

**Herefordshire Council Children and Families**

**Medical treatment and intervention for Looked After Children protocol**

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1. **Introduction**

Whether used to alleviate the pain of a toothache or to perform a serious operation, medical intervention can be critical to the functioning and well-being of Looked After Children. Medical treatment when required, can be vitally important; given that Looked After Children are placed outside their own homes, it becomes even more crucial to manage and obtain appropriate consent for its administration.

Before any medical intervention can be effected, consent to routine or specific treatment needs to have been obtained.

The purpose of this guidance is to provide guidance as to obtaining appropriate consent for the treatment and intervention for Looked After Children.

Please note that there is a further separate Protocol in respect of those unfortunate situations where end of life decisions have to be made in respect of Looked After Children.

**2.** **Placement Planning in relation to medical intervention**

**Routine medical treatment**

Before a child is placed in foster care or residential care, consent(s) must be obtained wherever possible, usually from the parent, or a person with Parental Responsibility, for the following:

1. Urgent or emergency medical treatment;
2. First aid, health care assessments,
3. Planned medical advice and treatment, including immunisations;
4. Whether the child can be administered non-prescribed medicines (such as Paracetamol) or home remedies;

Where there is a person who holds Parental Responsibility such consent must be given, in writing, when completing the Placement Plan. Please see the separate guidance (at x) which relates to health care assessments.

If consent is refused or any conditions are placed upon the consent, details of the refusal or conditions must be recorded in the child’s Placement Plan;

Even when the parent, or person with Parental Responsibility, gives consent to medical assessments, treatment and advice, it should be understood that children aged sixteen and over, and others under that age who have sufficient understanding, may override the consent in some circumstances. This is explained in further detail below.

Furthermore, having secured initial overarching consent for routine treatment, it may be necessary for the child’s social worker to seek further specific consent for the child in respect of non-routine medical treatment and interventions.

If the Looked After Child requires routine medication, foster carers must be provided with sufficient information so that they can understand how to administer the medication, including the purpose, dosage, schedule, duration of use, and side effects and how to respond to potentially dangerous side effects.

Medication must only be given on the guidance of a medical practitioner. However, some minor conditions can be resolved with an “home remedy” for example, calpol / paracetamol. Foster carers must be advised that all “home remedies” must not be continued beyond forty-eight hours without seeking advice from the child's GP.

**Specific treatment**

Consent must be obtained for any medical treatment that is not included in the placement plan as routine treatment. Please see the “obtaining consent checklist” which should be used to assist those seeking to obtain consent, and if there is any query over whether consent should be obtained, or whether consent is valid please seek legal advice regarding this. Further guidance is provided below in respect of consent.

**3.** **Consent to Medical Treatment and Intervention for Looked After Children**

Consent to medical treatment must be sought before any medical treatment is given or intervention effected. In order to consider consent, it is first necessary to take into account the age of the Looked After Child:-

**Child 16 and over**

* Children aged 16 and over have the right to consent to medical treatment

**Child below 16 and “Gillick Competent”**

Where a child is competent, their consent should be sought in the first instance. A “Gillick competent” child is a child aged sixteen years and over or a child that has sufficient understanding and intelligence to enable him or her to fully understand what is proposed‟ (Gillick v West Norfolk and Wisbech AHA, 1986).

Other than in exceptional circumstances, all reasonable steps should be taken to inform the parent(s) or others with parental responsibility before medical advice or treatment is sought for a Gillick Competent Looked After Child, they should be informed as soon as practicable thereafter. The level of information imparted should reflect the current care plan;

* Steps should always be taken to promote decision-making on the part of children and to ensure their views and wishes are obtained, considered and accounted for;
* It is the responsibility of the child’s social worker, together with residential staff and foster carers to support the child to engage with medical professionals. The older and more mature a child, the greater weight should be given to their views. For any consent by a child to be valid, it must be informed and freely given for those under as well as over 16 years;

**Child under 16 who is not “Gillick Competent”**

If a child is under 16 and is not considered to be Gillick Competent (they do not “have capacity‟), consent from someone who has parental responsibility is required except in an emergency when it would be unreasonable to wait (e.g. the hospital would make a decision to undertake treatment without consent of parent of LA as if they did not carry out the treatment the life of the child would be at risk).

Parents of Looked after Children or other holders of parental responsibility retain parental responsibility in relation to their children, even though in some circumstances the exercise of that responsibility may be limited (by s33 Children Act 1989 which is explained further below). All parents and holders of parental responsibility should be informed and consent should be obtained, whenever possible, in relation to their children's health and medical treatment.

Those who have parental responsibility other than the child's parents include:

• the child‟s legally appointed Special Guardian – appointed either by a court or by a parent with parental responsibility in the event of their own death;

• a person in whose favour a court has made a Child Arrangements order concerning the child;

• a local authority designated in a care order in respect of the child (but not where the child is being looked after under Section 20 of the Children Act);

• a local authority or other authorised person who holds an emergency protection order in respect of the child.

Foster carers only have the right to consent to medical treatment when this has been delegated to them in the placement plan, and this will only ever cover routine treatment.

In respect of a Looked After Child who is subject to a Care Order or Interim Care Order, whilst consent should be obtained from all holders of parental responsibility, it is the Local Authority under s.33 Children Act 1989 that determines the level at which parents exercise their parental responsibility in respect of their child. In essence, the Local Authority has the final say.

A Local Authority should only be restrictive (and take a decision without consent from all holders of parental responsibility regarding medical treatment) where s.33 is concerned if to do so would safeguard or promote the child's welfare. Actions that would safeguard and promote the child's welfare are topics that are up for debate, and will clearly need to be considered subjectively on a case by case basis. And whilst legally only one person with parental responsibility is required for consent to minor medical treatment where s33 applies, it is good practice to involve all those close to the child in the decision-making process. Please therefore seek legal advice if you are not clear about whether consent is required from the holders of parental responsibility.

It may be the case that if a decision to provide medical treatment to a child under a care or placement order becomes contentious and concerns particularly invasive or high risk treatment, the matter may need to be placed before the Court.

**Holders of parental responsibility withhold consent**

In situations where the child's parents, other holders of parental responsibility or the child refuse or are unable to consent to medical treatment this should be brought to the attention of senior management and legal advice should be sought as a matter of urgency.

There are medical interventions that are sufficiently serious that they do not fall within s33 Children Act 1989. This means that that it is not possible for the Local Authority to provide consent and they are not able to limit the exercise of parental responsibility of all holders parental responsibility to said treatment/intervention and consent of all those with parental responsibility is required. In these circumstances the child's social worker should actively seek to involve the parent/all holders of parental responsibility in discussions with medical staff prior to giving their consent and where there is a dispute, legal advice should be urgently sought as an urgent application to the High Court for declaratory relief may be required to settle the dispute.

**Emergency situations**

In an emergency situations, when urgent medical treatment is required and every effort has been made to locate parents or a person with Parental Responsibility, the following may apply:

* A child who has reached his/her sixteenth birthday may give consent;
* Dependent on his/her age and level of understanding, a child who has not reached the age of sixteen may be regarded by a doctor as capable of giving consent (Gillick Competent);
* In a ‘life or limb’ situation, a doctor may decide to proceed without any consent if this is in the child’s best interests;
* If the intervention falls within s33 Children Act 1989, the local authority may provide consent
* If the matter falls outside of s33 Children Act 1989, legal advice should be sought as an application to the High Court may be necessary
* Consent should be given in writing, but it is equally valid if given verbally, provided it was informed and freely given. Written consent is preferred where children are in receipt of services away from home and may require urgent medical treatment in an emergency. Where it is only possible to acquire verbal consent, it should be given in the presence of a reliable witness e.g. acting on behalf of the Local Authority.