Delegated Authority to Foster Parents

This policy sets out the arrangements for delegation to carers to make decisions relating to Children Looked After, under the Care Planning, Placement and Case Review and Fostering Services (Miscellaneous Amendments) Regulations 2013 (which amend the Care Planning, Placement and Case Review (England) Regulations 2010), and revised Children Act 1989 Guidance and Regulations - Volume 2: Care Planning, Placement and Case Review.

Principles:

- Authority for day-to-day decision making about a child Looked After should be delegated to the child's foster parent unless there is a valid reason not to do so;
- A child's Placement Plan should record who has the authority to take particular decisions about the child. It should also record the reasons where any day-to-day decision is not delegated to the child's foster parent;
- Decisions about delegation of authority should take account of the child's views, and consideration should be given as to whether a child is of sufficient age and understanding to take some decisions themselves.

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1. Delegated Authority

It is essential to fulfilling the local authority's duty to safeguard and promote the child's welfare that, wherever possible, the most appropriate person to take a decision about the child has the authority to do so, and that there is clarity about who has the authority to decide what.

Decisions about delegation of authority must be made within the context of:

- The child's Permanence Plan, which sets out the local authority's plan for achieving a permanent home for the child; and
- The legal framework for Parental Responsibility in the Children Act 1989.

The expectation must be that the assessment and approval of foster parents, their training and previous experiences of, for example, caring for their own children, will equip them with the skills and competence to undertake the day-to-day caring task, including taking day-to-day decisions about their foster child's care. Any skills gaps should be urgently addressed so that foster parents are able to carry out their parenting role effectively.

The Secure Base Model

The Secure Base Model adopted by the agency considers the five caregiving dimensions of Availability, Sensitivity, and Acceptance, Co-operation and Family Membership and the associated particular developmental benefits for the child of applying this model. This model underpins the care given to all children placed with the agency.

Where a particular decision is not delegated to a child's foster parent and rests with the local authority, there is a clear system in place for ensuring that decisions can be made by the appropriate person in a timely way, with arrangements in place to cover sickness and annual leave. Details of these arrangements are given to foster parents and children (subject to age and understanding).

2. Delegation in the Context of the Permanence Plan

When deciding who should have authority to take particular decisions, the most appropriate exercise of decision-making powers will depend, in part, on the long term plan for the child, as set out in the child's Permanence Plan. For example:

- Where the plan is short term, the Placement Planning Meeting should include discussion of which day-to-day decisions can be made by the foster parent. Decisions should be recorded in the Placement Plan. Examples of day-to-day decisions include:
    - Haircuts;
    - Overnight stays with friends and foster carer support networks;

- School trips up to 4 days;
- Medical treatment (consents should be given and logged in the child's 'Charms' record).

- Where the plan is for long term foster care, the foster parents should have a significant say in the majority of decisions about the child's care, including longer term decisions such as which school the child will attend;
- Whatever the Permanence Plan, the foster parent should have delegated authority to take day-to-day parenting decisions. This enables them to provide the best possible care for the child.

3. Delegation in the Context of the Law on Parental Responsibility

The child's parents do not lose Parental Responsibility when their child is Looked After. Where the child is Voluntarily Accommodated under Section 20 of the Children Act 1989, the local authority does not have Parental Responsibility, but the local authority does have Parental Responsibility where there is a Care Order or Emergency Protection Order. The foster parent never has Parental Responsibility.

Where a child is being voluntarily accommodated, the child's Care Plan, including delegation of authority to the local authority or child's foster parent should (where the child is under 16), as far as is reasonably practicable, be agreed with the child's parents and anyone else who has Parental Responsibility. If the child is 16 or 17 the Care Plan should be agreed with them. A local authority cannot restrict a person's exercise of their Parental Responsibility, including their decisions about delegation, unless there is a Care Order or an Emergency Protection Order in place.

Where a child is subject to a Care Order or Emergency Protection Order, the local authority should, wherever possible and appropriate, consult parents and others with Parental Responsibility for the child. The views of parents and others with Parental Responsibility should be complied with unless it is not consistent with the child's welfare.

It is important to build effective relationships between parents and others with Parental Responsibility so that they understand that appropriate delegation is in the best interests of the child. Where parents initially feel unable to delegate, this may change over time as trust develops, so decisions should be kept under review through the care planning process, which parents should be involved in, where reasonably practicable (whether the child is Voluntarily Accommodated or under a Care Order).

Where a parent is unable to engage in the discussions about delegation of authority for whatever reason, or refuses to do so, the local authority will need to take a view. If the local authority has a Care Order, then they can exercise their Parental Responsibility without the parent. Where the local

authority does not have Parental Responsibility they can still do what is reasonable in the circumstances for the purpose of safeguarding and promoting the child's welfare.

There are some decisions where the law prevents authority being delegated to a person without Parental Responsibility. These include applying for a passport (a child aged 16 or over who has the mental capacity to do so can apply for their own passport). Where there is a Care Order, the child cannot be removed from the UK for more than a month without written consent of everyone with Parental Responsibility or the leave of the Court (where the child is Voluntarily Accommodated the necessary consents must be obtained as for a child outside the Care system). A local authority cannot decide that a child should be known by a different surname or be brought up in a religion other than the one they would have been brought up in had they not become Looked After.

4. The Child's Competence to Make Decisions Themselves

Any decision about delegation of authority must consider the views of the child. In some cases a child will be of sufficient age and understanding to make decisions themselves. For example, they may have strong views about the often contentious issue of haircuts, and if the child is of sufficient age and understanding, it may be decided that they should be allowed to make these decisions themselves.

When deciding whether a particular child, on a particular occasion, has sufficient understanding to make a decision, the following questions should be considered:

- Can the child understand the question being asked of them?
- Do they appreciate the options open to them?
- Can they weigh up the pros and cons of each option?
- Can they express a clear personal view on the matter, as distinct from repeating what someone else thinks they should do?
- Can they be reasonably consistent in their view on the matter, or are they constantly changing their mind?

Regardless of a child's competence, some decisions cannot be made until a child reaches a certain age, for example, tattoos are not permitted for a person under 18 and certain piercings are not permitted until the child reaches age 16.

Where appropriate, consider seeking the child's views when making a decision.

5. Types of Decision

Decisions about the care of a Child Looked After are likely to fall into three broad areas:

- Day-to-day parenting, e.g. routine decisions about health/hygiene, education, leisure activities;
- Routine but longer term decisions, e.g. school choice;
- Significant events, e.g. surgery.

Day-to-day Parenting

All decisions in this category should be delegated to the child's foster parent (and/or the child if they can make any of these decisions themselves). Any exceptions and reasons for this should be set out in the child's Placement Plan. It should be explicit within the Placement Plan exactly what decisions in relation to the child's health that the foster carer has the authority to give consent to, including whether a signed medical treatment consent form has been provided.

Decisions about activities where risk assessments have been routinely carried out by those organising / supervising the activity, e.g. school trips or activity breaks, should be delegated to the child's foster parent. There is no expectation that Children's Social Care should duplicate risk assessments.

Reasons not to delegate to the foster parent may include, if the child's individual needs, past experiences or behaviour(s) are such that some day-to-day decisions require particular expertise and judgement. For example, where a child is especially vulnerable to exploitation by peers or adults, overnight stays may need to be limited and the foster parent may need the local authority to manage this.

See also the agency's Safeguarding Children and Young People Procedure, Children Absent/Missing from Care Procedure and Safeguarding Children and Young People from Sexual Exploitation Procedure.

Routine but Longer Term Decisions

This category of decisions will require skilled partnership work to involve the relevant people. The child's Permanence Plan will be an important factor in determining who should be involved in the decision. For example, if the plan is for the child to return home, their parents should be involved in a decision about the type of school the child should attend and its location, because ultimately the child will be living with them. Where the plan is for long term foster care until age 18, then while the child's parents must be involved (unless there is a Care Order and the local authority has decided not to

involve them), where possible the school choice should fit with the foster parent's family life as well as be appropriate for the child.

Significant Events

This category of decisions is likely to be more serious and far reaching. Where the child is Voluntarily Accommodated, the child's birth parents or others with Parental Responsibility should make these decisions. Where the child is under a Care Order or Emergency Protection Order, decisions may be made by the birth parents or others with Parental Responsibility, which includes the local authority, depending on the decision and the circumstances. Such decisions should, however, always take account of the wishes and feelings of the child and their foster parent.

6. Delegation Relating to the Child's Education

The Education Act 1996 defines 'parent' as including a person who has care of the child in question. Therefore a child's foster parent is deemed a parent for the purposes of education law. This means, for example, that a foster parent should be provided with information about the child's progress; invited to meetings about the child; and should be able to give consent to decisions regarding school activities.

Young people can sometimes apply in their own right for a place at sixth form or FE College. If they are of compulsory school age their application must also be signed by a parent (which in the context of education includes foster parents) confirming their approval of the application. Once they are over compulsory school age they can apply in their own right without the need for parental consent. Young people can also appeal against the refusal of a sixth form place along these lines.

7. Delegation in the Context of the Child's Health

Young people aged 16 or 17

Young people aged 16 or 17 are presumed to be capable of consenting to their own medical treatment, provided they do not lack mental capacity, the consent is given voluntarily and they are appropriately informed regarding the particular intervention. If the young person is capable of giving valid consent, then it is not legally necessary to obtain consent from a person with Parental Responsibility. It is, however, good practice to involve the Local Authority and the young person's family in the decision-making process - unless the young person specifically wishes to exclude them or does not consent to their information being shared.

Children under 16

1. A child under 16 may consent to medical treatment (or refuse treatment) if they are judged by the medical professional to be competent. This is sometimes referred to as 'Gillick Competence' and the health professional will refer to the Fraser Guidelines when the issue relates to sexual health services. A young person who is competent will have:
    - the ability to understand that there is a choice and that choices have consequences;
    - the ability to weigh the information and arrive at a decision;
    - a willingness to make a choice (including the choice that someone else should make the decision);
    - an understanding of the nature and purpose of the proposed intervention;
    - an understanding of the proposed intervention's risks and side effects;
    - an understanding of the alternatives to the proposed intervention, and the risks attached to them;
    - freedom from undue pressure.

    Competence will be assessed by a qualified health professional for each treatment/intervention, and on a continual basis. A young person might have the capacity to consent to some interventions but not to others. Their capacity will be assessed carefully in relation to each decision that needs to be made.

    If a child is judged to be competent to make a particular decision about their health treatment, that consent will be valid and additional consent by a person with Parental Responsibility will not be required. It is, however, good practice to involve the Local Authority and the child's family in the decision-making process, if the child consents to their information being shared.

2. Even if a child under 16 is not judged to be competent to make their own decisions, doctors should aim to involve them in decisions relating to their medical treatment, as much as they are able. It should be clear within the Placement Plan what type of decisions (if any) a child may make for themselves, which decisions the Local Authority delegates to the foster parent, and circumstances under which the Local Authority must be contacted for consent before treatment can commence.

    In an emergency, where treatment is vital and waiting to get parental consent would place the young person at risk, treatment can proceed without any consent.

Refusal of consent

Where a child or young person who is judged to be competent refuses treatment, it is possible that such a refusal could be overruled by the Court of Protection if it would in all probability lead to the death of the child/young person or to severe permanent injury. The Local Authority and/or health professionals involved will initiate legal procedures.

The Court of Protection also has the power to overrule a refusal to consent by a person with Parental Responsibility.

Accurate and timely recording on the child or young person's case record on CHARMS must be undertaken in all situations where decisions are made in respect of the child or young person's health.

8. The Placement Plan

The Care Planning, Placement and Case Review (England) Regulations 2010 (as amended) require that each child's Placement Plan must make clear who has the authority to take decisions in key areas of the child's day-to-day life, including:

- Medical or dental treatment;
- Education and educational trips;
- Leisure and home life including overnight stays and holidays;
- Faith and religious observance;
- Use of social media; and
- Any other areas of decision-making considered relevant with respect to the particular child.

The person(s) with the authority to take a particular decision or give a particular consent must be clearly named on the Placement Plan and any associated actions (e.g. a requirement for the foster parent to notify the local authority that a particular decision has been made) should be clearly set out in the Placement Plan. Placement Plans must be agreed with the child's foster parent, and are likely to be most effective when drawn up in a placement planning meeting which involves everyone concerned, including the foster parent.

Where a decision is not delegated to the child's foster parent, but can be predicted in advance, the agreement of those with Parental Responsibility to the decision should be sought in advance and recorded in the Placement Plan, so that when the decision arises, delay can be avoided.

For some decisions that are made by a person other than the child's foster parent, it may be expected that the foster parent will implement the decision. For example, parents or the local authority may agree to the provision of Child and Adolescent Mental Health Services, but ask the foster parent to take the child to appointments. This is not delegation of decision making to the foster parent, as the decision will have been taken by those with Parental Responsibility and a medical professional, but it will enable the delivery of the service to continue without the need for ongoing support from social workers. The child's Placement Plan should make clear what the expectations of the foster parent are in such cases.

The appropriate distribution of decision making powers is likely to change over time, as the child matures and circumstances change. The Placement Plan forms a part of the child's overall Care Plan. Decisions about delegation of authority should be considered at each review of the Care Plan.

9. When and How to Share Information

Practitioners should use their judgement when making decisions on what information to share and when, and should follow their organisation procedures or consult with their manager if in doubt. The most important consideration is whether sharing information is likely to safeguard and protect a child. See Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, 2018)

Practitioners must decide whether sharing information is a necessary and proportionate response to the need to protect the child in question. The decision making process must weigh up what might happen if the information is shared against what might happen if it is not shared. It is important to note that a lack of information sharing is a consistent theme within Serious Case Reviews.

Further sources of information

Other advice and guidance:

- **The Children Act 1989 Guidance and Regulations - Volume 2: Care Planning, Placement and Case Review (2015);**
- **The Children Act 1989 Guidance and Regulations - Volume 4: Fostering Services;**
- **Fostering Services: National Minimum Standards;**

Associated resources (external links)

- **General Medical Council guidance for doctors treating children 0-18 years;**
- **British Medical Association Children & Young People Ethics Toolkit.**