Neutral Citation Number: [2021] EWCOP 31

Case No: COP 13496635

COURT OF PROTECTION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 30/04/2021

Before :

THE HONOURABLE MR JUSTICE HAYDEN
VICE PRESIDENT OF THE COURT OF PROTECTION

- -

Between :

SS **Applicant**
(by her Accredited Legal Representative)

- and -

London Borough of Richmond upon Thames **1st Respondent**

- and –

South West London Clinical Commissioning Group **2nd Respondent**

- -
- -

Ms Rebecca Handcock (instructed by **Atkins and Palmer**) for the **Applicant**
Mr Tony Harrop-Griffiths (instructed by **South London Legal Services**) for the **1st Respondent**
Ms Amelia Walker (instructed by **South West London CCG**) for the **2nd Respondent**

Hearing dates: 30th April 2021

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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.

.....

THE HONOURABLE MR JUSTICE HAYDEN

This judgment was delivered following a remote hearing conducted on a video conferencing platform and was attended by members of the public and the press. 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 applicant 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. The Court is concerned with SS, an 86-year-old woman currently residing in a care home. This application is brought within the context of proceedings under section 21A of the Mental Capacity Act 2005. SS has a diagnosis of dementia, and is objecting to her placement in the Care Home, believing that she still lives with her (long deceased) parents, and needs to return to their home and resume working at the job she held in her youth. She has no recollection of the property she owns, or of the majority of her life-story. I have been told that SS is a woman who has never married, does not have children and has no history of personal relationships. She lived with her parents for much of her life.

2. For a long time, she worked for the Lyons cake factory in Chiswick, as a secretary. At 4pm, every afternoon she grabs her handbag and jacket and prepares to return to her parents' home, believing that she is still at work. A member of the care staff discovered that at the Lyons factory a siren sounded at 4pm signalling home time. Her carers consider that in her own mind SS is living at some point in the late 1940's or early 1950's. When SS grabs her handbag and jacket the care staff deal with her gently and sensitively. Almost as soon as she leaves the care home, she becomes overwhelmed by the outside world. This is before she gets to the end of the garden.

3. These proceedings were issued in July 2020, and have been progressing constructively, with the matter being set down for a final directions hearing on 19th April 2021. The parties have largely been in agreement throughout proceedings and matters appeared to be heading towards a conclusion in respect of SS's standard authorisation, relevant conditions, and her wider best interests in respect of care and residence. After extensive and detailed evidence from the Local Authority, the remaining options being considered for SS's care and residence are either to remain in her current placement, or to move to a smaller, more "homely" residential placement, the Local Authority expressing a preference for the latter.

4. Dr Pramod Prabhakaran, was instructed to undertake an assessment and to provide an expert opinion addressing whether SS has an impairment or disturbance in the functioning of the mind or brain and whether she has capacity: to conduct these proceedings; to decide where she should live and make decisions about her care and support. Dr Prabhakaran is a Consultant Psychiatrist (general adult psychiatry and psychiatry of older adults). He made the following pertinent assessment of SS's mental state:

> *"21. SS was initially reluctant to engage but cooperated with the support of staff. She was able to focus and maintain eye contact. There was evidence of emotional lability, predominantly irritability but I could not elicit features of depression or mania. I could not elicit any psychotic symptoms.*
>
> *22. There was also no evidence of acute changes in level of alertness suggestive of an acute confusional state.*
>
> *23. SS did not engage in a formal cognitive assessment but there was evidence of marked global deficits including in orientation to time and place, impairment in short-term memory and deficits in executive*

> *functioning, affecting judgement and insight. She had limited insight into her health and care needs. She denied she had any memory issues, she had limited insight relating to the extent of cognitive impairment, and of how this affected her activities of daily living and care and support needs."*

5. In his more general observations Dr Prabhakaran noted:

> *29. SS has a progressive neurodegenerative condition i.e. Dementia, manifesting with multiple cognitive deficits that affect orientation, memory, language and executive functioning. Although she is able to understand information, in my opinion, she is unable to retain, use and weigh up information of a complex nature especially when there are several parts to the information or considerations that need to be considered at the same time.*

6. Later in his report Dr Prabhakaran recorded the following observations whilst evaluating SS's capacity to make decisions regarding residence and care:

> *32. Due to the severity of her cognitive deficits, SS was disoriented to the fact that she was residing in a care environment and receiving support from the care staff. SS had limited insight in relation to her care and support needs. In my opinion, SS was able to understand the information provided, but unable to retain, use and weigh up this information. The information in relation to her care and accommodation needs was repeated in order to support SS to retain and use the information. However, SS was unable to repeat any of the salient aspects of the information discussed.*
>
> *33. I explored SS's views about where she wished to live. She explained that she was living in her own home and was visiting. I explained to SS that she was receiving support within a care environment. SS did not appear to retain this information. She did not use it as part of a decision-making process.*

7. It is clear that SS lacks capacity in all the spheres of decision taking assessed by Dr Prabhakaran. Those conclusions are accepted by both the Applicant and the Respondents in these proceedings.

8. The application today has been brought due to concerns relating to SS refusing the Covid-19 vaccination. This arises in the context of SS having become increasingly resistant to medical interventions of any kind. Whether this is due to her advancing dementia or is a longer-term feature of her personality and general approach to life is unclear.

9. The care home is a large care home, it has a hundred members of staff. At the outset of the pandemic the care home had 99 residents. Within the first few months of what has become known as the first lockdown, 27 of the residents died from infection with the Coronavirus i.e. almost 28% of the community. I heard from the team leader at the care home, Ms Kelly Fisher and the manager of the care home, Ms Christine Fisher. They gave evidence, with Ms Kelly Fisher taking the lead and her colleague making

supplementary observations. I found the two women to be profoundly impressive. Their understanding of SS was insightful, caring and sensitive. Despite the challenging times carers and residents have lived through, their commitment to their work and to the people they care for was striking. People who enjoy their work reveal themselves quickly when they talk about it. It was obvious that they both enjoyed working at the care home.

10. As I hope is apparent, from the detail in the prefacing passages of this judgment, which derives from the carers' evidence, they succeeded in bringing something of the nature and personality of SS into the court room. Both Ms Fishers had seen death in consequence of this virus at close quarter. They were under no misapprehension about how dangerous and insidious the virus is. They also indicated to me the distressing and frightening nature of its impact. Those awful months in 2020 will stay in the minds of these two women almost certainly forever, at least in some way. I had a sense that the continuing challenges of the present have not yet afforded them any real chance for reflection. I also sensed that they were not yet entirely ready to do so.

11. Since January 2021, the general practitioner, Dr N, has been visiting the care home on a regular basis to administer initial and follow-up vaccinations to residents and staff. She has regularly spoken with SS to try to encourage her to have her vaccination. This has been reinforced by the care staff. Dr N conducted a capacity assessment with SS on 23rd March 2021, she noted:

> *"patient appears confused and unable to fully understand. Initially agrees to have vaccination and reports will go down the road to her usual doctor and get it. Subsequently refuses the vaccination. Carer.. re explained what I had relayed to the patient and the patient has difficulty understanding the reason for the call and the vaccinations. Doesn't appear to understand what Coronavirus is despite being explained to twice. Unable to retain any information given. Patient then declines to continue with the consultation. Patient failed capacity assessment as unable to fully understand the information given nor retain the information [SS] doesn't have capacity to consent for Covid-19 vaccination.*
>
> *In the event of a best interest meeting, I would support vaccination and it would not be necessary to review the patient's capacity at the time of administration of vaccine given that her dementia is a progressive condition since at least 2019 when it was last formally assessed."*

12. The ambit of this assessment strikes me as entirely consistent with that contemplated in: **SD v Royal Borough of Kensington And Chelsea [2021] EWCOP 14; E (Vaccine) [2021] EWCOP 7**. I hope Dr N will not think me too pedantic if I make the observation that *"patient failed capacity assessment"* strikes me as awkwardly expressed. It is not a test that an individual passes or fails, it is an evaluation of whether the presumption of capacity has been rebutted and if so, for what reason.

13. Dr N completed a full and more detailed assessment on 31st March 2021. She has produced a written report. In it, Dr N makes the following observations:

> *"I understand a court protection order is pending. I suspect if the decision is made to administer the vaccine, the administration would be challenging with this patient. Any physical restraint would need to be necessary and proportionate with the minimum amount of force for the shortest period of time. I believe restrictive physical intervention will be required in this case to protect the patient and staff from coming to harm. Clinical holding by several staff members should be sufficient for administration in this case. However, this would be a decision taken jointly with the vaccine administrator and care home staff."*

14. This application was made on 29th March 2021, following discussion between the parties, at that time the Local Authority and SS's Accredited Legal Representative. The South West London Clinical Commissioning Group (CCG) had not yet been joined as a party.

15. In preparing to make this application, those representing SS have reviewed her medical history and spoken with TB, who is her cousin, next of kin, and the only relative with whom she is in contact. TB prepared a short statement in which he considered that SS'S father would have encouraged her to take the vaccine. He, it seems, was an enthusiastic follower of science. Her Mother was a freer and less conventional spirit, she was a *"spiritualist and believed in ghosts"*. SS was deeply attached to both her parents. In her confusion she remains so. She believes she still lives at home with them.

16. TB has, on occasion, felt constrained to deploy this confusion to practical utilitarian effect. By way of illustration, when TB brought SS's clothes to the care home, SS initially refused to accept them. TB told her that they had been specifically sent by her parents for her to wear. She accepted this and happily wore the clothes. This strategy, I sense, has been resorted to on occasions of frustration. Looked at in isolation, through the prism of court proceedings, it may seem to be a deception. I think it would be wrong to characterise it in this way but the appropriateness of such an approach must be evaluated in its particular context. It has been suggested that a similar strategy, invoking a fiction of parental approval, might be deployed in encouraging SS to comply with the vaccine.

17. Ms Kelly Fisher told me that SS had struggled to establish trusting relationships with the care workers and other professionals. With gentle persistence SS now shows a greater degree of cooperation and interaction. Much of her spirit, fight and independence remains but on a day to day basis there are certain individuals whom, I am told, she feels she can trust.

SS's belief structure

18. SS is recorded as having been compliant with her medical regime when she first arrived at the care home. However, as has become clear from several sources, there came a point when she discovered a newspaper article which she read as arguing that medicine *"did more harm than good"*. Quite when she first came by this article is unclear. In any event she had not been at the care home for very long before she started to brandish it, with characteristic forcefulness, at anybody who sought to afford her medical care of any kind. The consequence has been that SS has been almost entirely non-compliant with any attempted intervention. Ms Kelly Fisher told me that some attempt had been

made to administer covert medication to keep SS's blood pressure more stable. However, she said SS was *"like a blood hound"* who could tell something was amiss and this plan was abandoned. I hasten to add that she made this remark in an affectionate way. Indeed, I was struck by the extent to which all Ms Fisher's remarks about SS were both kind and respectful.

19. In June 2020 SS developed a rash on her legs. Even though this only required the application of cream SS resisted steadfastly. Staff and medical professions made great effort with her to encourage her to receive the treatment, but the outcome can only best be described as having "limited success".

20. In her report, (see para 13 above) Dr N reviewed the medical records and noted that there is no record of SS receiving any vaccination of any kind at all. The records go back to 1997. Even more strikingly there is an unambiguous note that SS declined both seasonal influenza and pneumococcal vaccines when offered them by the surgery. The first of these refusals is recorded in 2002 with entries identified in 2010, 2012 and 2014. Thus, there is a clear and consistent pattern of behaviour which predates SS's diagnosis of dementia by a significant period.

21. As Ms Hancock, counsel for SS, points out, whilst the above behaviour gives a strong indication of what SS's capacitous wishes and feelings might be on the question of the Covid-19 vaccination, that must still be placed in the context of medical records which signal a history of co-operation and engagement with medical professionals. The notes prior to 2015 reveal SS to be a woman who is responsible and proactive in her treatment. Thus, there is a pattern of routine blood tests every few years; vital signs checked and monitored annually by the GP surgery; she has attended walk-in clinics, out-patients hospital clinics (on six occasions, with various complaints, between 2002 and 2010). It is also notable that she underwent a series of sometimes intrusive investigations between 2004 and 2009 e.g. endoscopy, x-rays and ultrasounds. As the dementia took hold, SS was noted to have presented to her pharmacist seeking to collect her prescribed medications before finishing the previous prescription. It seems likely that this behaviour reflected her deteriorating short-term memory. Reinforcing this is a changing pattern, after 2015, when SS misses appointments, fails to pick up prescriptions etc.

Evaluation of risk to SS

22. Apart from her cousin, TB, who has, in the past, visited approximately 3 or 4 times per year and during the period of social restriction spoken to her occasionally by telephone, SS receives no visitors at all. She is reserved and private in her approach to life and temperamentally inclined to keep her distance from others. She is at very low risk of infection from the other residents, all but one of whom has been vaccinated.

23. As care homes finally open up to more visits from family and friends, an identifiable risk is presented which has to be negotiated. This large care home makes provision for compulsory lateral flow test to visitors, many of whom will themselves be fully vaccinated. There is a further risk presented by staff members. The team leader in the care home has told me that 77 of the 100 members of staff have been vaccinated. Of the 23 who have not been, a few have declined for recognised medical reasons. The remaining individuals resist the vaccine in principle, some believe that it is, as yet, insufficiently tried and tested. By this, as I understand it, they are contemplating some unidentified adverse reactions which have yet to be exhibited.

24. Certainly, nobody could sensibly doubt the efficacy of the vaccination programme. The National Health England statistics, almost daily updated in the public domain, tell their own explicit success story. A few weeks ago, Covid-19 was reclassified as 'endemic' in the UK i.e. no longer 'pandemic'. The forthcoming months generate cause for optimism but without any guarantees. The need for booster vaccinations and/or vaccinations modified to combat Covid variants remains a likelihood. Thus, the greatest risk, statistically, to SS comes from unvaccinated members of staff circulating in the community away from the care home. Properly recognising this risk Ms Christine Fisher tells me that all staff members are required to have two lateral flow tests per week and one Polymerase Chain Reaction (PCR) test. The extent of the weekly testing reflects the calculation of risk. Having manifestly given the matter very deep consideration, Ms Fisher told me that ultimately, though she would wish all staff to be vaccinated, she considered the decision to have the vaccination to be an exercise of personal choice.

25. For all the reasons set out above, there can be no doubt that SS lacks the capacity to take a decision on the question of vaccination. Nobody has sought to argue to the contrary. The issue for the court therefore is one of determining what is in SS's best interests. Having regard to the available evidence I consider that there is substantial material from which to conclude that SS if capacitous would most likely have declined the vaccination. Though she attended quite fastidiously to her general medical welfare, she plainly resisted vaccinations. The evaluation of what SS would have wanted is in this case, inevitably imperfect. Capacitous individuals facing a frightening pandemic might very well take a different view of a vaccination which restores them to their liberty than, for example, a decision not to take a flu vaccine. Ultimately, the forensic tapestry can only be woven from the available thread. However, it must be borne in mind that even though a capacity to weigh and balance the decision in focus has long disappeared, SS has nonetheless consistently and volubly opposed the vaccination. SS's reality is undoubtedly delusional, but that does not stop it being her reality. This has to be both recognised and respected.

Best interests

26. There is now a considerable body of case law setting out the appropriate approach to the weight to be given to the wishes and feelings of an individual who has lost capacity. In **Barnsley Hospital NHS Foundation Trust v MSP [2020] EWCOP 26**, I reviewed many of the cases. It is unnecessary for me to do so as extensively here.

27. In **Re M, ITW v Z [2009] EWHC 2525(COP) [2011] 1WLR 344** (at para 35) Munby J (as he then was) observed:

> *"I venture, however, to add the following observations:*
> *(i) First, P's wishes and feelings will always be a significant factor to which the court must pay close regard: see Re MM; Local Authority X v MM (by the Official Solicitor) and KM [2007] EWHC 2003 (Fam), [2009] 1 FLR 443, at paras [121]-[124].*
> *(ii) Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry*

> *very little weight. One cannot, as it were, attribute any particular a priori weight or importance to P's wishes and feelings; it all depends, it must depend, upon the individual circumstances of the particular case. And even if one is dealing with a particular individual, the weight to be attached to their wishes and feelings must depend upon the particular context; in relation to one topic P's wishes and feelings may carry great weight whilst at the same time carrying much less weight in relation to another topic. Just as the test of incapacity under the 2005 Act is, as under the common law, 'issue specific', so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.*
> *(iii) Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to all the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:*
> *a) the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings: Re MM; Local Authority X v MM (by the Official Solicitor) and KM at para [124];*
> *b) the strength and consistency of the views being expressed by P;*
> *c) the possible impact on P of knowledge that her wishes and feelings are not being given effect to: see again Re MM; Local Authority X v MM (by the Official Solicitor) and KM, at para [124];*
> *d) the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and*
> *e) crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests."*

28. In **M v N (by her litigation friend, the OS), Bury Clinical Commissioning Group [2015] EWCOP 9**, I noted (at paras 28 & 30):

> *"...where the wishes, views and feelings of P can be ascertained with reasonable confidence, they are always to be afforded great respect. That said, they will rarely, if ever, be determinative of P's 'best interests'. Respecting individual autonomy does not always require P's wishes to be afforded predominant weight. Sometimes it will be right to do so, sometimes it will not. The factors that fall to be considered in this intensely complex process are infinitely variable e.g. the nature of the contemplated treatment, how intrusive such treatment might be and crucially what the outcome of that treatment maybe for the individual patient. Into that complex matrix the appropriate weight to be given to P's wishes will vary. What must be stressed is the obligation imposed by statute to inquire into these matters and for the decision maker fully to consider them.*
> *Finally, I would observe that an assessment of P's wishes, views and attitudes are not to be confined within the narrow parameters of*

> *what P may have said. Strong feelings are often expressed non-verbally, sometimes in contradistinction to what is actually said. Evaluating the wider canvass may involve deriving an understanding of P's views from what he may have done in the past in circumstances which may cast light on the strength of his views on the contemplated treatment. Mr Patel, counsel acting on behalf of M, has pointed to recent case law which he submits, and I agree, has emphasised the importance of giving proper weight to P's wishes, feelings, beliefs and values see Wye Valley NHS Trust v B."*

29. Identifying the best interests of an incapacitated person is to be determined in accordance with s.4 MCA 2005 the key parts for these purposes provide:

> *"(2) The person making the determination [for the purposes of this Act what is in a person's best interests] must consider all the relevant circumstances and, in particular, take the following steps.*
> *(3) He must consider—(a) whether it is likely that the person will at some time have capacity in relation to the matter in question, and (b) if it appears likely that he will, when that is likely to be.*
> *...*
> *(5) Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.*
> *(6) He must consider, so far as is reasonably ascertainable—(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.*
> *(7) He must take into account, if it is practicable and appropriate to consult them, the views of— . . . (b) anyone engaged in caring for the person or interested in his welfare, . . .as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6)."*

30. Applying these provisions in **Aintree University Hospital NHS Trust v James [2013] UKSC 67** Baroness Hale stated:

> *"[39] The most that can be said, therefore, is that in considering the best interests of this particular patient at this particular time, decision-makers must look at his welfare in the widest sense, not just medical but social and psychological; they must consider the nature of the medical treatment in question, what it involves and its prospects of success; they must consider what the outcome of that treatment for the patient is likely to be; they must try and put themselves in the place of the individual patient and ask what his attitude towards the treatment is or would be likely to be; and they must consult others who are looking after him or are interested in his welfare, in particular for their view of what his attitude would be."*

> *"[45] Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being."*

The options

31. Dr Prabhakaran filed an addendum report, dated 30th April 2021, he outlines the options as follows:

> *"**Potential options available in a non-consenting adult such as SS**:*
>
> *3. I note that there has been no record of SS ever having been administered sedative medication including benzodiazepines or antipsychotics. In such a 'neuroleptic naïve' individual, it would be advisable to use sedative medication such as Lorazepam (0.5 mg – 1 mg) orally as a single dose approximately one hour before the proposed injection. This is an anxiolytic and sedative medication which is used across NHS trusts in management of anxiety, sleep disorder and also in management of acutely disturbed behaviour. Lorazepam is available as an oral solution. Consideration could be given to covert administration in SS's best interests. I would not advice use of an antipsychotic medication such as Haloperidol or Olanzapine (antipsychotic medication).*
>
> *4. Use of a sedative medication such as Lorazepam often leads to a reduced need for physical restraint. Physical restraint should it be required, would need to be proportionate, performed in conjunction with use of appropriate communication and de-escalation methods by experienced staff. Staff trained in behavioural management and control procedures should be deployed where possible. Staff familiar with SS should be available during the vaccine administration process so as to reassure her, de-escalate and support her in the post-vaccine administration period.*

The likely impact upon SS of administering the Covid-19 against her wishes using any of the available methods, and how any such risks could be minimised:

5. With vaccination, there remain some general risks including common side effects of pain in injection site, swollen lymph nodes, general malaise. of side effects, and with Astra Zeneca vaccine, rare risk of blood clots.

6. In SS's case, due to the presence of advanced dementia, SS would be at higher risk of developing 'Delirium', an acute confusional state due to the vaccination.

7. It is likely that SS will manifest with irritability and possibly agitation and a degree of hostility, during the process and in the subsequent period. Staff that SS has a positive relationship and familiarity with should be available to support her during this period. She may also require continued treatment with anxiolytics for a few days following the injection. Other supportive measures such as analgesics and anti-inflammatory medications may be required for general side effects."

32. I would add to the identified options above, TB's suggestion that SS be told that her father (now long dead, though very much alive in her mind) has requested that she take the vaccination, in the hope that this will cause her to comply. This involves feeding into a delusional belief system. Whilst that may occasionally have been necessary in negotiating routine day to day challenges, it risks, in this context, compromising all involved. It requires there to be a collusion to trick SS into complying with a vaccination which, on balance, it seems unlikely she would have wanted whilst capacitous and certainly does not want at this point. It is an artifice of a different magnitude and complexion to those earlier more mundane negotiations. It becomes disrespectful to her, not merely as the woman she once was but to the one she is now. Though undoubtedly a well-intentioned suggestion, it risks compromising her dignity and suborning her autonomy. It cannot, in my judgement, be in her best interests. I entirely understand TB's instinctive view that such means might justify the end, given the protection that the vaccine would afford SS. I hope he does not read my reasoning above as, in any way, intended to be a criticism of him. It most certainly is not.

33. Alongside my own evaluation of risk, in the context of the situation in the care home, it is important to consider Dr Prabhakaran's medical assessment of risk:

"8. General infection risk in care homes in England has reduced considerably due to various factors, as below.

- *Covid infection rates are currently very low in England.*
- *There has been a high level of vaccination uptake amongst care home residents and health and care staff. Vaccines have been effective with studies demonstrating that healthcare staff are 86% less likely to develop infection after two doses of vaccine.*

- *Sero-positivity rate in age group 70-84 is high at 98.4 in weeks 12-15 2021(April data – see attachment)*
- *Effective use of PPE. And other infection prevention and control measures.*
- *Effective test and trace including use of rapid lateral flow testing visitors to care homes.*

9. However, SS would be considered 'clinically vulnerable' based on Public Health England criteria primarily due to age, presence of advanced dementia and other medical conditions such as hypertension and high cholesterol. Although current infection levels remain low, residing in a care home environment confers a higher risk of being infected with coronavirus compared to being in a private residence. There are concerns of a third wave of Covid 19, which would place SS at higher risk."

34. Dr Prabhakaran has provided a succinct and up to date summary of the risk of infection in care homes. He emphasises both SS's clinical vulnerability and the implications for her in the event of a further '*wave of Covid-19'*. In crisp and unambiguous terms, the medical risk assessment underscores the important message that whilst in the UK people are no longer dying from infection in anything like the numbers they were, they continue to live with it. It has not gone away, and further vaccinations and/or booster injections may be with us all for some time to come.

35. Where a question of vaccination of an incapacitated person arises, in the context of a care home, these cases are now usually heard by judges sitting in Tier 1 and Tier 2. The cases of **SD v Royal Borough of Kensington And Chelsea; E (Vaccine)** (supra at para 11 above) were heard at Tier 3 (i.e. the High Court) in the early stages of the availability of the vaccine, when the issue was a novel one and in order to assist the courts below. This case has been allocated to Tier 3 because it presents, for the first time, an opportunity to evaluate strongly and consistently expressed views by P relating to vaccination and the weight they should be given, in the broader landscape of the insidious risk arising from the Covid-19 public health crisis.

36. It was submitted on behalf of the CCG that the Court should conclude that vaccination is in SS's best interests. For all the reasons Dr Prabhakaran says I have no doubt that is correct, were I to confine the issue solely to the health-related states, events and data he identifies. A determination of "best interests" in this context however is, for all the reasons discussed above, not to be confined to the epidemiological; it requires evaluating welfare in the broader sense. As Baroness Hale said, it requires us to put ourselves in the place of the individual concerned.

37. I was told that there was no question of SS being supine or passive if she recognised that the vaccination was being given against her will. One of the carers noted that those involved in attempting any "gentle restraint" had better be "kung fu experts", as she put it. The plan which involves both sedation and restraint contemplated the carers' involvement. Ms Fisher did not think that was appropriate. She told me that she thought that SS would look to her carers for help. They would not be able to intervene; that would be distressing for both parties. Moreover, in Ms Fisher's analysis it would most likely dismantle the tentative trust that had been established over the months and in

consequence of sensitive and determined professional effort. I find this reasoning to be measured and persuasive. The Local Authority and the Accredited Legal Representative on SS's behalf both submitted that when evaluating welfare in the broader sense, it could not be said to be in SS's best interests. I agree.

38. I delivered this judgment, ex tempore, whilst sitting remotely by video conferencing platform. A note was prepared by counsel and I have perfected it, incorporating documentary references (**Piglowska v Piglowski [1999] UKHL 27**).