[2022] EWCOP 21

Case No: 13887856

IN THE COURT OF PROTECTION

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

Date: 30 May 2022

Before :

HIS HONOUR JUDGE BURROWS

- -

Between :

A CLINICAL COMMISSIONING GROUP	**Applicant**
- and -	
FZ	**First Respondent**
(by her litigation friend, the Official Solicitor)	**Second Respondent**
-and-	
TZ	

- -
- -

Hannah Haines (instructed by **Hill Dickinson LLP**) for the **CCG**
Ben McCormack (instructed by **Southerns Solicitors**)
for **FZ, by her litigation friend, the Official Solicitor**
TZ appeared in person

Hearing dates: 4 May 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 FZ 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 woman in her 40s of British Muslim and South Asian heritage. I will refer to her as FZ. In this judgment it is my intention to preserve her privacy. For that reason, not only will I anonymise her, but also her family members, the name of the CCG bringing this application and its employees, and I will refer only in very general terms to where she lives.

2. FZ lives in the north of England with her family. She has a diagnosis of learning disability, Down's syndrome, and it is suspected she may be asthmatic. Other recorded health concerns in the past have included hypothyroidism and psoriasis.

3. She is cared for by her family, primarily her sister-in-law, TZ and her husband, FZ's brother. They have been most involved in raising objections to FZ receiving the vaccination against COVID-19. TZ has represented the family.

4. The CCG has decided that FZ lacks the mental capacity to consent to the vaccine, and that it is in her best interests to receive it. They consulted with TZ's family and sought their agreement. However, it became clear by early this year that their agreement would not be forthcoming. As a result, proceedings were

issued in the Court of Protection (COP) on 14 February 2022. On 16 February 2022, I made directions and listed the matter for a directions hearing which eventually took place on 1 March 2022, by video link at Manchester. The matter was then listed for a final hearing that took place on 4 May 2022, by video link at Manchester. The delay between hearings was due to lack of judicial availability.

5. At that hearing I benefitted from a sensitive and focussed approach by counsel for the CCG, Ms Haines, and for the FZ, by the Official Solicitor, Mr McCormack. I was also greatly assisted by TZ. Although she is not a lawyer, and has a great personal emotional investment in FZ, she was measured and respectful in her opposition to the CCG's case.

6. I also heard from two other witnesses on behalf of the CCG. Dr HS, a General Practitioner, and the Designated Nurse for Safeguarding Adults in the CCG's area, SP.

7. I read a number of statements and other materials. In particular, there were statements from other members of FZ's family, all opposing the administration of the vaccine.

8. At the end of the hearing I took some time to consider the narrow issue which has troubled me the most.

9. What follows is a relatively short judgment explaining the reasons for my decision.

CAPACITY

10. In order for this Court to have jurisdiction, the person on whose behalf the Court is asked to make the decision in question must lack the capacity to do so herself. I must be guided in determining this by sections 1 and 2 of the Mental Capacity Act 2005 (MCA).

11. In this case, Dr HS provided evidence that FZ lacked capacity. She suffers from learning disability and Down's syndrome and, due to those conditions and the effect they have on her, she is unable to understand the information relevant to the decision, and certainly is not able to use and weigh that information to make a decision about whether or not to receive it.

12. Initially, TZ stated that FZ had "some" capacity to make the decision. However, when she expanded on this, it became clear to me that she simply meant that FZ had her own views on the subject and they should be respected. I entirely agree with the need to respect her views, even though they may not be determinative of the issue.

13. In so far as I was called to determine the issue of capacity, it is my clear view on all the evidence I read and heard that Dr HS's assessment is correct. The evidence, including Dr HS's assessment rebuts the presumption of capacity under s. 2 MCA. FZ lacks the capacity to make the relevant decision here, namely whether she should receive a vaccination against COVID-19.

14. The Court therefore has jurisdiction to make that decision for her in her best interests.

BEST INTERESTS: THE LAW

15. I was provided with high quality position statements and oral submissions on the applicable law by counsel. It is right that I summarise here the approach I must take to the issues in this case.

16. It is clear to me that a decision has to be made at this stage. The CCG has a duty to ensure that FZ is offered treatment, including vaccinations that are in her best interests (as the CCG assess them). Just because she has disabilities, FZ should not be disadvantaged or discriminated against in the offer of healthcare. The COVID-19 pandemic is still with us. 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 FZ's best interests.

17. The starting point is s. 4 MCA. The most important factors are as follows.

18. I need to "consider all the relevant circumstances" (sub-s (2)). The nature of FZ's disability is such that there is no prospect of her gaining capacity (sub-s (3)). She is unlikely to be capable of being permitted or encouraged to participate in the decision making (sub-s (4)).

19. In relation to sub-s (6) there almost certainly has never been a time when FZ had capacity. However, as I will outline below there is some evidence of a history of past wishes and feelings towards vaccines that I will consider. I have to take into account the "beliefs and values that would be likely to influence [her] decision if [s]he had capacity", and "other factors that [s]he would be likely to consider were [s]he able to do so".

20. There may be also be cultural and religious factors that might play a role in FZ's decision making if she were able to make a decision for herself. I must also take into account the views of other people close to FZ who would influence her. In this case that means her carers and family. These are the people she would be likely to be influenced by, were she making the decision for herself (sub-s (7)).

21. 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 FZ's welfare in the widest sense and not just in a narrow medical one (see Lady Hale at [39]). If I conclude that FZ would be more likely to be less ill, or less likely to die if she 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 [her] attitude to the treatment is or would be likely to be, and [I] must consult others who are looking after [her] or interested in [her] welfare in particular for their view of what [her] attitude would be".

22. In a case where the historical and capacitous views of P are known that approach can be powerful and determinative. Here, FZ was probably never capacitous. However, I did hear evidence that she used to be more able to make decisions in the past, so this maybe of some assistance to me in this case.

23. One further factor relevant to the best interests of FZ is whether she 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 her 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 FZ have behaved like a responsible citizen and consider the effect of her decision on other people had she made the decision for herself? (see Secretary of State for the Home Department v Skripal [2018] EWCOP6, Mr Justice Williams).

24. The views of family members are significant. But such expressions of opinion must be considered critically by the Court, with FZ's interests at the centre: see Mr Justice Hayden in Abertawe Bro Morgannwg University Local Health Board v RY [2017] EWCOP 2.

25. As I said in A CCG v DC, MC and AC [2022] EWCOP 2, vaccination cases have become a sub-group of their own. The following summary appears to me to represent the correct state of the law at the present time.

26. 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.

27. 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"

28. 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.

29. 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).

30. I repeat what I said in DC: I see no reason why this approach should not apply to adults lacking capacity when making decisions using 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 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. This will be an important factor when considering FZ's best interests.

COMPETING CASES: EVIDENCE

37. The CCG's approach is as follows. As I see it, it falls into two parts. First, taking into account FZ's vulnerability due to her disability, diagnosis of Down's syndrome, her South Asian ethnicity and history of asthma, she is "extremely clinically vulnerable" (see Nurse SP, and the second opinion doctor). There are no obvious risks associated with the vaccine itself that would be so significant as to tilt the balance away from FZ receiving it. Without more, it is in her best interests to receive it.

38. However, there is more. The CCG recognises that due to her previous history of refusing vaccines and her hostility and fear of the act of vaccination by injection, a special support plan must be adopted to stop the process causing her trauma, and perhaps making it impossible. As part of the plan, devised by Learning Disability services, a PA would be commissioned who would befriend FZ over a number of visits prior to the vaccination. Then, on the day, partly through distraction and partly by support, the "vaccinator" would attend and inject her swiftly, essentially before she was able to understand what was happening. When pressed on this, SP agreed there would be no use of physical interventions and restraint beyond the entirely usual holding of the target arm to ensure a safe injection.

39. I emphasise that the decision to administer the vaccine is in line with JCVI and the "Green Book". On purely medical grounds it is a decision the clinicians are entitled, and perhaps obliged, to make.

40. The objections on the family's behalf have been put by TZ and other members of the family. Although I am not at all critical of TZ, and, as I said above, I found her to be intelligent and measured, there are a number of arguments she advanced that I have to reject.

41. Firstly, TZ expresses concerns over unexpected and adverse side effects that FZ would find difficult to tolerate. These include a sore arm at the injections site, mild headaches and perhaps some sickness. Although I accept FZ would be less able to understand these phenomena than someone without her challenges, I do not consider these to outweigh the benefits of the vaccine.

42. Secondly, and relatedly, there was a suggestion that the emotional fallout of the vaccination would be as significant for FZ as it was when she had cataracts in both eyes treated surgically- leaving her completely without sight for a significant period of time. This is alleged to have caused her great trauma. I simply refuse to accept the comparison. A swift and sudden injection with nothing but a sore arm for a few hours is in no way as distressing as being left blind with eye patches on without understanding how or why.

43. Thirdly, TZ challenges whether FZ is clinically vulnerable. Looking at the evidence and the criteria- particularly the factors of her learning disability, Down's syndrome and ethnicity- it seems to me unarguable that she is not in the vulnerable category.

44. Fourthly, there was a suggestion that FZ was at greater risk of the vaccine because of cardiac issues. In fact, there is no evidence that she has a heart defect. Furthermore, if she did have such a defect, according to Dr HS it would strengthen the argument that she needs the vaccine to keep her safe.

45. Fifthly, there was a suggestion that the vaccines themselves are not properly tested and may be more dangerous than we presently know. This has been dealt with elsewhere at some length (see DC). However, in summary, I agree that the COVID-19 vaccines are novel (mRNA type). Their introduction has been accelerated due to the public health need to address the rapidly spreading and mutating virus to ensure that it did not kill more people and that rampant serious infections did not damage the healthcare infrastructure. To that extent there are aspects of these vaccines that are unusual. However, as already cited, the COP is not the proper venue to deal with theories concerning the safety of a vaccine or vaccines that have been approved by the regulators. Furthermore, in view of the emergency situation caused by the pandemic, an urgent and less than perfect response has been necessitated.

46. Sixthly, FZ has already contracted COVID-19 and experienced a very mild infection. TZ appeared to suggest she would be immune (this would be without scientific foundation, as I understand it), or at least would not be very ill because of her previous infection (I am not convinced there is any scientific justification for this view, either).

47. Finally, there was the suggestion that the vaccine is un-Islamic. I did not understand TZ's argument here. The CCG referred me to a document entitled "Position Statement on COVID-19 Vaccine" by the British Islamic Medical

Association which considers Moderna and Pfizer/BioNTec vaccines and does not consider them un-Islamic.

48. However, I do realise when considering s. 4(6)(b) of the MCA, namely "the beliefs and values that would be likely to influence [her] decision if [s]he had capacity", I must consider the specific beliefs and values of FZ's family and community. They may have a particular view of their faith that is not mainstream. They maybe outliers. In this case, I am not concerned with the main foundations of Islam and whether and to what extent observance of them is required in the case of those who lack capacity: as was the case, for instance, in Re IH (Observance of Muslim Practice) [2017] EWCOP 9 (Mr Justice Cobb). I am concerned with what attitude FZ's family has towards the COVID vaccines when applying their faith. However, I did not find TZ's explanation of the objection at all coherent- which was in contrast to her evidence in general. My overall conclusion on what she says about the vaccine being un-Islamic is that it does not convince me, and I doubt it convinces her, either.

THE STRONG OBJECTION: FZ'S LIKELY REACTION TO BEING VACCINATED, INCLUDING THE PROPOSED PLAN.

49. The strongest argument the family advanced was as follows. FZ is extremely suspicious of strangers. She does not like doctors or clinicians treating her, and needles. This is evidenced by her reaction to treatment in the past- the details of which I will come to below. Were FZ to be subject to the treatment, even using the planned intervention outlined in this case, it would cause FZ trauma that would last for the long term. TZ told me that she has built up trust over a period

of time and there is a danger that would be destroyed, or at least damaged, if FZ saw TZ as conspiring against her with clinicians.

50. This was TZ's best point. She was cross examined on FZ's medical records and her previous involvement with medical treatment. There is a list of "relevant health experiences" in the evidence. Important here are the following. FZ has been resistant to ear de-waxing in the past. She would not tolerate abdominal ultrasound or pressure checks. She removed attached equipment placed on her by an anaesthetist who was trying to monitor her chest- although she had allowed him to place them on her initially. A COVID swab had been obtained from her, but that was by her brother. She was agitated by the visit of a GP and learning disability nurse but was settled by reassurance from family members. Most of these events were within the last 3 or 4 years.

51. Importantly, in 2005, FZ refused to have a vaccination even though it was essential for her to observe hajj.

52. Furthermore, there was the attendance note from the Official Solicitor's representative a few days before the hearing. In response to that visit, and even in the presence of her close family, FZ was agitated and responded aggressively- at one point raising a clenched fist. She was later heard to raise her voice to TZ and say "No" to the proposed conversation with the representative.

53. The CCG's plan to overcome this type of reaction is an essential part of the whole vaccination strategy in FZ's case. SP was questioned and I pressed counsel for details as to how it would work in practice. It seemed to me almost inevitable that FZ would react with agitation when confronted with a vaccinator, even if she was able to trust the PA sent to befriend her- which in itself seems

less than likely. How many times would they try this? To what extent would they find themselves distracting her momentarily so as to inject the vaccine in her arm as she was distracted? Would it not be inevitable that the hand on the target arm would involve a forcible hold once FZ realised what was going on? What would the fallout be for TZ and the rest of FZ's family? What aftercare would there by, if any, to assist them to rebuild trust?

54. TZ's concern is that if trust is lost during a vaccination, what would happen in an acute situation, or an emergency? Would FZ resist when it was crucial that she did not?

55. All these matters are relevant to the decision I have to make.

DISCUSSION

56. The COVID-19 pandemic is now over 2 years old. There have been 18.7 million cases in England alone, and 154,000 people have died. The official figures for the 10 May 2022 are that 76,867 people tested positive and 284 died. Masks are no longer mandatory. Social distancing is no longer required. People are freely using sometimes crowded public transport and attending large sporting and entertainment events. Regular and freely available lateral flow testing has ended.

57. The Governments of the UK have used the vaccination against COVID-19 as their main measure to reduce the intensity of the pandemic and to enable the healthcare infrastructure to survive. Things appear not to be as bad as they were at the beginning of this year. They are certainly not as bad as they were in early 2020. However, as the figures show, COVID-19 is still present. It is still

infectious. It is still lethal. And that does not include the suffering of people who have long term symptoms from the infection after it has gone- so called "long-COVID".

58. That is the general context in which I have to consider FZ's case. She is still at risk. She is unvaccinated. It is possible she will be infected again. It is possible she will become ill. She may become very ill. She may even die. Even if she were just mildly or moderately ill, she may not be able to understand what was happening to her and that may cause her disproportionate trauma. She may have symptoms and not report them because she does not understand them thereby delaying treatment and increasing her risk of a more serious illness. The vaccine would reduce the risk of illness, severe illness and death.

59. However, it is clear to me on the evidence I have heard and read that FZ will resist a vaccination. This is obviously a view shared by the CCG, hence their plan. The measures proposed are a method to attempt vaccination without the use of physical intervention and restraint. No one has suggested the use of such physical interventions, and the Court would not entertain such an application were it to be made.

60. However, FZ's family are extremely opposed to the vaccination by whatever method. They have stated they will not assist at all in enabling it to take place. Whilst I am not sure that is a threat they would carry out, it is highly likely that they would only assist if FZ was becoming agitated and traumatised. I am quite sure there would be little or no assistance given when the PA seeks to befriend and gain the trust of FZ.

61. In those circumstances, I am extremely doubtful that the plan has realistic prospects of success. More likely, it will fail. That would leave the CCG wondering whether and when to try again, and if so, for how long? How many failures would it take before the plan was abandoned? These were questions SP had clearly considered with her colleagues. She was, however, quite uncertain I felt in her evidence on this, stating there would be further MDT meetings and assessments, but not having any clear idea of what would actually happen to FZ.

62. Another factor I must consider is the non-medical benefits/dis-benefits of the vaccine. Earlier this year it was widely believed that normal life "after" COVID-19 might be difficult without proof of vaccination ("the COVID-passport"). It is not clear to me whether that is still the case. However, in FZ's case, she lives with her family and I was told they are almost her entire world. With or without the vaccine, TZ told me, FZ would still engage in the activities she always has.

DECISION

63. I have found this case extremely challenging. The benefits of the vaccine are plain. However, the difficulty in administering it in a way that is likely to work is immense, and the damage a failed attempt could cause to the relationships within the family is hard to assess. I am quite sure, however, that the plan put forward by the CCG would be met with resistance and there would have to be a retreat by the vaccinator.

64. Having considered the matter at great length, I wonder what the proposed plan actually amounts to? It seems to me what is proposed is to engage with FZ, if that is possible. That engagement would then lead to an appointment with the vaccinator which FZ would not know about. She would not even see the

vaccinator until the moment immediately before the injection. At that point, I am not sure what is envisaged. I am satisfied that it is almost inevitable- certainly more likely than not- that FZ will resist. This will be verbal, and physical. I base that on the evidence of past interventions and the evidence of what happened when the entirely friendly and benign Official Solicitor's representative visited her just to speak.

65. When making a choice in this case I have to look not only at the outcome of the treatment, but how it will be carried out. I am satisfied that vaccination will have a good outcome for FZ. However, I am not satisfied that the option I am being asked to approve will achieve that outcome. I am satisfied that it will be met with resistance and will in all likelihood have to be aborted.

66. As I have already made clear above, best interests have to be evaluated by taking into account factors that go beyond narrow medical concerns. In this case, I am satisfied that the CCG is right to advise that the vaccination should be offered to FZ. They have made efforts to ensure that a sensitive plan is devised to enable the vaccination to take place. I have no criticisms of them.

67. However, taking all the factors I have discussed into account I am not satisfied that the option placed before this Court is in FZ's best interests. It is likely to result in trauma for her (and her family). It is likely to have to be aborted and then, possibly tried again and again until the CCG finally removes it as an option. I am satisfied that it would be wrong for me to authorise the plan before me.

68. This application is therefore dismissed.