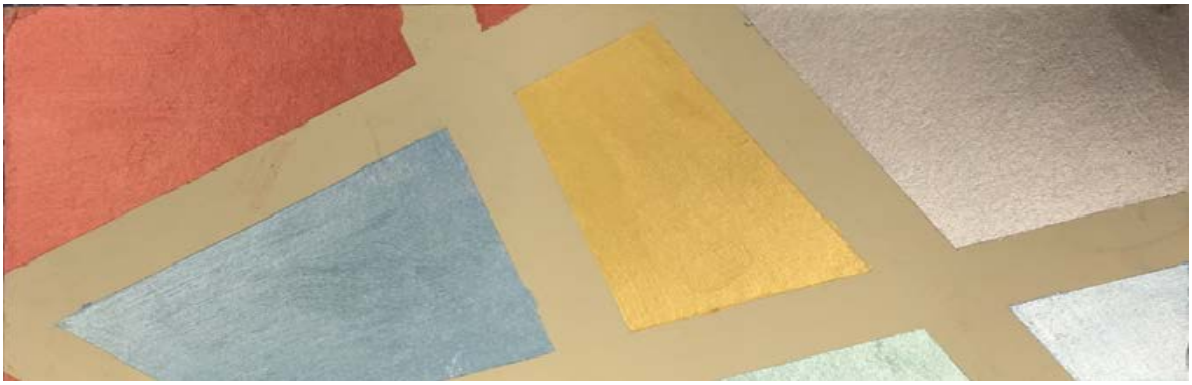
# RAPID RESPONSE GUIDANCE NOTE: VACCINATION AND MENTAL CAPACITY (SIXTH UPDATE)

December 2022



## A: Introduction

1. The Court of Protection team are regularly asked for assistance as to the legal position in relation to vaccination for COVID-19. What follows is a general discussion, as opposed to legal advice on the facts of individual cases. It primarily relates to the position in England in relation to those aged 18 and above; specific advice should be sought in respect of Wales and those under 18. Reference should also be had to the NHS's standard operating procedure. Please note that it is important to use the most recent version of this guidance note, which can always be found on our website here.

## B: The context

2. This guidance note does not address clinical matters such as the precise effect of vaccination on the risk of onward transmission. Professionals should keep themselves abreast of the developments via Chapter 14A of the 'Green Book.' Rather, this guidance note addresses the question of how decisions should be made about the administration of vaccines in individual cases.

3. In many cases, the person in question will actively want vaccination, and have capacity to consent to it. Materials to document consent can be found here, although it should always remembered that:

    a. a person only completes and signs the form if they are actually able to consent (and indeed also **does** consent);

    b. the **record** of consent is secondary in importance to the **process** of considering consent.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

4. In supporting a person to make the decision whether or not to have the vaccination, it may help to have reference to our capacity assessment guide. As that guide makes clear, it is important to identify the information that it is relevant to the decision in question. The Green Book, Chapter 2, suggests that information should include details of the process, the benefits of immunisation, and the risks, including rare and common side effects and what to do if they occur. Importantly, the Green Book identifies that "[w]*here feasible, healthcare professionals seeking consent should find out what matters to individuals so that they can share relevant information about the benefits and risks of immunisation, including the risks of not proceeding with immunisation*."

5. Useful materials to help in the process of communicating information to the person include:

   a. A guide to vaccinations for COVID-19 | British Society for Immunology: not an 'easy read' guide, but a clear source of information about vaccination;

   b. The PHE/NHS Easy Read *Guide to your COVID-19 Vaccination*;

   c. The "wordless story" *Having a Vaccine for Coronavirus* from Books Beyond Words;

   d. The collection of materials for those working with people with learning disabilities gathered by Oxford Health NHS Foundation Trust.

6. In *E (Vaccine)* [2021] EWCOP 7, Hayden J observed (at paragraph 11) that:

> *Evaluating capacity on this single and entirely fact specific issue is unlikely to be a complex or overly sophisticated process when undertaken, for example, by experienced GPs and with the assistance of family members or care staff who know P well.*

7. Hayden J has made similar observations in *E (Vaccine)* [2020] EWCOP 14 and in *SS v London Borough of Richmond Upon Thames & Anor* [2021] EWCOP 31, in the latter case also noting that the doctor's record that "patient failed capacity assessment" was awkwardly expressed, as it is not a test that is passed of failed, but an evaluation of whether the presumption of capacity has been rebutted and if so, for what reason.

8. However, what happens if the person (1) does not have capacity to decide to be vaccinated; or (2) has capacity to decide to be vaccinated but refuses to be? We address each in turn.

## C: Lack of capacity to decide

9. If the person lacks capacity to decide whether to have the vaccination, then, unless there is a health and welfare attorney or deputy who can consent on their behalf,[3] or unless the person has made

[3] The attorney or deputy is bound by the same obligations to consider the person's best interests as professionals. As noted in the next footnote, we do not think that vaccination constitutes life-sustaining treatment. This means that, in principle, a deputy could refuse it, as could any health and welfare attorney albeit that such a decision would be constrained by the requirement always to act in P's best interests.

an advance decision to refuse vaccination,[4] the relevant professionals will have to decide whether they reasonably believe that vaccination is in the person's best interests. A very important point in practical terms here is **who** the relevant professionals will be. We discuss the concept of who the decision-maker is for purposes of the MCA 2005 in our best interests guide; precisely who should be treated as the decision-maker in this context will depend upon how the vaccination is being delivered. The process of delivering the vaccine across the country is being led by the NHS, and in the community by the Primary Care Network. It is overwhelmingly likely, therefore, that the decision-maker will be a healthcare professional. However, it is not necessarily the case that the actual vaccination will be carried out by (for instance) the patient's GP.[5]

10. Whoever is, in fact, going to be the decision-maker in any given case, the critical points[6] are:

    a. That whoever is actually administering the vaccine must be in a position properly to say that they reasonably believe that the person lacks capacity to consent, and that they are acting in the person's best interests;

    b. That these beliefs may arise because they, the person administering the vaccine, have assessed the person's capacity and made their own decision as to whether vaccination is in their best interests. In many cases, though, and especially those of any complexity, the person actually administering the vaccine will be acting on the basis of a plan which has been drawn up and agreed by everyone interested in the person's welfare. At the point of delivering the vaccination itself, they will need to be satisfied that the plan remains the right one, but the more detailed the plan, the easier it will be for them to be satisfied;

    c. Well before the actual date for the potential administration of the vaccine, therefore, it will be necessary for those involved to start collating the information required to enable a best interests determination to be made, which will mean consulting with family members (and, where relevant, friends) as those best able to give input as to the person's wishes, feelings, beliefs and values. This is not the same as saying that the decision rests with those family members, even if one of them might have parental responsibility for the person when they were a child.[7] In the context of a care home, the relevant forms for obtaining information from

[4] Our view is that it is unlikely that an advance decision to refuse vaccination would constitute an advance decision to refuse life-sustaining treatment, so as to give rise to the additional requirements for validity contained in s.25 MCA 2005 (i.e. that the advance decision must be witnessed, be in writing, and to state that it is to apply even if life is at risk). This, however, may have to be tested in court. If a person has made an advance decision to refuse vaccination, and if it applies to the vaccination in question (which, by definition, is unlikely unless the decision was made since the start of the pandemic, unless it was a blanket refusal of **any** vaccination), then they would be in the same position, legally, as a capacitous individual refusing to consent.

[5] The Standard Operating Procedure for delivery of vaccination in the community provides that this can be undertaken by non-registered healthcare providers, appropriately trained, supported and supervised by a clinician.

[6] Which are consistent with, but more detailed than, the points made at page 39 of the Standard Operating Procedure.

[7] This point was forcefully reiterated by Hayden J in *Re RN* [2022] EWCOP 53.

family members (and also for obtaining a decision from an attorney) can be found here. This consultation may also involve consideration of adjustments that need to be made in order to provide the vaccine, such as arranging for it to be given to the person in their own home, or obtaining a prescription for a sedative.

11. There cannot be a blanket decision that vaccination is in the best interests of a group of residents or patients, as this would be contrary to the requirement of the MCA 2005 that it is the best interests of that particular person at that particular time which are determinative.[8] Further, in *SD v Royal Borough of Kensington And Chelsea* [2021] EWCOP 14, Hayden J identified that "*there is a strong draw towards vaccination as likely to be in the best interests of* [the person]. *However, this will not always be the case, nor even presumptively so*" (paragraph 33).[9]

12. It is also important to be clear that the decision is to be taken at the time, in the context of the person's actual situation: in *Re A (Covid-19 vaccination)* [2021] EWCOP 47, for instance, HHJ Brown endorsed vaccination as being in the best interests of the person, but declined to give authorisation in advance for a booster vaccination to be administered, noting that:

> *The guidance and medical advice may have changed by the time any booster may be required. Any individual would wish to consider whether to have the booster at the time that it is available and those representing AD should be afforded the same opportunity. I respectfully accept the submission of the Official Solicitor that it would represent "overreach" to sanction administration of the booster at this time.*[10]

13. In many cases, it may be possible to identify that the person, were they able to, would consent to the vaccination if they had capacity, in which case the decision is an easy one, as there would be

[8] See *Aintree v James* [2013] UKSC 67 at paragraph 39 (all case references here are hyperlinked to case-law summaries).

[9] In *A CCG v DC* [2022] EWCOP 2 at 34, HHJ Burrows found "no reason" to think that the approach applied in relation to children by Macdonald J in *M v H, and P & T* [2020] EWFC 93 should not apply in relation to adults: i.e. that it would be very difficult to foresee a case in which vaccination would not be endorsed as being in the person'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.*" With respect, it is suggested that this is problematic to the extent that it does not properly account for the distinction that needs to be made in respect of (older) children and adults to take into account their wishes, feelings, beliefs and values. That there is no presumption in favour of vaccination was made clear by Poole J in *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15 at 37. However, in the context of a series of cases in which family members have sought to challenge the decision to offer vaccination on the basis of challenges to the underlying legitimacy (and clinical validity) of the vaccination programme, Poole J also made clear (at paragraph 53(iii) that "[t]*here 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*." The challenges have continued since Poole J's judgment, the most recent attempt being rebuffed by Hayden J in December 2022 in *Re RN* [2022] EWCOP 53.

[10] Although it is relevant to consider that this decision was given before booster vaccination was part of accepted public health guidance, so this is an example of the court applying the situation-specific approach.

an alignment between 'what P would have done' and the outcome that would be in their best interests. Adopting this approach, Hayden J found this to be the case in both *E (Vaccine)* [2021] EWCOP 7 and *SD v Royal Borough of Kensington And Chelsea* [2021] EWCOP 14, cases in which family members had expressed reservations about the person receiving the vaccine. In both cases, Hayden J found that those reservations reflected the views of the family member, rather than the person themselves. In *Re IOSK* [2021] EWCOP 65, Senior Judge Hilder took a similar approach. In *NHS Liverpool CCG v X and Y* [2022] EWCOP 17, HHJ Peter Gregory was 'unpersuaded' that the individual in question would automatically align herself to the position of the family members involved and decline the vaccination, and accepted submissions made on her behalf that, if she had capacity, she would appreciate that she would be appropriately designated to be in the 'vulnerable' category to whom the virus represented a greater level of risk.

14. In some cases, it may not be possible to identify the person's wishes and feelings as regards the precise question of vaccination. In *Re CR* [2021] EWCOP 19, HHJ Butler considered the situation of a young man with learning disabilities, whose father was concerned about his receiving the vaccine on a number of grounds. HHJ Butler identified what factors CR would consider if he were likely to be able to do so, which were a combination of 'generic' facts about vaccination, and specific facts about his own position and risks to him were he to contract COVID.[11] In *Re IOSK* [2021] EWCOP 65, Senior Judge Hilder noted that the young man in question had previously accepted vaccinations without difficulty, and that it was generally agreed he liked being outside and being active, liking social contact on his own terms, and would wish to be able to engage in such things as far as possible in the future. In *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15, Poole J[12] identified that it was not possible to know what the individual's own values and beliefs would have been had he capacity nor was it possible to ascertain his present wishes and feelings about the issue in question except to note that he was likely to want to participate in the full range of activities available for residents at his home.

15. Even if it is clear that the person would **not** have wished to receive the vaccine, or is currently expressing a wish to refuse it, the best interests test is – ultimately – not a pure 'substituted judgment' test, and it is legitimate to take into account other factors in deciding whether to override the person's known past or present wishes, above all the risks to them if they catch COVID-19. However, this is a decision which should be taken with due caution: in *SS v London Borough of Richmond Upon Thames & Anor* [2021] EWCOP 31, Hayden J found that it was not in the best interests of SS to receive the vaccine, a conclusion founded upon a combination of: (1) the evidence

[11] In both *CR* and *Re IOSK*, the concerns arose in part because of parental beliefs around the links between the MMR vaccination and the current presentation of the person: as Senior Judge Hilder emphasised in *Re IOSK* (following the Court of Appeal in *Re H (A Child)(Parental Responsibility: vaccination)* [2020] EWCA Civ 664, there is simply no basis on which a belief in such a link could be considered properly based (paragraph 34).

[12] Who did conduct a 'thought experiment' as to what P would have done, before reaching the conclusion set out above. Poole J also accepted that vaccination would "enable him to be risk assessed as a vaccinated individual for activities which should open up to him the same opportunities to participate in the full range of activities that he has enjoyed in the past" (paragraph 50). He rejected in so doing a submission made that he should ignore such a factor because any restrictions based upon P's vaccination status would arguably unlawful (see paragraph 45).

that she would have declined it had she had capacity; (2) the relatively low risk that SS herself was at in her specific circumstances; and (3) the fact that she would have had to be restrained in order to receive it.

16. To the extent that vaccination has a public health element, it is important to recall that best interests checklist provides for the taking into account of 'other factors that [the person] would be likely to consider if he were able to do so' which might, depending on the person, include the effect the decision will have on those around them.[13] That would mean that, in asking whether the person would have consented, it would be relevant to consider whether they would see themselves as a 'responsible citizen'[14] more broadly.

17. Although vaccination involves at least one injection, in most cases it will be possible to carry it out in such a way that it cannot sensibly be said that any restraint of the individual will be required. If restraint or sedation is required, then consideration will have to be given as to whether the conditions in s.6 MCA 2005 are met. We note that these conditions include a specific focus upon whether the act in question is necessary to prevent harm to the person[15] (as opposed to others). Wherever vaccination appears primarily to be for the benefit of the person, it seems relatively clear that in most cases the first hurdle – necessity – would be satisfied. It would still, though, be important to consider whether restraint would be proportionate. By way of example, in *Re A (Covid-19 vaccination)* [2021] EWCOP 47, the use of sedative medication, but not physical force, was authorised. The court has also been willing to approve arrangements in which the person is not told in advance that they will be receiving the vaccine. However, if it is clear that the person is likely to resist at the point when they do see the vaccinator, that is a factor which needs to be taken into account, and may (depending on the facts) lead to the conclusion that it is not in their best interests for the process to be undertaken. As HHJ Burrows noted in *A Clinical Commissioning Group v FZ & Anor* [2022] EWCOP 21 (at paragraph 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.*

18. Linked to this, particular care will be needed if the reason to consider that the process of carrying out the injection, itself, would cause the person serious distress or other harm – for instance if they cannot tolerate a needle. We should note that Hayden J was very clear in in *SS v London Borough of Richmond Upon Thames & Anor* [2021] EWCOP 31 that in the particular circumstances of SS's

[13] Best interests might include "*altruistic sentiments and concern for others*": see Report on Mental Incapacity (1995) Law Com No 231 at para 3.31; see also *Aintree v James* [2013] UKSC 67 at [24].
[14] See, for the idea of being a responsible citizen, *SSHD v Sergei Skripal; SSHD v Yulia Skripal* [2018] EWCOP 8 and the MCA Code of Practice at paragraphs 5.47-48.
[15] Section 6(2).

case the potential that restraint might be required was a very strong pointer against administration of the vaccine being in her best interests.[16] In any case where there is no other way of securing administering the vaccine in an acceptable fashion other than by more than minimal restraint, we strongly advise seeking legal advice as to whether an approach to the Court of Protection is required.[17]

19. An approach to the Court of Protection may also be required where:

a. There is a disagreement between the professionals and the person's attorney or deputy which cannot be resolved, or a dispute about an advance decision to refuse treatment. If a health professional proposed to administer the vaccine despite the person having made an advance decision to refuse it, they would need to apply to the Court of Protection for a declaration that the advance decision was invalid or inapplicable. Similarly, if professionals consider that an attorney or deputy is not acting in the person's best interests, and if after appropriate discussion they do not change their mind, an application to the Court of Protection will be required. In that application, the most important evidence will be as to why the best interests of the person dictate that they are vaccinated. Evidence as to the motive of the attorney or deputy in refusing will be less relevant unless their refusal indicates that they might be ill-suited more broadly to continuing to discharge their functions;

or

b. There is no attorney or deputy (or relevant advance decision) but it is not properly possible to say that there is a consensus as to whether or not vaccination is in the person's best interests. It is important to note, however, that judges of the Court of Protection have made clear that they now consider COVID-19 vaccination to be routine, such that disagreements amongst family members should be resolved without the need for court proceedings.[18] In particular, they have made clear that disputes which are "*at their root disagreements about the rights and wrongs of a national vaccination programme*[19] are not suitable for determination by the court."[20] In deciding whether there is a lack of consensus requiring application to the Court of Protection, therefore, professionals can and should focus on whether the concerns raised by family

[16] Interestingly, Hayden J was also clear that the approach suggested by SS's nephew of playing upon her belief that her father was alive to seek to persuade her that he wished to have it was inappropriate. There might be situations where this could be justified, but the hurdle would be a high one.
[17] See the Serious Medical Treatment Guidance issued by the Vice-President in January 2020 ([2020] EWCOP 2).
[18] *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15 at paragraph 52 per Poole J.
[19] Or about the relevant guidelines, as:
*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.*
*North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15 at paragraph 53(ii) per Poole J, citing Hayden J in *SD v Royal Borough of Kensington And Chelsea* [2021] EWCOP 14.
[20] *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15 at paragraph 53 per Poole J.

members (or others) relate to the issues specific to the person's situation addressed above. If the concerns raised are, in effect, concerns about the legitimacy (in the broadest sense) of the concept of COVID vaccination, the 'steer' given by the courts is that professionals can be robust in concluding that these do not impact upon whether vaccination is in the best interests of the person concerned.

20. We have been asked on a number of occasions whose responsibility it is to bring a case to the Court of Protection in either of the situations above. Somewhat frustratingly, the courts have still not given a clear answer, and the waters are muddied by the fact that the vaccine rollout proceeded in a way which has (in effect) bypassed many of the conventional NHS structures, so it is not as easy as it is in some other medical treatment situations to identify the relevant medical body to bring the application. We say 'medical body' because, as this is a medical decision, it seems to us that the primary responsibility for bringing the application will be a medical body as opposed to (for instance) the local authority. However, ultimately, as identified by Hayden J in *SD v Royal Borough of Kensington And Chelsea* [2021] EWCOP 14 (at paragraph 14):

> *When an issue arises as to whether a care home resident should receive the vaccination, the matter should be brought before the court expeditiously, if it is not capable of speedy resolution by agreement. This is not only a question of risk assessment, it is an obligation to protect P's autonomy.*[21]

21. The courts will therefore – rightly – not be sympathetic if delays in identifying who is responsible leads to delays in bringing the application: it is always possible for one body to bring an application on the basis that they do not consider that they are the 'right' body but that they recognise that the priority is to get the situation before the court. A salutary focusing of the mind is also often obtained by the sending of a pre-issue letter (required in any event by Practice Direction 3B: see paragraph 2.2) sent by the 'last resort' applicant in such a situation to the other body or bodies who are declining to act, and indicating an intention to seek the costs of making the application.

22. We have been asked whether vaccination for COVID-19 constitutes serious medical treatment for purposes of s.37 MCA 2005, which would mean that it would be necessary for any NHS body carrying out the vaccination[22] to instruct an IMCA if the person is 'unbefriended.' We can now say with some confidence that this is not the case as a general proposition.[23] However, if there is a specific reason to consider that the very process of carrying out the vaccination (for instance to overcome any resistance on the part of the person) would be likely to "involve serious

[21] The need to avoid delay was also reiterated by Poole J in *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15.
[22] It is not clear whether every vaccination will be carried out by an NHS body. There is a gap in the law in relation to a situation where the vaccination is to be carried out by someone else as the duty to instruct an IMCA would not arise.
[23] Not least because of the observations of Poole J to this effect in *North Yorkshire Clinical Commissioning Group v E (Covid Vaccination)* [2022] EWCOP 15 at paragraph 52.

consequences for the patient" or "there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail", then it may be that an IMCA should be instructed. In any event, however, and as set out above, this is a situation in which it is suggested that an approach to the Court of Protection is likely.

23. We should note that everything that we have said above could apply in any setting – including the inpatient psychiatric setting where the person is detained under the MHA 1983.[24]

## D: Capacitous refusal

24. We cannot see that there is a power to compel a person to undergo vaccination if they have capacity to decide whether or not to have the vaccine and refuse.[25] We say this also in relation to patients detained under the MHA 1983, because it would be difficult to say that vaccination for COVID-19 represents treatment for mental disorder. If it is not treatment for mental disorder, the relevant professionals cannot avail themselves of the provisions of Part 4 of that Act so as treat against the patient's will.

## E: Useful resources

25. Useful free websites include:

- The 39 Essex Chambers Mental Capacity Resource Centre – database of guidance notes, case summaries and case comments from the monthly 39 Essex Chambers Mental Capacity Law Report (to which a free subscription can be obtained by emailing marketing@39essex.com).
- www.mentalcapacitylawandpolicy.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to 'do' the MCA 2005 better. It has a specific page of resources relating to COVID-19 and the MCA 2005.
- www.lpslaw.co.uk – a website set up by Neil which includes videos, papers and other materials (much of them free) relating both to the Liberty Protection Safeguards and the MCA 2005 more widely;
- www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.
- www.scie.org.uk/mca-directory/ - the Social Care Institute of Excellence database of materials relating to the MCA.

[24] See in this regard here also the article by Callum Ross and others: COVID-19 Vaccination in those with mental health difficulties: A guide to assist decision-making in England, Scotland, and Wales.
[25] Or have made a valid and applicable advance decision to refuse it.

Chambers UK Bar
Court of Protection:
Health & Welfare
*Leading Set*

The Legal 500 UK
Court of Protection and
Community Care
*Top Tier Set*

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