



[2022] EWCOP 17

IN THE COURT OF PROTECTION

IN THE MATTER OF THE MENTAL CAPACITY ACT 2005

AND IN THE MATTER OF HM

Case number: 13888531

BETWEEN:-

NHS LIVERPOOL CCG

Applicant

-and-

X (1)

(By her Accredited Legal Representative Jola Edwards)

and

Y (2)

Respondents

Before His Honour Judge Peter Gregory

Mr Adam Fullwood (instructed by Rachel Kelly-Brandreth, Hill Dickinson solicitors) for the Applicant

Mr Tom Hughes (instructed by Peter Edwards Law solicitors) for the First Respondent

Mr Francis Hoar (instructed by Broad Yorkshire Law) for the Second Respondent

Hearing date: 17 March 2022

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Judgment

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1. This application comes before the court at the behest of the NHS Liverpool Clinical Commissioning Group who seek a declaration that it is in the best interests of the first respondent , (hereafter referred to as X), to be provided with a vaccination to protect her against the potential consequences of being infected with the COVID-19 virus.
2. X is a 50 year old woman with a diagnosis of severe epilepsy and mild learning difficulties. She resides in a bungalow along with two other tenants in a supported living placement at West Derby in Liverpool, receiving 24 hour care and support and, in her specific case, 1:1 support in accessing the community.
3. Those responsible for X's medical care: Dr Z, her General Practitioner, and Professor M, Consultant Neurologist, are each of the professional opinion that to receive a vaccination against COVID-19 would be in X's best interests. Existing government guidance identifies X as 'clinically vulnerable' as a result of her diagnosis.
4. It is put forward on behalf of the applicant CCG that X does not have any known allergies or other contradictions to vaccination and so the established physical risks to her from receiving a vaccination are relatively minor - potentially tenderness to the injected site, a raised temperature and a headache lasting for up to a few days immediately following the vaccination. These side effects it is submitted should be considered to be relatively innocuous and outweighed by an appreciable margin by the advantage to X of receiving significant protection against the risk of serious illness or death from infection by the virus.
5. It is proposed that, in the event that the Court does approve the application, X be offered the opportunity to receive the vaccine and that it will be administered in accordance with an 8 point care plan drawn up which, in the words of Mr. Hughes who appears on behalf of the ALR has X 'at the front and centre'. It is clear from the care plan that ultimately it will be X's

choice whether or not to accept the vaccine and that she will not be physically or in any other way restrained in order to secure its administration. Neither will she be offered any treat or inducement to accept the vaccine. The applicant and the first respondent are both in agreement that X should be offered the vaccine in accordance with the plan subject to minor modification.

6. However, X's sisters and two brothers all dispute that it would be in her best interests to receive the vaccine. Their views are forcefully and most effectively communicated through the second respondent, Y, who has put before the court two detailed and closely argued witness statements, supported by the fruits of extensive research. It is clear from paragraphs 6 – 12 in particular of her first statement [E12-14] that Y has been closely and continuously involved in X's welfare, care and upbringing from a very early stage. She regards herself as a 'mother figure' in relation to her younger sister, has been aware of X's special needs from an early age, and has been actively involved in ensuring that she has received appropriate healthcare - including medicinal cannabis to assist in controlling her epileptic seizures.
7. Having heard her give evidence, it is clear that Y is implacably opposed to her younger sister receiving the vaccination: citing the unknown risks, in her perception, attendant upon vaccination by any one of a number of covid vaccines, each of which has been developed, approved, licensed and introduced on a dramatically accelerated and truncated basis and in circumstances where it has not been possible to evaluate the potential for any adverse medium or long term side effects.
8. A significant feature in Y's view is that X has in fact tested positive for antibodies to the virus [E42], and therefore can be considered to have a measure of natural immunity to it. It is clear from the evidence that I have considered, that neither Dr Z or Professor M was aware of this position at the time when, in the case of Dr Z, she prepared her witness statement [E1-10], and Professor M wrote his response to Dr Z's query concerning the potential for deleterious interaction between a Pfizer or Astra Zeneca vaccine and X's existing medication [E35-36].

9. In the course of preparing this Judgment I have taken into account the respective position statements and the enormously helpful closing submissions of all three counsel. I have revisited the documents in the hearing bundle to which I was referred during the course of the proceedings, and to the bundle of authorities which were lodged with the court on 22 March 2022, and which includes copies of all reported decisions to which counsel referred me during the course of the hearing. I took a full note of the oral evidence which I heard, and I have re-read this in its entirety to assist in preparing the Judgment. My review of the evidence as set out below is not intended to be an exhaustive or verbatim account of all matters canvassed with each of the witnesses - but those parts of the evidence which I consider to be relevant to the issue which I must determine: namely whether it is in HM's best interests to be offered the vaccine.

10. **The Legal Framework**

Happily there is no dispute between the parties as to the relevant legal framework. X's capacity to decide whether or not to receive the vaccine is not in dispute: all parties accept that she does not enjoy capacity in this respect. The court is assisted by the capacity assessment carried out by Dr Z on 24 May 2021 and referred to at paragraph 9 of her statement [E2]. This assessment appears comfortably to meet the requirements of the relatively informal test for capacity referred to by the Vice President, Hayden J, in **Re E [2021] EWCOP 7**, (another case involving the COVID-19 vaccine), where he stated that " ... evaluating capacity on this single and entirely fact specific issue is unlikely to be a complex or overly sophisticated process when undertaken, for example, by experienced GPs and with the assistance of family members or care staff who know P well."

In the circumstances I am satisfied, on the balance of probabilities, that the presumption of capacity in relation to the COVID-19 vaccination is, in this case, rebutted.

11. What remains in dispute however, and falls to be determined by the court in this case, is whether it is in X's best interests to be offered the vaccine. That specific issue has to be evaluated by reference to the provisions of s.4 of the Mental Capacity Act 2005 and involves a consideration of all the relevant circumstances. It should emphatically not be confined to a simple evaluation of the best medical interests of the patient. The proper approach is that identified by Baroness Hale in **Aintree University Hospitals NHS Trust v James [2013] UKSC 67** (an authority to which all 3 counsel make reference in their respective position statements), where she said:

“in considering the best interests of this particular patient at this particular time, decision makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask themselves what his attitude to the treatment is or would be likely to be; and they must consult others you are looking after him or interested in his welfare, in particular for their view of what his attitude would be...”.

12. The specific factors under s. 4 that appear to me to be relevant to the circumstances of this case are those matters listed at s. 4 (6) (a) - the patient's past and present wishes and feelings; 4 (6) (b) the beliefs and values that would be likely to influence the patient's decision if they did enjoy capacity; 4 (6) (c) any other factors that the patient would be likely to consider were they able to do so.

I must also take into account where practicable and appropriate, the views of anyone identified by the patient someone to be consulted on the matter in question or matters of that

kind (s.4 (7) (a)) , and anyone engaged in caring for the patient or interested in their welfare (s. 4 (7) (b)).

The court must also, as far as reasonably practicable, permit and encourage the patient to participate as fully as possible and any decision affecting them (s.4 (4)).

- 13.** An important illustration of the role of the Court of Protection in the balancing and evaluation of relevant considerations as identified at Section 4 of the 2005 Act is to be found in **SD v Royal Borough of Kensington and Chelsea[2021] EWCOP 14**, (another vaccination case), and the Judgment of Hayden J where he states (at paragraph 26):-

“... in circumstances where an individual is not capacitous and cannot take medical decisions for themselves, the court is required, in the absence of agreement to identify best interests for itself, surveying the entire canvas of the available evidence. Strongly held views by well-meaning and concerned family members should be taken into account but never permitted to prevail or allowed to create avoidable delay. To do so would be to expose the vulnerable to the levels of risk I have identified, in the face a foot remains an insidious and highly dangerous pandemic virus...

... it is not the function of the Court of Protection to arbitrate medical controversy or to provide a forum for ventilating speculative theories. my task is to evaluate P’s situation in the light of the authorised, peer reviewed research and public health guidelines, and to set those in the context of the wider picture of P’s best interests... (paragraph 31)

... in cases such as this, there is a strong draw towards vaccination as likely to be in the best interests of a protected party. however this will not always be the case, nor

even presumptively so. What is important to emphasise here, as in so many areas of the work of the Court of Protection, is that respect for and promotion of P's autonomy and an objective evaluation of P's best interests will most actively inform the ultimate decision. It is P's voice that requires to be heard and which should never be conflated or confused with the voices of others, including family members however unimpeachable their motivations or however eloquently their own objections are advanced." (paragraph 33).

14. Dr Z

Dr Z is X's General practitioner with whom she has had about 7 personal consultations over a period of about 6 years. She is well aware of X's history of epilepsy and seizures and readily acknowledged the support that her family had given X over the years, including access to medicinal cannabis.

She made it clear from the outset of her evidence - and at various junctures during the course of it - that she laid no claim to be an expert witness in the sense of epidemiologist or immunologist. She deferred to Professor M in relation to whether X should be offered the vaccine given her ongoing treatment with medication to treat her epilepsy.

15. The substance of her witness statement is helpfully summarised at paragraph 12 (a) – (r) [A12-14] of the first respondent's position statement. It is clear that she has throughout the pandemic relied upon and followed government recommendations and advice in respect of the vaccine and its roll out, which itself is based on the advice of the JCVI.

16. Taken to specific concerns voiced in the first statement of Y at paragraphs 49 to 50, [E24-5], she was unsure of any contra indications represented by cetirizine prescribed for X in 2020. Any fear that X would be unable to verbalise symptoms of any injection side effects did not cause her to revise her opinion that X should be offered the vaccine. She stated that, as far as

she was aware, there was no alternative treatment currently available to X in the form of antivirals or the like - she didn't consider that X would be eligible. She did not regard X's epilepsy as a specific risk factor in this case observing that covid was fundamentally a respiratory condition rather than neurological. Referred to paragraph 15 of her statement [E3] she was unable to help with the evidential basis behind the contraindications listed at (a) to (f). She presumed that the JCVI had the evidence and reviewed it.

She did agree with the general proposition put to her by Mr Hoar that there may be other contraindications and side effects which might arise that we don't currently know about.

17. With regard to the question of natural immunity, she again acknowledged a lack of specific expertise in this area. She had heard of 'cytokine storm' as being a potential reaction to infection with the virus. She was unable to say whether natural immunity would prove better protection than a vaccine - pointing out that there was a huge variation amongst individuals and the extent of any protection was unknown. Also, natural immunity waned with time - as does a vaccine. She did however acknowledge that, in general terms the presence of antibodies would afford some protection against severe disease and that a patient would be more able to fight that infection if infected again. She understood and respected the position of H's family and why they were fortified by the information that X had been infected and had antibodies; she accepted the sincerity of their belief that they had X's best interests at heart, but repeated that she did not know for how long the antibodies would protect X for.

18. She agreed, in response to a question from Mr Hoar, that there had been a drop off in severity in terms of cases and outcomes explaining that that was due, at least in part, to the extensive vaccination programme and observed that generally those people who fell seriously ill and died from the virus were those who had not been vaccinated - although she was careful to qualify that by saying that she was 'not an expert on the figures.'

19. Dr Z repeated that she received guidance and felt that she had to accept to a certain extent the information with which she was provided: the current guidance was that the vaccine should still be given to patients even if they've previously had covid - observing that if natural immunity was as good as vaccination 'they'd probably tell us to stop vaccinating people.'
- the current recommendation was - even if you have previously had the virus that it was best to 'boost' protection with the vaccine.
20. She accepted that given the circumstances of X's living arrangements X was generally not mixing with people who have it, but stated that the loosening of restrictions within the community meant that covid was easier to get than previously. She identified a real risk that X would get it again emphasising that the guidelines with which she had been issued promoted 'topping up' to minimise the risk. She also observed the dramatic increase in numbers of infections over the last week. The vaccine boosts and gives an extra level of protection - is to say a benefit additive to whatever protection may be provided by antibodies.
21. With regard to the practicalities of providing H with the opportunity to have the vaccine: she would only receive it if she indicated a wish to. Nothing would be done to override X's wishes and feelings. The published care plan supported her autonomy.

22. **Y**

The second respondent gave evidence, the terms of some of which I found a little confusing and perplexing, having been informed at the outset of the hearing that the second respondent would co-operate in the event that the court authorised the proposed plan to offer X the opportunity to be vaccinated. She didn't accept that the proposed care plan was 'person centred' around her sister, stating that she would oppose the implementation of the plan, feeling, as a sister, that she should. She would follow her own beliefs and values regardless of the outcome of the hearing. She confirmed her position as set out at paragraph 59 of her first statement [E27] then, somewhat confusingly, she stated that she would 'stay silent.'

23. When it was put to her that the Care Plan expressly provided that the vaccine wouldn't be administered to H if she refused it, and that the plan put H's autonomy 'front and centre,' she said that 'if X wants it I'll support it' - before going on to observe that X wasn't able to make that decision.
24. She stated that she believed that if X did have capacity she would decide not to have the vaccine and defer to our (the sisters') views. 'I would oppose it even if X wants it.' She then repeated that she considered it inappropriate for X to be consulted given her lack of capacity.
25. She pointed to X's reluctance to contemplate accepting the vaccine or even discuss it when the issue was broached by Abby Watson a trainee solicitor with Peter Edwards Law (instructed on behalf of X by her ALR) on 4 March 2022 when she attended upon X in an effort to ascertain her wishes and feelings [E367]: ' ... I do not like the needles... I won't like it... I won't like it... I don't like it no.'
26. For the sake of completeness in relation to the evidence, I should say that I have also read the statement of Leanne Harrison, [E8-10], the manager of the facility which provides care and support for X in her supported living setting.

I have also considered the contribution from Professor M in response to Dr Z's inquiry concerning the potential for adverse interaction between the proposed vaccine and X's epilepsy medication, [E35-6]. His response is pithy and to the point: 'thanks for your note about X. I would strongly encourage that X is vaccinated against COVID-19.'

27. **Closing submissions**

In his closing submissions Mr Fullwood reminded me that my obligation in arriving at a best interests decision on X's behalf was not confined to a consideration of medical matters. He took me to the Judgment of the vice president in **SD v London Borough of Kensington and Chelsea** at paragraph 33 with its emphasis on the promotion and respect for X's autonomy,

warning of the risk of X's voice being drowned by others - however unimpeachable their motivations or however eloquently their own objections were advanced.

28. He, and Mr Hughes on behalf of the ALR, also directed my attention to the recent decision of HHJ Burrows in the Manchester case of **CCG v DC, MC and AC [2022] EWCOP 2** – a decision which, I am bound to say that I have found to be helpful in formulating my Judgment in this case. I am particularly assisted by the observations at paragraphs 33, 34 and 35 of his Judgment with its references to the approach favoured by the Court of Appeal: **Re H (a child) (Parental Responsibility: Vaccination) [2020] EWCA Civ. 664** and the Family Division of the High Court: **M v H and PT [EWFC] 93** , in relation to the guidance afforded by Public Health England and the Green Book in cases involving the vaccination of children. I also note his view that parallel considerations should apply to adults in respect of best interests decisions under the Mental Capacity Act.

I also consider that HHJ Burrows's observations on the evidence and approach taken by the General Practitioner in that case, referred to at paragraphs 39, 40, 42 and 52, closely mirrored that of Dr Z in the instant case.

29. Mr Hoar spoke to and developed the matters set out in his position statement and written submissions in which at paragraphs 7 – 9 [A27-28] the position of the second respondent is set out clearly and succinctly, with specific factors identified at paragraph 8 sub paragraphs (1) to (6) [A28].

He emphasised the nature of the substituted judgement that must be made on behalf of X at paragraph 19 [A31] and urged me to find that, in the event that X had enjoyed capacity to make the decision for herself, she is likely to have been influenced by her family.

He submitted that the only evidence that the CCG could rely on was that of Dr Z – who could not be treated as an expert witness - but acknowledged that she was prepared to give 'pause

for thought' when she learned X's anti-body result. He pressed on me the document accepted by Public Health England at page E229 at lines 156-166 which he submitted supported the proposition that there was no difference in the protection enjoyed by those who had received two vaccine doses and those not vaccinated but antibody-positive. He pointed out that there was no source identified by Dr Z in support of her 'added benefit' evidence in respect of the protection afforded by vaccination in addition to antibodies.

30. Mr Hoar also took me through certain bodies of evidence in the public domain and referred to at paragraph 53 of MH's second statement [E107-108], the substance of which was summarised at sub paragraphs (1) – (6) inclusive - with all of the source material being exhibited to the statement. The burden of these studies, all of which were published between spring and late summer 2021 are suggestive of an apparently superior level of protection afforded against re-infection to at least some variants enjoyed by persons with natural immunity over those vaccinated.

31. Mr Hoar also submitted that this virus was following the path of historic epidemics, currently very transmissible but less severe than in its earlier stages. He observed that the medium and long term effects of the vaccine can't be known – referencing swine flu vaccine and thalidomide, and suggested that the medical evidence in this case was at best 'finely balanced.'

32. In the round, he submitted, it was not in the best interests of X, who had very limited understanding or ability to communicate her wishes and feelings, to be offered the vaccine.

33. Mr Hughes, on behalf of the ALR, was supportive of the CCG and Mr Fullwood's position and submissions. He reminded me of X's status as a clinically vulnerable individual and the existing advice from PHE remained that H should be offered the vaccine. The materials of a medical and scientific nature referred to, and exhibited to, Y's statement at [E107-108] he

observed had been in the public domain and available to PHE since mid-2021, but had not caused PHE to shift its position on the advisability of receiving the vaccine.

34. He reminded me that, of course, the court's evaluation of X's best interests is not confined to consideration of medical matters. There is no available evidence of her wishes and feelings on matters of this nature before her incapacity. Her indication that she wished to accept the vaccine, when asked during the relatively informal capacity assessment carried out by Dr Z in May 2021, may well have proceeded on the erroneous basis that, if not vaccinated, she may have been precluded from going on outings in the community.

35. He submitted that it is difficult to ascertain X's beliefs and values that would be likely to influence her decision if she did enjoy capacity, but it is far from certain that the close relationship that she undoubtedly enjoys with Y would necessarily mean that she would slavishly follow her sister's views in relation to the vaccine. If she had capacity she would appreciate that she was in a clinically vulnerable group and at greater risk from the virus than those not so vulnerable.

Mr. Hughes also warned against the real risk of the voice of Y overshadowing that of X herself. The best way forward he submitted was to offer X vaccination in accordance with the prepared care plan which he repeated didn't seek to override X's autonomy and wishes, which, if the plan is adhered to, would yield to X's wishes and feelings at the relevant point in time.

36. **Discussion and findings**

I am clear that, on balance, it is in X's best interests to be offered the vaccine in accordance with the 8 point care plan, appropriately modified to remove any suggestion and that she may be offered a 'treat' in consideration for accepting the vaccination.

I appreciate that Y and the other members of the family whose views she helps to articulate will be disappointed at my decision. I accept without reservation that they are genuinely and

sincerely motivated by the best of considerations and a true feeling of concern for their sister's safety.

37. As I have already observed at paragraphs 11 and 12 above, I must approach the task of evaluating X's best interests on the basis identified by Baroness Hale in the Aintree hospitals case. In considering all the relevant circumstances I should strive, where possible, to put myself in the same place as X and, specifically, to take into account the factors identified at s. 4 (4), (6) and (7).
38. With regard to the medical position (which is but one of the factors that I should take into consideration): the appropriate starting point, in my view, is clearly set out in the Judgment of Hayden J. in the case of SD, some relevant extracts from which are set out under paragraph 13 above. I also accept the observations of HHJ Burrows in the DC case from which identifies the approach of the Court of Appeal in two vaccination cases involving children. I also see no reason why these same considerations should not govern the approach to this issue in respect of adult patients under the jurisdiction of the Court of Protection.
39. I accept the evidence of Dr Z, supported as it is by Professor M in respect of the likelihood of any adverse interaction between the COVID vaccine with the medication that X currently takes for her epilepsy. I found the evidence of Dr Z in general terms to be measured and helpful: she did not at any stage pretend to a level of expertise beyond that of her chosen discipline of General Practitioner. I accept her evidence that the clear policy of the Department of Health, informed by Public Health England, is that it remains the position and advice that getting vaccinated is the most effective method available to extend protection to the community against the potential for serious illness, hospitalisation and death. I also accept her evidence that X is not affected by any of the listed contraindications to receiving a vaccine.

40. There is no doubt that the pandemic has generated a significant volume of often controversial work and research in the scientific and epidemiological communities - the impressive body of material exhibited to Y's statement is evidence enough of this. but I am mindful of the observations of Hayden J in the SD case - this court's function is not to arbitrate medical controversy, or provide a forum for ventilating speculative theories, but rather to evaluate X's situation in the light of public health guidelines and peer reviewed research.

The fact that the public health guidelines have not changed notwithstanding publication during 2021 of the various items of research literature refer to at paragraph 53 of Y's witness statement and by Mr Hoar in his submissions to the court, is not without significance.

41. And whilst it may be observed, as Mr Hoar suggests, that the pandemic may be following a 'classic' course - apparently very transmissible but less severe than in its earlier stages, it is clear from the current steadily rising tide of infections accompanied by uplifts in hospitalizations and deaths that the virus continues to represent a threat. As HHJ Burrows observed at paragraph 52 of the DC case: the virus is potentially lethal, and there is evidence that even if it does not cause death it can leave people very ill and with long term sequelae.

42. Learning to live with the virus does not mean that we should now ignore it or neglect to make use of the protection afforded by available vaccines that have been shown to have a significantly beneficial effect in terms of inhibiting the spread of the virus, reducing the numbers catching the virus, or, in the case of those who still get infected or reinfected, reducing the risk of developing serious illness, admission to hospital or death.

43. With regard to the wishes and feelings of X, these are on the available very limited evidence difficult to be definitive about. There is reason to believe that the positive response elicited by Dr Z when the issue was canvassed with X at the time of her capacity assessment in May 2021, was driven by a belief or expectation on the part of X that she would gain greater access to the community than if she elected not to accept it. Equally, the hostility that she

demonstrated towards the idea of accepting a vaccination when it was raised with her by a representative of her legal team on a visit on 4 March 2022 may have been due, at least in part, to the fact that the discussion was not framed in the structured fashion anticipated by the 8 point care plan.

44. I am satisfied that this care plan does indeed have, as Mr. Hughes puts it, X ‘at its front and centre.’ It represents a genuine attempt to determine X’s wishes and feelings and preserve for her whatever measure of autonomy may be possible in the circumstances.

45. Whilst Y is sure in her own mind that were she to enjoy capacity to make the decision herself, X would automatically adopt a position aligned to that of herself and other family members. I am unpersuaded that this is indeed the case. I take on board the submissions made by Mr. Hughes on behalf of the ALR that, were she to have capacity, X would appreciate that in accordance with current guidelines she would be appropriately designated to be in the ‘vulnerable’ category to whom the virus represented a greater level of risk. In those circumstances she may well choose to accept a vaccine notwithstanding the views of other family members.

46. In the circumstances, I accede to the application of the CCG and direct that X be offered a vaccination in accordance with the published care plan. I trust that counsel will be able to draw up an appropriate Order.

It only remains for me to thank counsel for their exceptionally helpful contributions both in writing and in their oral submissions.

HHJ Peter Gregory

The Court of Protection sitting at Liverpool

28 March 2022

