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Neutral Citation Number [2022] EWCOP 2

Case No: 13860597

IN THE COURT OF PROTECTION

Manchester Civil Justice Centre
1 Bridge Street West,
MANCHESTER
M60 9DJ

Date: 31/01/2022

Before :

HIS HONOUR JUDGE BURROWS

- -

Between :

A CLINICAL COMMISSIONING GROUP	**Applicant**
- and -	
DC	**First Respondent**
(by his litigation friend, the Official Solicitor)	
-and-	
MC	**Second Respondent**
-and-	
AC	**Third Respondent**

- -
- -

Philip De Berry (instructed by **Hill Dickinson**) for the **Applicant CCG**
Nicola Kohn (instructed by **Irwin Mitchell**) for the **First Respondent, by the Official Solicitor**
Francis Hoar (instructed by **Broad Yorkshire Law) for the Second & Third Respondents**
Hearing dates: 17 January 2022

- -

JUDGMENT

HIS HONOUR JUDGE BURROWS :

INTRODUCTION

1. This judgment follows a remote hearing on 17 January 2022 at Preston. It did not finish until after 5 p.m., and it was not possible for me to deliver judgment then. I took some time to consider the matter, and this is my decision. I will deliver this judgment in public and it is likely to be published. I have therefore anonymised the names of the family members concerned, the care home in which DC lives, the CCG and its employees. The purpose is to protect DC's identity and privacy, with the express agreement of his mother and father.

2. DC is a young man who lives in a residential care setting near in the North of England. He suffers from schizencephaly, microcephaly and cerebral palsy. He suffers from epilepsy, curvature of the spine, dystonia, and intermittent stridor, as well as pseudomonas of the lungs. He suffers regular respiratory illnesses and a number of admissions every year. He is unable to communicate verbally.

3. On the question of his capacity to make the decisions with which this Court is concerned, there is no dispute between the parties: DC lacks capacity to decide whether he ought to receive a vaccination against SARS-CoV-2, more commonly known as the COVID-19 vaccination, along with boosters.

4. In very simple terms, DC's parents, MC (his father) and AC (his mother) are opposed to him receiving the vaccine. The CCG has decided that he should be vaccinated, and they have made this application. At the first hearing, I invited the Official Solicitor to become DC's litigation friend, which she did. She has reached the conclusion that it is in DC's best interests to receive the vaccine.

5. One issue that I must address before moving on to the substance of this case is delay. There has been a very substantial lapse in time since DC's need for the vaccine was first identified by the CCG and this matter reaching court. Having briefly considered some of the other recent cases concerning the COVID-19 vaccine, this seems to be a common theme. I appreciate there has been an attempt by the CCG and DC's parents to discuss and consult over the vaccine. However, as long ago as February 2021 it was clear that there was a dispute over this issue. There was then a delay until July 2021 for a review of DC's unvaccinated status. It was not until September 2021 that a best interests meeting was convened. Then there was a further delay until December 2021 until these proceedings were issued.

6. It seems to me this is unacceptable. If, as the CCG contends, DC is a highly vulnerable person for whom infection with COVID-19 could be extremely serious, then they have a duty to act speedily to protect him. Once it becomes clear there is a dispute between clinicians and the family on an urgent matter over important treatment of a mentally incapacitous adult, an application to the Court of Protection should be brought- and determined- with urgency.

7. I have treated this case as a matter of urgency.

8. I heard evidence from Dr H on behalf of the CCG. I also heard from MC. AC made a short and impassioned statement to me during the hearing. I also was provided with quite a significant volume of other documents, which I will refer to below.

9. I was also greatly assisted by counsel, both in their written and oral submissions. They made what could have been a protracted and rancorous process much more straightforward and focused. I am grateful to them.

10. I will say at the outset that I have decided on fine balance that it is in DC's best interests to receive the vaccine and boosters, although there are some caveats as I outline below. I know that DC's parents will be distraught with my decision. I consider their objections to be grounded on a genuine concern for their son's welfare and not on an ideological objection to the vaccine. However, their objections are only part of the picture, albeit a very important part. As I shall explain below, I have evaluated DC's best interests taking a number of factors into account.

THE LAW

Choices

11. In this case it seems to me preferable to outline the legal approach I have to take first. The parties did not disagree to any great extent on this.

12. Under the Mental Capacity Act 2005 (MCA), if a person is incapable of making a decision for themselves due to "an impairment of or a disturbance in the functioning of [his] mind or brain", then that decision will have to be taken by someone else. In this case, the decision maker is the Court- the other potential decision-makers in this case, the CCG and DC's family have been unable to agree, so it has come to me. As the decision-maker, I have a statutory duty to make a decision in DC's best interests, in accordance with the criteria outlined in s. 4 MCA.

13. In this case, there are two options:

    (a) DC has the vaccine in accordance with the plan of the CCG; or

    (b) He has no vaccine.

14. That being said, the Court is able to probe the options put forward with a view to exploring whether there may be other options that may be available that will be better for the person concerned. In this case, for instance, Mr Hoar for the parents invited the Court to explore other avenues for DC's treatment.

15. First, that ivermectin ought to be used to treat him in place of the vaccine. This is, however, not an available option because there is no physician willing to prescribe this medication, which is not licensed in this Country for such use, in any event.

16. Secondly, I was invited to direct that further evidence ought to be sought from an expert to fine-tune the risk/benefit analysis upon which the CCG has based the proposed vaccination. However, the application was made late, and would have required a further adjournment of a number of weeks (at least). In any event, Mr Hoar was unable to identify a specific expert and was somewhat vague even on the discipline in which that witness should be an expert. He settled eventually for a paediatric respiratory specialist.

17. In view of the (a) lateness of the application, (b) the urgency of the application as well as (c) the uncertainty of the proposed expert or their field, I refused the application.

18. Thirdly, there was an application for evidence from a judicial review case in which Mr Hoar was concerned, to be adduced before me. There was a statement from Dr Clare Craig, on the lawfulness of decisions made by the Secretary of State for Health on the advice of the JCVI when authorising the use of the vaccine on children, particularly because of the post-vaccine incidents of myocarditis and other markers of concern in young males. There was also a statement from Marek Pawlewski on data on the risk of certain batches of vaccine appearing to cause a greatly elevated risk of death.

19. Again, the application was very late, and admitting it would have required an adjournment to enable the other parties to take detailed instructions and (perhaps) seek to adduce evidence of their own. I dismissed the application and indicated that I did not require either Mr De Berry for the CCG or Ms Kohn, for DC by the Official Solicitor to deal with these issues in their questioning or submissions.

20. I did say I would keep the application for an independent expert in my mind and return to it if I considered it to be necessary. I have concluded it is not.

21. The other potential "option" was for a test to be carried out on DC to establish whether he has already been infected with the virus and has developed natural immunity. This is an option I will deal with below.

Best interests

22. As I have already said, there is no controversy over the law here. I was provided with comprehensive and authoritative position statements/skeleton

arguments from counsel. I adopt their analysis, and will simply summarise it here.

23. The starting point is s. 4 MCA. I will not set the section out here. The most important factors are as follows.

24. I need to "consider all the relevant circumstances" (sub-s (2)). Such is level of DC's disability, there is no prospect of him gaining capacity (sub-s (3)). Equally, he cannot be permitted or encouraged to participate in the decision making (sub-s (4)). In relation to sub-s (6) there are no past and present wishes and feelings to consider, but I will have to take into account the "beliefs and values that would be likely to influence his decision if he had capacity", and "other factors that he would be likely to consider were he able to do so". In this case, DC's parents are people whose views he would be likely to consider, if not blithely adopt. Equally, I must consider his parents' views, as well as those responsible for his care and treatment when I make my decision (sub-s (7)).

25. When considering a person's best interests I must be guided by the Code of Practice and by Aintree v James [2014] AC 591. There is a strong element of substituted judgment in such cases. I must consider DC's welfare in the widest sense and not just in a narrow medical one (see Lady Hale at [39]).

26. It was submitted that I must to a large extent try to put myself "in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be, and [I] must consult others who are looking after him or interested in his welfare in particular for their view of what his attitude would be". Whilst this is a useful and sometimes practically determinative exercise (as in

the case of Mr Briggs[1]) it depends on the circumstances. In Briggs, P was a former soldier and policeman who had often discussed what he would like to happen if he were to have a disorder of consciousness. He did not wish to be kept alive in such a state. That exercise is more problematic in a case like DC, where he has never expressed any opinions or wishes from which the Court could confidently predict what he would decide.

27. One factor relevant to the best interests of DC is whether there would be an expression of altruism in his decision? This has long been an issue in Court of Protections cases (for instance, with gifts in property and affairs cases). But it is relevant also to consider whether DC would act like a responsible citizen and consider the effect of his decision on other people (see Secretary of State for the Home Department v Skripal [2018] EWCOP6, Mr Justice Williams). This is a particularly important subject when considering the administration of a vaccine designed to prevent the spread, or at least the rapid spread of a virus.

28. I must consider the views of family members, but those expressions of opinion must be considered critically by the Court, with P's interests at the centre: see Mr Justice Hayden in Abertawe Bro Morgannwg University Local Health Board v RY [2017] EWCOP 2.

29. Vaccination cases have become a sub-group of their own, and I have been addressed in writing and orally on many of these. I think the following can be distilled from these cases.

30. Firstly, the context in which the vaccine is prescribed. In E (Vaccine) v Hammersmith and Fulham LBC [2021] EWCOP7, Hayden, J. took into

[1] Briggs v Briggs [2016] EWCOP 48, Mr Justice Charles.

account the fact that in January 2021 the UK had one of the highest death rates in the world and if E contracted the virus her prospects would "not be propitious". He was influenced by that factor in making a declaration that it was in best interests to receive the vaccine.

31. In SD v Royal Borough of Kensington & Chelsea [2021] EWCOP 14, when the vaccine was still very new, Hayden, J. had to consider arguments around the vaccine's safety and efficacy. In an important passage he stated:

> "…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 light of authorised, peer reviewed research and public health guidelines and to set those in the context of the wider picture of [P's] best interests".

32. I think it is important to distinguish, however, between older, more established vaccines, such as MMR, and the present crop of COVID-19 vaccines. They are technologically new- the Pfizer BioNTech vaccine favoured for DC is an mRNA type vaccine, which works in a different way to classical vaccines. Secondly, due to the emergency caused by the pandemic, licensing of these vaccines has been accelerated. Trials that would normally take many years before a medication or vaccine is approved for general use have been truncated, for very good reasons, but truncated nevertheless. This is the one aspect of this case that has caused me some prolonged reflection.

33. In cases involving children and the exercise of parental responsibility there is a clear pointer from the Court of Appeal (albeit obiter) as to the approach the

Court should take. It favours the Court being guided by Public Health England and the Green Book: see Re H (a child)(Parental Responsibility: Vaccination) [2020] EWCA Civ. 664 Eleanor King, L.J.

34. In another case involving a child receiving the MMR vaccine, decided under the Children Act 1989 by way of the High Court's inherent jurisdiction, Macdonald, J. said in light of Re H he found it: "very difficult to foresee a case in which a vaccination approved for use in children, including vaccinations against the coronavirus that causes COVID-19, would not be endorsed by the Court as being in the child's best interests absent a credible development in medical science or peer reviewed research evidence indicating significant concern for the efficacy and/or safety of the vaccine or a well evidenced medical contraindication specific to the subject child" (M v H, and P & T [2020] EWFC 93).

35. I see no reason why this approach should not apply to adults where the decision making is by this Court under the MCA.

36. Those "wider best interests" include how the vaccination would have to be administered. In the case of a very resistant patient, in circumstances where there would have to be use of force to facilitate the administration of the vaccine it may be that the best interests balance would be tilted again vaccination even though it would reduce P's risk of harm due to the vaccine: see SS v Richmond upon Thames [2021] EWCOP 31, where Hayden, J. refused to authorise the administration of the vaccine.

EVIDENCE

37. I heard evidence from Dr H and MC, both of whom were cross-examined. I read statements from others which I will refer to where necessary. I also heard from AC, who made a statement to me. There was a wealth of other documentation. There were statements from Ms X-Y and Ms Z of the CCG, who provided the historical background to this case, and the plans for the administration of the vaccine and the proposed care afterwards. Included was a statement and attachments from Dr McCullough, from Dallas who is a "board certified doctor in internal medicine and cardiovascular disease…". I am told his statement was not intended to provide me with expert evidence, but rather to act as a guide to the publicly available materials.

38. I do not intend to summarise or outline all this evidence in any detail. The factual disputes, such as they were, are very simple to outline.

39. Dr H is a General Practitioner and adult safeguarding lead at his practice. He is also the Medical Director at the CCG and responsible for the rollout of the vaccine in the CCG's area. He does not pretend to be an expert as to how vaccines work. He is educated in his decision making by the guidance he is given by the NHS, and that relies on the JCVI and the Green Book at Chapter 14a. DC is at high risk of serious consequences if he contracts COVID-19 because of his complex condition. In particular, his respiratory condition, the fact he has profound learning disability, he resides in a residential care home (where everyone else is vaccinated) place him in that category. Having considered the guidance in the above sources, Dr H considers the adverse risks

of the vaccine to be greatly outweighed by the protection it offers towards a virus that could be catastrophic for DC.

40. Having heard Dr H respond to cross examination from Mr Hoar, it seems very clear to me that he did not feel able to engage with some of the points put to him about risk and benefits. It is obvious to me that the CCG's evidence rests on the official-line towards the vaccine. Dr H was not before me to look behind the official guidance and advice, but simply to ensure that he applied it faithfully. When some figures which are emerging from vaccinations in certain groups (Israel and the US Armed Forces, for instance), were put to him Dr H did not attempt to question them by reference to any research carried out elsewhere. This is no criticism of him. He is a G.P. and CCG Medical Director with a task of ensuring the vaccine is effectively rolled out. He explained that he considered this an extension of his role as a G.P. because through the widespread use of the vaccine he is ensuring the good health of most of those in the CCG's area.

41. He would also not be drawn on the size of the dose of the vaccine and whether that should be determined by DC's age (he is 20) or his weight (he weighs as little as a small child). He was guided by the "best" advice- namely age.

42. At the end of his evidence, Dr H remained clear that taking into account all the risks and benefits associated with the vaccine, it was in DC's medical best interests to receive it.

43. MC is a professional risk assessor, albeit not in the medical/pharmaceutical field. During the period after March 2020, he has been unable to practise in his professional field and has been largely at home. He has carried out an

enormous amount of research on-line into the literature on the developing mRNA type vaccines. He has accessed research data and reports from trials worldwide.

44. He described himself as an "overthinker" and he considered every eventuality arising out of the vast reading he had done. I read his statements and the other supporting documentation. I listened to his oral evidence very carefully, too. I hope I do him no injustice when I summarise his position as follows. The pandemic has led to the rapid development of new vaccines- new not only in their use, but also in their science. These mRNA vaccines have not gone through the usual tests and regulatory scrutiny as they would in normal times. He describes the vaccine as "experimental". Having looked at figures from around the world, from emerging studies and data, he is not satisfied that the vaccine his son is being offered is as safe and efficacious as he (and the rest of us) have been led to believe. He points to concerns over myopathy and other respiratory, vascular and neurological issues that may arise, and about which there is an inadequate database for a decision to be made. He is particularly concerned about blood clots because there are a number of examples of family members with illnesses due to blood clots.

45. That being said, I did not get the impression MC was an "antivaxxer": a term I take to mean someone whose opposition to vaccinations is motivated by conspiracy theories rather than a proper consideration of the data. MC may well be opposed to this vaccination being administered to his son, but that is due to reasons he has been able to explain and rationalise.

46. AC is also opposed to the vaccination. She told me that she was brought up in the Church of Scientology, which in the past has opposed vaccinations. However, she was not opposed to vaccines *per se*- indeed both DC and her daughter have had vaccines with their parents' consent. Her opposition is that she believes that DC is a very delicate young man who has in the past recovered very rapidly from apparently serious health problems. She believes that administering this vaccine might send him into ill health from which he will not recover.

47. With this in mind both parents urged me to refuse to order the vaccination until there was evidence as to whether or not DC has natural immunity from having caught the virus in the past. In relation to this point, Dr H was of the view that the taking of blood in order to carry out such a test would be more traumatic than administering the vaccine, and so it was not something that he would advise or offer. It is not an available option. In any event, Dr H told me that the official line on natural immunity is that the vaccine is better.

48. Neither parent is vaccinated against COVID-19. Their daughter, DC's sister- who is an adult- has chosen not to take the COVID-19 vaccine.

49. The impression I got from DC's parents is that they are highly intelligent, articulate and highly independently minded. I suspect their daughter is probably the same. If he were a capacitous adult and had not been suffering from the disabilities he has, there is every reason to believe DC would be similarly independent.

ANALYSIS

50. When considering what is in DC's best interests I must consider the following circumstances.

51. In early 2022, the UK has had around 16 million cases of COVID-19 infection. Deaths officially attributed to the infection are around 155,000. The per capita death rate is high for a European country. The UK Government, and devolved Governments have focused their efforts on the roll out of the vaccination programme as a way of combating COVID-19. On the day this judgment was written, the UK Government (i.e. in England) has removed the mandate for people to wear masks indoors. The number of doses of vaccination was 115 million, with 40.5 million fully vaccinated (about 72% of the population in England). The full vaccination rate for the UK as a whole is just a little lower at 71.8%.

52. The virus is potentially lethal. There is also evidence that even if it does not cause death, it can make people very ill and leave them with long term sequelae. Public health policy to get the public out of the pandemic and back to "normal" in the UK has been predicated on the successful use of the vaccine. That is why Dr H and his colleagues have been mobilised very effectively to ensure that everyone gets the vaccine. This has been a vaccination strategy on an industrial scale. Dr H's expertise is to ensure that as many as possible are vaccinated, singling out only those who manifestly do not need the vaccine on the basis of the risk/benefit analysis he receives from the NHS and JCVI. This policy is based on the ongoing emergency and the need to slow down the spread of the virus to enable the existing healthcare infrastructure to cope.

53. The vaccine itself (or vaccines themselves) has been developed rapidly and in response to the emergency. The regulatory process has been used accordingly. It is undeniable that these vaccines do not have the track-record that they would have had in times where there was no pandemic. As a result the data on risk and benefit is not as well developed as it might be.

54. That being said, there is clear evidence that the vaccine has worked to slow the spread of the virus. The official guidance indicates that to be so and recommends that those who are vulnerable ought to be vaccinated. DC falls into that category on a number of counts, as outlined above. The Green Book indicates that he is vulnerable and he would benefit from the vaccine.

55. However, there are matters which MC points to that call into some question the risk assessment and efficacy based upon figures that are continuing to emerge. It is possible that as time passes and the number of people in the world who are vaccinated increases that more data will emerge that changes the current assessment.

56. I am quite sure that if DC were able to make decisions for himself, he would be influenced by the approach taken by his father and mother: he would challenge the figures, he would investigate them, and he would have conversations with his parents about the data. He would likely be influenced by his sister.

57. That being said, a reasonable approach to such inquisitiveness would also take other factors into account. Firstly, that the vaccine is a response to an emergency, and therefore decisions have to be made before the level of understanding of risks/benefits is as full as might ideally be the case. A

decision not to have the vaccine is as much a decision to expose oneself to risk as is the decision to have the vaccine. If one criticism can be made of MC, it is that his overthinking means that he is unable to act urgently, that he is perhaps somewhat paralysed by his own fixation on greater and greater information and drilling further and further down into an issue before he is able to make a decision. It could be argued that the coronavirus pandemic makes that a luxury he cannot afford. A decision has to be made if one is in a high risk category like DC.

58. Furthermore, having the vaccine is designed to slow the progress of the virus and to relieve pressure on healthcare services. To that extent the decision to have the vaccine is altruistic as well as selfish. A reasonable person with high risk is likely to be inclined to receive the vaccine for altruistic reasons.

59. Another important factor concerns DC's ability to leave his room and undertake activities. Risk assessments in respect of other people now include whether those having contact with them are or are not vaccinated. In other words, having the vaccine can open up the options available to engage with other people. It is clear from the evidence from the care home that DC is alone in being unvaccinated there. This has meant that he has been unable to attend outdoor events and has been required to isolate for up to 10 days after home visits.

CONCLUSION

60. During closing submissions, Ms Kohn addressed me on the approach I should take to all these factors. It is not just a question of putting myself in DC's place and predicting what I think he would decide, although there is an

element of that. What I have to do is identify all the relevant issues- summarised above- and weigh them up against each other to see whether there is a particularly important factor- magnetic north- that points to DC's best interests.

61. In this case, I have found the balancing very demanding. I see a young man who could hardly be more vulnerable. His parents, who love him and have cared for him full time until relatively recently, have very strong views against him being vaccinated. They are strong emotionally. But they are also backed up with a rational analysis. AC was very upset at the thought of DC having the vaccine. She is fearful it will do him more harm than good, maybe even kill him. Her evidence was powerful. I hesitate to go against DC's mother's instinct and his parents' analysis.

62. I have to place DC at the centre of my decision-making. I am persuaded that without the vaccine he is at risk of COVID-19 causing him much greater harm than if he has it. He is at high risk. There are risks associated with the vaccine, and these are not yet fully understood. However, I am satisfied on the basis of the CCG's evidence that those risks do not outweigh the advantages. The main reason I will allow the application from the CCG is because I can see it having a positive effect on DC's enjoyment of life by allowing him to be more involved in the life of his care home and with his parents. If DC were able to make a decision for himself, I am satisfied that would be a magnetic factor for him.

63. I therefore allow the application and declare it in DC's best interests to receive the vaccine and boosters in accordance with the present plan. The caveats to that will be:

(1) The CCG will ensure that DC is reviewed after the vaccine is administered to identify any side effects. Any such side effects will be included in an ongoing risk/benefit analysis.

(2) MC's parents will be made aware of any findings and the state of the ongoing risk/benefit analysis.

(3) That analysis will be kept up to date and in line with NHS/JCVI advice

(4) No physical intervention in the form of restraint is authorised.

64. That is the end of the judgment. I invite counsel to agree an order.

POSTSCRIPT

65. After the draft judgment was circulated, but before hand-down, Mr Hoar emailed me to ask for permission to appeal this judgment. I have considered the short argument he put in his communication. I refuse his application for permission to appeal.