BIRMINGHAM CHILDREN'S TRUST

Guidance on Consents for Children in Care

Version 2

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Contents

1. Placement Planning

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

a. Urgent or emergency medical treatment;

b. First aid, health care assessments, advice and treatment, including immunisations;

c. Allowing the child to participate in swimming, outdoor or other pursuits which have a risk attached to them;

d. Whether the child can be administered non-prescribed medicines (such as Paracetamol) or home remedies;

e. Overnight stays with friends away from the foster home or residential home.

Where there is a person who holds Parental Responsibility such consent must be given, in writing, when completing the **Placement Information Record** (ICS).

Having secured initial overarching consent, it may be necessary for the child's social worker to seek further specific consent for the child to participate in activities/events which are outside the normal scope of those which a child in care would usually access.

Specific consent will usually also be required for **holidays and school/educational visits inside and outside the UK.**

2. Consent for the Adoption of a Relinquished Child

A parent may consent to their child being adopted, and/or to the child being placed for adoption. The consent may relate to specific identified adopters or to any adopter chosen by Children's Services.

When a parent is prepared to consent to the child being adopted, this must be formally witnessed by an officer of CAFCASS. The social worker will make the request to CAFCASS. This request must include the "Schedule 2 information" as detailed in the **Arranging the Adoption of a Relinquished Child** guidance.

The CAFCASS practitioner will:

- Satisfy him/herself that the parents fully understand the consequences of giving consent and that they do so unconditionally;

- Ask the parents to sign the appropriate consent form(s);
- Countersign the form(s) as witness to the parents' signatures, and
- Send the completed consent form(s) (or a standard letter saying that they are unable to countersign the consent) to Legal Services.

When the signed consent form(s) have been received, Legal Services will keep the originals and send copies to the area social worker (to be placed on the child's adoption case record) and to the panel adviser. The original consent form, signed and witnessed, must accompany the application to court for an adoption order; a copy will not be accepted for this purpose.

The social worker should:

- Note the date on which consent was given (the first adoption review must be within 3 months of this);
- Ensure that the information to be presented to the adoption panel clearly states that consent has been given, including the type of consent given – whether it was consent to placement for adoption, or to adoption, or both, and whether it is given in general or relates only to specific adopters; and

If consent is refused or any conditions are placed upon the consent, details of this must be must be recorded in the child's Placement Information Record and the process followed in the **Arranging the Adoption of a Relinquished Child** guidance.

3. Consent for Medical Treatment

When the parent, or person with Parental Responsibility, gives consent to medical assessments, treatment and advice, it should be understood that children aged 16 years and over, and others under that age who have sufficient understanding, may override the consent in some circumstances.

- For children under 16 years subject to a **Care Order** or **Interim Care Order**, the Team Manager should give consent to routine examinations and treatment if the parent is unable or unwilling to do so.
- Where the child is in need of surgery, a general anaesthetic or other specific medical intervention, the child's social worker should actively

seek to involve the parent(s) in discussions with medical staff prior to giving their consent.

- If the child is **Accommodated,** or more serious treatment is required for a child on a Care Order or Interim Care Order and the parent refuses consent, this should be brought to the attention of a senior manager and legal advice should be sought as a matter of urgency. Where appropriate, the senior manager will give consent for a Social Worker, Team Leader or Deputy Team Leader to attend the hospital, discuss the surgery, anaesthetic and risks with the doctor(s), and sign consent. The Social Worker, Team Leader or deputy should complete the internal form for a senior manager to sign, and then attend the hospital themselves to discuss and sign the hospital consent form. Please refer to the **Scheme of Delegated Decision Making** guidance for further information on this.

- Children of 16 years of age and over have the right to consent to medical treatment and some children below 16 may be regarded as of sufficient understanding and maturity to consent to medical treatment without the need for parental consent (this is referred to as **Fraser Competence).**

- 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 **Looked After Child**. If this is not achieved, 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). Indeed, a doctor may regard a child as **Gillick Competent** i.e. capable of giving or refusing to give consent, even if under 16 years. This will be the decision of the medical professional involved. For such consent by a child to be valid, it must be informed and freely given for those under as well as over 16 years.

- In an emergency, when urgent medical treatment is required and every effort has been made to locate the parent(s) or person with Parental Responsibility, the following may apply:

    a) A child who has reached his/her 16th birthday may give consent;

b) A responsible adult acting in loco parentis, may give consent on the parent's behalf as long as all reasonable steps have been taken to consult the parent(s) or those with Parental Responsibility and such action is not against their expressed wishes. In the case of a child who is in care, this will involve the relevant senior manager having a discussion with the medical professional involved before considering whether it is appropriate to give consent;

c) Dependent on his/her age and level of understanding, a child who has not reached the age of 16 may be regarded by a doctor as capable of giving consent (Gillick Competent);

d) In a 'life or limb' situation, a doctor may decide to proceed without any consent;

e) 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. an individual acting on behalf of the Children's Trust/Local Authority.

4. Consent to Share Personal Information

Staff should always seek to gain informed consent from children and/or parents where it involves the sharing of confidential and personal information, and should take reasonable steps to obtain this.

In every case, it is important to record the necessity; proportionality; relevance; adequacy; accuracy; timeliness; and security of the information being shared.

It is important to respect the wishes of those who do not give consent, except where safety may be a risk or when it is inappropriate to seek their agreement. If consent is not given, a record of why it is believed to be a safety risk must be recorded as well as why it was felt inappropriate to seek their agreement.

Shared information should not be kept for longer than is necessary. Further guidance on information sharing is available the **Consent, Information Sharing and Thresholds Guidance**.

5. Considerations When Seeking Unconditional Consent

Consent must be given unconditionally and with full understanding. If a parent is only willing to consent with conditions attached, for example about

the amount or type of contact for an adoption, this is not acceptable. Consent given only in respect of a particular placement is acceptable.

The social worker should note any issues relating to the capacity of the parents to consent, for example:

- Whether either parent has learning difficulties or mental health issues;
- Whether there are any issues relating to substance misuse;
- Whether anyone may be putting pressure on the parent to consent;
- Any cultural or religious factors relevant to the parents' understanding and awareness of the implications of giving consent; and
- Whether the parents may wish to set conditions on their consent.