# Delegation of Authority to Foster Carers and Residential Workers

We want children in our care to have the opportunity to experience as normal a family life as possible. This means, where children are looked after by Calderdale Council, the carers for the child will be given delegated authority to make as many everyday decisions as possible about the children in their care. The arrangements will be specific for each child, taking into account their particular circumstances and needs, their legal status, the children's views and the views of their own parents.

Wherever possible, foster carers and residential workers will be authorised to take the same sort of every day decisions about children placed in their care as would any parent. This is particularly important for those children who are in long term placements where this is their permanent home.

It is vitally important that all practitioners involved with looked after children, as well as the carers, are aware of this policy and are clear what this means in practice for the child and the family who look after the child.

This document should be read in conjunction with the Foster Carers Charter.

Acknowledgement: This tool is based on the model devised by Leeds Council, whose permission has been sought.

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## Introduction

The Department for Education (DfE) requires the Local Authority to publish a policy for delegating authority to foster carers and residential workers caring for children that Calderdale Council is responsible for. This policy has also taken into account the statutory guidance published by the DfE in July 2013 and in particular, the need to maximise the delegation of authority for day to day decisions wherever possible to the primary carer for the child.

## Regulation and Guidance:

The Care Planning, Placement and Case Review (England) Regulations 2010 as amended by the Care Planning, Placement and Case Review and Fostering Services (Miscellaneous Amendments) Regulations 2013 sets out the guidance for Delegated Authority and the expectations on Local Authorities to produce a clear policy on delegated authority.

## Key principles:

Where children are looked after by Calderdale Council, the carers for the child will be given delegated authority to make as many everyday decisions as possible about the children in their care. The arrangements will be specific for each child, taking into account their particular circumstances and needs, their legal status, the children's views and the views of their own parents. Wherever possible foster carers and residential workers be authorised to take the same sort of every day decisions about children placed in their care as would any parent.

It is acknowledged that the distribution of decision making powers is likely to change over time, as the child matures and their 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.

The child's placement plan must record who has the authority to take particular decisions about the child. It must also record the reasons where any day-to-day decision is not delegated to the child's carer. A separate form is used for this purpose, outlining who is responsible for the range of decisions that are likely to be needed in a child's life.

Decisions about delegation of authority should take account of the looked after child's views. Consideration should be given as to whether a looked after child is of sufficient age and understanding to take some decisions themselves.

## Delegation of authority:

Managing the relationship between a looked after child's parents (or other carers with parental responsibility), the local authority, the foster carer(s) or the registered manager of a children's home is challenging, particularly as those providing the day-to-day care do not hold parental responsibility. It is essential in 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.

Poor planning around delegation of authority can delay decision-making and lead to children missing out on opportunities that enable them to experience a fulfilled childhood and feel part of their foster carer's family or the daily life of their children's home. Looked after children say that problems obtaining parents' and local authorities' consent to everyday activities make them feel different from their friends and cause them embarrassment and upset. Similarly it is important that the carers of the child are clear about their responsibilities so that they are not left feeling compromised in their caring role and decisions can be made in a timely way for the child. This enables carers to provide the best possible care for the child without the need to consult the social worker before a decision can be made.

All 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 (PR) in the Children Act 1989.

## Delegation in the context of the permanence plan:

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 for the child to return home, the child's parents should have a significant role in decision-making; where the plan is for long term foster care, the foster carers 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 carer will be given delegated authority to take day-to-day parenting decisions.

## Delegation in the context of the law on parental responsibility (PR):

The child's parents do not lose PR when the child is looked after. Where the child is voluntarily accommodated under section 20 of the Children Act 1989, the local authority does not have PR.

The local authority does have PR where there is a care order or emergency protection order. The foster carer never has PR.

Where a child is being voluntarily accommodated, the child's care plan, including delegation of authority to the local authority or child's carer, 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 PR. Where the child is 16 the care plan should be agreed with them, subject to their level of understanding and taking into account any vulnerability of the young person.

Where a child is subject to a care order or emergency protection order, the social worker will, wherever possible and appropriate, consult parents and others with PR for the child. The views of parents and others with PR will be complied with unless it is not consistent with the child's welfare and best interest. The views of the child must also be taken into account.

Delegation of responsibility to the direct carer will always be considered at the child's review in case of any changes and taking into account the child's age.

## Decisions that cannot be delegated to someone who does not have PR:

There are some decisions where the law prevents authority being delegated to a person without PR. 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 PR 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). The 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.

## 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.

For older children, they may have clear views regarding contact with their birth families and their views will need to be very carefully considered in the context of all the other factors which have led to the child becoming looked after.

- When deciding whether a particular child, on a particular occasion, has sufficient understanding to make a decision, the following questions must 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?
- Is it legal?

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 age 18 and certain piercings are not permitted until the child reaches age 16.

## Types of decision:

The Delegated Decision tool will be used to ensure that the decision making is clearly recorded and agreed with all the relevant people. Children of sufficient age and understanding will need to agree to the arrangements as well. Where day to day and routine parenting decisions are not delegated to the carers, reasons for this must be set out in the child's placement plan within their care plan.

Decisions about the care of a looked after child fall into three broad areas:

### 1) Day-to-day parenting

Routine matters will usually include decisions about health/hygiene, education, leisure activities and such things like school trips, having friends over and sleepovers. These will be delegated to the child's carer and the child if they can take any of these decisions themselves. Reasons not to delegate to the carer may include the child's welfare, if the child's individual needs, past experiences or behaviour 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, where overnight stays may need to be limited, the foster carer or children's home may need the social worker to manage this and agree jointly what is in the best interest of the child.

Similarly the use of digital technology, (mobile phones, computers and lap tops etc.) although part of daily life, may require the agreement for use to be drawn up into a more formal agreement, depending on the age of the child. Consideration should be given to using the “digital use” agreement.

### 2) Routine but longer term decisions

These decisions will usually be made between the social worker, carer and parent where they have active involvement with their child. . 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, or care in a residential unit until age 18, where possible the school choice should fit with the foster carer’s family life as well as be appropriate for the child.

### 3) Significant events

These decisions are likely to be more serious and far reaching. Where the child is voluntarily accommodated the child’s birth parents or others with PR should make these decisions. Where the child is on a care order, all those with PR should make the decisions, unless this is not possible, e.g. where a parent is not contactable or capable of making the decision. However decisions must always take account of the wishes and feelings of the child and their carer. An example of a significant event may be the need for surgery or to attend a significant family event which may have possible implications or repercussions for the child.

## Delegation in the context of 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 carer or residential worker is deemed a parent for the purposes of education law. This means that a foster carer should be treated like a parent with respect to information provided by a school about the child’s progress; should be invited to and attend meetings about the child; and should be able to give consent to decisions regarding school activities. Similarly Residential workers/Key workers will also be involved in educational matters. Foster carers and residential workers must share the information with the child’s social worker as well as the child’s parents, unless it would be unsafe to do so. Parental involvement in a child’s education must be considered in the placement plan and subsequently reviewed, as some parents may wish to be actively involved in their child’s education. This is particularly important in short term placements or when children are to be returned home.

## Delegation in the context of the child's health:

The legal position concerning consent and refusal of health treatment for those under 18 years old is set out in chapter 3 of the Department of Health's *Reference guide to consent for examination or treatment (second addition 2009).* Below are extracts from this document which gives a sense of the decision making authority for children and young people:

It is a general legal and ethical principle that valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. This principle reflects the right of patients to determine what happens to their own bodies, and is a fundamental part of good practice.

People aged 16 or 17 are presumed to be capable of consenting to their own medical treatment, and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily by an appropriately informed young person capable of consenting to the particular intervention. However, unlike adults, the refusal of a competent person aged 16–17 may in certain circumstances be overridden by either a person with parental responsibility or a court.

If the 16/17-year-old is capable of giving valid consent, then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process, (unless the young person specifically wishes to exclude them) if the young person consents to their information being shared. "Family" are those people with PR so this will include the Local Authority and the child's parents, but not the foster carer.

For Children under the age of 16, in the case of *Gillick*, the court held that children who have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention will also have the capacity to consent to that intervention.

This is sometimes described as being 'Gillick competent'. A child under 16 may be Gillick competent to consent to medical treatment, research, donation or any other activity that requires their consent. The understanding required for different interventions will vary considerably. Thus a child under 16 may have the capacity to consent to some interventions but not to others. The child's capacity to consent will be assessed carefully in relation to each decision that needs to be made and good practice would be, as in any family, following discussion with the foster carer, residential worker or social worker for the child.

Where a young person of 16 or 17 who could consent to treatment in accordance with section 8 of the Family Law Reform Act 1969, or a child under 16 but Gillick competent, refuses treatment, it is possible that such a refusal could be overruled if it would in all probability lead to the death of the child/young person or to severe permanent injury.

Parents can consent to their competent child being treated even where the child/young person is refusing treatment. However, there is no post-Human Rights Act 1998 authority for this proposition, and it would therefore be prudent to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the child.

## The placement plan:

Ensuring each child has a placement plan is a requirement of the *Care Planning, Placement and Case Review (England) Regulations 2010* and require that each looked after 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:

a. medical or dental treatment;
b. education;
c. leisure and home life;
d. faith and religious observance;
e. use of social media; and
f. any other areas of decision-making considered relevant with respect to the particular child.

Placement plans must be agreed with the child's carer, and should be drawn up in a placement planning meeting which involves everyone concerned, including the carers, the social worker, the supervising social worker, the child and the parent. The Delegated Decision Tool must be completed, alongside the placement plan.

## Timeliness:

Where a particular decision is not delegated to a child's carer and rests with the local authority, there must be 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.

This will normally be either the social worker, the social worker's Practice Manager or Service Manager and in some cases the Head of Early Intervention and Safeguarding. Written details of all the arrangements must be given to parents, carers and children (subject to their age and understanding).