CLINICAL PROTOCOL FOR CLARIFICATION OF PARENTAL RESPONSIBILITY

RATIONALE

The Care Quality Commission (CQC 2010) state there must be standards in place to ensure the correct identification of who has parental responsibility in circumstances where a child is unable to give consent.

TARGET GROUP

The protocol applies to all staff employed by the Trust who have contact with children as part of their role as stated within their job description.

TRAINING

All clinical staff within the Trust are required to complete the Essential Learning Programme every two years which includes sessions on parental responsibility and consent.

RELATED POLICIES

Please refer to relevant Trust policies and procedures, particularly the Trust’s Consent Policy.

CLARIFICATION OF PARENTAL RESPONSIBILITY

Health professionals need to confirm that the adult presenting with a child for treatment has parental responsibility; this should not be assumed (CQC 2010). If the adult is not the child’s legal guardian, the health professional needs to seek confirmation from the legal guardian if the treatment / consultation can proceed.

In services that send out formal appointments, there needs to be a statement that children will need to be accompanied by an adult who has parental responsibility. This reduces unnecessary re-booking of appointments.
LEGAL FRAMEWORK FOR PARENTAL RESPONSIBILITY

Parental responsibility (PR) in family law is a legal status derived from the Children Act (1989). Having parental responsibility means assuming all the rights, duties, powers, responsibilities and authority that a parent of a child has by law.

While the law does not define in detail what parental responsibility is, the following list sets out the key roles:

- providing a home for the child
- having contact with and living with the child
- protecting and maintaining the child
- disciplining the child
- choosing and providing for the child’s education
- determining the religion of the child
- agreeing to the child's medical treatment
- naming the child and agreeing to any change of the child's name
- accompanying the child outside the UK and agreeing to the child’s emigration should the issue arise
- being responsible for the child's property
- appointing a guardian for the child, if necessary
- allowing confidential information about the child to be disclosed

Consent for treatment, examination and immunisation can only be given by a person who has parental responsibility. The Children Act (1989) sets out who has parental responsibility and these include:

- Mother
- Both parents if married at the time of the child’s conception, birth or at some time after the child’s birth
- If the parents have never been married (prior to December 2003) only the mother has PR but the father may acquire PR by order of a court
- Since December 2003, the father acquires parental responsibility if he jointly registers his child’s birth with the mother (even if not married)
- Legally appointed guardian
- Local authority (care order)

Parental responsibility includes the right to consent to medical treatment on behalf of the child and the disclosure of information held by healthcare professionals about the child. Those with parental responsibility also have a statutory right to apply for access to their children’s health records, unless the child is capable of consenting. These rights exist in order to allow those with parental responsibility to exercise their duty of care towards their child. This is a dynamic process, and as the child becomes competent to make more decisions for themselves, the extent of the parents' rights to act on their behalf diminishes.
When a person is exercising parental responsibility and giving consent for a child’s treatment, it is important that they have the necessary information both about the proposed procedure and the child, in order to take a proper view as to the child’s best interests. This may be relevant if consent is being given by a person with parental responsibility that does not normally have day-to-day contact with the child. Even when children are not able to give valid consent for themselves, Trust staff need to involve them as much as possible in decisions about their own health and care.

The Children Act (1989) allows a person who does not have parental responsibility for a child but who has care of a child to do what is reasonable for the purpose of safeguarding or promoting the child’s welfare. This may apply to childminders and teachers, where explicit authority to consent on behalf of a child has not been given by the person with parental responsibility. However, it would be rare for those with care of a child to consent to treatment on the child’s behalf if a parent could be contacted instead.

Foster parents, step-parents and grandparents
Trust staff need to recognise that foster parents, step-parents and grandparents do not automatically have parental responsibility for a child they are presenting for assessment, examination or treatment.

Emergency Situations
If an emergency situation becomes apparent, treatment relevant to the best interests of the child can be given if no-one with parental responsibility can be contacted. All attempts to contact the parents/legally appointed guardian must be documented in the health care record. A Trust incident form would need to be completed and the relevant Line Manager made aware of the situation. If appropriate the Trust Safeguarding Team may also need to be contacted.

Safeguarding
When there is doubt about whether a parent is acting in the best interests of the child or young person, it is unwise for the healthcare professional to rely on the parent’s consent. Trust staff must liaise with their relevant Line Manager and contact the Safeguarding Team for further guidance and advice.

Disagreement between those with parental responsibility
Consent given by one person with parental responsibility is valid even if another person with parental responsibility withholds consent; however consensus between those with parental responsibility should be achieved if at all possible. Where persons with parental responsibility disagree as to whether certain procedures are in the child’s best interests, it is advisable to seek further advice from the relevant service manager as this may need to be referred to the Trust solicitors.

Competency to give parental consent
In order to consent on behalf of a child, the parent with parental responsibility must themselves have capacity (DH 2001a). Where the person with parental responsibility for a child is themselves under 18, they will only be able to give valid consent for the child’s treatment if they are classed as competent under Fraser guidelines. Whether or not they have capacity may vary, depending on the seriousness of the decision to be taken (DH 2001a).
FRASER GUIDELINES

Fraser guidelines are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions. Fraser guidelines are a set of criteria which must apply when healthcare staff are offering contraceptive services to children under the age of 16 without parental knowledge or permission. Although the criteria specifically refer to contraception, the principles are deemed to apply to other treatments (DH 2001b). If a child is not competent to give consent for themselves, Trust staff should seek consent from a person with parental responsibility. This will often, but not always, be the child’s parent. Legally, consent is only required from one person with parental responsibility. However, it is good practice to involve all those close to the child in the decision-making process.

INTIMATE EXAMINATIONS

It is imperative professional boundaries are maintained when intimate examinations are being conducted, as examinations with clothing removed, or of the breasts, genitalia and rectum can be perceived as extremely intrusive. Children who are under the legal age of consent and their parents and/or guardians must receive an appropriate explanation of the procedure to be undertaken in order to obtain their cooperation and consent. Alternatively, if a young person is capable of giving valid consent as in line with Fraser Guidelines, it is not legally necessary to obtain consent from a person with parental responsibility 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 (DH 2001b), this discussion would be fully recorded in the health records. Staff must also refer to the Trust’s Clinical Protocol for Chaperoning.

WERE TO GET ADVICE FROM

Trust staff need to contact their Line Manager if further guidance and clarification is required. Liaise with the Trust Safeguarding Team if further advice is needed.

INCIDENT REPORTING

Clinical incidents or near misses must be reported using the Trust’s incident reporting system.

SAFEGUARDING

In any situation where staff may consider the patient to be vulnerable, they need to follow Safeguarding Policies and discuss with their line manager and document outcomes.

EQUALITY ASSESSMENT

During the development of this protocol the Trust has considered the clinical needs of
each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation). There is no evidence of exclusion of these named groups.

If staff become aware of any clinical exclusions that impact on the delivery of care a Trust Incident form would need to be completed and an appropriate action plan put in place.

REFERENCES


Department of Health (2001b) Reference guide to consent for examination or treatment.

Trust Consent Policy

Trust Clinical Protocol for Chaperoning
# Clinical Protocol for Clarification of Parental Responsibility

**Title**  
Clinical Protocol for Clarification of Parental Responsibility

**Purpose**  
The aim of this protocol is to support healthcare professionals in the process of ascertaining parental responsibility.

**Author**  
Quality and Governance Service (QGS)

**Equality Assessment**  
Integrated into procedure | Yes | No

**Subject Experts**  
Caroline Hewitt / Safeguarding Team

**Document Librarian**  
QGS

**Groups consulted with :-**  
Clinical Policies and Procedures Group

**Infection Control Approved**  
N/A

**Date formally approved by Risk and Governance Group**  
April 2012.

**Method of distribution**  
Email √  |  Intranet √

**Archived**  
Date 3rd April 2012  |  Location:- S Drive QGS

**Access**  
Via QGS

---

**VERSION CONTROL RECORD**

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Author</th>
<th>Status</th>
<th>Changes / Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 1</td>
<td>Quality and Governance Service</td>
<td>N</td>
<td>First version to comply with CQC standards</td>
</tr>
</tbody>
</table>

---

**CLINICAL PROTOCOL FOR CLARIFICATION OF PARENTAL RESPONSIBILITY**

6/6