Neutral Citation Number: [2020] EWHC 220 (Fam)

Case No: FD20P00047

IN THE HIGH COURT OF JUSTICE
FAMILY DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/02/2020

Before :

THE HONOURABLE MR JUSTICE HAYDEN

- -

Between :

London Borough of Tower Hamlets	**Applicant**
- and -	
M	**1st Respondent**
- and -	
F	**2nd Respondent**
- and -	
T (a child)	**3rd Respondent**
(by the Child's Guardian)	

- -
- -

Mr Chris Barnes (instructed by **London Borough of Tower Hamlets**) for the **Applicant**
Mr Michael Bailey (instructed by **Lillywhite Williams & Co**) for the **Mother**
Father acting in person
Ms Nina Hansen (**Freemans Solicitors**) for the **Child**

Hearing date: 5th February 2020

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered in private. 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 the children and members of their family 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.

Mr Justice Hayden :

1. This is an application made by the applicant Local Authority for a declaration that it is in the interests of T (a 10-month-old child) to receive a schedule of vaccinations, conveniently set out in the report of Dr Neil Douglas. Dr Douglas specialises in community paediatrics and is responsible for Looked-After Children ('LAC') in the relevant NHS Trust.

2. On 23rd January 2020, I made a care order and a placement order in respect of T, reported at **[2020] EWFC 4** . In September 2019, T was placed with foster carers, where he remains. The history of the case reveals many contested hearings. Virtually every hearing has resulted in an appeal. M is represented by counsel and solicitor. F has elected, at every hearing, to appear as a litigant in person. As I have recorded in previous judgments, this decision is driven by his fundamental belief that neither the court nor the State, through the arm of the Local Authority, has any jurisdiction to take decisions in relation to his children. He invests great belief in the Cestui Cue Vie Act 1666, which he interprets as conveying on himself a "decree of divine sovereignty." I have accepted both the strength and the sincerity of these views. At an early stage in the proceedings, F refused to cooperate in registering T's birth, the determination of this issue is reported at **[2019] EWHC 1572 (Fam)**. The essence of F's objection lay in his belief that registration would cause his son to become a creature of the State, which he believes to be both authoritarian and capricious. I consider something of this belief structure underpins his opposition to the contemplated vaccinations.

3. At this hearing, the opposition to the application has been led by M through her counsel, Mr Bailey. Her case is that she and her previous partner, and F with his former partner, have had children with multiple health conditions. She insinuates, as opposed to directly asserting, that these conditions may be linked to vaccination.

4. The question of vaccination arose during the course of the care proceedings. As my earlier judgment reveals, there were a wide range of issues to be resolved, many generated in an application by F to reopen findings. The application had not been foreshadowed in writing. I indicated that the consideration of the vaccination issue should be dealt with at a separate hearing. My order of 27th November 2019 records the following:

> '***AND UPON*** *the court giving a preliminary provisional indication that the contested issue of the administrations of vaccinations to the child would require to be determined by the court in the course of a discrete application seeking permission to invoke the court's inherent jurisdiction*.'

5. I did not intend the above to be taken as any indication as to my view of the applicable jurisdiction. I was intending merely to separate this issue from those I was addressing at the earlier hearing. The application was issued on 28th January 2020. The Local Authority seeks declaratory relief pursuant to the court's inherent jurisdiction.

6. Mr Barnes, who appears on behalf of the Local Authority, invites the court to consider as a preliminary matter whether the Local Authority is capable of authorising vaccination under s.33(3) of the Children Act 1989 ('CA'). The Local Authority, having regard to the case law, understood the appropriate route as being to require an application for declaratory relief. Mr Barnes gives particular emphasis to the judgment of MacDonald J in **Re SL (Permission to vaccinate) [2017] EWHC 125 (Fam)**:

> "*33. In this case the court is concerned with the issue of vaccinations in the context of children who are the subject of care orders and thus the dispute is between the local authority sharing parental responsibility for the child and the parent with parental responsibility. In the circumstances where SL is in the care of the local authority, by virtue of s 9(1) of the Children Act 1989 the local authority cannot apply for a specific issue order with respect to the issue of vaccination. Further, given the gravity of the issue in dispute, it is not appropriate for the local authority simply to give its consent to immunisation pursuant to the provisions of s 33(3) of the Children Act 1989 on the basis of its shared parental responsibility for SL under the interim care order (see* ***A Local Authority v SB, AB & MB) [2010] 2 FLR 1203*** *and* ***Re Jake (Withholding Medical Treatment) [2015] EWHC 2442 (Fam))***."

7. Mr Barnes also highlights the judgment of Munby P in **Re AB [2013] EWFC 2**, at paragraph 24(iii):

> "*Whatever its strict rights may be, a local authority will usually be ill advised to rely upon its parental responsibility under section 33(3)(a) of the 1989 Act as entitling it to authorise medical treatment opposed by parents who also have parental responsibility: see* ***Barnet London Borough Council v AL and others [2017] EWHC 125 (Fam), [2017] 4 WLR 53****, para 32, and the discussion in* ***Re C (Children: Power to Choose Forenames) [2016] EWCA Civ 374, [2017] 1 FLR 487****, paras 92-95.*"

8. I note that King LJ in **Re C (Children) [2016] EWCA Civ 374** was rather more circumspect as to the scope and ambit of the inherent jurisdiction for applications of this sort. Nonetheless, she recognised the cohort of cases that had been brought before the court:

> "*90. Whilst I may not necessarily agree with the precise way that jurisdictional issues have been approached or expressed in these very difficult cases, what is clear is that there is a cohort of cases where the common theme is that a party (whether it be a local authority or, often, an NHS Trust) has sought to bring an issue before the court, believing it to be of too great a magnitude to be determined without the guidance of the court, and without all those*

> *with parental responsibility having an opportunity to express their view as a part of the decision making process.*
>
> *91. Most commonly, examples are found in the so called 'medical treatment' cases where, either an NHS Trust seeks a declaration from the court that they would not be acting unlawfully in pursuing or desisting from a form of treatment notwithstanding the parent's refusal to consent, or alternatively, a local authority seeks to invoke the inherent jurisdiction of the court and thereby to submit to the court's jurisdiction notwithstanding that care proceedings may have been open to them.*"

9. It is an historical fact that nearly 20 years ago vaccination of infants became a highly controversial issue, particularly in respect of the MMR vaccine. The debate was ventilated before Sumner J in **Re C and F (Children) [2003] EWHC 1376 (Fam)**. Following the careful analysis of that judgment, much of the controversy fell away and immunisation became, once again, recognised as likely to be in a child's best interests. It requires to be highlighted, though, that Sumner J was considering the application in the particular context of two individual children.

10. In **Re T (Wardship: medical treatment) [1997] 1 FLR 502**, cited in **Re C and F** (supra), Waite LJ made the following observations:

> "*All these cases depend on their own facts and render generalisations – tempting though they may be to the legal or social analyst – wholly out of place. It can only be said safely that there is a scale, at one end of which lies the clear case where parental opposition to medical intervention is prompted by scruple or dogma of a kind which is patently irreconcilable with principles of child health and welfare widely accepted by the generality of mankind; and that at the other end lie highly problematic cases where there is genuine scope for a difference of view between parent and judge. In both situations it is the duty of the judge to allow the court's own opinion to prevail in the perceived paramount interests of the child concerned, but in cases at the latter end of the scale, there must be a likelihood (though never of course a certainty) that the greater the scope for genuine debate between one view and another the stronger will be the inclination of the court to be influenced by a reflection that in the last analysis the best interests of every child include an expectation that difficult decisions affecting the length and quality of its life will be taken for it by the parent to whom its care has been entrusted by nature*."

11. That identification of a spectrum of parental opposition is both helpful and recognisable to practitioners.

12. In **Re SL** (supra) MacDonald J characterised the issue of vaccinations as one of "gravity" in which it is appropriate for the Local Authority to give its consent to vaccination pursuant to s.33(3) CA. Vaccinations are not, in my view, properly

characterised as 'medical treatment'. They are a facet of public preventative healthcare intending to protect both individual children and society more generally. In the UK, the vaccination of children is properly reposited with parents, recognising that this is an aspect of parental responsibility rather than a decision of the State. Thus parents who, for whatever reason, decide that their child should not be vaccinated face no sanction.

13. Judges in the Family Division are occasionally called upon to resolve complex questions of treatment which, quite literally, involve life and death. The advances in medical sciences, as well as the evolution of our understanding of the importance of individual autonomy, occasionally create moral, legal and ethical dilemmas which provoke genuine and sincerely held differences of views between parents and doctors. I agree with Waite LJ that where those circumstances arise the court will be slow to override the views or reservations of a devoted and responsible parent. Sometimes, however, the child's interests require the court to do so.

14. It is important to place applications for authority to vaccinate in this spectrum. This is to confront the fact that they lie at the least intrusive end of the scale of intervention. I do not in any way intend to diminish the inevitable stress and anxiety that such vaccination will always carry for loving and responsible parents. But neither do I regard them as a 'grave issue' outside the scope of s.33(3) CA. This provision states:

> "*(1) Where a care order is made with respect to a child it shall be the duty of the local authority designated by the order to receive the child into their care and to keep him in their care while the order remains in force. […]*
> *(3) While a care order is in force with respect to a child, the local authority designated by the order shall–*
> *(a) have parental responsibility for the child; and*
> *(b) have the power (subject to the following provisions of this section) to determine the extent to which*
> *(i) a parent, guardian or special guardian of the child; or (ii) a person who by virtue of section 4A has parental responsibility for the child, may meet his parental responsibility for him.*
> *(4) The authority may not exercise the power in subsection (3)(b) unless they are satisfied that it is necessary to do so in order to safeguard or promote the child's welfare.*
> *[…]"*

15. For completeness, the above section should be considered alongside the general duties of a local authority in relation to LAC, set out at s.22 CA:

> "*(3) It shall be the duty of a local authority looking after any child–*
> *(a) to safeguard and promote his welfare; and*
> *(b) to make such use of services available for children cared for by their own parents as appears to the authority reasonable in his case. […]*

> *(4) Before making any decision with respect to a child whom they are looking after, or proposing to look after, a local authority shall, so far as is reasonably practicable, ascertain the wishes and feelings of–*
>
> *(a)the child;*
> *(b) his parents;*
> *(c) any person who is not a parent of his but who has parental responsibility for him; and*
> *(d) any other person whose wishes and feelings the authority consider to be relevant, regarding the matter to be decided*
>
> *(5) In making any such decision a local authority shall give due consideration–*
>
> *(a) having regard to his age and understanding, to such wishes and feelings of the child as they have been able to ascertain;*
> *(b) to such wishes and feelings of any person mentioned in subsection (4)(b) to (d) as they have been able to ascertain; and*
> *(c) to the child's religious persuasion, racial origin and cultural and linguistic background.*"

16. I have no doubt at all that if the Local Authority had signalled its intention to have T vaccinated under the authority of s.33(3) CA, this would have led to an immediate application on behalf of the parents to invoke the inherent jurisdiction. Nonetheless, I, for my part, can see no reason why what are ultimately routine vaccinations should not fall within the scope of the interventions contemplated by s.33(3) CA. Indeed it strikes me as disproportionate to expect a Local Authority to be required to apply to a High Court Judge to initiate proceedings, the result of which has been in every reported case to authorise vaccination.

17. In this application, as in every application of its kind, the Local Authority has been required to commission an immunisation report. This has been undertaken by Dr Douglas, who has been responsible for assessing T in the course of the LAC adoption medical process, and who has had overall responsibility for T's health throughout his life. T has been subject to interim and now final care orders since birth and is considered by Dr Douglas to be in good health. For reasons that will emerge below, it is important to record that Dr Douglas has considered T's medical records, most recently in preparation for the adoption medical.

18. Dr Douglas' report is not dated but is manifestly very recent. He refers to the guidelines published by Public Health England relating to '**Vaccination of individuals with uncertain or incomplete vaccination status'** by reference to those coming into effect on 1st January 2020. For T, as a full-term, healthy infant, the consequences of not vaccinating him are therefore both generic and specific. Dr Douglas summarises them in these terms, which require to be set out:

> "*1. **Diptheria** is a contagious bacterial infection affecting the nose and throat and sometimes the skin. It is potentially fatal but rare now in the UK due to the success of the vaccination programme. There is a small risk of catching it when travelling in some parts of the world.*

*2. **Tetanus** is a rare but serious bacterial infection caused by the release of toxins when bacteria infect an open wound. The toxins cause muscle spasms and lockjaw which are potentially fatal. Tetanus is rare in the UK due to vaccination and is not contagious but the bacteria is present in soil and manure.*
*3. **Polio** is a viral infection that in a small number of cases can affect nerves in the spine and base of the brain causing paralysis. It is rare now due to effective vaccination.*
*4. **Whooping Cough** is a bacterial infection that can cause dehydration, breathing difficulties, pneumonia and fits. It can be fatal particularly in babies under 6 months of age. In older children it may cause hernias, nose bleeds and sore ribs. Whooping cough is contagious and the pattern of outbreaks occur in a 4 yearly cycle.*
*5. **Haemophilus Influenzae** is a contagious bacterial infection that causes meningitis, sepsis, pneumonia, pericarditis, epiglottitis, septic arthritis, cellulitis, and osteomyelitis. The infection is now rare due to the vaccination programme that started in 1992 but many children who have this infection become very ill. One in twenty with this type of meningitis will die and those who survive have long term problems such as hearing loss, seizures and learning disabilities.*
*6. **Hepatitis B** is a viral infection which can cause hepatitis (liver inflammation). The infection is less common in the UK than other parts of the world but some groups are at increased risk including people from high risk countries, people who inject drugs and people who have unprotected sex with multiple partners. Hepatitis symptoms usually pass within one to three months but some infected people will go on to get chronic hepatitis infection which may cause liver cirrhosis, liver failure and liver cancer later in life.*
*7. **Menigitis B** is a contagious bacterial infection that is a common cause of meningitis in the UK. It is estimated that one in ten cases of meningitis in the UK is fatal. One person in every 2 or 3 who survive have one or more permanent problems as a result of infection. These include hearing loss, epilepsy, learning difficulties, visual loss, loss of limbs, arthritis, kidney problems and co-ordination difficulties.*
*8. **Pneumococcus** is a contagious bacterial infection which can cause pneumonia, septicaemia (blood poisoning) and meningitis. Some infections are fatal and the consequences for children who survive are similar to that for meningitis.*
*9. **Measles** is a highly infectious viral infection that may cause pneumonia and encephalitis (brain inflammation). In rare cases it may cause death. Due to fall in the uptake of MMR vaccination it has become more common in the UK with 991 cases confirmed in 2018.*
*10. **Mumps** is an infectious viral infection that can be complicated by meningitis, encephalitis, hearing loss, pancreatitis, swollen testicles and swollen ovaries*
*11. **Rubella** is an infectious viral infection that can cause a flu-like illness and rash. If contracted by a non-immune pregnant woman it can cause miscarriage and severe birth defects.*

> *12. **Meningitis C** is a contagious bacterial infection that is a less common cause of meningitis in the UK but has similar consequences for people infected with other types of bacterial meningitis.*"

19. Dr Douglas is equally thorough in his review of the potential side effects of vaccination. For both completeness and balance, these too require to be set out:

> "*1. **6-in1 vaccine** is a single injection which protects against diphtheria, hepatitis B, Haemophilus influenza, polio, tetanus, and whooping cough. It is inactivated which means it does not contain live organisms. Very common side effects (more than one in ten) include high temperature, pain and swelling at the injection site, loss of appetite, tiredness, crying, irritability and restlessness. Common side effects (up to one in ten) include diarrhoea, vomiting, high fever and a hard lump at the injection site. Uncommon side effects (up to one in a hundred) include respiratory tract infection, sleepiness, cough and large swelling on the injected limb. Rare side effects (up to one in a thousand) include rash, bronchitis, swollen glands, thrombocytopenia (low platelet count causing bruising/ bleeding) and in premature babies an increased risk of apnoea (pauses in breathing). Swelling of the face, lips mouth and tongue may also occur (angioedema).*
> *2. **Meningitis B vaccine** may cause a fever that peaks around 6 hours after vaccination. Because of this it is recommended to give paracetamol after the injection. Other common side effects include pain, swelling and redness of the injection site, vomiting with or without diarrhoea , crying and irritability. These side effects occur in up to one in ten people. Uncommon side effects include high fever, seizures, dry skin and paleness which may affect up to one in a hundred people. Rarely (up to one in a thousand people) it ca cause Kawasaki disease – prolonged fever, with swollen lymph glands, peeling skin red eyes and skin rash – which requires specific treatment. Very rarely the vaccination can cause an allergic reaction which if severe would need treatment for anaphylaxis.*
> *3. **Pneumococcal vaccine** may cause mild side effects including fever, decreased appetite, irritability, drowsiness and redness or swelling at the injection site. Rare side effects include allergic skin reactions and a high fever leading to febrile seizures.*
> *4. **Haemophilus influenza/meningitis C vaccine** commonly causes fever, pain or redness at the injection site, irritability, loss of appetite and drowsiness. Uncommonly (up to one in a hundred doses) it may cause high fever, rash, vomiting, diarrhoea and skin allergies. Rare side effects (up to one in a thousand doses) may include abdominal pain, feeling unwell and sleeplessness. Severe allergic reactions occur in less than one in ten thousand people who are vaccinated.*
> *5. **MMR vaccine** is a combination of attenuated live measles, mumps and rubella viruses. About a week to eleven days after injection some children get a mild form of measles which includes fever, rash, loss*

> *of appetite and being unwell for two to three days. About one in fifty children develop a mild form of mumps three to four weeks after the injection which includes swelling of the salivary glands in the cheeks and lasts for a day or two. Rare side effects include a small rash of bruise like spots about two weeks after vaccination which is known as idiopathic thrombocytopenic purpura (ITP) and is due to a decrease of platelets (which aid blood clotting). This occurs around one in twenty four thousand doses. This side effect usually gets better without treatment and there is a greater risk developing this side effect from the natural virus infections. Seizures occurring around six to eleven days after vaccination occur in around one in every thousand doses and again it is less likely to develop this complication from vaccination than from natural virus infection. Very rarely severe allergic reactions may occur after vaccination. More complex conditions such as Stevens-Johnson syndrome (inflammation of fatty tissue, skin rashes and ulceration of eyes , skin and mouth) and Guillan-Barre syndrome (a neurological condition causing muscle weakness) have been reported after vaccination but are so rare that the risk cannot be accurately calculated.*"

20. I would point out, finally, that Dr Douglas has also highlighted, in what I consider to be appropriately moderate language, that extensive research has not shown any link between the MMR vaccine and autism. Addressing concerns that the parents have expressed in the past, Dr Douglas emphasises that vaccinations in the UK no longer contain thiomersal (a compound containing mercury). Neither, he states, is there any evidence that the small amounts of aluminium contained as an ingredient in some vaccines cause problems such as dementia or autism. Single vaccinations for the conditions that I have set out above were also not recommended in the NHS schedule, there being no evidence that they are either more effective or any safer in terms of the potential side effects. It is, to my mind, self-evident that for T, as a healthy, young infant, the risks contingent upon not vaccinating him significantly outweigh the benefits. The conditions identified include potential for catastrophic consequences which, as illustrated, involve paralysis, seizure, learning disabilities, visual loss and cancer. T's Guardian comes to the clear conclusion that, "*as a healthy, well-grown baby*" there are "*no contra-indications for T for the vaccines proposed*."

21. In his position statement, Mr Bailey, on behalf of M, particularises her views, in relation to her other children, in order to establish what he terms to be "*the potential impact on T*":

> "*(i) X (22) was in pain for many years after receiving the Gardasil vaccination (HPV), and also led to her being hospitalised for a week. No diagnosis was ever made and still suffers pain today. She was also given 5 doses due to a nurse telling us it was perfectly fine to have extra doses. The recommended dose is 3.*
> *(ii) After receiving vaccinations Y's (11) development was delayed which has led to him having to receive growth hormone*

replacement. It was ruled out that his condition was genetic and to this day it remains a mystery as to why this has happened.
(iii) U (18), F's son, was in good health growing up but now has a condition called Russell-Silver syndrome (SRS-a congenital condition). This was diagnosed when he was 8 years old;
(iv) V (16), F's son, began fitting a week after having the first set of MMR vaccinations. He was subsequently diagnosed with West syndrome (severe epilepsy). V's IRO has informed the parents that V no longer has this condition and no other diagnoses have been made. Currently, V is in a wheelchair, cannot walk, talk, or do anything for himself. He wears nappies 24/7 and self-harms by punching and biting himself. He is said to have a developmental age of a 6 month-old baby.
(v)Research (undisclosed for the purposes of this Position Statement) indicates that a. some vaccinations contain aborted human foetus matter and b. some vaccines contain other ingredients that the mother objects to.
(vi) If T is to have vaccinations then the mother would want these to be given separately as research (undisclosed for the purpose of this Position Statement) shows that multiple vaccines at the same time shock the system and some children go on to develop autism and other conditions. The mother believes that it is safer for T to be given vaccinations separately.
(vii) T is now 10 months old and is in very good health. Apart from a few colds (in foster care) he has not had any childhood illnesses in spite of not being vaccinated and has a strong immune system. Research (undisclosed for the purposes of this Position Statement) shows that babies and children who have a good healthy balanced diet with the correct nutrition build a healthy immune system and do not need to be injected with viruses and heavy metals.
(viii) The Local Authority once informed M than T had contracted measles, but to date this has never been confirmed. If this was in fact the case then M will say that this shows that T's immune system naturally fought of the virus and his immune system is strong."

22. Very properly, Mr Bailey highlights, at (v) and (vi) above, that the research said to support these submissions is "*undisclosed for the purposes of this position statement.*" By this, Mr Bailey was signalling, I think, that he had not seen any such research. In any event, he did not produce any during the course of his oral submissions. Though attractively presented, the submissions are both tenuous and tendentious. They were supported by F, who read from a document which purported to say that some of the vaccinations contained "*MRC-5, the genetic code of a human male*." I pressed F on this, as to what it actually meant, and, in particular, I asked him whether this was the point raised on behalf of M to the effect that some vaccinations contained "*aborted human foetus*." He agreed that it was.

23. At this hearing, in a complete break with all his previous appearances, F did not file any paperwork or a position statement. Neither did he file the document from which he was reading. It is, I consider, significant that F has the 'research' which purports to

be supportive of M's argument but which is not produced by her or her counsel. It points to the indivisibility of their respective cases which has characterised this litigation and reflects the highly dependent relationship of M on her partner, analysed in my previous judgment.

24. Mr Bailey argued that the Local Authority had advanced its application by supporting the principle of immunisation generally. That approach would be misconceived. It was deprecated in **Re SL** (supra); in **Re C and F** (supra); and in **LCC v A and Ors (Minors By Their Children's Guardian) [2011] EWHC 4033 (Fam)**. Mr Bailey queried whether Dr Douglas had seen T's medical records. Whilst the inference of his report was that he had seen the records, it was certainly not explicit. This led Mr Bailey to submit that Dr Douglas and, by implication, the Local Authority itself had not approached the issue with the necessary "*individuation*." By this he meant that the merits and demerits of vaccination had been considered theoretically rather than with specific focus on this child.

25. With respect to Mr Bailey, this point turns to dust in the face of the adoption medical report, which reveals Dr Douglas, in my judgement, to have a detailed and empathetic understanding of his patient. The report highlights:

> "***2. Growth and development.*** *T was born with moderately low birth weight (between 2 and 2.5kg) which is probably due to maternal smoking in early pregnancy. Low birth weight can be associated with poor growth and delayed development although he has shown good catch-up growth since birth and his development is within normal limits at present. However, his growth and development need ongoing monitoring and recognition of any problems such as decreased growth velocity, motor delay or speech and language delay should prompt early referral for assessment*."

26. It also requires to be highlighted that Dr Douglas was aware of the health issues relating to the other children:

> "***5. Sibling medical history.*** *There is a significant sibling history of growth and developmental problems but these do not affect all his siblings and the conditions that his half siblings have often arise spontaneously rather than having a strong genetic link. T does not have a particular risk of developing these conditions*."

27. Concerning T's psychological wellbeing in the future, Dr Douglas noted the background of depression and addiction:

> "***3. Maternal addiction.*** *T's mother has a history of alcohol dependence and alcohol was also abused by maternal grandparents. There is no indication that she drank alcohol during her pregnancy with T and he does not show any signs of Foetal Alcohol Syndrome. However, children of parents with addiction problems have an increased genetic risk of developing addiction themselves and this risk is independent of environmental factors. It is important that*

> *adoptive parents are able to raise this sensitive issue with him when he is older and that they are aware of the risks of peer pressure and experimentation with addictive substances during adolescence.*
> ***4. Maternal depression***. *Children of parents who have a history of depression have an increased risk of developing depression themselves. Depression is extremely common and is experienced by around 10% of people in a lifetime. The chances of developing depression rise to around 26% with a parental history. Depression is often a secondary reaction to adverse events and being brought up in an emotionally secure environment with supportive relationships will help to build resilience and mitigate some of the risk.*"

28. The report considered the impact on T of his early years:

> "***6. Change in care settings.*** *T's mother had a complicated pregnancy and spent some time in prison during this period. His care setting was subject to change in the first few weeks. It is likely that he has been exposed to greater than usual levels of cortisol (the 'stress hormone') during this period. Prolonged exposure can be associated with difficulties in cognitive development and behaviour although the risk of this is mitigated by placement in a supportive and secure environment.*"

29. Priority is given in the report to the fact that T had not received the necessary vaccinations. Dr Douglas emphasised that these immunisations are now required as soon as possible. He stresses the fact that T has not had routine blood spot screening and that, if possible, he should have this completed. Dr Douglas notes that T was not taken for his initial six week check-up. Dealing specifically with the implications for T's future health, it is recorded:

> "***1. Immunisation.*** *T is not currently vaccinated against a range of preventable childhood illnesses detailed in the text. This makes him vulnerable if he is exposed to these infections and he should be vaccinated as soon as possible. There is no medical contraindication for this to be done.*"

30. Dr Douglas summarises his overall conclusion in these terms:

> "*T requires a safe, consistent and emotionally stable family environment free from the risks posed by neglect, addiction and exposure to domestic violence in order to thrive and develop to fulfil his potential. It is important that he has equitable access to all aspects of child health including vaccination against preventable illnesses, health promotion, and monitoring of his growth and development.*"

31. All of this information, weighed alongside the analysis in the main report to which I have referred above, leads Dr Douglas to the clear conclusion that the vaccination

schedule, in the context of T's growth and development, meets his best interests and outweighs such risks as are identified.

32. Mr Bailey also pursues a Part 25 application for the appointment of Dr David Elliman, a highly respected immunologist, who for many years was a member of the British Paediatric Association (now the Royal College of Paediatrics and Child Health). He is one of the editors of the '**Manual of Childhood Infections**', now in its fourth edition. The proposed piece of work, as I understand it, is that Dr Elliman should consider the entire medical histories of each of the children in this family, including T, to evaluate whether there may potentially be any link between their various conditions and childhood immunisations. This would seem to incorporate any link, even with a diagnosed congenital condition. Again, I repeat, Mr Bailey recognises that the research base said to underpin this application has not been disclosed to him by F or, I assume, by M.

33. I consider the application to be entirely without merit. Certainly it is not a 'necessary' report, which is the test I have to apply. Moreover, it would of necessity import significant delay at a time when Dr Douglas considers it is important to proceed with the vaccinations. I accept his evidence. There is in reality no base to the application at all. The objections to vaccination fail to withstand scrutiny. Mr Barnes suggests that to elevate and amplify these objections merely serves to have a "*potentially deleterious effect on the broader public consideration of the question of vaccination.*" He may very well be right, but that it is not a matter that I weigh in the balance when considering this application. My focus is entirely on T and whether these immunisations are in his best interests. I am satisfied that he is a robust and healthy infant and as such requires this basic and essential preventative healthcare.

34. Having heard the submissions on behalf of the Local Authority and M, F, at this late stage in the hearing, made three applications. Firstly, he suggested that I recuse myself. This is an application that he has made on two previous occasions, though it requires to be noted that he has also, at different stages of the case, urged me not to transfer the case to another judge. At this hearing, he suggests that I have demonstrated a "*pro-adoption bias*" driven by what he perceives to be my "*liberalist Blairite agenda.*" This is entirely gratuitous and I need not engage with it. Secondly, F urges me not to appoint a guardian. Thirdly, F objects to any Cafcass involvement, preferring instead an individual appointed by the "*Youth Advocacy Service.*" As I understand it, the foundation for this objection lies in F's assertion that Mr Edward Timpson, the Chair of Cafcass, is also part of the "*pro-adoption agenda.*" Given that the issue at this hearing is confined entirely to the question of immunisation, I asked how F considered the bias he perceives to exist would have an impact, in any event, on this particular question. F did not respond.

Conclusion

35. For the reasons that I have analysed above, I consider that this question of immunisation properly falls within the Local Authority's remit, as prescribed by s.33(3) CA. However, given that it comes before me as a contested application for a declaration under the inherent jurisdiction, I am prepared to grant the declaration sought by the Local Authority. I take this approach because I am entirely satisfied that

had the Local Authority signalled that they intended to pursue the schedule of immunisation under s.33(3) CA, this would have been met by an immediate application on behalf of the parents for a declaration that such a course would be unlawful. Thus, the inherent jurisdiction would have been triggered in any event.