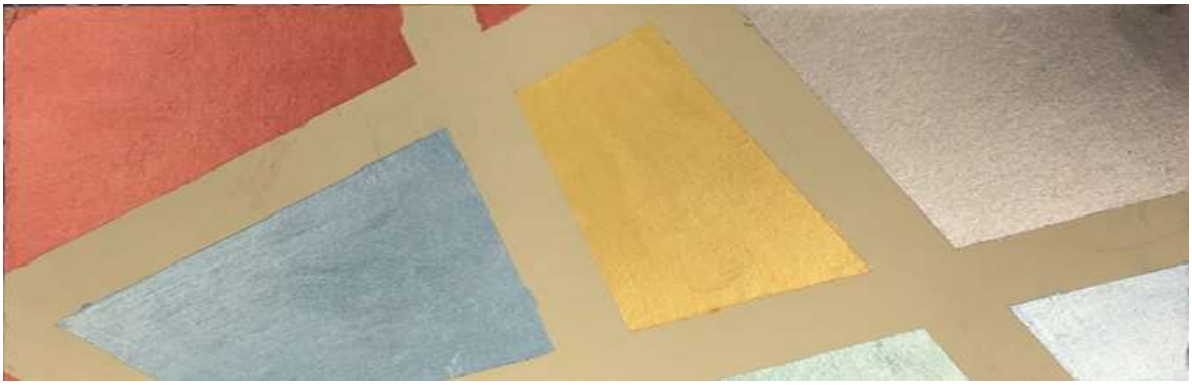
RAPID RESPONSE GUIDANCE NOTE: VACCINATION AND MENTAL CAPACITY (THIRD UPDATE)

February 2021



A: Introduction

1. The Court of Protection team has been asked to advise on a number of occasions 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 DSHC's guidance, which now includes specific reference to vaccination, as well as to NHS guidance, including the standard operating procedure for community settings available here (this guidance referring to the 14 January 2021 iteration, addressing in Appendix D care homes, and Appendix E housebound individuals). Readers may also find useful our rapid response guidance note on testing, available here.

B: The context

2. Vaccination is seen as a key part of the Government's strategy to bring COVID-19 under control. This guidance note does not address the very important – and difficult – issue of prioritisation of vaccines. Rather, it addresses the question of how decisions should be made about the administration of vaccines in individual cases.

3. Whilst there are clear indications that the vaccines being administered may serve to lower the risk of onward transmission, the evidence base at present is still clearest that the primary benefit is to the person themselves. The picture is still evolving, however, and professionals should keep themselves abreast of the developments via Chapter 14A of the 'Green Book.'

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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.

5. 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.

6. 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 NHS's standard operating procedure for primary care networks for the community setting published on 10 December 2020 (most recently updated on 14 January 2021) suggests that the relevant information is:

    a. the anticipated benefits of vaccination in the simplest of terms;

    b. the likely side effects from vaccination and any individual risks they may run;

    c. the disbenefits of not consenting to the vaccination.

5. We also suggest that, in addition, the relevant information includes the number of injections that will be required.

6. 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.

7. 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.*

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

7. 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 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]

8. 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 is 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 this belief 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

[3] If the attorney or deputy refuses, then there will be a serious question mark as to whether they are acting – as they are required to – in the best interests of the person; at that point, unless they change their stance, an application to the Court of Protection will be required. As noted in the next footnote, we do not think that vaccination constitutes life-sustaining treatment such that, in principle, a deputy could refuse it, as could any health and welfare attorney. If it does constitute life-sustaining treatment, then a deputy could not refuse it, and an attorney could only refuse it if specifically empowered to do so.

[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 envisages in Appendix A that vaccination itself will 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 in Appendix D to the Standard Operating Procedure document noted above, Appendix D being directed to the situation where vaccination is being provided in care homes. Appendix E, relating to those individuals who are housebound, adopts the same approach to capacity and best interests as Appendix D.

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. As emphasised in the DHSC's guidance, 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. In care home context, the relevant forms for obtaining information from family members (and also for obtaining a decision from an attorney) can be found here.

9. 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.[7] 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).

10. However, with one exception and bearing in mind that it all does depend on the circumstances, it is likely that vaccination would be in the person's best interests for the following reasons:

a. 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 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;

b. Even if it is clear that the person would not wish to receive the vaccine, 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 wishes, above all the risks to them if they catch COVID-19.

11. As noted at paragraph 3 above, the picture is evolving in relation to whether the vaccines on offer serve to reduce the risk of onward transmission. It should not therefore be assumed that the public health matters that we discuss in our testing guidance note will be relevant – i.e. that having

[7] See *Aintree v James* [2013] UKSC 67 at paragraph 39 (all case references here are hyperlinked to case-law summaries). Blanket decision-making in the context of COVID has been identified in the DHSC guidance about testing as being problematic; it is also of course problematic as a general principle of public law.

the vaccine means that the person may pose less of a risk to others.

12. If and when it does become clear that vaccination has an identifiable public health element, then we note that the 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.[8] 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'[9] more broadly.

13. We should also emphasise that, despite media reports, at present **not** being vaccinated does not have consequences for the person in terms (for instance) of access to buildings or services. This, therefore, should not play into the consideration at present, but if the position does change then this will be another factor potentially speaking in favour of vaccination being in the person's best interests.

14. 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 – which would not necessarily need to involve physical force – is required, then consideration will have to be given as to whether the conditions in s.6 MCA 2005 are met. We note that the conditions include a specific focus upon whether the act in question is necessary to prevent harm to the person[10] (as opposed to others). At present, where 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.

15. The one caveat to the position that vaccination is likely to be in the person's best interests is where there is proper 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. In such a case, and if there is no other way of securing administering the vaccine in an acceptable fashion, we **strongly** advise seeking legal advice as to whether an approach to the Court of Protection is required.[11]

16. An approach to the Court of Protection may also be required where it is not properly possible to say that there is a consensus as to whether the vaccination is in the person's best interests. In *SD v Royal Borough of Kensington And Chelsea* [2021] EWCOP 14, Hayden J emphasised (at paragraph

[8] 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].
[9] 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.
[10] Section 6(2).
[11] See the Serious Medical Treatment Guidance issued by the Vice-President in January 2020 ([2020] EWCOP 2).

14) that:

> *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.*

17. 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[12] to instruct an IMCA if the person is 'unbefriended.' Whilst vaccination undoubtedly constitutes medical treatment, it is not immediately obvious that it would fall within the definition of serious medical treatment for the purposes of the MCA and the associated regulations. 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 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.

18. 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.

D: Capacitous refusal

19. By comparison with the equivalent section in the guidance note on testing, this section can be short. 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.[13] We say this also in relation to patients detained under the MHA 1983, because we cannot see how it could sensibly be said 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.

20. If the legal fiction is that the person is refusing because either an attorney or deputy (with the appropriate power to do so) is refusing on their behalf, careful consideration will need to be given as to the position. If those involved consider that the 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.

[12] 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.
[13] Or have made a valid and applicable advance decision to refuse it.

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.

E: Useful resources

21. Useful free websites include:

- www.39essex.com/resources-and-training/mental-capacity-law – database of guidance notes (including as to capacity assessment) 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.mclap.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 to both the Mental Capacity Act 2005 and Mental Health Act 1983. 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.

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