

**Mr Justice: Sumner**

Introduction

1. There are 2 applications before me relating to 2 girls. One of them is 4 years old the other is 10 years old. The applications are in no way connected. They do however raise the same issue and have other points in common. For that reason they have been listed together.
2. Each of the girls live alone with their mother. Neither of the mothers has been married to the fathers. The fathers have been granted parental responsibility orders by the court in respect of their daughters and are in contact with them.
3. The girls have not been inoculated nor received any form of immunisation. Though it is strongly recommended by doctors and widely taken up, it is not a legal requirement. The fathers wish their daughters to receive a range of immunisation appropriate to their age. The mothers oppose that course. There is therefore a dispute between the parents involving the welfare of their child.
4. Where there is such a dispute between parents which they are unable to resolve, either of them may apply to the court for a specific issue order pursuant to s.8 of the Children Act 1989 to determine the issue. The fathers have so applied. This is believed to be the first time that the question of immunisation has arisen for determination. Other disputes involving for instance medical treatment, choice of schools, and change of name quite frequently arise.
5. In all such cases, under s.1 of the Children Act 1989, the court has to determine whether immunisation is in each of the girls' best interests as their welfare is the court's paramount consideration. If it is in their best interests, the court has next to consider whether there are good reasons why that declaration should not be made. Such reasons might arise if making the declaration would so affect the mother that her ability to care for the child would be impaired, or it would be otherwise adverse to the child's best interests.
6. If there are no reasons and it is in the child's best interests, I am asked by the fathers to make a declaration and give directions. It is hoped that, if the court makes the declaration asked for, an agreement may be reached between the respective fathers and mothers without further court appearances.

## The hearing

7. The hearing has taken longer than was expected. A week was fixed in Winchester from 8 to 12 July 2002. Only the evidence of the parents could be heard. The balance of the week taken was spent considering an application by the press that the hearing be in open court. I ruled against that.
8. A further week was arranged from 9 to 13 December. I heard medical evidence on that occasion and submissions from counsel.
9. Finally 2 further days were listed on 10 and 11 February 2003. This was because of a point raised by one of the parents on which further expert evidence was required. Since then there has been a further hearing on 2 May 2003 relating to matters to be excluded from any publication of the judgment, and the form of the order that results from the judgment.
10. The hearing has involved the wishes and beliefs of each of the parents. It has also involved a consideration of a range of childhood illnesses in respect of which immunisation is available. It has meant that within a limited time scale a substantial body of evidence has had to be considered. The task which would not have been possible without the great assistance that I have received from counsel.
11. Mr Cohen QC with Miss Branigan and Mr Kelly appeared on behalf of the fathers. Miss Gumbel QC with Miss Davis and Mr Courtney-Stewart appeared on behalf of the mothers. CAFCASS Legal represent the 2 children. They were represented by Miss Mayer, now Her Honour Judge Mayer, and subsequently Miss Probyn.
12. I propose to set out my judgment in the following way. Firstly I shall set out the disputed medical evidence and then the evidence relating to each of the parents. I shall consider the relevant law. I shall then turn to whether there are reasons why an order and declaration should not be made. In the light of the law and my conclusion on the facts, I shall reach my decision.
13. I shall not make public details personal to the families for the same reasons that I gave for refusing to hold the hearing in open court. It is because the court does not permit publication of information relating to children.
14. Before I consider the family details, I shall set out the position of each of the parties and the main grounds on which they rely. This will set the parameters within which this dispute is to be decided.

## Summary of the parties' arguments -the fathers

15. They do not differ in their approach. They say that there is convincing medical evidence supporting immunisation. It shows that the risk of serious illness or infection for a child with all the complications which may arise if they do not receive appropriate immunity demonstrate that vaccination is in their best interests.
16. They accept that no programme of immunisation is without risk. Those risks are however heavily outweighed by the benefit for a child of a full immunisation policy. If that is established, there are no good reasons why the policy should not be implemented. To go against the mothers wishes, though upsetting for them, is not such as should deter the court from making the declaration sought.

## The mothers

17. The mothers unite in their opposition to any immunisation at all. The basis upon which they do so differs to some extent. But they are in agreement that immunisation presents unacceptable risks.
18. One mother was never immunised herself and came to no harm. Her daughter has not come to any harm either. She does not believe in it and it is wrong to impose immunisation upon her.
19. To the other mother it represents a total rejection of the holistic approach to life that she has adopted. She breast fed her daughter for 3 years partly to ensure that her daughter had all the advantage of her own immunity. Vaccination is not required and is contrary to all her strongly held beliefs.
20. Both say that the emotional effect on them of making the declaration should be taken into account, given the strength of the views they hold. Both are involved in other disputes with the fathers. It would be unduly distressing for them to have an invasive procedure imposed on their daughters contrary to their wishes.
21. They claim that the medical evidence in support of immunisation is uncertain. The sheer volume of medical evidence produced on these applications implies that the benefits have not been established.
22. There are two additional anxieties. Firstly there is the Vaccine Damage Payments Act 1979 under which payments for damage caused by vaccination are still being paid. Secondly litigation is pending in the High Court

concerning claims on behalf of a group of children said to be adversely affected by the combined measles, mumps and rubella injections ("MMR") that they have been given. This adds to their worries.

23. Secondly it is for the fathers to show that the making of an order is better for each of the children than not making one. This arises under s.1(5) of the Children Act. That has not been established.
24. Finally there is the right to respect for family and private life set out in Article 8 of the European Convention of Human Rights. It provides that a public authority including the court will not interfere in the right to respect for private and family life except for the protection of health or morals or for the protection of the rights or freedoms of others. That protection has not been proved.

### CAFCASS Legal

25. At an early stage CAFCASS Legal, the successor to the Official Solicitor, was appointed as an independent party with considerable expertise to represent the best interests of the children. They carried out their own investigation, appointed an expert to prepare a report and were represented by counsel. After careful consideration they support the application made by the fathers.
26. Against that background I turn to the medical evidence and then the details of each family. Unless the context indicates otherwise what follows represents my findings of facts.

### The medical evidence

27. I heard from 3 doctors. Dr Conway was instructed on behalf of the fathers, Dr Donegan was instructed on behalf of the mothers, and Professor Kroll by CAFCASS Legal on behalf of the 2 children.
28. Before I summarise their evidence and set out my conclusions, I shall refer to their respective standing in the medical world and the expertise they bring to the issues they were asked to consider. I shall also consider the extent to which I have been able to rely upon their evidence in forming my decision.

### Dr Conway

29. He is a consultant in paediatrics and lead physician of nearly 15 years standing at St. James's Hospital, Leeds, one of the largest children's hospitals

in the UK. He has a special interest in infectious diseases and immunology. He is the co-author of some 100 medical papers.

30. He has held a series of positions on national and international bodies. In particular he has been since 1995 a member of 3 Committees relevant to the issues before me. They are the Royal College of Paediatrics and Child Health Infectious Diseases and Immunology Group Committee, the Joint Committee on Vaccination and Immunisation (an independent body advising the Department of Health), and his College's Standing Committee on Immunisations and Infectious Diseases.
31. He was a clear and careful witness. He spoke with authority and an understanding of both his subject and the concerns of parents which I found impressive.

### Professor Kroll

32. He has been for nearly 10 years Professor of Paediatrics and Molecular Infectious Diseases at Imperial College School of Paediatrics. He too is the author or co-author of some 100 medical papers. He has researched in particular the agents responsible for major human infections.
33. He is a member of various national Committees. He is a member of or Vice-Chairman of 2 of the Committees of which Dr Conway is also a member and mentioned above.
34. His great knowledge and professional standing is obvious. He was a no less impressive witness. His anxiety to meet parent's concerns was clear. He supported Dr Conway in all his conclusions save as I otherwise indicate. Where they differed it was in emphasis rather than on any fundamental points.
35. Both were anxious to accommodate the views of both sets of parents. They accepted without reservation that parents have a right to decide about immunisation for their children. They recognised that immunisation was an area where concerns, personal beliefs, and religious convictions might well discourage a parent from accepting the advice they were given.
36. In supporting the present immunisation policy, I find that they spoke from no doctrinal basis nor from an inclination to support the views of the Department of Health. I am satisfied that I heard from 2 leading experts in their field who formed their own opinions. They both fully understood their obligations as experts to the court. The opinions they held were genuine and based on learning and informed research and practical experience.

## Dr Donegan

37. She was called as an expert witness on behalf of the mothers. She is a General Practitioner and Homeopath. Qualified for nearly 20 years, she was originally a strong supporter of the national Childhood Vaccination Programme. She regarded those who did not vaccinate their children as misguided and socially irresponsible. She immunised her own 2 children.
38. She started to look more closely at the whole area in the early 1990s when advice was given about an expected measles outbreak. This was to boost the immunisation they had already had. To her this meant that advice previously given about the effectiveness of the original vaccination became suspect. She started wider reading on the subject and published some medical papers.
39. With patients in general she gives information not recommendations. She discussed pros and cons. She does recommend vaccinations where parents do not vaccinate and are terrified whenever their child is ill. She gives advice given by the Department of Health and other advice.
40. She prepared 2 main reports for the hearing. They throw doubt on the combined views of Dr Conway and Professor Kroll. Mr Cohen QC accurately summarised her general principles as follows -
  - i) Over the years diseases have become milder.
  - ii) Immunity declines because of the effectiveness of immunisation.
  - iii) Even where there are no contrary indications, immunisation is likely to do more harm than good.
  - iv) Decline in the incidence of disease has been due not to immunisation but other factors.
41. She said that her views had been informed by reading a large number of medical papers. Her reports refer to over 120 which she exhibited. She argued that they supported her claims.
42. This caused Dr Conway and Professor Kroll to examine those papers and produce further papers themselves. In all they fill 4 lever arch files. I have not read or scanned the majority of them. It has not been necessary given the analysis in their reports.

43. I have endeavoured to follow the medical arguments and reach conclusions based on the written evidence. I have also had the advantage of hearing the evidence of all 3 doctors.

44. It has not been a well-balanced exercise. At the end of her first statement Dr Donegan made this declaration -

"... this is an independent medico-legal report based on my opinion, knowledge and research on the diseases, their vaccines and taking into account the particular cases of the children involved. I understand that the court will use it in coming to a decision as to what is in the best interests of the children involved. I have indicated my sources extensively. The facts and opinions expressed in this report are true and accurate to the best of my knowledge. I confirm that any fees are independent of the outcome of the case."

45. I regret that Dr Donegan has not fulfilled that declaration. Mr Cohen submits that she has not understood nor complied with her duty to the court. I am satisfied that his submission is well founded. Had I heard her evidence alone, I might have been misled and could well have reached a decision not supported by the research upon which she largely relied.

46. Such a difficult decision is more easily reached in the light of Dr Donegan's answers in cross-examination, sometimes with disarming frankness. Thus she expressed the view in evidence that if a parent did not vaccinate a child and was terrified every time the child was ill, that terror could have an effect on the immune system of the child. She accepted in cross-examination that there was not a medical paper she had found which suggests there is such a link; she did not tell parents that.

47. She agreed that the Faculty of Homeopathy recommended that, where there were no medical contraindications, "then immunisation should be followed". She does tell patients of this but she does not agree with it.

48. Again though she does not for instance support vaccination for diphtheria and quoted papers in support, all the authors to which she referred agree with regular diphtheria immunisation. She did not mention this.

49. Her explanation was that sometimes the facts relied upon by the authors do not support their conclusions especially where they are backing immunisation. She considered that they were so pro vaccination that they did not see the wood for the trees, a description she accepted that could be applied to her.

50. It was she agreed appropriate to alert the court to the fact that all the authors she quoted, save for 2, did not agree with her views; she did not do so. She accepted that despite her view to the contrary, there was no evidence for instance that the virulence of diphtheria had diminished.
51. She was against immunisation for whooping cough. Not one of the authors she cited was against it, a fact to which she had not drawn attention. She argued that one study which she accepted underestimated the problem. She did not say that it had been heavily criticised for the opposite conclusions.
52. I was referred to 2 authors who were against immunisation. This was in a paper written over 30 years ago in respect of a vaccination no longer in use.
53. Dr Conway considered Dr Donegan's first paper in a response of over 60 pages with which Professor Kroll entirely agreed. I am satisfied he was not over critical. But at various places he points to Dr Donegan being confused in her thinking, lacking logic, minimising the duration of a disease, making statements lacking valid facts, ignoring the facts, ignoring the conclusion of papers, making implications without any scientific validation, giving a superficial impression of a paper, not presenting the counter argument, quoting selectively from papers, and of providing in one instance no data and no facts to support her claim.
54. Professor Kroll in his response adds 3 particular points where he consider Dr Donegan has been somewhat selective in her quotations from medical papers. He considered she conveyed a misleading impression in one case, and made unsubstantiated claims in another. All their criticisms are well founded. Dr Donegan answered these charges but only in cross-examination accepted the points I have set out earlier.
55. Mr Cohen rightly drew my attention to guidance on the duties of experts in giving evidence in family proceedings. He relies upon *Re R (A Minor) (Expert's evidence)* (1991) 1 FLR 291 and *Re AB (Child Abuse: Expert Witness)* (1995) 1FLR 192.
56. He says that though the Civil Procedure Rules Part 35 does not apply to family proceedings, the guidance effectively follows it. I am satisfied that his submission is well founded.
57. I set out the relevant parts of CPR 35 -

"CPR 35.3

### 35.3 Experts -overriding duty to the court

- (1) It is the duty of an expert to help the court on the matters within his expertise.
- (2) This duty overrides any obligation to the person from whom he has received instructions or by whom he is paid.

### CPR 35.10

#### 35.10 Contents of report

- (1) An expert's report must comply with the requirements set out in the relevant practice direction.

### EXPERT EVIDENCE -GENERAL REQUIREMENTS

1.1 It is the duty of an expert to help the court on matters within his own expertise: rule 35.3(1 ). This duty is paramount and overrides any obligation to the person from whom the expert has received instructions or by whom he is paid: rule 35.3(2).

1.2 Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation.

1.3 An expert should assist the court by providing objective, unbiased opinion on matters within his expertise, and should not assume the role of an advocate.

1.4 An expert should consider all material facts, including those which might detract from his opinion.

1.5 An expert should make it clear:

- (a) when a question or issue falls outside his expertise; and
- (b) when he is not able to reach a definite opinion, for example because he has insufficient information.

1.6 If, after producing a report, an expert changes his view on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court."

58. I am compelled to the reluctant conclusion that in this case Dr Donegan has allowed her deeply held feelings on the subject of immunisation to over rule the duty she owes to the court. She has the capacity to see that when it is pointed out and to accept it. Her views are genuine in the sense that she has now convinced herself. But on an objective approach I have been unable to accept her conclusions where they differ without independent corroboration.
59. It follows that I consider that on the issue of immunisation I should treat her evidence with great reserve until she complies with the guidance to which I have referred. When I continue by looking at various childhood illnesses and the nature, effectiveness, and side effects of the immunisation which is available, I lack a reliable opinion which differs from Dr Conway and Professor Kroll.
60. This is a disadvantage on such an important subject. But I have heard careful, balanced and I conclude convincing evidence from them on which I have felt able to rely. I therefore turn to it, inevitably in summary form.

#### Diphtheria -The Disease

61. It is an acute infectious disease. It is spread by coughs and sneezes as well as by infected bedding or clothes. The bacteria can be detected in people who have no symptoms but can pass it on to others. The infection causes an acute inflammatory reaction of the superficial tissues and a diphtheria membrane is formed usually in the throat. It can affect the heart, kidneys and nerves. It can be fatal.
62. Most deaths are due to obstruction of the airway by the membrane and the effects on the heart or nervous system. Treatment is mainly supportive. Anti-toxins and penicillin therapy are of unproven benefit. The immunisation is given together with a tetanus injection.
63. There is a low risk of becoming infected in the UK. It is rife in some Baltic states, parts of the former Soviet Union, and Eastern European countries. There are risks from travellers from abroad or visiting certain countries. National immunisation started in the UK in 1940 resulting in a fall in the number of cases from over 46,000 with 2,000 deaths to 37 cases and 6 deaths in 1957.

## Immunisation

64. Professor Kroll described it in evidence as a terrible disease; the risk of contracting it is extremely small though greater than with polio. For children under 10 he and Dr Conway made a strong recommendation for a primary course of immunisation with 3 doses at intervals of 1 month.
65. A single dosage separate from whooping cough and tetanus with which it is normally given may be hard to obtain. There are few cases of diphtheria. The risks of contracting it are small but significant. Side effects from the vaccine are mild.

## Medical Argument

66. Dr Donegan did not recommend immunisation. She argued that the few cases were likely to be due to a trend towards decreased virulence of the organism and better resistance in human beings.
67. She said the vaccine contains aluminium phosphate. It also has thiomersal, a compound containing mercury which can cause kidney damage. Mercury is being phased out as Dr Conway agrees. A low dose formulation she says is recommended in children of 10 and over because of the reaction compared with that in babies.
68. Dr Conway pointed out illogicalities in Dr Donegan's argument and her selective choice of material. It was not a case of decreased virulence or better resistance but effective vaccination. It was wrong to take whooping cough, measles and mumps as examples of other diseases vaccinated against but which have not disappeared. Measles mumps and rubella have virtually disappeared from countries with a high MMR vaccine uptake. For diphtheria in the UK the uptake has been above 90%, but with MMR uptake has been variable.
69. Furthermore the low dose vaccine in older children is because of the risk of an adverse reaction with a large load of antigen. The children may have been immunised already or had natural contact with it. Professor Kroll agreed.
70. In relation to mercury, this is not in a high dosage. It is only found in the combined DTP and DT vaccine. The single DTP vaccine without thiomersal could be made available to the children. Without accepting that a case is established about any adverse effect of mercury, I support a vaccination which does not contain it.

71. Dr Donegan in evidence accepted that, though she had not pointed it out, all the authors of the medical papers to which she had referred agreed to regular diphtheria immunisation. Not one agreed with non-vaccination. She had no evidence to support her theory of the disease being less virulent. She was reduced to arguing that sometimes the facts did not support the conclusions especially where the authors were backing immunisation.
72. In her view because the authors were so pro-vaccination they could not see the wood for the trees. As I have said she accepted that the same argument could be applied to her.
73. It is interesting to note that when Professor Kroll and Dr Donegan met in July 2002 prior to the first hearing there was a measure of agreement. That was that the chance of either child acquiring diphtheria is low in the UK at present though this may change. Also that in numerical terms both risk and benefit are small. They disagreed on the ratio of risk to benefit of vaccination however.
74. As Mr Cohen pointed out, Dr Donegan accepted that there was no evidence that the virulence of the disease is reducing. She ignored the fact that the attack rate, severity of disease, and risk of complications was much lower with immunised patients as I accept is established.
75. Professor Kroll regarded this as a low priority if the vaccination could be excluded from tetanus. This might be difficult. Miss Gumbel has not otherwise sought to support Dr Donegan ' s conclusions.

### Conclusion

76. This is a serious disease now rare. The risks of contracting it are limited mainly to travel and visitors from abroad. Side effects from the vaccination are almost wholly mild and transitory. I hold that it is in the best interests of both children to receive the vaccination, the test I apply on each occasion I accept a recommendation. My acceptance is not necessarily conclusive as I shall consider in my conclusions.

### Tetanus

#### The Disease

77. It is caused by a bacteria found in the soil. A minor injury can be enough for the spores to be introduced into the body.

78. The toxin is only produced when the organism is deprived of oxygen. This is why it is classically associated with deep penetrating wounds for instance from dirty or rusty nails.
79. It can lead to muscle rigidity and spasm. It can progress to lockjaw, laryngeal spasm causing difficulty in swallowing saliva, and spasm of the respiratory muscles necessitating artificial ventilation. There are other severe complications including death.
80. Wounds do not have to be severe to carry a tetanus risk. Conventional cleaning of a wound does not guarantee safety. A preventive dose after a wound has been sustained is by blood product with its own risks. Those who survive recover completely in 4 weeks with no residual defect.

### Immunisation and Medical Argument

81. Dr Donegan accepted that the vaccine available for the last 50 years has reduced mortality from the disease. She argues that though there can be local reaction which is expected to settle within a day or two, there can be more serious reaction. This includes a skin rash, swelling of the face, difficulty in breathing, and severe allergic reaction with heart and lung collapse. It can also lead to nerve damage.
82. Because of the importance of prompt and adequate care of wounds and the availability of tetanus immunoglobulin in established cases, she considered that it was a reasonable alternative to the vaccine. That would amount to promotion of a healthy immune system together with scrupulous wound care.
83. However she agreed in cross-examination that none of the authors of the 10 papers to which she referred said other than that it was important to immunise. She also agreed that infection could occur after a trivial injury. The concern she did not point out is that the victim may not know of the wound and the risk attaching to it. She accepted that it was one of the most successful preventative measures in medical practice.
84. It emphasises the seriousness of the infection that about half a million people in the world die every year from the disease. Research showed that though there can be natural immunity it covers only about 1/3 of a group; it is not clear whether the 30% had sufficiently high level of natural immunity.
85. The conclusion is that in developing countries "it is important to implement immediate immunisation". It had reduced the incidence of tetanus in Israel by 95% between the 1950s and the late 1980s.

86. I have not found support for anything other than mild local side effects of the immunisation. Furthermore there is evidence that tetanus in children without active immunisation or naturally acquired immunisation is usually severe. Fatalities resulting from the disease range worldwide from about 8% to 60%; in the United States with its level of medical care it is 20%.
87. Professor Kroll in evidence said that tetanus had a high priority. The vaccination was highly effective and the disease was terrible. Treatment was possible after a wound was sustained but this was from human products. It is not 100% safe, as following the BSE outbreak, blood sources are now coming from outside the UK.

### Conclusion

88. This vaccination has I accept a high priority. Miss Gumbel rightly invites me to balance the risks in respect of each child which is what I have done in every case. There is the risk of infection, the potential outcome, and the prospect that a human blood product used after infection may be contaminated.
89. I am in no doubt about accepting the recommendation. Significant reactions are rare. The potential effect of the infection and the ready risk of contracting it make this immunisation most important. The failure rate is low. Professor Kroll recommended a vaccine from a non-human source. I agree.

### Pertussis (Whooping Cough)

#### The Disease

90. Pertussis is highly infectious. It is spread by droplet infection. It is characterised by paroxysmal coughing which can last for 2 to 3 months. There can be serious consequences in young children and especially babies including secondary pneumonia, coughing hernia, apnoea and even death.
91. There used to be an annual incidence in England and Wales of about 100,000 cases. Where vaccine acceptance reached over 80% of the population, this was reduced to about 2,000 cases a year.

#### Medical Evidence

92. Dr Donegan highlights some of the unpleasant features of the disease which I accept. A child may vomit their last meal while coughing, become blue with

bloodshot eyes and, when the coughing has ended, give a long whoop as the child breathes in.

93. Caring is tiring and time consuming. The child has to be kept calm and quiet as excitement and exertion provoke coughing attacks. Some small babies may require suction and oxygen after a spasm has ended.
94. Babies less than a year old have the most severe forms of the disease where complications and death can result. There can be convulsions, areas of the lung may collapse. Pneumonia, which may result, is a major cause of death.

### Medical Argument

95. Dr Donegan argues that the vaccine has limited use in preventing whooping cough which was already in decline before its introduction. The incidence has however been increasing since 1995. It is of waning effectiveness for babies who have a poorer quality of antibodies transferred from their mothers, themselves vaccinated. There has been a failure to protect the most vulnerable from the disease.
96. Furthermore papers have been published describing neurological complications of the vaccination supported by a study in 1981. Studies elsewhere have also found an association.
97. They all say that the risks of vaccine are small. But Dr Donegan says that where there is insufficient evidence to accept or reject causal connection which is taken to mean that parents should be encouraged to carry on vaccinating their children.
98. There have also been papers connecting vaccinated children to a greater risk of asthma. Because of side effects, the Swedes she says abandoned wholesale pertussis vaccination in 1979. In the light of this Dr Donegan only recommends the acellular vaccine to parents wishing to have it administered.
99. She says these 2 children are past the age when whooping cough is likely to produce major complications. Accordingly the risk of side effects outweigh the risk of having the disease. In support of her conclusions she refers to some 24 papers.
100. Dr Conway has subjected Dr Donegan's views to a lengthy and detailed analysis running to over 25 pages. He relies in part on papers not referred to by Dr Donegan. I shall not review the papers. A full consideration would involve a lengthy process beyond the scope of this hearing. I should however

refer to the main points made by Dr Conway and my views on the respective positions.

101. He points to his own experience and paper to emphasise the seriousness of the illness. Those admitted to hospital were there on average for over 12 days. Recovery time was about 14 weeks. Over a third of the children admitted were emotionally upset and for several weeks afterwards. Parental anxiety and exhaustion was common and routine family life appreciably disturbed.
102. He does not accept that it has become a milder disease. There is a lack of evidence to support this. However monitoring has become better which has reduced the number of deaths. Dr Donegan's figures showed that notifications reduced as vaccine coverage increased. He emphasised that research showed that no significant chronic neurological results can be attributed to the vaccine.
103. He sets out well-known criticisms of the 1981 study on which Dr Donegan relied. She accepts this but says it underestimates the side effects; almost universal medical opinion criticises the study for doing the opposite. She does not make clear that the only paper which does not recommend the vaccine relates to a vaccine no longer used.
104. Dr Conway points out that the reduction in immunisation coverage, due to adverse reaction to such papers, was a factor leading to the rise in deaths from whooping cough in the early 1970s from 2 or 3 a year to between 8 and 16. He establishes that far from lacking effectiveness, what was realised was that childhood immunity was not life long and that booster immunisation was needed.
105. He accepts that there was an accelerated vaccination schedule in the United Kingdom. This was because of a wish to protect children most vulnerable to risk of death namely in the first few months of life. He disproves her view of an increased risk of asthma.
106. Dr Donegan failed to draw attention to the fact that in the age group of 6 to 11 months efficacy is measured at 96% and in the 5 to 14 year old group at 76%. She accepts a need for a booster immunisation for the older group in part to protect the younger group.
107. Furthermore she failed to point out that whooping cough in vaccinated cases produced a milder illness. Unvaccinated children were more likely to be admitted to hospital and more likely to have complications.

108. In relation to whether the vaccination causes any permanent neurological harm, he cites a number of papers in a closely argued and extended passage. I shall not further review the material, nor the equally lengthy response from Dr Donegan. It is sufficient to note that in one 7-year study of over 130,000 children receiving 3 doses of DTP and a similar number completing courses of DT, the DTP vaccine could not be blamed unequivocally for any neurological disease.
109. Prof Kroll, in supporting Dr Conway's conclusions, pointed to a particular paper in 1990 which "in my opinion lays out in a particularly clear fashion the convincing lack of evidence for any causal relationship between this vaccination and brain injury". He concluded -
- "Subsequent studies have supported the conclusion that no long-term neurological damage can be linked to pertussis immunisation."
110. There was in this instance a difference between Dr Conway and Professor Kroll. It is common ground that there is no vaccine licensed for a child of over 7 years of age. It means that there has been no research or trial for this age group.
111. The reason for this absence of a licensed vaccine is I am satisfied because it is not needed. The customary practice of giving immunisation in infancy makes it unnecessary.
112. Dr Conway, based on his clinical experience of seeing children and growing adults with whooping cough and the great nuisance it can be, recommends it for F. Professor Kroll, taking a more cautious view, does not recommend an immunisation for F which is not licensed. They are in agreement in recommending immunisation for C.
113. Dr Conway would give it in a cellular form to protect against what he describes as a very unpleasant illness. Dr Donegan accepted that it can be mild, moderate or severe. She agrees too that in one of the papers she quotes it is described as "one of the more serious diseases of childhood". She also accepted the correlation between the increase in vaccination and the decrease in notification.
114. Not one of the authorities she has cited is against it. It would have been helpful if she had drawn attention to this in her report.
115. Professor Kroll thought that a vaccine for F would come in time. For F, were she to contract whooping cough that would be very unpleasant but very unlikely to be fatal or have serious long-term consequences at her age.

Whooping cough is in the middle band of seriousness. There had been a great falling off in immunisation after one paper because of a strong feeling of anxiety. It was wrong he felt.

### Conclusion

116. There is a significant risk of both children catching whooping cough. It is of medium significance. The mother B may be prepared to nurse C through the illness. But the question is whether it is in C's best interests for her to run the risk of catching the disease as against any risks from the vaccination.
117. As there is no approved vaccination for F, I adopt Professor Kroll's cautious approach and do not support it for her. I do support it for C. The benefits far outweigh any potential disadvantage. It should be designated acellular pertussis vaccine as he recommends.

### Poliomyelitis

#### Disease

118. It is caused by a virus. Transmission comes from someone with the disease or a symptom-less carrier. It usually enters the body through the gut and may reach the nervous system via the blood stream. It is an acute illness which can lead to a whole series of serious complications including muscle paralysis.
119. If the paralysis is still present after a month it is likely to remain with muscle atrophy and deformity of limb growth. Treatment is mainly supportive. The only effective remedy is prevention by prior vaccination.
120. There have been no cases in the UK for many years. If an un-immunised individual in the UK does not propose to visit any of the few parts of the world where the virus remains, the risks of contracting infection are very small.

### Immunisation

121. There are 2 forms of immunisation. One is an attenuated live virus. There is also an inactivated vaccine which is also highly effective. There is a risk of side effects of the live virus causing paralysis in about 1 in 500,000 cases for the first dosage and 1 in 12,000,000 for the second.

## Medical Evidence

122. Dr Donegan points to the risk of paralysis if the oral vaccine is taken. She argues that 28 cases of paralytic polio in the UK between 1984 and 1994 must have been vaccinated related. About 20% of those contracting it in the USA during the same time are also attributable to the oral vaccine.
123. There have been epidemics of paralytic polio even in highly vaccinated populations. The inactivated polio vaccine is potentially tumour causing and its possible that a late adverse effect of the polio vaccination programme is emerging. Given its rarity it would put the children at risk to have the immunisation. She relies upon some 17 papers in support of her conclusions.
124. Dr Conway points out that Dr Donegan has not sufficiently understood the paper which she says supports her view that there have been epidemics of polio in highly vaccinated populations. It was based on a large outbreak in Albania in 1996 after there had been national immunisation days (NIDs).
125. The author notes that the incidence was low amongst young children "indicating the efficacies of the NIDs". There was a relatively high incidence amongst children of less than 6 months who were born after the NIDs. The conclusion was -

"The Albanian polio outbreak strongly indicates that until global eradication is accomplished ... immunisation in all community sub-populations are needed."
126. Two other papers relied upon by Dr Donegan did not question the efficacy of the vaccination programme in the results that they considered. Equally Dr Conway takes issue with Dr Donegan's claim that the SV40 virus which contaminated polio vaccines in 1961 may still be causing a problem. No large-scale studies had been undertaken. Controlled tissues had often been inadequate and findings have not been replicated in all laboratories.
127. Dr Conway recommended the inactive virus first and then the active one. He accepted that the risk was very small of some one catching the disease if they did not leave the UK.
128. Prof Kroll firmly believed in vaccination but pointed out that it was commonsense to acknowledge that there were no cases for many years. It could be considered when someone is going to travel.

## Conclusion

129. This disease has almost been eradicated. But there is a risk with travel and contact with people from abroad. It would be one where I would consider not ruling in favour of immunisation if this vaccination in particular caused a high degree of anxiety.
130. But the mothers evidence does not establish a particular apprehension to this particular vaccination. The harm is potentially very great, the risk is very small. I am satisfied that balancing the benefit as against the risk, prudence not excessive caution points clearly to a child having the vaccination. Practically all the risks arising from the vaccination arise from using the live virus first. This I hold should not be used on the first vaccination, it can be on the second.

## Haemophilus Influenza Type B (Hib)

### Disease

131. Before effective immunisation, it was one of the 3 commonest causes of bacterial meningitis at all ages and especially in babies and young children. Meningitis is inflammation of the membranes covering the brain. It can lead to significant and potentially fatal illness.

### Immunisation and Medical Evidence

132. It is according to Dr Conway an extremely safe vaccine with very limited side effects of swelling and redness at the site which normally resolve in 24 hours. Professor Kroll describes it as a very safe vaccine. It is not usually offered to children of over 5 years.
133. Dr Donegan points out that it is more common in boys than girls and often follows coughs, colds, and ear infections. She says that 90% of healthy individuals carry the bacteria in their nose and that approximately 5% will be type B. As a result antibodies naturally form.
134. She claims that of the 5 available vaccines depending upon which they are joined with, the 2 most effective are not available in the UK. There are side effects and she says there are reports of causing a neurological disease. It was not introduced for children over 4 because they were regarded as already immune.

135. There was a substantial reduction in the spread of the disease once vaccination was started though some thought this was due to under-reporting after the introduction. However thereafter it rose from 0.15 per 100,000 in 1998 to 3.97 per 100,000 in 2001. It could be due to problems with vaccine efficacy.
136. A substantial reduction in the number of children who are possible carriers has led to invasive disease in older children who would previously have been expected to be immune. She says that with one child of 9 outside the risk age and the 3 year old almost there, given the risks associated with the vaccine and the disruption to natural long-lasting immunity she would not recommend either of them.
137. Dr Conway said that you cannot claim a link between a rise in Hib disease, the introduction of mass vaccination, and the use of antibiotics without a proper statistical basis. This should make allowance for other variable and confounding factors. Dr Donegan has provided no data, no facts, and no statistics to support her claim.
138. He refutes the alleged lack of long-term data quoting a paper in 1996 showing protection against severe Hib disease. It mirrors his own experience of a very significant decrease in the number of children admitted to hospital with Hib.
139. In relation to the side-effects, practice has shown it to be a very safe vaccine. There is almost no vaccine against which there are not some warnings about potential side effects.
140. He takes her to task in relation to her claim of a rise in Hib infections. He points out that in the past 10 years the incidence of Hib disease in the United States has declined by 99%. As long as the organism continues to circulate in the population un-immunised, susceptible individuals will continue to be at risk of the disease.
141. In evidence he accepted that it was at greatest risk for children under 5. He did not consider that the protective level in older children was sufficient. He pointed out that there was a very good safety record. If a child already has protection it acts as a booster.
142. Prof Kroll also looked at the question of particular benefits from natural infection as compared to that brought about by immunisation. It is his view that it is a question of the quantity of the antibodies rather than their quality which makes the difference.

143. He pointed out for instance that in the pre-immunisation time when mothers had measles when young and were subsequently exposed periodically to the virus their immunity increased. Babies born to such mothers were likely to be initially well protected.
144. With immunisation, maternal anti-body levels are lower because they do not have the natural boosting from time to time from exposure to the virus. It does leave the babies less well protected.
145. He said in evidence he said that this immunisation was particularly safe with particularly few side effects. A child may have immunity already which could be shown from a blood test. If there was no immunity then he would recommend vaccination.
146. There would be no harm to giving the vaccination in any event. For C it would be a good idea and for F if she had no immunity as shown by a blood test. He considered for F that the risk was small; Dr Conway was least concerned for F with this vaccination. It was optional.

### Conclusion

147. I accept the recommendation of Dr Conway and Professor Kroll as set out at the meeting of experts. C should have the vaccination; with the danger so much over for F, I am not persuaded that she should have it.

### Meningitis C

#### The disease

148. It is one of the 3 most common forms of meningitis. Though over 10% of the population carry it in their nasal passage, it only becomes serious if it invades the blood stream, brain, or spinal chord.
149. The results of such an invasion can be serious even fatal. There is antibiotic therapy but if the infection is established this may not prevent neurological harm or even death. It has a peak between 6 months and a year. It has a second peak in late teenage years when the risks of contraction and fatality are as high as in infancy.

## Immunisation and Medical Evidence

150. The vaccine was introduced in the UK in 1998 when there were some 1,530 cases of meningitis and/or septicaemia leading to death for 10%. By the latter part of 2000 following the introduction of the vaccine there was a reduction for all under 18 year olds by 71 %, 90% in the first group to be immunised between 15 and 17 years of age, and a reduction of 82% in the under 1 years olds.
151. Dr Donegan argues that the percentage of cases of disease rose from 30% to 40% in the late 1980s. She says that children are having more vaccines and this may be affecting their immune system. When the vaccine was introduced in November 1999 there were unprecedented numbers of side-effects reported.
152. Furthermore she argues that while meningococcus vaccine has been regarded as a success, meningococcus B has continued to rise. Both children are likely to have natural immunity. The risks of side effects in older children outweigh the benefits of vaccination.
153. Dr Conway joins issue on the alleged side effects. The vaccine has been very safe. He points out that she has not taken into account the second peak in the incidence of the disease in late teenage life.
154. Professor Kroll agreed. He gave the vaccine high priority. The vaccine is now given to all infants at 2,3 and 4 months of age. A catch-up programme was run in 1999-2000 to make it available to all children under 18.
155. He said in evidence that he could not see the benefit of delaying the vaccine for C till she became older. He accepted that the risks increased as F became older. Unless the mother's anxiety would be lessened by postponing immunisation, he was not for delay.

## Conclusion

156. I am in no doubt that the value of this vaccine is considerable. The risks are great, the side effects mild, and there is no sufficient value for deferring a decision. Both children should receive it now. Where there is risk now which increases, I consider delay is not justified.

## Tuberculosis and tubercular meningitis ("TB")

### Disease

157. It is caused by infection from the tubercle bacillus. It is spread by coughing, sneezing, or talking. It affects the lungs and can be fatal. In babies it can cause meningitis. In older children it is rarely serious but it can set up worse symptoms later.

### Vaccination and medical evidence

158. This is normally given when a child is 13 after she has been shown to be tuberculin-negative. It is about 70-80% effective. There are adverse local reactions in about 3-5% of cases which can include scarring at the site but are otherwise not serious.
159. Dr Donegan questions how effective it is. She says that there is no evidence that it is effective for adults. From this she seems to say that the same is true for children. This is not accepted by Dr Conway and Professor Kroll. They recommend it for F if she does not prove to have immunity already.

### Conclusion

160. I accept the recommendation. The risks of catching it are not high, but the seriousness of the illness makes it in F's best interests if she proves to be tuberculin negative.

## Measles, Mumps, and Rubella

161. I now consider the evidence I have heard in relation to the MMR vaccination. Before I do so I shall consider the individual illnesses against which MMR is designed to prevent infection. I shall then consider the significance of combining the 3 vaccinations in one injection.

### Measles

162. Measles is an acute viral infection transmitted by droplet infection. It is very infectious. The acute stage of the illness lasts about 2 weeks. Its characteristics include a rash, fever and general misery. Light hurts the eyes, and neck glands are swollen and sore. After about 5 days the rash starts to fade.

163. There are a range of potential complications. They include secondary infection, pneumonia bronchitis, and convulsions. It can prove fatal.

#### Vaccination and medical evidence

164. In the late 1980s before vaccination was introduced, there were between 50,000 and 100,000 incidents of the disease reported annually in the UK. There were about 13 deaths each year. There were serious complications in about 10% of cases.
165. The vaccination is now administered as a joint one. There have been mild repercussions. They include febrile convulsions in about 1 in 1,000 children, swelling of a gland near the ear in about 1% of children up to 4 years of age, and a fall in the blood count involving coagulation process all of which usually resolve spontaneously.
166. Dr Donegan argues that deaths due to measles follow complications. The reason it is such a killer in developing countries is because of severe poor nourishment and chronically ill children.
167. It is a live vaccination. She says a high titre measles vaccination used in Africa caused higher death rates in girls from other infectious diseases than with boys or un-vaccinated girls. Outbreaks in un-immunised people tend to be mild where they do not have underlying medical conditions. The attack rate in infants of less than 1 year is low where there is not general immunisation because of superior maternal antibodies.
168. There is evidence that vaccinating against measles in the USA increased the attack rate in young children. Results showed that a booster vaccination had little effect on the student population. The figures showing a reduction in the onset of measles after vaccination are suspect. Furthermore there are a whole series of documented side effects of MMR.
169. The death rate from measles had declined by 99% before the vaccination started. It is normally a mild disease in healthy children. Vaccination puts off having measles to a later age when it is more serious. She therefore considered the most sensible course of action was to try and get the disease. There were enough well documented adverse reactions to MMR. It made them undesirable.
170. Dr Conway demonstrates convincingly that Dr Donegan had not given a full account about cell mediated immunity and whether the vaccine would have the same effect. He accepts that maternal antibodies following natural infection are better than those produced by vaccination. However he points

out Dr Donegan has not taken into account the second booster dose of measles vaccine.

171. Furthermore it is not just that the death toll rises in the case of malnutrition or existing medical conditions. In the UK and France a rise in vaccination was associated with a fall in death rate from measles.
172. He counters the argument about shifting measles epidemic to older children by reference to the booster dose. He sets out figures relating to the beneficial effect of the measles/rubella booster campaign in reducing susceptibility to measles and rubella. He states that Dr Donegan referred to one study only linked to a particular disease without referring to the conclusion. That conclusion was that the incident of such a disease remained relatively low with a favourable immediate outcome.
173. It is wrong of her to describe measles as generally mild when it causes significant misery and discomfort. He draws attention to other incidents where Dr Donegan has not presented the full discussion or conclusions of papers, has quoted selectively, or relied upon questionnaires from what he describes as a biased parental viewpoint.
174. In evidence Dr Donegan accepted that measles was at the serious end of children's diseases. The consequences can be grave even fatal.
175. Professor Kroll pointed out that Dr Donegan relied on one serious complication of the injection called ITP arising in about 1 in 100,000 cases. What she does not mention is that it occurs in about 1 in 6000 cases of those who contract the disease.
176. Equally before 1988 when the MMR jab was introduced, research shows that more than half the acute measles' death occurred in previously healthy children who had not been immunised. He points out that the vaccine is highly effective at preventing disease.

### Mumps

177. The virus can cause an acute febrile illness. It may be mild in young children or associated with moderate discomfort and gland enlargement. It can lead to a degree of irreversible deafness, meningitis, and after puberty a small proportion of men may become sterile.

178. The incubation period averages 18 days. For most patients the problems are difficulty in eating, swallowing and talking. It usually resolves in under 2 weeks with a complete recovery.

#### Vaccination and medical evidence

179. There is agreement that unvaccinated children are highly likely to get the disease. Dr Donegan expresses concerns about the vaccination. She says that an earlier mumps virus was withdrawn in 1992 because it caused mumps-meningitis. It was however used in South America. Mumps has been increasing in instance with one third being over 15. It was pushing the disease into the higher age range when for boys it was more serious.
180. Dr Conway says it is a safe vaccination. He joins issue on Dr Donegan's argument that the vaccination is pushing those susceptible to over 15 years of age. The reason he says is that there has been a fall in vaccination uptake. Where the uptake is increasing the notification of mumps is falling. It is a safe vaccine. Mumps has virtually disappeared in countries which have achieved high coverage.

#### Rubella

181. It is a mild viral infectious disease. The main concern is for mothers in the first 8 to 10 weeks of pregnancy where an infection can result in foetal damage in up to 90% of infants. The damage can be severe and range from mental handicap to deafness and cardiac abnormalities. Babies affected are likely to have multiple congenital abnormalities.

#### Vaccination and medical evidence

182. Dr Donegan accepts that side effects of the vaccine, normally more marked in adults than children, are usually transient. She points out however that since the introduction of the vaccine the number of children born with congenital rubella has increased.
183. She says that the immunisation wears off. She considers it far better for girls to have the disease. Later they can check to see the extent of their rubella antibodies. Vaccination could then be considered if they do not have the necessary antibodies. She does not consider it in children 's best interests to be vaccinated.
184. Dr Conway does not accept Dr Donegan's figures. He pointed to a rubella programme review in 1997 which concluded that the incidence of congenital

rubella is now very low. Most affected infants are born to women coming to the UK not covered by the immunisation programme. Professor Kroll said in evidence that the case for immunising girls was very strong.

The impact of the 3 vaccinations together ("the MMR jab")

185. Dr Donegan comments on the connection between the jab and autism. She points out that many of the arguments rely on sophisticated statistical analysis of papers not written with a view to considering a link. Autism was only described as a disease for the first time when the major vaccination programmes were started. She concludes that if there is a link it is certainly not the only vaccine which may be responsible.
186. She does however rely on other side effects. She claimed the vaccination doubled the prospect of having a form of pan encephalitis, but then only to 1 in 3 million doses.
187. She does not argue that the fact of taking 3 vaccinations at the same time adds to any risks there may be. It is not therefore an issue before me on medical grounds though it is to the mothers given the publicity it has received. Professor Kroll has set out the background which I accept. I summarise the position.
188. He points out that MMR has accepted side effects. These are generally transient and mild. There can be a brief feverish illness 7 to 10 days later. Children already susceptible to convulsions (and 5% of children may in any event have a seizure or convulsion under the age of 5) may be caused a further convulsion. Research has shown no long term consequences when this does occur.
189. Controversy arose he says from a press report in 1998 when a research gastroenterologist, Dr Wakefield, spoke about a paper colleagues had written. The paper looked at any association between autistic regression, bowel disorder, and the MMR jab. The paper concluded -

"We did not prove an association between measles, mumps and rubella vaccine and the syndrome described..... If there is a causal link between measles, mumps and rubella vaccine and this syndrome, a rising incident might be anticipated after the introduction of this vaccine in the UK in 1988. Published evidence is inadequate to show whether there is a change in incidence or a link with measles, mumps and rubella vaccine."

190. At the press conference Dr Wakefield offered an opinion that it was not wise to administer the MMR jab as a combined preparation. He said it would be safer to give the individual components at widely separated intervals. He suggested a year.
191. Professor Kroll was unaware of any research or special knowledge which substantiates that opinion. It caused wide spread controversy. Experts in the field of childhood immunisation published rebuttals.
192. New claims were made by Dr Wakefield and colleagues. Professor Kroll has reviewed a series of papers about this topic since then. He has looked at a link with autism and the effect of combining the 3 vaccines together.
193. He concludes that the MMR vaccination is safe. He points to a paper where 1.8 million individuals were considered with almost twice that number of vaccine dosages having been given. It concluded that serious events causally related to MMR vaccine are rare and greatly outweighed by the risk of natural MMR disease.

### Conclusions

194. I am satisfied that I should accept Professor Kroll's conclusions. He relies also on the fact that over 20 million doses of MMR have been delivered in the United States alone. It is used in Canada, Australia and over 30 European countries. He is unaware of any country where the doses are given separately. He considers that if there were real problems they would have emerged.
195. I accept his argument that there are dangers in giving injections one by one over a period of time. The reason is that the child is exposed to the unvaccinated illnesses in the meantime.
196. On the evidence before me the benefits of having the 3 vaccinations at one time outweigh any risks there may be. A child's immunity is not overloaded by receiving 3 vaccinations in one. It is daily exposed to a vast array of potential infections. The risk is I am satisfied as Professor Kroll said rather the reverse, namely that the effectiveness of the vaccinations may be reduced. On the evidence I see no advantage and much disadvantage in staging the administration of the 3 vaccines over a period of time.
197. His conclusions, supported by Dr Conway which I concur are -

"1. Measles, mumps and rubella are serious infections, each of which carry an appreciable risk of dangerous complications in healthy individuals. Vaccination is the only practical way to prevent an individual from contracting infection, and all the evidence is that it is effective and has a very low level of side effects, which are generally mild and transient.

2. Despite the formal impossibility of proving a negative, the accumulating and substantial body of evidence shows no link between MMR vaccination and autism.

3. There is no evidence to support the suggestion that combining measles, mumps and rubella vaccines in a single injection is harmful, or that giving the components separately is safer. On the contrary, the delivery of the vaccine components in stages increases the risk of an unprotected child contracting one or other of the infections it is intended to prevent.

4. With due consideration for established contraindications to vaccination in an individual case, it is otherwise in every child's interest to be protected against measles, mumps and rubella with the MMR vaccine."

198. I am aware that in relation to autism and MMR there is a civil trial due to start in London in April 2004 expected to last 6 months. The claimants have children who suffer from autism. They claim that it is linked to the MMR vaccine. The claimants have received public funding for their case.

199. I am unable to form even a preliminary view about the strength of the claimants' case. That such substantial litigation is publicly funded is a clear indication that the case deserves a lengthy hearing on its merits.

200. No one has asked me to adjourn until the conclusion of that case. That is unlikely to be in much under 2 years time. I have confidence in the conclusions set out above because of my regard for the integrity, standing, and knowledge of Professor Kroll and Dr Conway. I therefore consider that in the children's best interests I should make the declaration sought in relation to the MMR triple vaccine.

#### The case of A v B

201. On 15 March 2001 the father A was granted parental responsibility on his undertaking not to let his daughter C have any vaccinations without the written consent of the mother. On 19 November 2001 the father issued his present

application for a specific issue order to provide for appropriate immunisation of C.

202. In his statement in support the father stated that he had read widely about immunisation. He accepted that it was a balance of risk and benefit which had to be weighed carefully. However he truly felt that it was better for C to be vaccinated than for her not to be vaccinated.
203. The mother B in opposition said that she had not been irresponsible. Working in the medical field she had accumulated what she describes as a wealth of information. She had weighed up the pros and cons. She considered that breast feeding for nearly 3 years was a protective mechanism sufficient for C.

### The father's evidence

204. For him it was a matter of odds and they were in favour of the scientific approach as against a spiritual or other alternative approach. He said the mother had never had a good opinion about doctors. She was generally against medication. He accepted that mother had been upset when a chemist had recommended Sudafed and he had given it to C.
205. He now saw C every other weekend, Friday afternoons until Monday morning when he dropped her off at school. In addition he had 10 days in December and in April. In the summer she stayed with him for an additional 21 days.
206. In cross-examination he accepted that she was a pretty good mother. He agreed too that she had given careful thought to the view that C should not be vaccinated. It was part of her lifestyle. He accepted that her view was that C was less likely to get illnesses through good food, good care and breastfeeding.
207. He understood that the mother was under a bit of stress which was not good for C. But it was a balance with the possibility that serious illness or death could occur by his not pursuing his application.
208. He did not accept that vaccination could lead to very severe damage to the person vaccinated. He was aware of the vaccine damage compensation fund paying compensation to persons at least 80% disabled as a result of vaccination.
209. He had had an incident whilst at college when he was scratched by a cat. His whole body had swollen up, he could not move his left arm and he had to stay

in hospital for a long time. This brought home to him the value of immunisation.

### The mother's evidence

210. She said she had been interested in holistic health and natural parenting since 1990. She became very friendly with people who were breast-feeding longer than the usual 4 months.
211. She considered a lot of medical research could be interpreted in many different ways. There was a lot of dissent. She did not believe there was enough evidence to point conclusively to any answers. She would like to see the evidence because she did not feel her view was entrenched.
212. She explained that once you start looking at holistic health issues it is a way of life. She thought it was up to each individual to weigh up what they feel is at risk. The medical community has not provided adequate information and the anti-immunisation lobby has provided some of the answers.
213. If C had been involved in an accident the risks for instance of tetanus go way up; it would be ludicrous to say no to tetanus at this point. Until that happened she did not think there was a risk. In respect of polio, it would depend because C was not mixing with people who were a risk.
214. She was not concerned with the measles, mumps or rubella. They are still childhood diseases. She was not sure about whooping cough as it takes a long time to nurse a child over whooping cough if it was a bad dose of it.
215. In relation to Hib it may be a virulent form of influenza but there are many other forms that cannot be vaccinated against. Meningitis C was very new and it had not been out long enough to see adverse reactions coming out.
216. She considered the father took a situation and stretched it and became extremely paranoid and anxious about it. Because he did not get an equal say in parenting he was going to try and get that by taking her through the courts.
217. She felt it was impossible to maintain a normal family life having filled 3 cabinets with papers already in relation to C. She was on a full-time course that required a lot of academic work and a lot of socialising. It was strenuous. She found it very hard to live when she had to go as she described it one hour at a time.

218. She did not know what the emotional effect would be of having C immunised. She was not prepared to go that far at this point. She found it really very threatening to even think about it. If anybody told her something that was not in her child's best interests that brought up a whole other set of emotional issues.
219. She found it very difficult to live with the issue of immunisation. The father arrived on the scene and demanded that C spent half the time with him at a time when she was still fully breast feeding. She had to get an eminent expert to say that it was important for a young child not to be separated from its mother when it is breast-feeding. It was basic psychology.
220. She felt that as a mother she was allowed to take certain decisions and not be challenged all the time on them. There was no law making compulsory vaccination. She was open-minded if there was evidenced based data that was incontrovertible.
221. She could not imagine being able to continue with her studies or with daily life should a decision be made that vaccination was in the interests of her daughter and should be enforced. Parenting when you are under stress is very difficult.
222. She had other responsibilities to juggle with including providing her with a better education and better food. She was on income support. It was a miserable existence.
223. C only started staying at her father's in July or August 2002. She was still breast-feeding at night. The court had determined that C was then ready.
224. She considered homeopathy a part of her holistic medicine. She was aware that the college of homeopathy advised vaccination. She had never been to a homeopath who was part of the college. She and the father do not talk. She did not tell him about C's health or indeed anything.
225. She had presented at an Accident and Emergency department in March 2001 as an anxious parent the day before the court hearing. C had had a fever of 104 for 2 days. She did not intend to let the father know anything that was going on because, when she did, he turned it around and made it an issue. She would not intentionally hide anything but she would not volunteer it.
226. From the beginning he had made it clear that C knew the difference between the good shiny sparkly things he gave her as compared to the stuff from the dump that she brought her. As a result C would choose to live with him. He had never retracted it.

227. He had always made it perfectly clear that he would use the court process to try and get what he wanted. He had got somebody in the village to spy on her.
228. She preferred C to get natural immunity. She believed it built the immune system. That is why there are childhood diseases. She would like C to get measles mumps and rubella. She had not thought of deliberately exposing her. If a friend's child had measles she would not avoid them like the plague because she was not afraid of measles for C. If she was afraid of the diseases she would get her vaccinated.
229. She has told patients that C is not vaccinated against rubella. Most days she was in nursery school from 09.00 until noon or 9.00 until 3.00. She had not taken up the father's offer to look after C because he did not want him any more in her life than necessary, or in C's life because it caused problems. Their relationship was acrimonious and C saw this.
230. She pointed out the stress and anxiety of being taken to court and not knowing how other people were going to make decisions which undermined her as a parent. There was the anxiety of court proceedings being used as a threat every time something did not go right. She said she had made up her mind but she continued to read. She had talked to people about the issue.
231. It was because of the level of stress felt by the mother that the proceedings were adjourned in December for a psychiatric report to be obtained. This was prepared by Dr Veasey and dated 21 January 2003.

#### Dr Veasey's report

232. He has been a consultant for 14 years with a particular interest in stress related psychiatric disorders. This has led to his appointment to carry out assessments and treatment of the victims of a series of major disasters in recent years.
233. The essence of the mother's feelings are well set out in the report. It is the trauma and pressure of the court system, her holistic approach, and how the present application strikes at the heart of who she is. Of the immunisation she said "It is not the risk - it is because it is unnecessary".
234. Dr Veasey concluded that there was no suggestion that she was either exaggerating or minimising her difficulties. She was not suffering from any diagnosable psychiatric disorder. She had suffered a major trauma when young but without long term effect in psychiatric terms. A decision against her

views in relation to C would be a major stress for her. He did not consider it would cause a depressive or anxiety disorder.

235. It is clear from a covering letter that Dr Veasey has personal reservations about immunising a child knowing that a mother who cared for her was against it. He thought most doctors would feel the same.
236. Miss Gumbel did not seek to add anything in the light of that report. Miss Probyn said it showed a very anxious state not a psychiatric state. I accept that.
237. It does however give further weight to Miss Gumbel's argument that the court has to take into consideration that it is the mother who will need to cope with any reactions to vaccination. The emotional effect of that will be felt by the child.

#### CAFCASS Legal

238. Miss Sue Oliver, from CAFCASS Legal Services and Special Casework acting on behalf of both children, interviewed both the father and mother. She noted that Dr Conway, instructed on behalf of both fathers, and Professor Kroll, instructed by CAFCASS Legal reached broad agreement on the course of vaccination which they considered C should have.
239. I have read the interviews. Most of the points made by the parents have been summarised above. There are others as well.
240. Firstly in respect of the mother B it is the dominating role she feels that pharmaceutical companies have, that the link between MMR and autism has not been properly investigated, and that the issue of parental choice is more important than the community aspect of the debate. She also feels she is in a war with the father that has brought her close to letting him look after C.
241. The father saw the issue as one where the mother was exercising control. C was hers and he appeared to be challenging that. He understood that the mother was concerned about the quality of vaccines and he would discuss it. He was happy to go along with single injections if this would help. He did not consider MMR a risk. Finally I note the father is somewhat isolated, finding it difficult to find like minded people in the area.

242. Miss Oliver concluded -

"The mother believes that the issue of immunisation for C has been raised by the father in his pursuit to have control. The mother firmly believes that breastfeeding and natural exposure to viruses is preferable to vaccinations, and does not trust the research which has been undertaken to date. The mother has presented as a responsible parent in her upbringing of C and C appeared in the interview with (her mother) to be a happy and well adjusted child.

I have carefully considered the mother's strongly held views and I take very seriously the importance of her bond with C as the resident parent. Nevertheless, on the evidence as it stands in the first limb of my investigation (the medical opinion) I am unable to share the view that immunisation in accordance with the schedule recommended by the doctors would in any way be contrary to C's best interests."

### Conclusion

243. I consider only at this stage the effect on the mother B were I to be satisfied that immunisation is in C's best interests. There are a number of factors.

244. Firstly there is in this application an express concern by the mother that the father is using the legal system to control her. She believes he wants to have C living with him. It is shown by his living near her without employment for 3 years. It is added to by what the mother considers is his relentless pursuit of her through the courts when he makes no financial contribution. It is plain that the stress for her is high.

245. The father sees all he has done as no more than necessary actions after the mother tried to hide his daughter from him. His wish is to have a part in C's life. He could not have achieved it without court proceedings. It is the mother who has made it all necessary.

246. I set out those competing views as I understand them to emphasise the parents' perceptions. A long and damaging hearing would be needed to determine how much truth there is on either side. This application has taken a major toll on the mother which is not to be underestimated in relation to a partner from whom she tried, rightly or wrongly, to escape. She cannot easily speak to him about contact, though C sees and stays with him.

247. The mother is trying to complete her training. That itself is stressful. She has to cope with the father whom she believes is out to separate her and C.

These particular proceedings are then brought which go against everything she believes to be the right approach to child rearing.

248. The cumulative effect is in my judgment not to be underestimated accepting as I do the conclusions of Dr Veasey. But whatever the father's motivations may be in general, I do not consider that his application is motivated solely or mainly by a wish to control the mother. There may be an element of control but it does not predominate. I shall return to this.

### D v E

249. I shall refer to the father as "D". I shall refer to the mother similarly as "E". I shall refer to their daughter who is now 12 as "F".
250. The father says that he was very involved in the care of F at first. The mother then returned to her mother and soon afterwards the father went to live elsewhere. The relationship continued until 1996 when the father started seeing his present partner. The parties were living apart but the father saw F on a regular basis, daily at first.
251. Contact came to an end at the time of the father's new relationship. In July 1997 the father applied to the court for a residence, contact, and parental responsibility order. I note that when the CAFCASS Reporter Mrs Young prepared a report in April 2001 that was the 7th such report.
252. At that time there was indirect contact. Contact was restored. F liked contact with her father.
253. The father first raised the question of F's lack of inoculation at the beginning of 2001. The mother and her sister had never been inoculated. She believed that it was not necessary and was concerned about the possible ill-effects. She felt that the father was bringing these proceedings to put pressure on her rather than having a genuine interest in F's welfare.

### The father's evidence

254. It was a shock to him on subsequently seeing F's medical records to note that she had not been inoculated. The stage had been reached however where there was no communication between him and the mother. He supported inoculation. He felt that the benefits outweighed any risks.
255. He said that his elder daughter attended a school where it became apparent that some of the parents had not had their children inoculated. There was a

meeting and the parents refused to send their children to school with those who are not inoculated, about 3 out of 300. Children were kept away from school and the 3 were either inoculated or transferred to a new school.

256. Ideally he would like the mother to take F to the doctor. If the court decided that F was to be inoculated, he would be content for the mother to have an opportunity to talk this through. This would be in the hope that the mother would be able to comply with any direction of the court. He would also like an opportunity for F to discuss it in case she had any deep-rooted objection.
257. He had assumed that the mother was having her vaccinated though he knew that her mother had disagreed with it. He had seen her medical notes. This was after he had seen a leaflet that said he was entitled to do so when he was granted a parental responsibility order.
258. His concern had nothing to do with residence or contact, it was purely for health reasons. He had not tried to minimise his conviction nor to make the mother out as someone inappropriate to care for F.
259. He would discuss with the mother if she was adamant that she did not want all the vaccinations but she was willing to have some of them. He had applied to have F's name changed back when her mother changed it during the course of the proceedings. The mother had never told him anything about F's life.
260. He put F's health first. This was even if it meant that the mother was upset though he was not persuaded about that.

#### The mother's evidence

261. She said the reasons for her opposition to the vaccinations was due to autism and disablement which a child could have through the jabs. Her father had never had his inoculations until he went into the army and he did not want any of his children vaccinated. She did not feel they were safe for F to have. She seemed a healthy child and she did not basically need inoculations.
262. She said that she had told the father of her view when F was a few months old. The father just accepted it. He was making the application now to cause trouble for her.
263. She felt diphtheria was rare here. She would not go along with jabs even if the doctors were to agree they were safe.

264. She had not heard much about tetanus. She did not think it was a particularly serious condition. Inoculations were for people who wanted them. If F wanted them it was because she was influenced by the father's children having jabs.
265. She would wait to see if F asked her to have any inoculations in a few years time. She would try and persuade her out of it. She did not think that F told Miss Oliver that she would like to have the meningitis injection. Even if F wanted to be inoculated, she was against it.
266. She did not tell the father when F had chicken pox. It was at a time when he was stalking them round the town. She would not speak to him.
267. She believed that there was mercury in MMR, though there was a Department of Health pamphlet that said it had not been used in any MMR in the UK. She would not have the MMR even in single injections. She did not think that F would pick up any of these illnesses. It would not be helpful for her to hear the medical evidence. She had already made up her mind.
268. If F had to have some jabs she would be the only person to be with her. If the court did say that it would be best for F she would be able to accept it.

#### CAFCASS Legal

269. Miss Oliver noted that there were no contra-indications to vaccinations in general for F. The parents were interviewed. The mother expressed opinions which were in part both extreme and bizarre. Examples were that F was just a child and it was not for her to decide what was best. The mother would not follow expert advice. Doctors were paid to jab people. She found it difficult to believe that the judge was not paid on the length of the case. F's poor attendance at school was because F did not like school.
270. The father said he had read a lot about vaccination. It was for F's safety he had not discussed it with F. He would if the court decided she should have vaccination. He felt that there were no real risks involved.
271. F was seen. She understood that some jabs could make you ill, some could make you better. She knew what she wanted and did not want. She wanted the meningitis injection because she knew of somebody who had nearly died. She did not want the MMR jab. She thought that if she did not have injections she would get ill and die. She would agree if a judge decided that vaccinations would be good for her.

272. Miss Oliver said this in conclusion -

"I have taken into account the mother's views, and I take very seriously the importance of her bond with F as the resident parent. The medical establishment's view is clear on the evidence as it stands in the first limb of my investigation (the medical opinion). I am unable to share the view that immunisation in accordance with the schedule recommended by Professor Kroll would in any way work against F's best interests."

### Hearing on contact

273. I learned that the mother had stopped contact in August 2002 after the first hearing in this application. The father was intent on enforcing earlier contact orders. I suggested that the matter might be listed before me which was accepted. There was a hearing on 11 February 2003 though the mother did not attend.

274. As I said in my judgment, if I had known the extent of the background and that Her Honour Judge Davis had been hearing the recent proceedings, I might well not have made the suggestion of listing the matter before me. It did however give me an insight into the dynamics of the present position which otherwise I would not have seen.

275. In essence the mother had brought contact to an end after it had been going well following a long period of protracted litigation. F was seeing her father and his family every other weekend for a day. This was even though the mother held strong negative feelings about the father. She considered he was a risk to F.

276. There were 2 psychiatric reports saying the father was not a risk to F. The mother had not accepted them.

277. I held that the reasons given by the mother were not sufficient to adjourn the hearing or stop contact. I heard from Mrs Young, the CAFCASS Reporter who had a regular involvement. The problem she saw was the mother's personality and her rigid attitude. There was also the father's position. He had not taken sufficiently into account the mother's difficulties. She told me that F wanted contact once a month.

278. I was concerned about the long and difficult litigation. I mentioned the potential value in a child psychiatrist reporting. Mrs Young felt it would help for her to speak to the mother about this. I ordered contact to resume monthly whilst this took place. I deferred a penal notice in relation to contact which had earlier been effective whilst Mrs Young conferred.

279. I have set out the recent contact application shortly. It has an impact on the issues with which I am concerned.

### Conclusions

280. I am satisfied that the father D has a genuine concern about the question of immunisation for F. He only knew that it had not taken place when he saw the medical records. He has a strong wish to have a proper relationship with F. He has shown an understanding of the mother's concerns by agreeing not to press for staying contact for a year. He has persisted against considerable opposition.

281. The mother has deep-rooted difficulties for the reasons I have set out above. She has a close relationship with F who is very loyal to her. But F likes visiting her father and his family. He has a baby she has not yet seen.

282. The mother's attitude to this application and to contact is rigid. What was good enough for her father is good enough for her. No harm has come to F and she feels genuinely and strongly that no order should now be made. It does not matter that F told CAFCASS Legal that she was willing to have some immunisation.

283. I am quite sure the mother will be upset if I make the declaration the father seeks after a review of the medical evidence. There is no realistic prospect of her being persuaded by rational argument of any value for F of immunisation.

284. But I do not consider that if I were to make the declaration sought that it would affect her care of F. She could cope with that and the aftermath as well as she has done with the protracted litigation. She said she could accept my decision. It is therefore mainly a question of F's welfare. I shall return to this.

### The Law

285. I have set out the principle which governs my approach to these 2 applications. It is in s.1 of the Children Act 1989 which is in these terms -

"(1) When a court determines any question with respect to -

a) the upbringing of a child; or

b) the administration of a child's property or the application of any income arising from it,

the child's welfare shall be the court's paramount consideration ...

(3) ... a court shall have regard in particular to -

a) the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding) ;

b) his physical, emotional and educational needs;

c) the likely effect on him of any change in his circumstances;

d) his age, sex, background and any characteristics of his which the court considers relevant;

e) any harm which he has suffered or is at risk of suffering;

f) how capable each of his parents, and any other person in relation to whom the court considers the question to be relevant, is of meeting his needs;

g) the range of powers available to the court under this Act in the proceedings in question."

286. The welfare test (or best interests of the child as it is sometimes called) does not exclude other relevant consideration. It may lead to conflict with other principles, for instance the right of free speech and free publication. This was a relevant factor in *Re Z (A Minor) (Freedom of Publication)* (1996) 1 FLR 191 where a mother was prevented taking part in a television broadcast which would highlight a successful method of treating her child's needs and would identify him.

287. Ward L J in the course of his judgment referred to an earlier case of *S v McC* (1972) AC 24 where Lord Reid said:

"But even if one accepts the view that in ordering, directing or permitting a blood test the court should not go further than a reasonable parent would go, surely a reasonable parent would have some regard to the general public interest and would not refuse a blood test unless he thought that would clearly be against the interests of the child."

288. Sir Thomas Bingham MR as he then was said at page 217:

'I would for my part accept without reservation that the decision of a devoted and responsible parent should be treated with respect. It should certainly not be disregarded or lightly set aside. But the role of the court is to exercise an independent and objective judgment. If that judgment is in accord with that of the devoted and responsible parent, well and good. If it is not, then it is the duty of the court, after giving due weight to the view of the devoted and responsible parent, to give effect to its own judgment. That is what it is there for. Its judgment may of course be wrong. So may that of the parent. But once the jurisdiction of the court is invoked its clear duty is to reach and express the best judgment it can.'

289. The next important case is that of *Re: T (Wardship: Medical Treatment)* 1997 1 FLR 502. The case concerned a baby boy who was 18 months old. He suffered from a life-threatening liver defect. His parents were health-care professionals experienced in the care of sick children. The unanimous medical view was that as soon as donor liver became available the baby should undergo surgery.

290. The prospects of success were good whilst without transplantation the expectation of life was just over 2 weeks. The baby at the age of 3 weeks had undergone surgery which had caused much pain and distress and been unsuccessful. The parents refused to consider a liver transplant but this was ordered.

291. The Court of Appeal in allowing the appeal held, as summarised in the head note -

"(1) On the exercise of the inherent jurisdiction, the court's paramount consideration was the welfare of the child and not whether a parent's decision was unreasonable.

(2) There was a strong presumption in favour of a course of action which would prolong life, but to prolong life was not the sole objective of the court and to require that at the expense of other considerations might not be in a child's best interests.

In the present case, the facts were unusual as the devoted caring mother was well informed as to the consequences of major invasive surgery. It was not in the best interests of the child to order a course of treatment with which she did not agree and the child's welfare required that future treatment be left for the parents to decide."

292. At Page 513, Waite LJ said -

" 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."

293. The same consideration arose in the case of *Re: C (HIV Test)* 1999 2 FLR 1004 where the parents of a baby born to a HIV positive mother were strongly opposed to the testing of the child for HIV and to any form of medical intervention. Wilson J. stated that the views of the parents looked at widely and generously were important factors in the decision, even, to some extent, irrespective of the validity of the underlying grounds for those views.

294. He noted that under the Children Act 1989, s.1(5), any applicant for an order had, in effect, to persuade the court that there positive grounds for taking the matter out of the hands of those with parental responsibility for the child. A court invited to over-ride parental wishes had to move extremely cautiously.

295. However, he concluded that in the instant case the arguments for over-riding the wishes of the parents and for testing the baby were overwhelming. The baby had rights of her own recognised in national and international law, the baby's welfare was paramount, and in the baby's interests the test should take place.

296. In the course of his judgment Wilson J said -

"This baby has rights of her own. They can be considered nationally or internationally. Under our national law I must determine the case by reference to her welfare (s.1(1)); and, in particular, I must have regard to her physical needs (s.1(3)(b)); to her background, namely her

mother's infection (s.1(3)(d)); and to the harm which she is at risk of suffering (s.1(3)(e)).

The UK has ratified the United Nations Convention on the Rights of the Child 1989 ...

The Convention does not have the force of law but assists in our interpretation and development of the law. It is interesting to note that, in requiring respect for the responsibilities and rights of the parents, Art. 5 links them to the provision of appropriate direction and guidance in the child's exercise of her or his own rights."

297. More recently in *Re: L (Contact: Genuine Fear)* 2002 1 FLR 621 Bruce Blair QC sitting as a High Court Judge had to consider a mother's total opposition to any contact between a child and his father. He was compelled to reach a decision with reluctance that the mother's phobic disorder not based on rational thinking nevertheless was of such genuineness and intensity that to order contact would cause the child marked emotional harm. He would be exposed to the emotional effect on the mother which would be profound and possibly de-stabilising.
298. From s.1 of the Act and those decisions I draw the following principles. I must consider each of the 2 children separately in respect of each of the vaccinations which are proposed. Their welfare is my paramount consideration.
299. I have regard in particular to the wishes and feelings of F to the extent she can at 10 years of age understand the issues with which I am concerned. The fact that she is in favour of one injection and against MMR are factors. Her views on MMR are influenced by her mother's unreasoning and rigid approach. As she will accept the court's decision I largely discount her concerns. C is too young at 4 to have her wishes taken into account.
300. My particular concern is the harm which each of the children is at risk of suffering if they remain unvaccinated. But that is not in isolation. I consider also their emotional needs. That includes the important bond they have with their main carer, their mothers.
301. I consider both are devoted mothers who have taken a stand in what they believe to be in their child's best interests. If however that is in conflict with my independent and objective judgment, I am entitled to give effect to my judgment if no other factors prevail.

302. Both mothers and both fathers have equal rights before the court. Where parents are in agreement that their child shall not be vaccinated, the law and doctors respect their view. It is not compulsory and no local authority, doctor, school, or other agency would in ordinary circumstances apply to the court for a contrary decision.
303. The issue only arises before me because 2 sets of parents with a common background of difficulties over contact are not in agreement. In each instance it is the mother caring for the child who opposes the application.
304. Where parents do not live together, the court recognises the importance of the particular bond which exists in most cases between a child and the parent with the principle care of the child. It exists with both children here. It does not give that parent greater rights. It does mean that the court will take care to safeguard and preserve that bond in the best interests of the child.
305. If therefore a course is proposed that is beneficial for the child but may cause damage to that relationship, the court will balance the issue with great care. If the benefit is not sufficiently significant or the risk of harm is clear, the court might well not make any order.
306. The case of *Re L* is a helpful example. Plainly there was a benefit to the child in having continuing contact with the father. But to proceed to enforce it would cause the child marked emotional harm because of the mother's likely response. With reluctance the court was compelled to place greater weight on the value of his relationship with his mother than contact to his father to avoid that degree of harm.
307. Thus here I undertake a similar balancing exercise. I have already done the first part and reached my conclusions taking into account not only contrary views but the valuable submissions of Miss Gumbel on the part of the mothers.
308. It is to the second part I now turn, namely a careful appreciation of benefit against risk. In each case I look at the position of the child individually in their relationship with both parents.

### The main submissions

309. Mr Cohen said the court can only act on the evidence before it. He compares the quality of the medical evidence on each side. The concessions made by Dr Donegan make a detailed examination of her medical references unnecessary. The test is an objective one.

310. He went through the individual vaccinations. It is unnecessary to repeat them in the light of my findings above. He accepted that C's mother presented in an anxious state, but she brought the situation on herself by her actions after C was born. Both mothers can cope with a decision against their wishes.
311. Miss Gumbel lists the unusual number of features common to both applications. They include the fact that the fathers have parental responsibility and have contact. But the age of the girls and the reasons for the mothers' objections is significant.
312. She rightly makes plain that this case is not a test case on whether children should be vaccinated. Nor is the court deciding if the MMR vaccination is potentially harmful.
313. The decision for the court is the assessment of risk in each case of contracting the disease for which she is not vaccinated and the risk of side effects if she is vaccinated. The court then has to consider the risk and benefit of vaccination as well as any the benefit of having the illness, the impact of having intensive immunisation now, and the impact on the children of treatment to which their main carer objects.
314. She emphasises that while vaccination is recommended, it is a decision for parents. For F it was confusing. The mothers have met the children's needs to date.
315. She argues that it is not a question of whether the mothers are being unreasonable. Given the Court of Appeal decision in Re T to which I have referred, it is the mothers who will have to cope with any reactions if immunisation is considered to be in the children's best interests. The emotional effect on the mothers has to be taken into account. I agree.
316. Miss Gumbel reviewed the medical evidence. In only a few instances did she rely upon the differing views of Dr Donegan. It is however the range of medical opinion between the other 2 doctors which is significant she argued, for instance with percussis and Hib. Given that and the take up rate on vaccination ranging from over 97% to less than 58% in the London region, there is reason for the mothers' anxieties.
317. This is only added to by the sheer volume of medical papers in this case, the Vaccine Damage Payments Act, and the MMR litigation. Potent reasons are needed to go against the mothers' wishes. Whilst accepting that the medical evidence of Dr Conway and Professor Kroll is eminent, Dr Donegan from an alternative medical view supports the mothers.

318. The course taken by the mothers is within acceptable parameters and shared by others where the court does not have to take a decision. The emotional turmoil of a contrary decision is not met by sufficiently strong evidence of benefit.

### CAFCASS Legal

319. Miss Probyn for the Guardian submitted that the medical evidence was compelling. I agree. The next points which arose were the impact of any order upon the care of the 2 children. If it is significant, the question is whether that should influence the grant of the application.

320. Subject to that the Guardian, having helpfully set out the small differences there are on the recommendations of Dr Conway and Professor Kroll, does not support C having the pertussis and Rib vaccinations. To allow the BCG vaccination now is to avoid the chance of hearing C's views when it becomes a relevant consideration in 2 or 3 years time.

### Decision

321. I have already indicated that I have been persuaded by the evidence of Dr Conway and Professor Kroll that it is the girls' best interests to have the vaccinations according to a schedule they will draw, and is subject to the points I have already made. That is their clinical judgment. It is importantly supported by the Guardian subject to the particular reservations to which I have drawn attention and which I accept.

322. There are other matters to consider. I turn firstly to the proposals made by Professor Kroll in an attempt to assist the mothers.

323. He was anxious to reduce the anxiety they felt. If this would help to reduce the number of vaccinations, he was prepared to advise removing certain of the less essential vaccinations. I would have given such a proposal careful consideration were I satisfied that reducing the number would be of more than marginal significance to the mothers. I am not so satisfied.

324. The objections of the mothers is so fundamental that the benefit of foregoing 1 or 2 vaccinations, otherwise in the children's best interests, is of little assistance to the mothers. It is more than outweighed by the potential benefit of the whole course of immunisation.

325. I have considered Article 8 of the Human Rights Convention. It is in these terms -

## "Right to respect for private and family life

1. Every one has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

326. The court may interfere with the rights of both parents and children where to do so is to protect the health of a child. That is what I determine lies behind the recommendations which I have accepted.

327. It leaves one issue which has from the beginning been of considerable concern. It is the opposition of the mothers who are caring for the 2 girls.

328. In such a situation the law recognises that it is each of these mothers who takes the day to day decisions in respect of the child. The fathers are entitled to be consulted on more major decisions in the child's life.

329. I have already set out the importance of the bond which exists between the caring parent and the child. I have emphasised the care required in the balance that is required. This is even more important where the mother has to look after a child who is to undergo evasive medical treatment to which she is opposed.

330. As the cases stress, it requires compelling evidence and a consideration of all the circumstances before this should be done. That is why I was anxious to ensure that the mother B should have the opportunity to put before the court all necessary evidence on which to evaluate the situation.

331. I have reached 2 clear decisions but not without lengthy consideration. Firstly the medical evidence I have accepted is both clear and persuasive. Secondly the impact on the mothers and their care of their daughters, whilst of great importance and properly to be weighed, is not in either case of such a potential impact as should in the children's best interests deter me from the decision to which I have otherwise reached.

332. Mother E will take the news and remain convinced the court is wrong. She will not be moved by the fact that her daughter actually wants at least I

vaccination. It is not because she is unfeeling but because, having reached her decision, it is difficult for her to see that there could be other factors which might change her mind.

333. I am concerned about her rigid approach and not just to this application. But though she will regret my decision, I do not consider it will affect her care of F. As she said, she will accept it.
334. I have considered F's declared wishes with care. She is old enough to express views and for the court to give some weight to them.
335. It is helpful that she has thought about it and recognises certainly some of the benefits. I am helped by her view that she will accept the court's decision.
336. Mother B is in a different position in part. The whole application is an affront to her beliefs. It is part of what she sees as a campaign being conducted by Father A. I do not find that it is deliberate. I am however concerned about the effect that that is having on her and C.
337. I have witnessed the extent to which she feels under siege. I do not believe that it is subjectively exaggerated. Objectively I do not consider it as serious as is claimed. I consider that she will be able to cope with my decision difficult as it will be. I find support in Dr Veasey' s report.
338. She will be upset. But my decision will not I find cause an adverse reaction as Dr Veasey says. Nor I am satisfied will it cause an impact into her relationship with C to an extent that runs any significant risks for C.
339. But she is in a vulnerable state in any event. She may well need a degree of court protection to ensure that, at what is obviously a difficult time for her, she has the necessary energy and ability to give C the care she requires.
340. If therefore an enforced respite from court proceedings is a step forward, that may be appropriate. This is not necessarily a reflection on the father. It is however a recognition that the mother's stamina to meet the emotional demands prolonged litigation has placed on her may need to be carefully preserved in her own and C's best interests.
341. I have not been addressed on this issue. I therefore reach no conclusion but I will consider any application which arises from it in the absence of agreement.

342. Finally I have considered anxiously the passage in the judgment of Waite U in Re T which I have cited earlier. He drew attention to the wide scope for parental opposition to medical intervention, which I summarise.
343. At the end of the scale are what I describe as obvious cases where the objection would be widely regarded as having no validity in child welfare terms. The court would readily intervene in such cases in the child's interest. At the other end there are cases where there is scope for genuine debate on the issue. In such case, whilst the court had to allow its own opinion to prevail, it was more ready to leave difficult health issues to parents rather than to make orders.
344. There are considerations which have weighted heavily with me. I accept a parent's right to choose whether they accept medical advice to have immunisation for their children or not. That is a subject of genuine debate.
345. Here parents do not agree. On the evidence I have heard and the facts I am satisfied I should make an order rather than make no order. I am persuaded by the evidence. Immunisation is in these girls best interests. There are anxieties for the mothers who care for the children. I do not consider the impact of my decision, upsetting though it will be, should in the final analysis prevail.
346. This decision should not be seen as a general approval of immunisation for children. It does not mean that at another hearing a different decision might be reached on the facts of that case.
347. It does mean that I consider I should make an order in this case. That is based solely on the evidence I have heard and the arguments presented to me.
348. I shall leave the parties to draw the order resulting from this judgment. I will consider any further submissions which may arise.

### Summary

349. The 2 applications concern girls of 4 and 10, C and F, who have received no form of immunisation. They live alone with their mothers, B and E.
350. The link between the 2 applications is that in each case the absent fathers, A and D, ask the court to declare that the girls should receive immunisation appropriate to their age. They have issued an application for a specific issue order.

351. The court reaches a decision based on what is in the children's best interests as their welfare is the court's paramount consideration. If it is in their best interests, the court will then consider whether there are good reasons not to make a declaration, (paras. 1-6). The fathers say they are supported by current medical research and thinking. There are risks but they are outweighed by potential advantages for the child.
352. The applications are opposed by the mothers. Immunisation has unacceptable risks. The medical evidence is uncertain and there are good reasons for their anxiety.
353. Even if the court was persuaded by the medical evidence that a programme of immunisation was in the girls best interests, this should not be ordered by the courts. Immunisation is voluntary. It is not right to impose it against the wishes of a caring mother. Finally it would cause them great distress which would affect the children, (paras. 15 -24).
354. The parents were each represented by counsel. In addition the children were represented by CAFCASS Legal formerly the Official Solicitor, (para. 11).
355. Dr Conway, a consultant paediatric physician with a special interest in infectious diseases and immunology, was instructed jointly by the fathers. Dr Donegan, a general practitioner and homeopath with a particular interest in immunology, was instructed jointly by the mothers. Professor Kroll, who holds a chair in paediatrics and molecular infectious diseases, was instructed by CAFCASS Legal.
356. Each of the experts produced reports, gave evidence, and referred to medical papers in support of their conclusions. The medical papers fill 4 lever arch files. Because of the analysis in the reports it was not necessary for the court to consider the majority of the papers, (paras. 27- 43).
357. The evidence of Dr Donegan is treated with great reserve. She has deeply held feelings on the risks of immunisation. She allowed this to over-rule her duty to provide objective unbiased opinion considering all the relevant facts including those which detract from her opinion.
358. The evidence of Dr Conway and Professor Kroll was careful, balanced, and convincing. Only on a few minor points did it differ. The court relies on it, (paras. 44-60).
359. Immunisation is considered in respect of each girl from a series of diseases. The diseases and the conclusions reached by the court on the medical

evidence on whether it was in their best interests (recommended) are as follows:

Diphtheria (paras. 61 -75)

Conclusion -recommended for both girls (para. 76).

Tetanus (paras. 77- 87)

Conclusion -recommended for both girls (paras. 88 -89)

Whooping Cough (paras. 90 -115)

Conclusion -recommended for C not for F (paras. 116 -117).

Poliomyelitis (paras. 118 -128)

Conclusion -recommended for both girls (paras. 129-130).

Haemophibes Influenza Type B (Hib) (paras. 131 -146)

Conclusion -recommended for C not for F (para. 147).

Meningitis C (paras. 148-155)

Conclusion -recommended for both girls (para. 156).

Tuberculosis and tubercular meningitis (TB) (paras. 157 -159)

Conclusion -recommended for F if she proves tuberculin negative, not for C (para. 160).

Measles, Mumps and Rubella (paras. 161- 184).

MMR injection involving all 3 at once (paras. 185-193)

Conclusion (paras. 194-200).

360. The circumstances of each family are considered. Firstly it is the father A, the mother B, and their 4 year old daughter C, (paras. 201-251, conclusion 252-257). Then it is the father D, the mother E, and their 10 year old daughter F. (paras. 258-291, conclusion 292-296).
361. The fathers approach to the application is similar in urging the court to follow the recommendations of Dr Conway and Professor Kroll. The mothers rely only in part on the evidence of Dr Donegan.
362. They were in common in opposing any form of immunisation, on the unacceptable risks, and the upset it would cause them. They differed in part on the full extent of their reasons for their opposition and the effect of a contrary decision on them.
363. The law and decided cases relevant to the issues are reviewed, (paras. 297-309). A series of conclusions are set out, (paras. 310-321). The final submissions of the parties are summarised, (paras. 322-332).
364. The courts decision is that on the medical evidence of Dr Conway and Professor Kroll supported by the Guardian, immunisation is in these children's best interests. Article 8 of the European Convention on Human Rights giving respect to private and family life is considered. There is an exception permitting the interference by the court for the protection of health. That it is held should prevail, (paras. 333-338).
365. The opposition of the mothers is of considerable concern. Both mothers and fathers have equal rights before the court.
366. The parent with whom a child is living, whether mother or father, does not have greater rights than an absent parent who is entitled to be consulted on major decision in the child's life. But the court does attach importance to the particular bond between a child and the parent with whom they are living and will take care to safeguard and preserve it in the best interests of the child, (paras. 339-354).
367. Where a course proposed is beneficial for a child but may cause damage to that relationship, the court will consider the issue with great care. It may prevent a course otherwise beneficial to the child being ordered. This is especially where the proposal is for invasive medical intervention to which that parent is opposed when compelling evidence is required, (paras. 317-320).
368. The important impact on the mothers in this case is not such as should prevent immunisation. One mother, E, who has rigid views will accept the

decision. Her daughter F would like one injection, not another. F will accept the court's decision. At the age of 10 her views are given some weight.

369. It is different for mother A. To her the application is an affront to her beliefs on a holistic approach to life. She is also in a vulnerable state which may need to be protected. A decision to immunise will be very upsetting for her but not impact on her relationship with C to any significant extent, (paras. 339-353).
370. Where medical intervention is concerned the more scope there is for genuine debate the less likely is the court to take a decision contrary to a parent's wishes. Difficult medical decisions should be taken by parents.
371. Here there is a dispute and the court has to decide whether immunisation is in their interests, whether the mothers' opposition should prevail, and whether an order should be made. Recognising the anxieties of the mothers and that an adverse decision will be upsetting, the children's best interests are served by receiving a programme of immunisations and an order should be made, (paras. 354-357).
372. The fathers application supported by CAFCASS Legal is granted. The court declares that immunisation to the extent set out is in these girls best interest and should prevail over their mother's opposition.