“Office Hours”: January 2025

JANUARY 9, 2025

KIRSTEN E. LELOUDIS, JD, MPH

UNC SCHOOL OF GOVERNMENT

The information provided in this presentation is for educational purposes only and does not constitute legal advice or establish an attorney-client relationship.

A Few Quick Notes

There’s a lot of text on these slides!

→ No expectation that you read it all- it’s just here for your reference later

I will be providing legal technical assistance (*what does the law say?*) but not legal advice (*what should I do to comply with the law?*)

→ Please consult an attorney or your licensing board, as appropriate, if you need situation-specific advice

Content Warning

When we do our refresher on mandatory reporting to DSS and law enforcement, we will be discussing abuse, neglect, and criminal offenses (including sexual violence) committed against young people.

- We will be discussing the law at a high level but will also review fictitious case studies that describe harm committed against young people.
- Please take care of yourself in whatever way you need.

Presentation Roadmap

Refresher: Where to Find Resources

Mandatory Reporting (25 mins)

- Review of mandatory reporting laws (chart)
- Case studies
- Questions + discussion

Consent to Care for Minor Patients (25 mins)

- Review of the "rainbow chart"
  - Focus on minor's consent law
  - Focus on consent to care for children in DSS custody
- Questions + discussion

Q&A Wrap Up

- What questions do you still have?

Where to Find Resources

UNC SCHOOL OF GOVERNMENT

FIELDS OF EXPERTISE
JUNE 2024

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Timothy E. Heinle 919.962.9594 · *heinle@sog.unc.edu*

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John B. Stephens 919.962.5190 · *stephens@sog.unc.edu*

Have a Question?

Give us a call or send us an email!

You can find a list of faculty areas of expertise, along with our contact information, here: https://www.sog.unc.edu/about/faculty-and-staff/.

Examples of Faculty Areas

Kirsten Leloudis- public health (incl. mandatory reporting, minor's consent)

Jill Moore- public health (incl. communicable disease control, repro health)

Sara DePasquale- child welfare (incl. abuse, neglect, dependency cases)

Kristi Nickodem- social services governance (incl. confidentiality)

Mark Botts- mental/behavioral health (incl. confidentiality)

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Kirsten Leloudis

Assistant Professor of Public Law and Government
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This list consists of blogs, blog posts, FAQ collections, legal summaries, listservs, microsites, pages and tools which are associated with this profile.

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LEGAL SUMMARY

Consent and Common Pathways for Providing Care to Minors (the "Rainbow Chart")

Edit

Sometimes referred to as "the rainbow chart," this document provides an overview of the most common ways in which care may be provided to minor patients and the associated consent requirements under North Carolina law.

LEGAL SUMMARY

"Required by Law" Disclosures of PHI to DSS: G.S. 7B-302 and 7B-3100 (Chart)

Edit

A chart summarizing the application of G.S. 7B-302(e) and 7B-3100(a) (requiring the disclosure of certain information to North Carolina departments of social services (DSS) in specific situations) to North Carolina local health departments (LHDs) that are also covered entities subject to HIPAA.

Consent and Common Pathways for Providing Care to Minor Patients*

Category	Name	Description	Citation
Minor's Consent	Minor's consent	A minor with decisional capacity may give consent to a physician (or provider working under the direction of a physician) for the prevention, diagnosis, or treatment of conditions specified in the statute.	G.S. 90-21.5(a)
Urgent/Emergency Care	Urgent/emergency care provided by physicians	A physician (or provider working unde physic ction) m provide care in certain time-sensitive situatio t first obtaining parental consent.	G.S. 90-21.1
	Urgent/emergency care provided by school employees	Public school employees au provide first aid, emergency obtaining parental consent.	G.S. 115C-375.1
Non-Parent Authorized to Consent to Care	DSS director consents for minor's care	The DSS director (or her design e, as well as testing and evalu custody. DSS director (court order.	G.S. 7B-505.1
	Parent authorizes non-parent to consent using a HCPOA	A "custodial parent" may deleg er person using a health care po r narrow in scope and may be d for a parent to delegate co	G.S. 32A, Article 4
Specific Health Care Services	Abortion	In addition to a parent, a grandparent ing for 6 months can consent to an abortion fo may waive the requirement for parental co nt to an in limit circumstances. Requirements of G.S. 90, Art. 1I mus o still be met.	G.S. 90-21.7, 90-21.8
Parental Consent	Parental consent to treatment	Parent (natural or adoptive parent whose rights have not been limited or terminated by a custody or court order; legal guardian; or person standing *in loco parentis*) consents to care that meets the definition of "treatment." Consent must be memorialized in writing or otherwise documented.	G.S. 90-21.10A, 21.10B, 21.10C

*Chart created by K. Leloudis- UNC SOG- Last updated 12/2023

Summary of Mandatory Reporting Requirements for Local Health Departments (LHDs) Serving Minors (July 2023)

Who is the report made to?	DSS	Law Enforcement		
When is a report required?	Cause to suspect that a child is abused, neglected, or dependent or has died due to maltreatment	Know or reasonably should have known that a juvenile was or is the victim of a violent offense, sexual offense, or misdemeanor child abuse	Certain wounds, illnesses, and injuries (regardless of patie[illegible] age); non-accidental trauma ca[illegible] recurrent [illegible]ss or seri[illegible]al injury in [illegible]	Suspect that a child under age 16 has disappeared and may be in danger
Who must report?	All persons ("universal")	Persons age 18+ (limited exceptions for some professionals with privilege; exception does not include doctors and nurses)	Physicia[illegible]	[illegible]sons ("universal")
Timing of report	Law does not specify (but given risks to child health and safety, reporting should not be delayed)	Immediately	[illegible]	[illegible]nable time
Criminal penalty for failure to report or preventing a report?	Yes- misdemeanor	Yes- misdemeanor	[illegible]	[illegible]
Immunity for good faith reporting?	Yes	Yes	[illegible]	[illegible]
Statutes	G.S. 7B-101; 7B-301	G.S. 14-318.6	G.S. 90-2[illegible]	[illegible]-318.5

Reminder: Some situations may trigger a requirement to make a report to both DSS and law enforcement. When this occurs, a person cannot make a report to just one agency (e.g., reporting to DSS, but not law enforcement) in satisfaction of their total reporting duties; instead, reports to both agencies must be made.

Reminder: Terms such as "abuse," "neglect," "serious physical injury," etc. have specific meanings under NC law. Definitions can be found by reading the relevant statutes.

Coates' Canons NC Local Government Law

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Categories

Child Welfare, Miscellaneous, Public Health

Medical Appointments, Consents, and Children in DSS Custody

Published: 04/15/24

Author Name: Kirsten Leloudis, Sara DePasquale

In North Carolina, a juvenile who is the subject of an abuse, neglect, or dependency petition may be placed in the custody of a Department of Social Services (DSS). When DSS has a court order of custody, it places a child outside of the child's home, often in a licensed foster home or in the home of a relative or other placement provider. Here at the School of Government (SOG), we are often asked whether North Carolina law authorizes foster parents (or the child's placement providers) to consent to health services for the children in DSS custody who are placed in providers' homes. Spoiler: the answer is "no." If foster parents or placement providers cannot consent to medical care for the children in their home, must the person whose consent is required (e.g., a DSS caseworker) attend and give consent at every appointment for every child who is in DSS custody? This blog post, co-authored by SOG faculty Kirsten Leloudis and Sara DePasquale, addresses these questions.

Coates' Canons Blog

Short pieces (2-5 pages) on timely topics, written in non-legalese

https://canons.sog.unc.edu/

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Women, Infant and Community Wellness Section: Training

Current and past trainings along with web sites listed below are just a few examples that you may use to obtain continuing education credit when available. You will need to follow instructions for receiving credit from the Women, Infant and Community Wellness Section (WICWS) or other web sites. It is your responsibility to maintain your receipt of credits from each training in a file for documentation purposes and to take all credits upon leaving the agency. Share this page with all local women's health staff including your providers, nurses, enhanced role nurses, health educators, nutritionists, social workers, management support, budget/financial personnel, etc.

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Training

Family Planning/Title X Medical Director Required Trainings Resource List 05/01/23

+ Required Title X/Family Planning Trainings 11/04/24

+ Women's Health Non-Required Trainings 03/26/24

+ Family Planning Non-Required Trainings - 01/06/25

+ Maternal Health Non-Required Trainings - 11/01/2023

NCDHHS Website

Current and past trainings, including the 2024 required Title X/Family Planning webinar

https://wicws.dph.ncdhhs.gov/provpart/training.htm

Mandatory Reporting to DSS and Law Enforcement

Introduction to Mandatory Reporting

Mandatory reporting = a legally enforceable duty to report certain conduct to government officials

Why do mandatory reporting laws exist?

Possible reasons:

- Protect vulnerable populations (e.g., children, adults with disabilities)
- Improve health and safety by connecting people to resources
- Prevent “falling through the cracks”
- And more

… It’s Not Just North Carolina

All states have mandatory reporting laws

- The Child Abuse Prevention and Treatment Act (CAPTA) requires states that receive federal funds for child welfare work to have a mandatory reporting law for child abuse and neglect
- Different approaches taken in different states
  - Ex: some states have a blanket requirement to report crimes (NC doesn’t)

Summary of Mandatory Reporting Requirements for Local Health Departments (LHDs) Serving Minors (July 2023)

Who is the report made to?	DSS	Law Enforcement		
When is a report required?	Cause to suspect that a child is abused, neglected, or dependent or has died due to maltreatment	Know or reasonably should have known that a juvenile was or is the victim of a violent offense, sexual offense, or misdemeanor child abuse	Certain wounds, illnesses, and injuries (regardless of patient age); non-accidental trauma causing recurrent illness or serious physical injury in a child under age 18	Suspect that a child under age 16 has disappeared and may be in danger
Who must report?	All persons ("universal")	Persons age 18+ (limited exceptions for some professionals with privilege; exception does not include doctors and nurses)	Physicians and health care facility directors/ administrators	All persons ("universal")
Timing of report	Law does not specify (but given risks to child health and safety, reporting should not be delayed)	Immediately	As soon as practicable before, during, or after the child's treatment	Within a reasonable time
Criminal penalty for failure to report or preventing a report?	Yes- misdemeanor	Yes- misdemeanor	No- but liability still possible, depending on the circumstances	Yes- misdemeanor
Immunity for good faith reporting?	Yes	Yes	Yes	Yes
Statutes	G.S. 7B-101; 7B-301	G.S. 14-318.6	G.S. 90-21.20(b)-(c1)	G.S. 14-318.5

Reminder: Some situations may trigger a requirement to make a report to both DSS and law enforcement. When this occurs, a person cannot make a report to just one agency (e.g., reporting to DSS, but not law enforcement) in satisfaction of their total reporting duties; instead, reports to both agencies must be made.

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Reminder: Terms such as “ab ... cific m ... the relevant statutes.

Anecdotally, the most common type of reporting for LHDs

Anecdotally, comes up more for hospitals (emergency departments)

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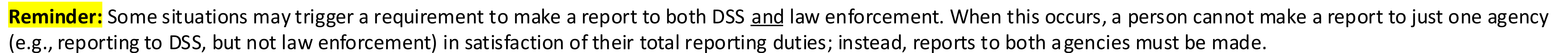

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Reports to DSS: A/N/D

Except in the case of human trafficking, reportable abuse, neglect, and dependency **must always tie back to an act (or failure to act) by the juvenile's parent, guardian, custodian, or caretaker.**

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Sexually violent offenses, as defined by G.S. 14-208.6(5) and 14-318.6(a)(4)

★ *Updated to reflect S.L. 2024-37*

Forcible rape and sexual offenses	
First- and second-degree forcible rape	G.S. 14-27.21; 14-27.22
First- and second-degree forcible sexual offense	G.S. 14-27.26, 14-27.27
Sexual battery	G.S. 14-27.23
Attempted rape or sexual offense as defined under former law	Former G.S. 14-27.33
Statutory offenses	
Statutory rape: victim under 13, perpetrator at least 4 years older	G.S. 14-27.23; 14-27.24
Statutory rape: victim ages 13-15, perpetrator at least 6 years older*	G.S. 14-27.25(a)
Statutory sexual offense: victim under 13, perpetrator at least 4 years older	G.S. 14-27.28; 14-27.29
Statutory sexual offense: victim ages 13-15, perpetrator at least 6 years older*	G.S. 14-27.30(a)
Offenses committed by a parents/parent substitutes or other relatives	
Sexual activity with a person under 18 by a substitute parent or custodian	G.S. 14-27.31
Incest (carnal relations with a person's biological or adoptive child, stepchild, grandchild, nephew, niece, sibling, half-sibling, parent, grandparent, uncle, or aunt)	G.S. 14-178
Parent or guardian commits a sexual act on a juvenile under age 16, or allows a sexual act to be committed on a juvenile under age 16	G.S. 14-318.4(a2)
Offenses committed by teachers or other school personnel	
Sexual activity with a student by a teacher, school administrator, student teacher, school safety officer, coach, or other school personnel	G.S. 14-27.32
Indecent liberties with a student by a teacher, school administrator, student teacher, school safety officer, or coach who is at least 4 years older	G.S. 14-202.4(a)
Trafficking /offenses related to prostitution**	
Human trafficking	G.S. 14-43.11
Subjecting or maintaining a person for sexual servitude	G.S. 14-43.13
Patronizing a prostitute who is a minor or has a mental disability	G.S. 14-205.2(c) & (d)
Promoting the prostitution of a minor or person with a mental disability	G.S. 14-205.3(b)
Parent or caretaker commits or permits an act of prostitution with or by a juvenile	G.S. 14-318.4(a1)
Offenses related to pornography/dissemination of obscene materials	
Employing or permitting a minor to assist in offenses against public morality and decency (includes preparing & disseminating obscene materials)	G.S. 14-190.6
First-, second-, and third-degree sexual exploitation of a minor (using, inducing, coercing, encouraging, or facilitating a minor under age 18 to engage in sexual activity for the purpose of producing pornography; creating, duplicating, or distributing such materials; or possessing child pornography)	G.S. 14-190.16, 14-190.17, 14-190.17A
★ **NEW** Obscene visual representation of sexual exploitation of a minor	G.S. 14-190.17C
Other offenses against children	
Felonious indecent exposure (victim under 16, perpetrator 18 or older)	G.S. 14-190.9(a1)
Indecent liberties with a child under 16 by a person 5 or more years older	G.S. 14-202.1
Using a computer or other electronic device to solicit a child to commit an unlawful sex act	G.S. 14-202.3

List of "Sexually Violent Offenses" That Trigger Mandatory Reporting to Law Enforcement When Committed Against a Juvenile

The original chart was compiled by Jill Moore, Associate Professor, UNC School of Government. Yellow highlighting indicates updates made to reflect S.L. 2024-37.

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Immunity for good faith reporting?	Yes	Yes		Yes
Statutes	G.S. 7B-101; 7B-301	G.S. 14-318.6	G.S. 90-21.20(b)-(c1)	G.S. 14-318.5

Prosecution for failure to report is not common; however, this past summer there was a situation in which someone was charged for failing to make a required report. Case is still pending.

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Reminder: Terms such as "abuse," "neglect," "serious physical injury," etc. have specific meanings under NC law. Definitions can be found by reading the relevant statutes.

Case Study

Scenario: A new patient (”Jane”) presents to the LHD seeking prenatal care. Jane is 16 years old and four months pregnant. Per Jane, the father of the baby (FOB) is her 25-year-old boyfriend. Jane says she and FOB first had sex five months ago (at which time, Jane was 16 years old). Jane lives with her mom, and mom was aware of Jane’s sexual relationship with FOB when it started. Since Jane and FOB learned about the pregnancy, FOB moved in and is now living with Jane and her mother.

Question: Based on these facts, is a report required and if so, to whom?

A) Yes- a report must be made to DSS

B) Yes- a report must be made to law enforcement

C) Yes- a report must be made to DSS and law enforcement

D) No report needs to be made

Summary of Mandatory Reporting Requirements for Local Health Departments (LHDs) Serving Minors (July 2023)

Who is the report made to?	DSS	Law Enforcement		
When is a report required?	Cause to suspect that a child is abused, neglected, or dependent or has died due to maltreatment	Know or reasonably should have known that a juvenile was or is the victim of a violent offense, sexual offense, or misdemeanor child abuse	Certain wounds, illnesses, and injuries (regardless of patient age); non-accidental trauma causing recurrent illness or serious physical injury in a child under age 18	Suspect that a child under age 16 has disappeared and may be in danger
Who must report?	All persons ("universal")	Persons age 18+ (limited exceptions for some professionals with privilege; exception does not include doctors and nurses)	Physicians and health care facility directors/ administrators	All persons ("universal")
Timing of report	Law does not specify (but given risks to child health and safety, reporting should not be delayed)	Immediately	As soon as practicable before, during, or after the child's treatment	Within a reasonable time
Criminal penalty for failure to report or preventing a report?	Yes- misdemeanor	Yes- misdemeanor	No- but liability still possible, depending on the circumstances	Yes- misdemeanor
Immunity for good faith reporting?	Yes	Yes	Yes	Yes
Statutes	G.S. 7B-101; 7B-301	G.S. 14-318.6	G.S. 90-21.20(b)-(c1)	G.S. 14-318.5

Reminder: Some situations may trigger a requirement to make a report to both DSS and law enforcement. When this occurs, a person cannot make a report to just one agency (e.g., reporting to DSS, but not law enforcement) in satisfaction of their total reporting duties; instead, reports to both agencies must be made.

Reminder: Terms such as "abuse," "neglect," "serious physical injury," etc. have specific meanings under NC law. Definitions can be found by reading the relevant statutes.

★ **Sexually violent offenses, as defined by G.S. 14-208.6(5) and 14-318.6(a)(4)**
Updated to reflect S.L. 2024-37

Forcible rape and sexual offenses	
First- and second-degree forcible rape	G.S. 14-27.21; 14-27.22
First- and second-degree forcible sexual offense	G.S. 14-27.26, 14-27.27
Sexual battery	G.S. 14-27.23
Attempted rape or sexual offense as defined under former law	Former G.S. 14-27.33
Statutory offenses	
Statutory rape: victim under 13, perpetrator at least 4 years older	G.S. 14-27.23; 14-27.24
Statutory rape: victim ages 13-15, perpetrator at least 6 years older*	G.S. 14-27.25(a)
Statutory sexual offense: victim under 13, perpetrator at least 4 years older	G.S. 14-27.28; 14-27.29
Statutory sexual offense: victim ages 13-15, perpetrator at least 6 years older*	G.S. 14-27.30(a)
Offenses committed by a parents/parent substitutes or other relatives	
Sexual activity with a person under 18 by a substitute parent or custodian	G.S. 14-27.31
Incest (carnal relations with a person's biological or adoptive child, stepchild, grandchild, nephew, niece, sibling, half-sibling, parent, grandparent, uncle, or aunt)	G.S. 14-178
Parent or guardian commits a sexual act on a juvenile under age 16, or allows a sexual act to be committed on a juvenile under age 16	G.S. 14-318.4(a2)
Offenses committed by teachers or other school personnel	
Sexual activity with a student by a teacher, school administrator, student teacher, school safety officer, coach, or other school personnel	G.S. 14-27.32
Indecent liberties with a student by a teacher, school administrator, student teacher, school safety officer, or coach who is at least 4 years older	G.S. 14-202.4(a)
Trafficking /offenses related to prostitution**	
Human trafficking	G.S. 14-43.11
Subjecting or maintaining a person for sexual servitude	G.S. 14-43.13
Patronizing a prostitute who is a minor or has a mental disability	G.S. 14-205.2(c) & (d)
Promoting the prostitution of a minor or person with a mental disability	G.S. 14-205.3(b)
Parent or caretaker commits or permits an act of prostitution with or by a juvenile	G.S. 14-318.4(a1)
Offenses related to pornography/dissemination of obscene materials	
Employing or permitting a minor to assist in offenses against public morality and decency (includes preparing & disseminating obscene materials)	G.S. 14-190.6
First-, second-, and third-degree sexual exploitation of a minor (using, inducing, coercing, encouraging, or facilitating a minor under age 18 to engage in sexual activity for the purpose of producing pornography; creating, duplicating, or distributing such materials; or possessing child pornography)	G.S. 14-190.16, 14-190.17, 14-190.17A
★ **NEW** Obscene visual representation of sexual exploitation of a minor	G.S. 14-190.17C
Other offenses against children	
Felonious indecent exposure (victim under 16, perpetrator 18 or older)	G.S. 14-190.9(a1)
Indecent liberties with a child under 16 by a person 5 or more years older	G.S. 14-202.1
Using a computer or other electronic device to solicit a child to commit an unlawful sex act	G.S. 14-202.3

List of "Sexually Violent Offenses" That Trigger Mandatory Reporting to Law Enforcement When Committed Against a Juvenile

The original chart was compiled by Jill Moore, Associate Professor, UNC School of Government. Yellow highlighting indicates updates made to reflect S.L. 2024-37.

Case Study

Scenario: A new patient (”Jane”) presents to the LHD seeking prenatal care. Jane is 16 years old and four months pregnant. Per Jane, the father of the baby (FOB) is her 25-year-old boyfriend. Jane says she and FOB first had sex five months ago (at which time, Jane was 16 years old). Jane lives with her mom, and mom was aware of Jane’s sexual relationship with FOB when it started. Since Jane and FOB learned about the pregnancy, FOB moved in and is now living with Jane and her mother.

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Case Study (cont).

Explanation: This scenario appears to just narrowly fall outside the scope of G.S. 7B-301, which would require reporting abuse to DSS, and G.S. 14-318.6, which would require reporting certain sexual offenses to law enforcement.

Based on the facts we have, there is no information to suggest that there are any crimes that might have been committed here that must be reported to law enforcement, exact perhaps statutory rape.

→ If we look more closely at the statutes that define various types of statutory rape, however, the law is generally concerned with incidents involving victims who are under age 16 at the time of the offense. If the patient was 16 at the time that she and the FOB first had sex, then no statutory rape laws have been violated (despite the 9 year age difference). Therefore, there is not a need to make a report to law enforcement under G.S. 14-318.6 on the basis of suspected statutory rape.

As for a report to DSS: the abuse, neglect, or dependency must have been caused by the child's parent, guardian, custodian, or caretaker (unless the harm the child has suffered is human trafficking, in which case the child is considered abused and neglected, regardless of who "caused" or knew about and allowed the trafficking to occur).

→ G.S. 7B-101(1) defines an "abused juvenile" and includes situations where the child's parent permits the violation of certain laws, including various sex crimes that are committed against the child.

→ This would include statutory rape- but again, based on the facts that we have, it appears that the statutory rape laws have not been violated. In that case- and absent any other information suggesting abuse, neglect, or dependency- a report to DSS would not be required.

Mandatory Reporting: Questions + Discussion

What questions do you have?

Is there a hypothetical situation you'd like to discuss?

Consent to Care for Minor Patients: Focus on Minor's Consent and Children in DSS Custody

Consent and Common Pathways for Providing Care to Minor Patients*

Category	Name	Description	Citation
Minor's Consent	Minor's consent	A minor with decisional capacity may give consent to a physician (or provider working under the direction of a physician) for the prevention, diagnosis, or treatment of conditions specified in the statute.	G.S. 90-21.5(a)
Urgent/Emergency Care	Urgent/emergency care provided by physicians	A physician (or provider working under the physician's direction) may provide care in certain time-sensitive situations specified in the statute without first obtaining parental consent.	G.S. 90-21.1
	Urgent/emergency care provided by school employees	Public school employees authorized by their local board of education may provide first aid, emergency care, and life saving techniques without first obtaining parental consent.	G.S. 115C-375.1
Non-Parent Authorized to Consent to Care	DSS director consents for minor's care	The DSS director (or her designee) may consent to routine and emergency care, as well as testing and evaluation in exigent circumstances, for a minor in DSS custody. DSS director (or designee) may also consent to other care as set out in a court order.	G.S. 7B-505.1
	Parent authorizes non-parent to consent using a HCPOA	A "custodial parent" may delegate the parent's consenting authority to another person using a health care power of attorney (HCPOA). HCPOA can be broad or narrow in scope and may be time-limited. Note: This is not the exclusive method for a parent to delegate consenting authority to a non-parent.	G.S. 32A, Article 4
Specific Health Care Services	Abortion	In addition to a parent, a grandparent with whom a minor has been living for 6 months can consent to an abortion for the minor. Alternatively, a court may waive the requirement for parental consent to an abortion in limited circumstances. Requirements of G.S. 90, Art. 1I must also still be met.	G.S. 90-21.7, 90-21.8
Parental Consent	Parental consent to treatment	Parent (natural or adoptive parent whose rights have not been limited or terminated by a custody or court order; legal guardian; or person standing *in loco parentis*) consents to care that meets the definition of "treatment." Consent must be memorialized in writing or otherwise documented.	G.S. 90-21.10A, 21.10B, 21.10C

**Chart created by K. Leloudis- UNC SOG- Last updated 12/2023*

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**Chart created by K. Leloudis- UNC SOG- Last updated 12/2023*

The NC Minor’s Consent Law

Who is a “Minor?”

Anyone under 18, unless married or emancipated

Emancipation of a minor

- Emancipation is not common
- Minors who are 16 or 17 years old can become emancipated by a court

Marriage of a minor

- These days, only minors who are 16 and 17 can get married
- Note: this is a change as of August 2021; before then, minors as young as 14 and 15 could marry in NC

Reminder: becoming pregnant or having a child *does not* emancipate a minor in NC

Minor’s Consent Law

According to the CDC, in 2022 all 50 states and D.C. allowed minors to consent to certain health services

- NC minor’s consent law is found at G.S. 90-21.5(a)

Law allows minors with decisional capacity to consent, on their own, to medical health services for:

- Prevention, diagnosis, and/or treatment of
- Venereal/reportable diseases, pregnancy, emotional disturbance, and abuse of controlled substances/alcohol

Minor’s Consent Law

But note: G.S. 90-21.5(a) specifically **does not allow** a minor to consent on their own to the following:

- Sterilization
- Admission to a 24-hour mental health care facility
- Abortion

Minors + Decisional Capacity

The law gives an unemancipated minor the legal capacity to consent to the services specified in the law…

- But legal capacity by itself is not enough!
  - Provider must also determine that the minor has the **decisional capacity** (sometimes called “competence”) to consent to the care
- Decisional capacity = ability to give informed consent
- Capacity can be assessed similarly to how it is assessed in adults

Decisional Capacity

To be clear: NC minor's consent law doesn't create a minimum or "cut off" age

- This means that the age at which a minor patient can consent to a health service described at G.S. 90-21.5(a) will depend on whether that minor is found to have decisional capacity
- Every kid is different; must assess the patient in front of you
- May also matter what the health service is

Who Can Accept Consent?

Law says a minor may give effective consent to a "**physician**" who is licensed to practice in NC

- Has long been interpreted to include providers working under a physician's supervision (e.g., nurses, physician assistants, etc.)
- **Note:** be mindful of other providers in your organization who may not be working under the supervision of a physician (e.g., some mental health providers)

Minor’s Consent + Confidentiality

G.S. 90-21.4(b) is the law that governs the confidentiality of information about health services that a minor has received under G.S. 90-21.5(a)

General rule:

- Cannot disclose information about a minor’s consent encounter to the minor’s parent, guardian, custodian, or PILP* without the minor’s permission

* PILP = a person standing *in loco parentis.* For more information about who can be a PILP, see this 2023 Coates’ Canons blog post: https://canons.sog.unc.edu/2023/03/in-loco-parentis-consent-healthcare-minors/.

Minor's Consent + Confidentiality, cont.

Exceptions: provider <u>may</u>* disclose to a parent, guardian, custodian, or PILP if:

- Disclosure is essential to the life or health of the minor
- Parent, guardian, custodian, or PILP "contacts the physician concerning the treatment or medical services being provided to the minor"

**Use of "may" in the statute means that disclosure is permitted, but not required*

Liability/Immunity

G.S. 90-21.4(a) establishes civil and criminal immunity for physicians who provide care to minors in accordance with G.S. 90-21.5

- Only covers providing care to a minor without parental consent when doing so is permitted by law
- Does not cover negligent provision of care
- Protections extend to those working under a physician (e.g., nurses, physician assistants, etc.)

Let's Take a Closer Look

Frequently asked questions (FAQs) about minor's consent and:

- Vaccines
- Pregnancy care

Minor’s Consent and Vaccines

Remember: G.S. 90-21.5(a) allows an unemancipated minor with decisional capacity to consent, on their own, to receive medical health services for **“prevention,** diagnosis and treatment” of:

- **Venereal diseases/other reportable diseases**
- Pregnancy
- Abuse of controlled substances/alcohol
- Emotional disturbance

FAQ: What About HPV Vaccines?

Can minors consent to HPV vaccine?

Answer: **Yes,** if the minor has the requisite decisional capacity.

Why?: G.S. 90-21.5(a) allows a minor (with decisional capacity) to consent to <u>prevention</u> of a <u>venereal or reportable disease.</u>

- → HPV is not reportable in NC (see 10A NCAC 41A .0101)
- → But HPV is a venereal disease (it is transmitted through sex)
- → HPV vaccines are therefore prevention of a venereal disease

FAQ: What About Pregnancy Care?

Can minors consent to contraception, pregnancy testing, and prenatal care?

Answer: **Yes, yes,** and **yes** (as long as they have decisional capacity!).

Why?: G.S. 90-21.5(a) allows a minor (with decisional capacity) to consent to the prevention, diagnosis, and treatment of pregnancy.

→ Contraception (including emergency contraception) = prevention of pregnancy

→ Pregnancy testing = diagnosis of pregnancy

→ Prenatal care = treatment of pregnancy

But remember: G.S. 90-21.5(a) specifically says minors can't consent on their own to sterilization or abortion.

Consent to Care for Minors in DSS Custody

Non-Parent Given Authority to Consent: DSS Director

G.S. 7B-505.1 authorizes the DSS director to consent to certain types of care for a child who is in DSS custody

Important things to know:

- Authority to consent is given to the DSS director- but director can also delegate that authority to a DSS caseworker (who then gives consent)
- DSS director can only consent to routine care, emergency care, and testing/evaluation in exigent circumstances (unless a court order says otherwise)
- **Foster parents not authorized to consent to care**

Coates' Canons NC Local Government Law

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Medical Appointments, Consents, and Children in DSS Custody

Published: 04/15/24

Author Name: Kirsten Leloudis, Sara DePasquale

In North Carolina, a juvenile who is the subject of an abuse, neglect, or dependency petition may be placed in the custody of a Department of Social Services (DSS). When DSS has a court order of custody, it places a child outside of the child's home, often in a licensed foster home or in the home of a relative or other placement provider. Here at the School of Government (SOG), we are often asked whether North Carolina law authorizes foster parents (or the child's placement providers) to consent to health services for the children in DSS custody who are placed in providers' homes. Spoiler: the answer is "no." If foster parents or placement providers cannot consent to medical care for the children in their home, must the person whose consent is required (e.g., a DSS caseworker) attend and give consent at every appointment for every child who is in DSS custody? This blog post, co-authored by SOG faculty Kirsten Leloudis and Sara DePasquale, addresses these questions.

A Note About Foster Parents

No NC law that authorizes foster parents to consent to care for their foster child

DSS director can delegate their authority to consent to care to their "staff" per G.S. 108A-14(d)

- Foster parents are not DSS staff

For more information, see this blog post: https://canons.sog.unc.edu/2024/04/consent-dss-custody/

Troubleshooting

What can you do if a foster parent presents a child for care and wants to be the adult who consents for that care?

Goal: not turning away (already vulnerable) children from receiving care

Options:

1. Call DSS 24/7 line, obtain oral consent from social worker on call (if oral consent is appropriate for this type of health service- consider standard of practice), document the consent in child’s chart
2. Review the child’s record- is there a general consent to treat on file that already covers this health service and that was signed by someone with authority to consent?
3. Minor’s consent may be an option, too

Consent to Care for Minors: Questions + Discussion

What questions do you have?

Is there a hypothetical situation you'd like to discuss?

Q&A Wrap Up

Wrapping Up

What else is on your mind?

What other resources would be helpful to you- more charts, written resources, trainings, other?

Image References

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Questions?

Thank you for your time.

If you have additional questions at a later date*, please send me an email or give me call.

**Except February 14-May 5, 2025, when I will be on leave.*

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