**CONSENT TO MEDICAL TREATMENT IN CHILDREN IN ENGLAND**

**CONSENT**

* At the age of 16 a young person can be presumed in law to have capacity to consent
* If they do not have capacity, consent will need to be obtained from someone with parental responsibility, unless it is an emergency

**WHO HAS PARENTAL RESPONSIBILITY?**

|  |  |
| --- | --- |
| Mother | YES - AUTOMATIC |
| Father married to mother at time of birth | YES – AUTOMATIC (this right is retained after divorce - This is true even if the parent without custody does not have contact with the child and does not make any financial contribution) |
| Unmarried Father | YES IFa) named on birth certificate AND child registered on/after 1 Dec 2003 OR b) has a Parental Responsibility Agreement with mother ORc) has a Parental Responsibility Order from court |
| Adoptive Parents | YES  |
| Other carers (e.g. Foster Parents, Grandparents) | ONLY if they have a Special Guardianship Order |
| Senior Social Worker for Children’s Services | A local authority acquires parental responsibility (shared with anyone else with Parental Responsibility) while the child is subject to a care or supervision order. (It is advised to clarify each case individually, parental responsibility may still lie with birth parents) |

**CONSENT FROM PARENTS (OR THOSE WITH PARENTAL RESPONSIBILITY)**

* Parents can consent to medical treatment on behalf of their children until 18 years of age (e.g. if a 16 or 17 year old lacks capacity)
* Consent from one parent is usually sufficient
* However, it is good practice to involve all those close to the child if possible. If parents cannot agree and disputes cannot be resolved informally, seek legal advice about whether you should apply to the court.

**CONSENT FROM CHILDREN**

* Young people under 16 years can be legally competent if they have sufficient understanding and maturity to enable them to understand fully what is proposed. This is known as Fraser (Gillick) competence.
* Parents cannot override the competent consent of young people to treatment deemed in their best interests.

**REFUSAL OF TREATMENT**

* If there is disagreement between the parents, the courts may limit the power of one parent to refuse treatment that is in the best interests of the child.
* If both parents refuse, an application may be made to the court to overrule the parents
* Where a Fraser competent child refuses treatment, healthcare professionals can, in principle, rely upon the consent of a person with parental responsibility, but they should always consider whether it is necessary to obtain the authority of the court. Discuss with the Trust’s legal team.

**IN AN EMERGENCY**

* Parental consent should be obtained if possible.
* Where treatment is vital and waiting to obtain consent would place the child at risk, treatment can proceed without consent in the child’s best interests .Discuss with the Trust’s legal team afterwards.

**DEVOLVING PARENTAL RESPONSIBILITY**

* Parents are not with their children 24 hours a day and there are times when parents might devolve the responsibility to consent to treatment to others - eg, grandparents or childminders - for certain interventions such as emergency care and treatment of minor illnesses.
* Such consent does not need to be in writing and the healthcare professional does not need to consult the parents, unless there is cause to believe parents' views would differ significantly.
* Where there is no specific agreement between parents and a third party in any given situation, the third party can give consent, providing it can be justified as being in the best interests of the child. An example of this would be a teacher accompanying a child to the A&E Department for urgent treatment required after an accident at school.

**FURTHER READING**

<http://www.aagbi.org/sites/default/files/AAGBI_Consent_for_anaesthesia_2017_0.pdf>

https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years