child's best interests and a dispute arises.

In Australia, South Australia (SA) has a legislative standard for assessing a child's capacity to make medical decisions which contains similar wording and intent to the UK's *Family Law Reform Act*. SA children who are 16 years or over can make decisions about their own medical treatment 'as validly and effectively as an adult' (Consent to Medical Treatment and Palliative Care Act 1995, s 6). Those decisions relate to any 'care, service, procedure and treatment' provided by health practitioners to 'diagnose, maintain or treat' the patient's physical or mental condition (ibid., s 14). Under SA legislation though, only children 16 years and over can make medical decisions for themselves if they have reached a requisite threshold of capacity as determined by the health practitioners. Children under 16 in SA cannot then make their own medical decisions because they do not fall within the legislative age threshold and so the common law Gillick test would apply to them.

New South Wales (NSW) also authorises children of a particular age to consent to medical treatment. Children who are 14 years or over, in NSW, can exercise the same decision-making authority as if they had reached the age of majority (Minors (Property and Contracts) Act 1970, s 49(2)). However, parents can consent to treatment for children under 16 years of age (ibid., s 49(1)). The effect of the NSW provisions is for children 14 years or over to be deemed competent to make medical decisions but a parent's responsibility to consent remains until they reach 16 years of age (See, e.g., Kerridge 2013). Similarly to SA, children below the legislative age would be subject to a Gillick competency assessment where they seek to make healthcare decisions.

The mature minor principle has clearly had a marked impact upon children's decision-making in their healthcare. The approach recognises children's autonomy and supports them to make decisions for themselves where those decisions are beneficial to them. It attempts to achieve a balance whereby mature children who reach the requisite understanding threshold have agency while those who cannot establish capacity are protected through parental authority or the court's protective jurisdiction. Such an approach offers a stark contrast to the 'children as property' conceptualisation in the past (Montgomery 1988).

However, there are still limitations to the mature minor principle. As a common law authority, it is almost 40 years old and there are situations, particularly in emerging health law issues, which it cannot resolve or were not within the realms of judicial consideration at the time (See, e.g., Telfer et al. 2018). Thomson argues the scope of Gillick's mature minor authority lacked clarity and results in courts being unable 'to formulate a precise standard to satisfactorily recognise the evolving capacities of the child' (Thomson 2001). Namely, it is not clear exactly what needs to be understood by the child; 'understanding' and 'intelligence' are such broad terms that health practitioners may not appreciate how to assess them; and in the healthcare setting in which health practitioners make decisions, it would be difficult for a child's competency to be properly assessed (ibid.). Further considerations relating to the complexities of children's decision-making will be considered further below. Courts making decisions outside of a medical or healthcare context do not consider a child's maturity despite its potential value in prescribing decision-making competency for children (Young 2019). Notwithstanding the challenges of the mature minor approach, it universally changed the nature of children's decision-making for healthcare decisions in Australia and influenced subsequent case law.

Three key themes have arisen from the mature minor principle, subsequent judicial authorities and other commentary, relating to children's health law decisional capacity assessments relevant to this article:

1. There are many factors influencing a child's ability to make mature and rational decisions;
2. Prescribing a decision-making age is arbitrary and unhelpful;
3. Decisions about children's healthcare reflects their best interests to the detriment of their autonomy.

These concepts will be explored further below and set a helpful context to apply children's decision-making beyond healthcare, especially to behaviour which engages the criminal law.

2.1. Factors Influencing Children's Decision-Making

The scope of children's decision-making under the law is incredibly complex, particularly in relation to healthcare. Dickey and Deatrick affirmed the varied difficulties discerning children's decision-making capacity:

> the nature of rational decision making is complex . . . the age that adolescents can reasonably be expected to make sound decisions regarding their own health care requires a multifaceted approach. The literature is confusing; the law, the laity, and many concerned professional disciplines often disagree with one another. No position is absolutely right or wrong. (Dickey and Deatrick 2000)

That 'multifaceted approach' (ibid.), then, can relate to the children's circumstances, neurological development and each individual decision. Deane J of the High Court of Australia noted

> [t]he extent of the legal capacity of a young person to make decisions for herself and himself is not susceptible to precise abstract definition. Pending the attainment of full adulthood, legal capacity varies according to the gravity of the particular matter and the maturity and understanding of the particular young person. (Marion's case 1992)

Further, according to Application of a Local Health District; Re a Patient Fay (2016), '. . . there is a scale or spectrum of capacity. The nature of the decision and its importance are both highly relevant to any decision-making process and an assessment of capacity'. This is true for adults, as well as children, but where adults are presumed competent to make healthcare decisions (Re MB 1997), children need to establish that competence. The added threshold for rebutting decisional incapacity is appropriate for children given their fluctuating brain development evident in children of different ages.

Brain development, then, has considerable influence on a child's capacity. While this paper does not address brain development concepts comprehensively, a brief overview to demonstrate the influence of brain development from the developmental and scientific literature on decision-making is helpful. Social and emotional influences affect children's decision-making. Grootens-Wiegers et al. argue that from the age of 12, children can be competent to make decisions; however, early development of the brain's reward system and late development of their control mechanisms make decision-making during adolescence challenging (Grootens-Wiegers et al. 2017). Psychosocial factors such as susceptibility to peer pressure, self-regulating behaviour and emotions, future orientation and sensitivity to rewards all develop throughout adolescence and do not mature until adulthood (Steinberg 2009). More specifically, scientific evidence has identified that risk-taking behaviours are heightened in adolescence when in the company of peers yet the social influence of peers on risk taking disappears when a person matures into an adult (Blakemore and Robbins 2012; Steinberg 2007; Reyna and Farley 2006). Young people's brain development is responsible for such a response. Further, adolescents are more likely than adults to exhibit risk taking behaviour caused by 'emotionally hot contexts' because their brain has not yet developed to enable them to regulate their emotions in the same way as adults (Blakemore and Robbins 2012). Pubertal changes can affect adolescent decision-making, causing 'impulsive, sensation-seeking behaviour' (Moritz and Christensen 2020; Steinberg 2007; Galvan et al. 2007). The maturation process of the brain systems required for decision making in 'hot contexts' continues until 18 to 21 years of age, which is as much as five years after the maturation of the brain systems responsible for decision making in 'cold contexts', not influenced by emotion (Steinberg and Icenogle 2019). The complexities of children's neurological development means prescribing a set decision-making age is challenging and problematic.

2.2. Appropriate Decision-Making Ages

As identified earlier, children reach the legal age of majority according to the date prescribed by law. In fact, it would be more difficult for the law to apply a method for determining an appropriate decision-making age other than prescribing a set date because it would require every individual to undertake assessment to determine whether they satisfy the indicia of adulthood. Difficulties do exist between science and law whereby 'scientific absolutes do not always translate into legal absolutes' (Delmage 2013). Lord Scarman, in Gillick's case (1986, p. 186), identified how a fixed age limit may be a preferable or safe option because of the certainty it offers yet would pose challenges for the law:

> Certainty is always an advantage in the law, and in some branches of the law it is a necessity. But it brings with it an inflexibility and a rigidity which in some branches of the law can obstruct justice, impede the law's development,

> and stamp upon the law the mark of obsolescence where what is needed is the capacity for development . . . If the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change.

While a prescribed legal age of majority is logical, and perhaps the most straightforward approach for legislators, it fails to reflect children's neurological development and individual characteristics which could influence their decision-making capacity. Namely, some children may possess an adult's decision-making capacity while some adults would possess a child's capacity. Children develop at different rates and so their intelligence and maturity depend upon their individual circumstances (McLean 2000). Determining decision-making solely by reference to an arbitrarily selected age is inherently problematic (Freckelton and McGregor 2016). The 'gradual process' of development should be reflected in the law (ibid., p. 832).

For children's healthcare decisions, the mature minor approach strikes an appropriate response to avoiding a fixed age limit. Instead of children being deemed to lack capacity until they reach adulthood, their capacity is assessed individually to allow their own circumstances to influence the decision. Such an approach is, therefore, not an arbitrary one. However, children's healthcare decision-making can still be incredibly restrictive.

2.3. Children's Best Interests

Another important consideration arising from the judicial commentary relates to the role of children's best interests in decisions which relate to them. Health care will generally be understood to be in a child's best interests where it will 'cure or improve a child's health' or there is medical evidence establishing diagnosis, prognosis or treatment as being in their best interests (Willmott et al. 2018). A range of factors comprise best interests including physical, emotional, psychological, economic and socio-cultural interests (Re B and B: Family Law Reform Act 1997). Although, 'best interests is not a precise science. It is multifaceted and complex . . . [resulting in] different conclusions being drawn by different people' (Director Clinical Services, Child and Adolescent Health Services and Kiszko 2016). As such, a 'best interests' approach depends on the children's circumstances (Trowse 2010) although

> [i]t will normally be in the best interests of the child of sufficient age and understanding to make an informed decision that the court should respect its integrity as a human being and not lightly override its decision on such a personal matter as medical treatment. (Re W (a minor) 1992)

Health practitioners who assess a child's decision-making capacity and determine they have not reached a decisional capacity threshold can rely upon parental decision-making. Parents (or guardians) are generally in the best position to determine what is in their child's best interests (Gillick's case 1986). However, parents are not the only decision-making authority for children, nor can they make every decision for a child.

The Supreme Courts of Australia have *parens patriae* jurisdiction to protect individuals who are not capable of protecting themselves (Carseldine v Department of Children's Services 1974). In the context of children, it can operate to override parental responsibility for healthcare decision-making (Royal Alexandra Hospital for Children v J 2005), determine an outcome in the case of special medical treatment (such as non-therapeutic sterilisation) (Marion's case 1992) or provide decision-making in the absence of an appropriate parent or guardian (Re A 2020). The practical effect of the Supreme Court's *parens patriae* power is that it can override a mature child's autonomous decision, where that decision is not in the child's best interests, rendering the child 'incompetent simply by reason of their childhood and irrespective of any psychological competence they may possess' (Lennings 2015, p. 461). The Family Court of Australia also has a role in cases where a parent of a child seeking treatment for gender dysphoria does not agree with the proposed treatment

plan or disputes a child's *Gillick* competency (Jowett and Kelly 2021; Kelly et al. 2022). In these cases, an application to the Court will be made for the Court to intervene in the best interests of the child (ibid.). In reality, most healthcare decisions involving children are 'uncontroversial' and so do not warrant detailed scrutiny by health practitioners or courts (Lyons 2011). However, children's vulnerability affects the scope of their decisional capacity.

Healthcare decision-making protects a child's vulnerability balancing their autonomy with their best interests. Children are the victims of their vulnerability and so they are protected from harm in a way which the law can easily articulate. Despite wide acknowledgement that individual autonomy is fundamental and personal bodily integrity is paramount (Malette v Shulman 1990), courts will not allow autonomy to prevail over a child's best interests (Minister for Health v AS 2004). Specifically, 'the interest of the state in preserving life is at its highest with respect to children and young persons who are inherently vulnerable, in varying degrees' (Mercy Hospitals Victoria v D1 2018). Such a distinction is particularly evident when it comes to refusal of treatment decisions.

Consent to beneficial treatment can be distinguished from consent to life altering treatment or refusal of treatment for children. Greater consequences arise where decisions relate to life altering treatment or refusal of treatment. Consenting to contraception, for example, poses less significant consequences for a child's health than refusing life-sustaining treatment. A capacity threshold is a sliding 'scale' that considers the 'importance of a decision' (Hunter v New England Area Health Service v A 2009, p. 93). Where a decision is 'significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information' (Bell v Tavistock 2020).

Refusal of treatment decisions, then, require a greater level of understanding to be demonstrated than where a patient consents to treatment because refusal of treatment decisions generally have more significant consequences for the patient. Refusing healthcare when the consequences could result in death is more serious than consenting to life saving treatment (despite a risk of that treatment being death). The higher threshold for capacity assessment for refusal of treatment cases relates to patients of any age. Adults who have capacity can refuse medical treatment even if it leads to their death (Brightwater Care Group v Rossiter 2009). Their decision does not need to be a rational one nor do health practitioners need to agree (Re T (Adult: Refusal of Treatment 1993)). Autonomy for adult decision-making is paramount and that is where treating adults differs to children. Children lack the authority to refuse treatment.

The mature minor principle's liberal approach to granting decision-making powers for children to consent to beneficial treatment does not extend to refusal of treatment cases. In fact, Australian courts are reluctant to allow children to make any healthcare decision not in the child's best interests (X v Sydney Children's Hospital Network 2013). Justifications for overruling a child's refusal of treatment are varied but include the child not appreciating the full implications of the refusal (See Re E (Minor) (Wardship: Medical Treatment) 1993). Realistically, though, where lifesaving treatment is necessary and in a child's best interest, most cases will have clinicians, parents and children agreeing to the proposed treatment; disagreement in this space usually arises where children are from Jehovah's Witness families and so have strong religious beliefs about treatment involving blood products (Freckelton and McGregor 2016).

The substantial health law commentary suggests that even where children are mature and have a clear understanding of the consequences of their decisions, Australian law does not want to ascribe them the full responsibility of their decisions. Mature children are still undergoing considerable brain development, as explored above. Despite clear intelligence, and support of their family, health law courts will not allow children to accept full responsibility and extend the unlimited autonomy which competent adults possess. Even children on the cusp of adulthood have been deemed to not be capable to make adult decisions where those decisions conflict with their best interests. In Mercy Hospitals Victoria v D1 & Anor (2018), for example, a pregnant 17-year-old was found to not have

the requisite decision-making capacity to refuse treatment despite having almost reached an adult capacity threshold. In that case, the child was declared to not possess sufficient understanding of her situation to refuse lifesaving blood products and her capacity for decision-making was limited to consent to a caesarean delivery which was in her best interests (Moritz and Ebbs 2021). Further case law examples also reflect the Australian courts' reluctance to permit children to make decisions which are not in their best interests.[2]

Where a health law response provides an acknowledgement of children's autonomy, it ultimately rejects children's ability to make any decision which is not clearly beneficial to them. It is, therefore, the perception of agency while providing 'a very important consideration [for health practitioners] in making clinical judgments and for parents and the courts in deciding whether themselves to give consent' (Re W (a Minor) 1993). Adult decision-makers, then, give proper consideration to a child's wishes while making a decision which is beneficial to them. As such, despite the appearance of autonomy, children are unable to make significant healthcare decisions for themselves because courts do not fully recognise some children's maturity.

Why, then, does the criminal law hold older children to the same decisional capacity standard as adults? Such an approach is in sharp contrast to the careful and layered judicial reasoning of children's decision-making present in health law authorities. Section 3, explores the criminal law approach to children's decision-making and how the health law concepts, raised above, highlight inconsistencies in the system of children's criminal responsibility.

3. Criminal Law

Criminal law approaches to children's decision-making are incredibly punitive. While younger children are exempt from criminal responsibility in some circumstances, older children are held to the same standard as adults. For those older children, there is no consideration of maturity, vulnerability or other external factors which might contribute to their decision-making. The scope to consider a child's understanding and intelligence does not exist for older children when the criminal law engages.

Australia's state and territory legislatures set very clear thresholds for determining children's capacity for decision-making in relation to their offending behaviour. The Australian jurisdictions prescribe an age of minimum criminal responsibility to be 10;[3] the Australian Capital Territory has committed to increase that age to 12 from 2023 (ACT Government 2022). Children under the age of 10, then, are not considered to possess the requisite mental competency to understand their actions and so they cannot be convicted of a criminal offence (See Goldson 2013). The minimum age limit is important because children under the age of 10 have not developed the cognitive reasoning to understand right from wrong (Delmage 2013).

The presumption of *doli incapax* currently applies to children between the ages of 10–13. Australia's states and territories approach *doli incapax* with four different capacity thresholds (Moritz and Tuomi 2022): actual knowledge that the behaviour was 'seriously wrong' (RP v The Queen 2016); actual knowledge that the offender's behaviour was 'wrong';[4] capacity to know their conduct should not occur;[5] and capacity to know the offending conduct was 'seriously wrong' (Criminal Code Act Compilation Act 1913). All

[2] X v Sydney Children's Hospital Network (2013) 85 NSWLR 294; Re Beth [2013] VSC 189; Minister for Health v AS (2004) 29 WAR 517; Children, Youth & Women's Health Services Inc v YJL (2010) 107 SASR 343; Hospital v T [2015] QSC 185.

[3] Children (Criminal Proceedings) Act 1987 (NSW) s 5; Criminal Code 1995 (Cth) s 7.1; Criminal Code 2002 (ACT) s 25; Criminal Code 1983 (NT), s 38(1); Criminal Code 1899 (Qld) s 29(1); Young Offenders Act 1993 (SA) s 5; Criminal Code 1924 (Tas) s 18(1); Children, Youth and Families Act 2005 (Vic) s 344; Criminal Code Act Compilation Act 1913 (WA) 29.

[4] *Crimes Act 1914* (Cth) s 4N(1); *Criminal Code Act 1995* (Cth) s 7.2(2); *Criminal Code 2002* (ACT) s 26(1); *Criminal Code 1983* (NT) s 43AQ.

[5] *Criminal Code 1983* (NT) s 38(2); *Criminal Code 1899* (Qld) s 29(2); *Criminal Code 1924* (Tas) s 18.

Australian jurisdictions, though, assess a child's behaviour to determine appropriateness to hold them criminally responsible between the relevant ages.

Doli incapax is a rebuttable presumption against criminal responsibility. A child is *presumed* to not possess criminal capacity prior to 14 unless prosecution can prove otherwise (C v DPP 1995). Australian children's courts will consider the child's decision-making capacity or understanding at the time of the alleged offence and make an assessment of whether the presumption can be rebutted. Courts will consider the extent to which children understand their behaviour as seriously wrong as opposed to merely being naughty (Fitz-Gibbon and O'Brien 2019). Many factors can be used to rebut the presumption including criminal history; type of offence committed; circumstances of the offending; expert evidence; and the child's upbringing, for example (Crofts 2018).[6] *Doli incapax* should act to divert children away from interaction with the criminal justice system (Fitz-Gibbon and O'Brien 2019), but it is also 'one of the key gateways to young people entering the criminal justice system' (Crofts 2018). The reality of *doli incapax* has been reported to be that despite the prosecution's onus to rebut *doli incapax* (RP v The Queen 2016), the defence will, in practice, need to raise it and establish it (Fitz-Gibbon and O'Brien 2019); there is also a lack of understanding and experience in applying the presumption amongst magistrates and lawyers, particularly in regional areas (ibid., p. 24). Ultimately, *doli incapax* is 'rarely a barrier to prosecution' and so many young people from 10 years of age find themselves fully responsible for their criminal behaviour and liable to sentencing outcomes (Atkinson 2018).

Capacity in decision-making is not to be mistaken with the *doli incapax* assessment of capacity. Queensland, Western Australia and Tasmania require prosecution to prove that a child had the capacity to know their conduct was wrong in order to rebut *doli incapax*.[7] Criminal law's capacity assessment is not one which assesses a child's understanding of the nature and effect of their decision. Rye v The State of Western Australia (2021) prescribed that the threshold for determining *doli incapax* capacity relates objectively to the 'ordinary standard of reasonable adults'. Neurodevelopment evidence indicates that no child could achieve a level of adult understanding because even the most mature child's brain does not fully develop until adulthood (Mendelson 2014). Prescribing an adult's capacity assessment onto a child is not something prosecution should ever be able to achieve and yet *doli incapax* is frequently rebutted for children. Assessing capacity for decision-making for healthcare decisions, though, is a subjective consideration of the individual's understanding at the moment of the decision. There is also a category of children who have reached the minimum age of criminal responsibility and yet *doli incapax* does not apply. Children 14 years and over are deemed to have an adult's level of criminal responsibility for criminal offences. Should they not have the capacity for criminal responsibility, they must establish a defence or excuse exists to exempt their culpability. In this way, those children 14 years and over are considered no differently to adults in relation to their *capacity* to offend even though different criminal procedures may apply during police investigations, courtroom processes and sentencing outcomes.

Failing to account for older children's capacity and maturity when dealing with criminal behaviour is problematic. Such an approach disregards children's neurological development as well as the mature minor principle. Children within the health law context are prevented from making decisions that may have adverse consequences for their healthcare because regardless of their understanding, courts cannot be completely satisfied of their maturity. However, criminal offending can also have significant consequences for children's wellbeing, with the child's maturity affecting their decision-making, yet Australian criminal law holds those same children fully responsible for their offending. Claire McDiarmid argued that

[6] RH v DPP (NSW) [2013] NSWSC 520; BP v The Queen [2006] NSWCCA 172; RP v The Queen (2016) 259 CLR 641; AL v The Queen [2017] NSWCCA 34.

[7] Criminal Code 1899 (Qld) s 29(2); Criminal Code 1924 (Tas) s 18; Criminal Code Act Compilation Act 1913 (WA) s 29.

> criminal capacity . . . rests not in a simplistic, single strand, such as knowledge of the difference between right and wrong but rather on interlinked understandings . . . the child's psychological development and his/her lived experience should be taken into account. (McDiarmid 2013)

The criminal law burden of proof also highlights flaws in holding children criminally responsible for their behaviour. Pillay argues that the 'beyond reasonable doubt' burden of proof for criminal matters cannot be established if courts consider the neurodevelopmental science which challenge a child's 'ability to formulate decisions and execute actions reflective of adult-type thinking and behaviour' (Pillay 2019). Health law authorities acknowledge and accept neurodevelopment science, vulnerability and maturity with Gillick and subsequent case law affirming developmental capacity. Australian criminal law, though, imposes arbitrary age thresholds at odds with the health law's approach. The criminal law's problematic imposition of criminal responsibility on children without considering maturity, development and its impact upon children's decision-making has led to comprehensive consideration of reform options amongst policy makers and academics.

Reforming Criminal Responsibility

There have been many proposals, and subsequent reforms, to adjust and improve the criminal law method of determining children's responsibility. Adjusting criminal responsibility has been to both protect children from criminal responsibility for their behaviour as well as ensure children can be held accountable for their actions. Such proposals have included raising the age of minimum criminal responsibility (Crofts 2015); extending *doli incapax* to older children (Fitz-Gibbon and O'Brien 2019); removing children's criminal responsibility (Pillay 2019); and incorporating a more rigorous capacity assessment to determine children's criminal responsibility (Delmage 2013). Removing criminal responsibility altogether and managing children's problematic behaviour outside the criminal justice system has also been suggested (Pillay 2019). Legislatures have adopted the above options in some international jurisdictions while others remain on a conceptual or theoretical basis. Each of these options will be explained briefly to provide context to the analysis of decisional capacity assessments.

There have been increasingly loud calls to raise the age of minimum criminal responsibility to 12 or 14. The #raisetheage campaign has been growing in momentum and notoriety in recent years (Raise the Age n.d.). The many reasons to increase minimum criminal responsibility age thresholds for children include the disproportionately high rate of incarcerated Indigenous children (Crofts 2015); disadvantaged backgrounds for children intersecting with the criminal justice system (Richards 2011); higher rates of recidivism when children enter the criminal justice system (ibid.); and detrimental effects of incarceration on children (Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory 2017). The minimum age of criminal responsibility, then, can adversely affect children.

There is movement in Australia's states and territories to address the challenges of the age of minimum criminal responsibility. Legislators in Queensland and New South Wales have both unsuccessfully attempted to raise the age of criminal responsibility from 10 years old to 14 years old 'consistent with current medical understanding of child development and contemporary human rights standards'.[8] The Australian Capital Territory has committed to raise the age to 12 in 2023 (ACT Government 2022). Despite the justifications for raising the age of minimum criminal responsibility, as outlined above, there is still community resistance to such changes. The United Kingdom's legal position may be one source.

[8] Explanatory Notes, Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021 (Qld) 1; Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021; Children (Criminal Proceedings) Amendment (Age of Criminal Responsibility) Bill 2021 (NSW).

While the United Kingdom's minimum age of criminal responsibility remains at 10 years of age, they abolished the presumption of *doli incapax* altogether (Crime and Disorder Act 1998). Such a response was designed to protect victims and hold children accountable for wrongdoing in the interests of justice (Bandalli 1998) but left children to feel the full force of adult's criminal responsibility. It is no wonder the British community felt unsympathetic to children who offend following the horrific circumstances leading to 2-year-old James Bulger's death in 1993 perpetrated by two 10-year-old children (Young 1996). After the Bulgar case, *doli incapax* was scrutinised as 'perverse' and 'outdated' (C (A Minor) v Director of Public Prosecutions 1996); it was ultimately removed (Crime and Disorder Act 1998). Removing *doli incapax* does little to address the challenges of children's capacity in decision-making considered in this article because it means children who may not have the maturity to understand the significance of their actions are still held fully accountable.

Another reform proposal for children's criminal responsibility has been to extend the presumption of *doli incapax* to older children (Fitz-Gibbon and O'Brien 2019). If *doli incapax* applied to all children from the minimum age of criminal responsibility up to the age of majority, children's decision-making, regardless of their age, would be subject to the rebuttable presumption. It would, arguably, ensure older children who lacked the understanding of the seriousness or wrongness of their behaviour, whether due to intelligence, disadvantaged background or otherwise, could not be treated punitively under the criminal law and would not be held accountable for their actions. While it may prevent unnecessary culpability for some children, the challenges of *doli incapax*, already outlined above, would still exist and would not prevent children entering the criminal justice system for prosecution.

Delmage (2013) proposed a 'defence of developmental immaturity' as a solution to the problem of assuming criminal responsibility in children. Such an approach is similar to extending *doli incapax* to all children (Fitz-Gibbon and O'Brien 2019). The defence would be a rebuttable presumption where the child is assumed to lack developmental maturity unless it is established. Delmage (2013) suggests the presumption be addressed by the prosecution for 14- and 15-year-old offenders and by the defence for 16-and-17-year-old offenders. Doing so would mean the protections afforded to the other younger children would apply to older children as well and ensure that children who did not properly understand their conduct to be wrong would not be held criminally liable for their actions. McDiarmid (2016) proposed a similar defence of developmental immaturity be applied to all children who do not understand the wrongfulness or consequences of their actions. *Doli incapax* or a defence of developmental immaturity as a solution to children's criminal responsibility, though, are still limited in that they do not use a capacity assessment for children's decision-making. They are rebuttable presumptions which prosecution can still, arguably, disprove through a range of strategic tactics including suggesting that after a child has been interviewed by police, they have realised the severity of their conduct and so are deemed to understand the wrongness of it (Crofts 2018).

Addressing children's behaviour outside the criminal justice system is the final reform option proposed in the literature. Pillay (2019, p. 232) indicates the neurodevelopment evidence highlights clear differences in how children respond to 'high arousal situations' compared with adults. Namely, children's ongoing brain development means their emotional regulation is less than that of an adult, particularly in emotionally 'hot' contexts, as already discussed above (Steinberg and Icenogle 2019). Removing children from the criminal justice system would not absolve them from responsibility or allow them to go 'unpunished' (ibid.). Instead, children should be supported by external agencies working towards their rehabilitation. Such a response would alleviate the overrepresentation of Indigenous children in the criminal justice system, as well as remove the harms of criminal incarceration for children (See, e.g., Kerig et al. 2016; Abram et al. 2004; McNair et al. 2019).

4. A Practical Use of Capacity Assessments

Health law and criminal law in Australia, then, have conflicting responses to children's decision-making. Criminal law does not test older children's capacity for decision-making, assuming them to be competent; younger children above the minimum age of criminal responsibility have their capacity or understanding scrutinised in a children's court. Health law supports mature children's decision-making where they are consenting to healthcare in their best interests but does not extend that autonomy to refusal of treatment decisions. These approaches are conflicting because they give differing weights to mature children's capacity for decision-making.

Delmage (2013) has attempted to consider the impact of developmental (im)maturity which is relevant to capacity assessments for children. A child's capacity in law depends upon that child's individual circumstances and the literature is clear that tests of capacity should be based on a range of factors, where age is but one of many (B & B & Minister for Immigration and Multicultural & Indigenous Affairs 2003). A child's 'psychological development' and 'lived experience' is entirely relevant to how they might respond in a scenario requiring them to exercise their decision-making (McDiarmid 2016). Almost 30 years of carefully layered judicial reasoning in health law identifies the complexity of capacity assessments while also emphasising their importance (Gillick's case 1986; Marion's case 1992).

Hendrick proposed that a conceptual binary exists for children. The conceptual binary outlines alternative viewpoints for categorising children's nature and is useful to outline here, briefly, to contextualise how children's decision-making can be considered. Hendrick, in a canvassing of child welfare over the previous century, identified that the 'social construction' labels children as either a victim or a threat meaning they can be 'categorised without reference to their individuality' (Hendrick 1993). This conceptual binary reflects current law. Some areas of law (such as health law) treat children as a 'victim' because decisions are made in a child's best interests or to protect them from harm. A victim perspective accounts for children's vulnerability because it assumes the adults know best whether those adults include parents or health practitioners. The criminal law's inflexible approach of failing to account for older children's capacity for decision-making treats children as a 'threat' because their inherent vulnerability is irrelevant to determining their criminal responsibility and legislators, police and courts facilitate their punishment and potential incarceration.

When decisions are made for children, whether because they are victims in need of protection or they threaten society's order, childhood is viewed from an adult's perspective. In fact, Mathews identifies adulthood as 'a social and legal construct' (Mathews 2003). Arbitrary ages of majority which dictate a specific date of a child's transition to adulthood regardless of maturity affirms this construct. Children have been viewed as irrational, ignorant and in need of protection and Australian law, both health law and criminal law, responds accordingly (Bridgeman 2007). Given adults are decision-makers for children, and are also responsible for making the law, it is no wonder such adult-centric approaches are adopted within the law.

Adults have the maturity, understanding and perspective to make decisions for children. Parental responsibility requires parents to act in the best interests of their children and the law gives parents those decision-making powers, as outlined above. Notwithstanding a parent's important role in protecting a child's vulnerability, parental responsibility has been acknowledged as problematic. Jo Bridgman (2007) argues that welfare principles, such as best interests, allow parents to protect children based upon a parent's understanding of what is best for a child. A child's own voice and perspective may not be reflected in a parent's decision. While parents do not have a right to control their child, the law authorises them to protect their child (Montgomery 1988).

Adults take responsibility for children because of their vulnerability. Children are vulnerable given they are 'at increased risk of harm or exploitation because their ability to make decisions, express concerns or defend themselves is diminished' (Moritz et al. 2020;

See also Byju and Mayo 2019; Ruof 2004). Most do not have the resources, expertise, knowledge or ability to advocate for themselves, particularly infants or younger children. Their vulnerability renders them open to exploitation and so protecting children, as a vulnerable group, becomes important. In relation to decision-making, children's vulnerability could mean their decisions are influenced by someone else, they do not understand the risks and benefits of a decision or there is a greater likelihood of something going wrong (Mattox 2010). Older children's vulnerability, despite committing criminal offences, does not factor into their culpability in the criminal law's response.

Unfortunately, Australia's criminal law cannot always be responsive to assessing a child's understanding at the time of the offending. Judicial consideration may arise many years after the criminal action so it can be difficult for prosecution to determine a child's understanding at a previous time (RP v The Queen 2016). The delay of time is one of the shortcomings of the current *doli incapax* approach which results in acquittals.

Notwithstanding the challenges of significant delay in criminal proceedings in some cases, criminal law currently lacks capacity assessments established in health law yet could so benefit from the mature minor approach. Applying a mature minor approach to a criminal context would mean 'testing each individual case on its own merits' (Delmage 2013). Individual assessments are conducted to some extent for children within the *doli incapax* age range but not for older children. A decisional capacity assessment, like the mature minor principle, is different to *doli incapax* because *doli incapax* is rebuttable requiring prosecution to establish and then defence to disprove (C (A Minor) v Director of Public Prosecutions 1996; Freckelton 2017). As addressed earlier in the paper, *doli incapax* factors can mean the presumption is rebutted without testing a child's understanding or decisional capacity such as relying on their previous offending or age to establish their understanding of seriousness.

Requiring a decisional capacity assessment for every child prosecuted for a criminal offence would be a resource-intensive exercise. For healthcare decisions, health practitioners do the capacity assessments; the decisional capacity assessment cases only go before the courts when there is a disagreement between relevant parties, where there is not an appropriate adult decision-maker, or the matter relates to special medical procedures, so courts are not overburdened with every healthcare decision involving children. The equivalent for the criminal law matters would be police or social workers, as community responders, to assess children's decision-making. Arguably, policing roles in preserving peace and good order; protecting the public from criminal offending; preventing crime; bringing offenders to justice; and upholding the law could mean police cannot impartially assess a child's understanding of their behaviour leading to criminal consequences (See Police Service Administration Act 1990).

Current criminal responsibility is so problematic because older children's capacity is equivalent to adults. Where children age out of the *doli incapax* threshold their capacity is not scrutinised (or not properly scrutinised). Their personal circumstances, intelligence, upbringing or backgrounds are irrelevant to their criminal responsibility and become a factor in sentencing only (unless a criminal defence is established). The Canadian Supreme Court in AC v Manitoba (Director, Child and Family Services) indicated that '[n]o state court has gone so far as to suggest that the "mature minor" doctrine effectively "reclassifies" mature adolescents as adults for medical treatment purposes.' Yet, that is what criminal responsibility laws do for adolescent children: they assess criminal responsibility treat for adolescents in the same way as adults.

It could be argued that the nature of decision-making under health law and criminal law are markedly different. Assessments of criminal law decision-making capacity are reactive in nature because they relate to past decisions. Children's understanding of the seriousness of their actions according to *doli incapax* are considered based upon their behaviour at the time of offending; in some cases, the assessment relates to a child's decision made years previous to the judicial proceedings. It is difficult to conduct a comprehensive

capacity assessment given a child may have matured in that time or the prosecution is unable to establish a child's capacity because of the passage of time.

Further, children who offend often do so because of factors outside their control (See, e.g., Richards 2011). Because children are susceptible to peer pressure and impulsivity, their reactive decision-making related to criminal offending can reflect their psycho-social immaturity (Steinberg 2009; Monahan et al. 2009). No amount of 'logical reasoning maturity' arising from proactive decisions can overcome their reactive psycho-social immaturity (Moritz and Christensen 2020, p. 825). As such, the criminal justice approach of holding young people responsible for their criminal behaviour may be more compatible with the developmental literature related to decision-making in a 'cold' context, where acts are premeditated, as opposed to 'hot' contexts, where children offend impulsively and amongst peers (Steinberg 2009). A criminal justice response which addresses cognition only, without considering the broader factors beyond a child's control, misses the connection between their psycho-social maturity and their ultimate reaction to a situation.

In contrast to decisions resulting in potential criminal sanctions, healthcare decisions are proactive ones. Capacity assessments relevant to healthcare decisions relate to children as they are making a decision. As such, every healthcare decision can be carefully weighed considering risk and benefit. In most cases, there is time for legal consultation and court intervention, if necessary. In fact, some children, even those as young as six, have been held to understand congenital heart disease because they 'depend on lifelong care', they have 'developed relationships of informed trust' with their treating health practitioners and have been fully supported in understanding their condition and the consequences attached to it (Alderson et al. 2022, p. 10).

While children's best interests are the paramount consideration for courts in most areas of law, the same is not extended to children who perpetuate criminal offences. While children's upbringing, background and other mitigating factors might be raised to assess their *doli incapax* status and/or at sentencing, courts fail to consider children's neurological development in making decisions which might ordinarily have criminal consequences for adults. A best interests approach simply does not exist for children who perpetuate criminal offences.

Children being brought before the criminal justice system is not in their best interests and, in fact, causes them harm (Crofts 2009). Involvement in the criminal justice system as a child can lead to poor educational and employment outcomes as well as greater likelihood of adult offending (Bernburg and Krohn 2003). Goldson (2013) argues that assessing children's decisional capacity for criminal responsibility is secondary to addressing the appropriateness of bringing them in to the criminal justice system. Specifically, decriminalising children's offending behaviours, or immunities from prosecution, should be the emphasis. It is unlikely the government will decriminalise children's offending behaviours though so children's decisional capacity is extremely relevant.

There is no threshold of responsibility under Australian state and territory criminal law. If we accept that different decisions require different levels of capacity, such as the capacity to consent to pain relief versus consent to major surgery, those different thresholds should apply when it comes to criminal responsibility. Delmage (2013) argues that the 'threshold' for finding a child responsible for more serious offences (such as murder and rape) should be higher than when they are found responsible for more minor offences (such as shoplifting). While the *doli incapax* ages might account for the seriousness of offences, the 14 and above age bracket do not have offence seriousness taken into account when apportioning responsibility which is a significant flaw and one inconsistent with the High Court of Australia's health law approach (Marion's case 1992).

The scientific literature and judicial authority relating to children's decision-making and brain development is clear: children develop at different rates (See, e.g., Cauffman and Steinberg 2000). As discussed above, it is arbitrary to assign an age to assess understanding given the factors that relate to decision-making competency. Children's decisional incapacity should be assessed at every age where children are alleged to have perpetrated criminal

offences above the minimum age of criminal responsibility. It is not enough to allow a rebuttable presumption which considers whether or not a child knew their behaviour was wrong, or expecting children over 14 to assume responsibility for their offending. If children are unable to make decisions about healthcare resulting in serious consequences, children should also not be responsible for decisions which have serious criminal consequences where those decisions are made in 'hot' contexts.

If children are deemed to have decision-making autonomy, a proper assessment of that autonomy needs to be undertaken which properly explores the child's decision-making approach and disregards incidental factors that sometimes contributes to rebutting the presumption such as age; previous criminal history; and admitting guilt to police.[9] What is significant, though, is even if a thorough capacity assessment can be undertaken to determine children's level of culpability, Australian health law does not allow children's autonomy to conflict with their best interests. Courts in their *parens patriae* jurisdiction acknowledge that even the most mature of children needs to be protected from the danger of making a choice that conflicts with their best interests because of their inherent vulnerability. Courts and legislators cannot expect that mature children given the benefit of a proactive healthcare choice are considered unable to make decisions conflicting with their best interests and yet hold potentially immature children accountable for spur of the moment decisions that result in criminal culpability. Those two competing dichotomies are completely incompatible.

The law needs to resolve and/or align its position on children's decision-making. Children's developmental immaturity needs to be acknowledged whereby children are protected from the consequences of life-changing decisions and prevented from making healthcare decisions which breach their best interests despite apparent maturity. What follows, then, is a criminal law response which acknowledges developmental immaturity and that children's decision-making is impaired by brain development, cognitive functioning and environmental factors that mean despite their apparent maturity, they do not have the same cognition as adults and should not suffer criminal consequences where decisions were made in 'hot' contexts.

5. Conclusions

Decisional capacity assessments are used in different ways to determine an appropriate level of children's involvement in decisions which affect them. Healthcare decision-making uses the mature minor principle to assess a child's understanding, maturity and capacity for decision-making, resulting in parents' dwindling responsibility to make decisions on their child's behalf. Significantly, Australian health law's decisional capacity assessments highlight how there are many factors which influence children's decision-making so a single approach is unhelpful for children's developmental maturity; prescribing a decision-making age results in arbitrary timelines; and despite maturity considerations, children's autonomy ultimately gives way to their best interests.

While Gillick promotes autonomy for mature children, the Supreme Courts' *parens patriae* jurisdiction impedes full decisional capacity. Courts are reluctant to permit children to make decisions which conflict with their best interests because of their inherent vulnerability. As such, children are protected from their developmental immaturity. Such an approach is dichotomous to the criminal law's punitive application of criminal responsibility for children.

When children over 10 make decisions which have criminal consequences, the law assesses their level of responsibility. Until children turn 14, prosecution must rebut the presumption of *doli incapax*, while children from 14 years of age have an adult's level of criminal responsibility imposed upon them regardless of their developmental immaturity. As identified in this paper, the criminal law's approach has been criticised as inconsistent with neurological research into children's brain development as well as introducing children

[9] RP v The Queen (2016) 259 CLR 641; R v JA (2007) 161 ACTR 1; R v EI [2009] QCA 177.

unnecessarily to the harms of the criminal justice system. The criminal law's approach which fails to assess, or properly assess, children's decisional capacity, highlights significant flaws in how the law understands and applies children's developmental immaturity to their behaviour.

The law must resolve its position on children's decision-making. Children do not have sufficient developmental maturity to be held accountable for reactive decision-making resulting in criminal consequences. Support outside the criminal justice system is, therefore, needed for those children. A consistent approach, spanning the different areas of law, would resolve the dichotomous approaches present in the current law.

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