

IN THE COURT OF PROTECTION

The Sessions House,  
Lancaster Road  
Preston PR1 2PD

Date: 28/09/2022

**Before :**

**HIS HONOUR JUDGE BURROWS**

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**Between :**

<b>AN ICB</b>	<b><u>Applicant</u></b>
<b>- and -</b>	
<b>RN</b>	
<b>(by his ALR)</b>	
<b>-and-</b>	
<b>TN</b>	<b><u>Respondents</u></b>

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**Adam Fullwood** (instructed by **Hill Dickinson**) for the **Applicant**  
**Oliver Lewis** (instructed by **Peter Edwards Law**) for the **First Respondent**  
**Francis Hoar** (instructed by **Broad Yorkshire Law**) for the **Second Respondent**

Hearing dates: 8 September 2022

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**APPROVED JUDGMENT**

This judgment was delivered in public. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of RN must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

## **HIS HONOUR JUDGE BURROWS :**

### **INTRODUCTION**

1. This case is about a young man I will call RN. He is 22 and lives in the North West of England. Due to the nature of certain conditions he has, he is said to lack capacity to make decisions about whether or not to receive the vaccine against the virus that causes COVID-19. His GP has reached the conclusion that RN ought to receive the vaccine because of the risk posed to him in the event that he catches the virus. This is rejected by his mother, TN. She believes that the risks posed to her son by the virus are limited, particularly since he has already been infected on one occasion, whereas the risks posed by the vaccine are unclear and maybe significant. There is an impasse. Consequently, the ICB (A CCG) brings this application to this Court in support of the GP.
2. I am asked to decide:
  - (a) Does RN lack the capacity to make this decision?
  - (b) If he does, whether it is in his best interests to receive the vaccine in line with the vaccination plan set out by his GP.
3. On 8 September 2022, I heard this application. I considered a considerable amount of written evidence, which I shall refer to again below. Importantly, I read a report and replies to answers posed by TN from Dr A, Consultant Cardiologist dated 2 and 7 September 2022 respectively. I read and heard evidence from Dr B, the GP- who has stepped in to deal with this case in the absence of Dr C, RN's usual GP.
4. At the end of the hearing, I decided to reserve judgment for a short time. This is my decision. I would like to thank counsel for their excellent written and oral arguments, as well as their focused questioning and submissions. I would also like to thank TN for her measured, if emotional evidence and expressions of her fears to the Court.

## **BRIEF BACKGROUND**

5. RN suffers from severe learning disability, as well as Partial Trisomy 13, and Tetralogy of Fallot, repaired in 2001. The last condition is particularly concerning to TN because she fears that the vaccine is more likely to cause her son very serious harm because of his heart condition. The Partial Trisomy 13 is a chromosomal irregularity that has had a significant effect on RN's cognitive development.
6. RN lives with his mother, who is his carer. His parents are separated, although he does have contact with his father. I make it plain at the outset that I did not hear from RN's father, and he contributed nothing directly to the Court. It was mentioned in the Court papers that he was in favour RN receiving the vaccine. However, I made it clear to TN, who became agitated when she mentioned RN's father and his views, that I could not be sure what his views were, and my decision would not be influenced by any speculation there may be on my part as to what they might be.
7. The issue of the vaccine was first raised some time ago by Dr C with TN. In 2021 there were discussions with her as to whether some agreement could be reached on RN having the vaccine. This was not possible. Given TN's concerns about RN's heart condition and the effect that may have on the safety of the vaccine, Dr A was asked to give his opinion. In late September 2021, he confirmed that it was his opinion that it was in RN's best interests to have the vaccine.
8. This application was made to this Court in March 2022. The progress has been slow. That was partly because the matter was adjourned by the consent of the parties in order to await what happened in another case concerning whether previous infection was a factor that ought to be taken into account when deciding on best interests—mainly because of the effect such an infection has on natural immunity. The issue was not resolved by the time of this hearing, sadly due to the death of the person concerned.

## **CAPACITY**

9. The role of the Court of Protection is to make decisions on behalf of people who are unable to make that decision for themselves on the grounds of mental incapacity. If, and only if, the person lacks capacity to make a particular decision may the Court proceed to make that decision on their behalf.
10. It was clear there was no dispute on this issue. I have seen the mental capacity assessment of Dr C dated 19 April 2022. This was not challenged. It confirms that, due to his learning disability, RN is unable to make any decision about whether he should receive the vaccine. He also lacks the capacity to litigate the issue. The statutory presumption of capacity is rebutted, and the Court has the jurisdiction to make the decision on his behalf. That decision has to be made in RN's best interests. Before I deal with the relevant law, I shall consider the factual arguments that have been put before me- pro and contra.

## **EVIDENCE**

11. The ICB's case was based on the advice given to clinicians by (effectively) the UK Government. That evidence is clear and simple. As a learning-disabled person, RN is at higher risk than other members of the general population of an adverse outcome should he become infected with COVID-19. That advice is based on the JCVI (Joint Committee on Vaccination and Immunisation) as contained in Chapter 14a of the Green Book, published by the UK Health Security Agency. Since RN suffers from a chronic neurological disease- namely "severe or profound and multiple learning disabilities" he is in an at-risk group.
12. None of the clinicians whose evidence I have considered are virologists. Dr B was clear that his role as a GP is to follow Government guidance on who needed the vaccine and how to factor that advice into the particular circumstances of each individual patient when giving them advice. That is why, given RN's cardiac condition, the GP sought the advice of Dr A.
13. Dr A's conclusion was that it was in RN's best interests to receive the vaccine. It is important that Dr A's clinic was already involved with RN. He had attended in May 2021 before the issue of the vaccine was raised with Dr A. Tests were carried out on RN. In his first report, Dr A considers in some detail the extent to which RN is vulnerable or at risk because of the cardiac conditions from which he suffers namely:

“Partial Trisomy 13; Cardiac Manifestation: Tetralogy of Fallot (repaired 2001). Currently sinus rhythm, preserved pulmonary valve function, preserved biventricular function”.

14. Tetralogy of Fallot appears to be a reasonably common condition- about 1:2500. Repairs to the tetralogy of Fallot are also, therefore, reasonably common. However, partial Trisomy 13 (also known as Patau’s syndrome) is less common (1:160000). Also, since many of those suffering from the condition die in their first year, and most before they become adults, the presentation of those with repaired tetralogy of Fallot and Partial Trisomy 13 is very low.
15. Dr A’s evidence therefore focuses on the cardiac issue of repaired Tetralogy of Fallot. He states (para 12):

“With regard to the underlying cardiac diagnosis, the need for lifelong cardiac surveillance for the repaired Tetralogy of Fallot relates to the need for re-operation to the pulmonary valve in ~40% of patients by the third decade of life, in addition to the later risks of rhythm abnormalities, which do come with an attendant risk of sudden death....”

He concludes, on the basis of his understanding of the figures, that patients born with Tetralogy of Fallot can expect to survive well into adulthood.

16. Crucially, Dr A then considers the COVID-19 advice given by the JCVI in the Green Book in the light of his specialist experience and understanding as a cardiologist. He states:

“My position with regard to COVID-19 vaccination follows public health recommendations which appear to have been responsible for the shift in the natural history of COVID infection following vaccination, which is now demonstrably less severe (death/ventilation/hospitalisation) than without vaccination....”

Having then explained that he is not a virologist, immunologist or intensivist, he goes on:

“We are nearly two years from the point of vaccine roll out, and although some cardiac issues have been raised that are attributable to the vaccine, cardiac issues (typically means myocarditis) are worse following natural infection than cardiac issues associated with vaccination even with sequential (i.e. booster) dosing”.

17. In a later document, in response to questions asked by TN's legal representatives, Dr A expands on what he said in his first report. Much of what was put to him was what is described as being "public domain" information, most of it dealing with statistics and hypotheses about the effects and efficacy of the vaccine. I will come back to this as a source of evidence later. Although Dr A largely reiterates the fact that he is a cardiologist and nothing else, he does engage sometimes with the information asserted in the questions. His two most important answers are these. First, his opinions are based on national guidance recommending vaccination for priority groups such as the one into which RN falls. Secondly, he has not seen any change in clinical practice around the vaccine stimulated by the public domain information to which he has been referred.
18. TN gave short oral evidence. This supplemented her four witness statements and around 500 pages of exhibits. I have read these. It consisted in a great number of articles and sources on the cardiac issues but mostly on the effects of vaccine, and, in particular, natural immunity in those who have been infected.
19. A number of hypotheses were advanced on the basis of these materials the balance of which is that having been infected with SARS-CoV-2 (the virus that causes COVID-19) there is natural immunity that materially improves the prospects of the sufferer to either escape infection or if infected experience a less serious experience second time round. No one was called to support these hypotheses. I was left with nothing that undermined the advice given by JCVI/Green Book. The evidence, as distilled through Dr B seems to be that whether any individual person infected with the virus benefits with immunity, by how much and for how long is so uncertain, that vaccination (with a booster) is still advised in all vulnerable groups.
20. Against TN's evidence and documents I had the evidence of Dr B in person, and Dr A in his written reports and answers. The doctors were extremely candid, in my view. Their clinical judgment and expertise- in the case of Dr A as a cardiologist, and Dr B as a GP- are directly relevant to RN only in so far as they apply the guidance and expertise of the JCVI to his case. The JCVI guidance and advice they do not and could not go behind.

21. I am concerned that in this case, like others I have been involved with, the use of “public domain” documents and sources is simply intended to engage the Court in an activity it is ill equipped for- namely, to act as an adjudicator as to whether the vaccines that are part of the Government’s anti-Covid policy are really safe, or whether they have been brought into general use before they should have been, with inadequate regulatory supervision. For reasons I will explain below, this is simply not the Court’s role. Of course, materials calling the vaccine into doubt, whether that be its safety, or its efficacy are matters any informed person would factor into his own decision-making process when consenting to the administration of the vaccine, or not. However, that is a decision that the Court deals with when applying s. 4 MCA, as I will do below.
22. In so far as I am asked to make any factual findings or evaluations here, they are these:
- (1) The JCVI/Green Book guidance is that RN is in a risk group and ought to have the vaccine (and boosters).
  - (2) The evidence is that the vaccines do give protection against serious illness and death.
  - (3) The Green Book does not record any evidence of cardiac issues in the general population following Moderna vaccination- that being the one proposed for RN.
  - (4) More specifically, in RN’s case, the evidence of a cardiologist whose opinion was sought by RN’s GP to consider his specific case is that the vaccination guidance should still be followed because it was in his best interests (medically speaking) for him to receive the vaccination.
  - (5) RN appears to have had the infection. That being so, the guidance is still the same for future vaccinations even when taking into account that RN may have some residual immunity.
  - (6) So far as the administration of the vaccine is concerned, the care plan does not envisage the need for physical intervention (beyond the gentle holding still of the target arm), and no problems are anticipated.

(7) TN does not wish for the vaccination to take place in their house. There is no reason to believe it cannot take place, without incident elsewhere.

### **BEST INTERESTS: THE LAW**

23. The GP/ICB has a duty to ensure that RN is offered treatment, including vaccinations that are in his best interests as they assess them. As Dr Lewis put it in his Skeleton Argument, just because RN has disabilities he should not be disadvantaged or discriminated against in the offer of healthcare. The COVID-19 pandemic is still with us, and winter is nearly here again. So, it is necessary for a decision to be made now. I need to decide whether the option placed before me- including the vaccination support plan- is in RN's best interests.
24. The starting point is s. 4 MCA. The most important factors are as follows.
25. I need to "consider all the relevant circumstances" (sub-s (2)). The nature of RN's disability is such that there is no prospect of him gaining capacity (sub-s (3)). He is unlikely to be capable of being permitted or encouraged to participate in the decision making (sub-s (4)).
26. In relation to sub-s (6) there almost certainly has never been a time when RN has had capacity. I cannot establish what his wishes and feelings are, or what he has in the past wished for.
27. There appear to be no cultural and religious factors that might play a role in RN's decision making if he were able to make a decision for himself.
28. I must also take into account the views of other people close to him, and who would influence him. In this case that means his mother as the probably the single most important person in his life. He is likely to be influenced by his mother, if he were making the decision for himself (sub-s (7)).
29. When considering a person's best interests I must be guided by the MCA 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 RN's welfare in the widest sense



and not just in a narrow medical one (see Lady Hale at [39]). If I conclude that RN would be more likely to be less ill, or less likely to die if he receives the vaccine, and that the likely adverse consequences of the vaccine are outweighed by those benefits, that is not the end of the best interests exercise. To a large extent I must 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".

30. In a case where the historical and capacitous views of P are known that approach can be powerful and determinative. That is not the case here.
31. One further factor relevant to the best interests of RN is whether he may have made an altruistic decision- i.e. to receive the vaccine to protect the community at large, or in a narrower way, such as his family. 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. In other words: might RN have behaved like a responsible citizen and considered the effect of his decision on other people had he made the decision for himself? (see Secretary of State for the Home Department v Skripal [2018] EWCOP6, Mr Justice Williams).
32. The views of family members are significant. But such expressions of opinion must be considered critically by the Court, with RN's interests at the centre: see Mr Justice Hayden in Abertawe Bro Morgannwg University Local Health Board v RY [2017] EWCOP 2.
33. There are a number of cases related to vaccinations, and I shall refer to those which are particularly relevant.
34. Firstly, I must consider the context in which the vaccine is prescribed. In E (Vaccine) v Hammersmith and Fulham LBC [2021] EWCOP7, Hayden, J. took into 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 her best interests to receive the vaccine.

35. 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, which has become central to most of these cases, 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"
36. 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.
37. In another case involving a child receiving the MMR vaccine, decided under the Children Act 1989 and 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). (emphasis added)
38. I see no reason why this approach should not apply to adults lacking capacity when making decisions using the MCA. This is particularly relevant to the present case, where the evidence against the Government/JCVI/Green Book guidance is based on documents from publicly available sources, but where no expert evidence is given to counter the guidance.
39. I must also consider 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 against 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.

40. In A CCG v FZ & TZ [2022] EWCOP 21, I concluded that although the administration of the vaccine would be of benefit to P, that benefit was outweighed by the effects of the steps that would be needed to administer it, the damage that would cause to P and the relationship she had with her family/carer and would likely fail in any event. It was therefore not in FZ's best interests and I refused the application.
41. In fact, recently Poole, J. in North Yorkshire CCG v E & others [2022] EWCOP 15 has given a succinct statement of the principles that must be applied to cases such as these- they are worth repeating and ought to be taken seriously (my emphasis):

The parties in this case and in all similar cases should know that the principles articulated by the Vice President in *SD* (above) are now very well established and will be applied by the Court of Protection in vaccination cases - both Covid-19 vaccines and other vaccines offered under national vaccination programmes.

xxxvi. The best interests assessment is not confined to evidence of the health benefits and risks of vaccination but involves a wide review encompassing all the relevant circumstances including those set out at s.4(6) and (7) of the MCA 2005;

- ii) In relation to the benefits and risks to the health of P from vaccination, it is not the function of the Court of Protection to “arbitrate medical controversy or to provide a forum for ventilating speculative theories.” The Court of Protection will “**evaluate P’s situation in the light of the authorised, peer-reviewed research and public health guidelines.**” **It will not carry out an independent review of the merits of those guidelines.**
- iii) There may be exceptional cases where P’s condition, history or other characteristics mean that vaccination would be medically contra-indicated in their case but in the great majority of cases it will be in the medical or health interests of P to be vaccinated in accordance with public health guidelines.
- iv) Hence, disagreements amongst family members about P being vaccinated which are at their root disagreements about the rights and wrongs of a national vaccination programme are not suitable for determination by the court. **It will be in P’s best interests to avoid delay and for differences to be resolved without recourse to court proceedings.**

## DISCUSSION

42. The submissions made on TN's behalf by Mr Hoar focus on the issues of risk to RN- particularly that of cardiac complications. In his position statement, he states:
- “Critical to the assessment of RN's medical best interests is the precautionary principle. This is particularly relevant for a vaccine which uses novel mRNA technology and which, while it has been administered to hundreds of millions of people, has been authorised for only 21 months and whose medium- to long-term effects cannot thus be known.”
43. I disagree that I should be guided by the “precautionary principle”, or that such a principle is a part of the assessment of medical best interests. When it comes to the safety of the vaccine itself, I must be guided by JCVI and the regulators. When it comes to the safety of the vaccine for RN I must be guided by evidence, including that provided by clinicians concerned with RN's interests. Although there is nothing to counter the evidence of Dr A- in his written report and answers- I am invited to determine that there is a risk that ought to be factored into the best interests decision making process.
44. It was submitted that RN's previous infection and the immunity he will have developed should also be taken into account, and that it points away from RN needing the vaccine. These matters are all relevant to my determination of RN's best interests. Indeed, if RN were to be making this decision for himself, as a competent adult, he would be guided by his mother. Taking all those matters into account, it is submitted that RN would probably not consent to receiving the vaccine.
45. In response to that Mr Fullwood and Dr Lewis submit that the medical evidence is “all one way”. I must evaluate RN's best interests by applying the caselaw I have

outlined above. If I do so, I must conclude that RN ought to have the vaccine in his best interests.

## CONCLUSIONS

46. Having taken all the evidence into account and approached that evidence in the way I must do in line with the authorities, I have come to the conclusion that it is in RN's best interests to receive the vaccine.
47. COVID-19 is still a dangerous and potentially fatal virus. At the time of the hearing 188,000 people had died of COVID-19, 384 within the previous 7 days. The experience of the past two years is that the effect of the virus and its spread is likely to increase in Winter. That means the increase in the risk to RN of infection, illness and death. That explains why the regulatory framework in which the vaccine rollout took place was speedier than would normally be the case. It was, and is, an emergency and the regulations reflect that.
48. Furthermore, the overall context of the pandemic, and the UK Government and the other Governments of the UK in their approach to tackling the virus has been to seek to protect the healthcare infrastructure from the impact on it of large numbers of very ill infected people requiring Hospital care at any one time. The vaccine strategy reduces the number of very ill people requiring that level of care. Consequently, there is a very clear argument that those who are vaccinated are not only reducing their own risk of serious illness, but also ensuring that those that are very ill (with COVID-19, or otherwise) will not be prevented from receiving a good level of care. This is the altruistic argument. This is a powerful factor that is likely to be a strong argument for the vaccine for people in a risk group such as RN.

49. Of course, RN would listen to his mother. She is sceptical about the vaccine and very concerned that it will harm her child. I believe that a capacitous RN would listen to his mother. He would be affected by what she said. Whether her views would persuade him, I am less sure. However, the views of TN cannot be determinative whatever effect they may have on RN.
50. My role is to make a best interests evaluation. I cannot escape the simple reality that the vaccine is likely to reduce RN's risk of developing a serious infection and dying of it. In the absence of any evidence that he is placed more at risk from having the vaccine than not having it- and there is none- I consider it clearly in his best interests to receive it.
51. I therefore declare:
- i) RN lacks the capacity to make decisions as to whether he should receive the vaccine
  - ii) It is in his best interests for him to do so, including subsequent vaccinations and boosters.
  - iii) The vaccine should be administered as soon as possible in accordance with the care plan.
  - iv) Nothing I have said authorises the use of restraint that goes beyond that envisaged in the care plan.
52. That is the judgment. I hope an order will be agreed between the parties.

**Court of Protection Approved Judgment:**  
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An ICB v RN (by his ALR) & TN