Adolescent refusal of MMR inoculation: F (Mother) v F (Father)

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Abstract
F (Mother) v F (Father) concerned a dispute between parents as to whether or not a 15 and 11 year old should receive the MMR inoculation. Mrs Justice Theis took into consideration the wishes of both parents and the two 'intelligent, articulate and thoughtful' minors and held that inoculation was in their best interests. The troubled history of the MMR vaccine and its importance to the public health provided the backdrop. Whilst the court's efforts to establish the views of the minors are to be commended, the decision is problematic in its assessment of the minors' individual medical interests; of their individual capacities; and in the significance placed on their views when determining whether inoculation would be in their best interests.

The Facts

Measles, mumps and rubella are highly contagious, untreatable viral diseases that can have serious, sometimes fatal effects. Incidence is vastly reduced by vaccination. The NHS offers a combined MMR vaccination in two courses. The first is usually given before the child's first birthday and the second between the child's third and fifth birthdays. In *F (Mother) v F (Father)*[1] a recently divorced father wanted his two daughters L and M, aged 15 and 11 respectively, to receive the MMR vaccine. As a baby, L was given the first course, but no booster. M had not received either course.

The parents had been influenced by widely held concerns about the safety of the vaccine that emerged shortly after L received the first course. These concerns were later allayed to the satisfaction of the father,[2] but the mother and daughters continued to reject inoculation. Section 2(7) of the Children Act 1989 enables a person with parental responsibility to provide sole consent. However, even if the father had been able to find doctors willing to carry out the inoculation in the face of the minors' objections, parental dispute about immunisation is one of a small group of decisions that parents cannot take unilaterally.[3] The father therefore applied to the court for a specific issue order that both daughters receive the MMR vaccination. Mrs F, the mother, opposed the application.

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[1] [2013] EWHC 2683 (Fam).
[2] Ibid, at [12], [17].
[3] *Re J* [2000] 1 FLR 571 at [577*]; Re C (Welfare of Children: Immunisation)* [2003] 2 FLR 1095, at [16].

Mrs Justice Theis established that the paramount consideration is the welfare of the minors, applying the welfare checklist in section 1(3) of the Children Act 1989.[4] Having met with L and M and found them 'charming, intelligent, articulate and thoughtful'[5] and consulted reports to determine the views of the minors and parents, Theis J made a declaration that it was in the interests of L and M to receive the vaccination and set a deadline.[6]

The context

Measles, mumps and rubella present a worldwide public health issue. A global vaccination campaign has led to a 71% drop in measles-related deaths between 2000 and 2011, making a huge impact on the estimated 2.6 million deaths per year in the 1980s.[7] Though often a mild condition, rubella infection during pregnancy can cause a range of foetal health problems and result in birth defects. Mumps is also generally mild, but can result in serious complications such as viral meningitis and fertility problems. In the UK, the incidence of all three diseases has been much reduced since the introduction of the triple (MMR) vaccine in 1988. The vaccine comprises weakened viruses that trigger the production of antibodies. Though usually given to young children, it can also be given to older children and adults.

L and M's parents, like many other parents at the time, decided against inoculating their young children due to safety concerns identified in a paper published in the *Lancet*[8] and much publicised by the media.[9] At first, the risks posed to the un-inoculated were negligible. People were unlikely to come into contact with the diseases due the success of the vaccination programme. However, as increasing numbers of parents rejected the vaccination, herd immunity was reduced. In 2013, reports of an outbreak of measles in Swansea[10] resulted in a national NHS campaign focusing on the inoculation of older children.[11]

Criticism on a number of counts eventually led to the retraction of the *Lancet* paper.[12] The NHS promotes the safety and efficacy of the vaccine.[13] Yet despite the public health

[4] [2013] EWHC 2683 (Fam), at [8].
[5] Ibid ,at [5].
[6] Ibid, at [23].
[7] World Health Organisation, 'Measles: Fact Sheet Measles N°286' (February 2013) at http://www.who.int/mediacentre/factsheets/fs286/en/ (last visited 31/10/13).
[8] A.J. Wakefield, S.H. Murch, A. Anthony, J. Linnell, D.M. Casson, M. Malik, M. Berelowitz, A.P. Dhillon, MA Thomson, P. Harvey, A. Valentine, S.E. Davies, J.A. Walker-Smith, 'RETRACTED: Ileal-Lymphoid-Nodular Hyperplasia, Non-Specific Colitis, and Pervasive Developmental Disorder in Children' (1998) 351(9103) *The Lancet* 637 (retracted).
[9] Nuffield Council on Bioethics, *Public Health: Ethical Issues* (2007), paras 4.33-4.35.
[10] NHS Public Health Wales, *Measles Outbreak Data* (July 2013), at http://www.wales.nhs.uk/sitesplus/888/page/66389 (last visited 31 October 2013).
[11] NHS Website, 'MMR catch-up campaign targets a million children' 25 April 2013, at http://www.nhs.uk/news/2013/04April/Pages/New-MMR-catch-up-campaign-one-million-children-targeted.aspx (last visited 31 October 2013).
[12] B. Deer, 'How the Case Against the MMR Vaccine was Fixed' (2011) 342 *British Medical Journal* 5347.

benefits, the Department of Health has not yielded to calls for 'incentives', such as making the payment of benefits conditional on inoculation.[14] Instead it has steadfastly maintained a policy of voluntary inoculation.[15]

Theis J's judgment in this case aligns with the public health agenda, which emphasises that MMR inoculation is in the best interests of children both individually and as a group. However, Theis J does not (at least overtly) rely on the public policy arguments to justify her decision. In fact, Theis J was keen in a previous parental inoculation dispute case, *LCC v A, B, C and D,*[16] to show that 'policy dogma' was not a relevant consideration.[17]

It is clear, therefore, that the decision in *F (Mother) v F (Father)* should turn on the best interests of L and M and not on the wider policy considerations.[18] Whatever the moral responsibilities of L and M, their parents and parents generally to do their part in protecting the public health, this was not the concern of the court in this case.

The relevance of parental views in determining best interests

Whilst the Children Act checklist in section 1(3) sets down a number of considerations relevant to welfare, they are broadly framed and in no particular order of priority. It is unsurprising therefore that there is a lack of certainty surrounding the definition of 'welfare' and that the court is frequently called upon to arbitrate 'best interests' disputes.

The court has the power to override the views of parents whose views do not accord with the welfare of the child. In *The NHS Trust v A* Holman J stated:

> [Parental wishes] are wholly irrelevant to consideration of the objective best interests of the child save to the extent in any given case that they may illuminate the quality and value to the child of the child/parent relationship.[19]

This and other relevant cases[20] lead the Nuffield Council on Bioethics to recommend that vaccination against the wishes of parents may sometimes be acceptable, with the proviso that: 'in relation to vaccination [of incompetent minors] in the face of parental refusal, a risk of serious harm would have to be demonstrated'.[21]

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[13] NHS Website, 'How Do I Know that Vaccination is Safe?', at http://www.nhs.uk/Conditions/vaccinations/Pages/Safety-and-side-effects.aspx (last visited 31 October 2013).
[14] In a Guardian poll 26% felt that child benefit should be linked to MMR vaccination?: *The Guardian* 23 Sept 2013, at http://www.theguardian.com/commentisfree/poll/2013/sep/23/child-benefit-mmr-vaccination-labour (last visited 31 October 2013),
[15] As recommended by Nuffield Council on Bioethics, n 9 above, para 4.32.
[16] [2011] EWHC 4033.
[17] [2011] EWHC 4033, at [17].
[18] Children Act 1989, s 1(3).
[19] [2007] EWHC 1744.
[20] *Re J (A Minor) (Wardship: Medical Treatment)* [1991] 1 FLR 366, per Donaldson MR at [370].
[21] N 9 above, para 4.30.

The case in hand poses a number of dilemmas. It is not clear that the minors were incompetent or that the risk of harm to L and M could be categorised as 'serious'. These issues will be considered in the next subsections. In this section it is pertinent to consider the relevance of the parental views, taking into consideration the fact that both might be considered 'reasonable' on the basis that the Department of Health recommends childhood vaccination but does not deem the risk to individual or public health sufficient that it be mandatory.

In *LCC v A, B, C and D,*[22] care proceedings had been initiated in respect to four children (aged 13, 9, 6 and 5) on the basis of neglect. The parents believed that their eldest child's autism was a result of the MMR and did not want him to receive a booster injection or for the other children to be immunised at all. They relied on the fact that around 12% of parents shared their concerns and rejected the MMR.[23] The parents shared parental responsibility with the local authority, which wanted the children to receive the vaccinations. Theis J gave consideration, 'in particular, to the understandable views of the parents'[24] but said:

> Nevertheless they should be weighed in the light of an almost complete failure by the parents to co-operate with health professionals and a neglect of the children's health. In respect of the link between autism and the MMR, they rely on discredited research.[25]

Theis J found the parental views to be 'understandable' but not necessarily reasonable. *In F (Mother) v F (Father)* there is no such evidence of neglect. However, the reasonableness of either or both parental views does not prevent Theis J from coming to an independent decision on best interests. This was made clear in *Re Z (A Minor) (Identification: Restrictions on Publication)*[26] where Sir Thomas Bingham MR said:

> [The parental decision] 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.[27]

In this case, neither parental view should be lightly set aside, but this does not mean that the case becomes a simple contest of reasonableness between the two positions. Although the outcome will inevitably coincide with one parental view rather than the other, the reasoning which leads to that outcome is guided but not determined by the parental views. The case turns on whether or not inoculation is in L and M's best interests.

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[22] [2011] EWHC 4033.
[23] Ibid, at [13].
[24] Ibid, at [17].
[25] Ibid, at [17]. And see *Re T (Wardship: Medical Treatment)* [1997] 1FLR 502), per Butler Sloss P at [509].
[26] [1996] 2 WLR 88.
[27] Ibid, at p 113.

The Court of Appeal decision in *Re C (Welfare of Children: Immunisation)*[28] set out how to go about the best interests determination. In this case the mother's objections were overruled on the basis that the benefits of vaccination outweighed the risks. At first instance, Sumner J first established that immunisation was in the girls' medical interests and then went on to determine that there were no sufficient non-medical reasons for refusing to order the vaccination. The Court of Appeal (where the two-stage test was challenged) commended the approach.[29]

Medical interests

In *F (Mother) v F (Father),* neither party took the opportunity to present medical evidence: 'The reason why it was not taken up is because from the medical perspective the evidence all points one way.'[30] The medical benefits of MMR inoculation, according to Theis J, were uncontested, which meant that she could focus on the non-medical best interests considerations.

Even if the mother did not contest the medical benefits of inoculation, I would argue on the above assessment, that Theis J should have considered how the medical perspective applies to L and M's cases in particular. After all, if the father's application was motivated not by the desire to protect his children from disease, but a less generous motive, the court would remain free to recommend inoculation. The court's independent assessment of best interests is guided by parental views. It is not a slave to them.

However, it seems that the mother *did* in fact contest the medical interests. She questioned the lack of evidence of medical benefit for L and M.[31] Furthermore, Theis J acknowledged the mother's belief that if L and M do contract the diseases, their health and robust immune systems render them unlikely to suffer serious complications, 'which she considers lowers the risk'.[32] The mother got this information from an NHS website[33] where it is prominently displayed in lay terms.[34] It seems a reasonable assumption that this factor might have been taken into account without the need for expert medical evidence. If so, then the court might also have considered the following factors:

1. Despite the fact that uptake of the MMR was adversely affected by the *Lancet* paper, herd immunity is such that L and M are unlikely to come into contact with the diseases.[35]

[28] [2003] 2 FLR 1095.
[29] Ibid, per Thorpe LJ, at [25].
[30] [2013] EWHC 2683 (Fam), per Theis J, at [16].
[31] Ibid, at [10] and [16].
[32] Ibid, at [11].
[33] Ibid.
[34] See for example NHS Choices Website, *Measles: Complications* at http://www.nhs.uk/Conditions/Measles/Pages/Complications.aspx, (last visited 31 October 2013).
[35] NHS Choices Website, *Measles*: '[Measles is] now rare in the UK… .' At http://www.nhs.uk/conditions/Measles/Pages/Introduction.aspx (last visited 31 October 2013).

2. The relevant medical benefit concerns the balance between elevated protection from disease over the next 7 years (for M) and 3 years (for L) with their not being (fully in L's case) inoculated *for the duration of that period*. Both will have the chance, when adults, to make an informed choice for themselves about inoculation. As adults, they might re-assess the risks and benefits or opt to request (or pay for) separate vaccines. For example, though they may later consider the rubella vaccination as a precursor to pregnancy, they will not necessarily benefit from that protection during childhood.
3. M and L are in very different positions vis-à-vis the medical benefits that flow from inoculation. L has already had the first course, which gives her approximately 90% protection from the diseases. M, on the other hand, has no protection at all.[36]

This assessment is backed up by public-facing NHS webpages on measles, mumps and rubella. It is comprehendible to layperson and judge. Yet the medical interests assessment in *F (Mother) v F (Father)* was judged to be no different to that in the *LCC*[37] case.[38] Consequently it was based on the conclusion that 'the benefits of vaccinations outweighed the risks'.[39]

It is not my intention to revisit the debates about the safety of the MMR. There are risks inherent in all medical treatment and preventative measures, but the Department of Health has reviewed the evidence and judged the MMR safe and effective. It is worth noting, however, that the court is required to assess L and M's individual medical interests whereas the NHS, in recommending the MMR, is concerned with both the individual risk-benefit ratio, and the public health benefits which flow from the minimisation or even eradication of disease. In short, the NHS has a (perfectly proper[40]) policy agenda, which it was argued in a previous section, is not relevant to the case of *F (Mother) v F (Father)*. The individual view (of L and M's medical interests in receiving inoculation) and the general view (that the MMR is safe and efficacious) can lead to very different assessments of best interests. In relation to 15 year old L, these might be expressed in the form of two extremes:

> Extreme 1: The MMR is a safe and effective vaccine that effectively eliminates the risk of contracting three potentially dangerous (even fatal) diseases.

Or

[36] NHS Choices, 'Measles Outbreak – What to Do', at http://www.nhs.uk/Conditions/vaccinations/Pages/measles-outbreak-advice.aspx (last visited 31 October 2013). The first dose of the MMR jab protects 90% of those who receive it, and the second dose tops this up to 99% protection.
[37] [2011] EWHC 4033.
[38] [2013] EWHC 2683 (Fam), at [16].
[39] Ibid, at [9].
[40] N 9 above, para 4.31.

> Extreme 2: Because the MMR is also available to adults, the court's concern is limited to the benefits associated with L's elevated immunity until the occasion of her 18th birthday. In the next three years, L will benefit from a mere 9% elevation in immunity to a disease with which she is unlikely to come into contact, but in the event that she does, is likely (due to her age and health) to be mild and of no lasting significance.

Theis J clearly leans towards the first version of best interests. The mother's allegation that medical interests of inoculation are not made out is powerless against a general rather than an individual assessment of medical interests.

Another factor relevant to L and M's medical interests that was not relevant in the *LCC* case, is the risks of inoculation that flow from its non-consensual nature.[41] This might serve to offset the arguably minimal medical (individual) benefits of inoculation in M and (particularly) L's case.

The extent of the risk depends both on the degree to which the refusal is autonomous and the practical response it necessitates. L and M might accept the court's judgment and assent to inoculation. If so, then arguably their medical interests are served by inoculation. The Child and Family Court Advisory Service report by Ms Vivian suggested that the children were likely to do as they were told:

> She considered these particular children to be very bright and have a lot of empathy and respect for their parents and would understand why decisions are made and the parental process.[42]

But this assessment rests on the assumption that overruling a refusal of a medical procedure is no different to other welfare decisions where there is a parental dispute:

> She was asked about the risks to them if their wishes and feelings were overruled. She acknowledged there is always a risk when children are involved to this degree but she did not consider it any different from other welfare based decisions that do not accord with the wishes and feelings of the children concerned.[43]

With respect, even if L and M willingly submit to the inoculation, this seems to be underplaying the impact of compulsory medical intervention: In *YF v Turkey,*[44] it was stated that 'a compulsory medical intervention, even if it is of minor importance, constitutes an interference with this [Article 8] right'.

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[41] [2013] EWHC 2683 (Fam), at [18].
[42] Ibid, at [15].
[43] Ibid, at [15].
[44] *YF v Turkey* [2003] ECHR 391, at [33].

On the other hand, L and M might refuse to cooperate,[45] in which case the first difficulty will be to find a doctor willing to carry out the procedure. The doctor would be protected from a claim in battery by virtue of the court's decision, but this is unlikely to remove the ethical concerns many doctors will have about non-consensual inoculation of older minors. The second problem is that a coercive invasive medical procedure is one of the most serious invasions of bodily autonomy sanctionable in a democratic society, despite the fact that in *Re C (Welfare of Children: Immunisation*),[46] Thorpe LJ rejected the 'repeated categorisation of the course of immunisation as non-essential invasive treatment. It is more correctly categorised as preventative healthcare'.[47] If L and M were adults lacking capacity, special conditions would apply where restraint is necessary, including the requirement that the treatment is necessary to prevent harm.[48]

If inoculation will have a detrimental effect on the physical and emotional wellbeing of L and M, this might counter the benefits of inoculation. This is a relevant factor even if L and M lack *Gillick* competence, though the stronger their capacity, the more weight should be given to their decision.[49]

Non-medical interests

In addition to the medical implications of non-consensual treatment, there are other, non-medical factors relevant to the best interests assessment. According to *Re C*, these would be considered in light of established medical benefit to determine whether there are valid reasons for prioritising other, non-medical benefits.

In the two previous cases where the court was called upon to resolve a parental dispute about childhood vaccination, the court opted for inoculation.[50] In the face of two capable but opposing parental views,[51] the balance swung with the medical benefits of inoculation.

This case, however, is complicated by virtue of the fact that L and M are opposed to inoculation. As a result, the first factor in the welfare checklist- 'the ascertainable wishes and feelings of the child concerned (considered in the light of his age and understanding)'[52] - comes into play. This factor is relevant both to the medical benefits of inoculation versus the harmful medical consequences of non-consensual inoculation, and the non-medical

[45] See S. Adams, 'Sisters Refuse to get MMR Jab Despite Judge Ordering them to be Vaccinated after their Divorced Parents Fight over Inoculation' *Mail Online* 12 October 2013, at http://www.dailymail.co.uk/news/article-2456878/Sisters-refuse-MMR-jab-despite-judge-ordering-vaccinated-divorced-parents-fight-inoculation.html (last visited 31 October 2013).
[46] [2003] 2 FLR 1095.
[47] Ibid, at [22].
[48] Mental Capacity Act 2005, s 6.
[49] UN Convention on the Rights of the Child, Article 12(1).
[50] *Re C (Welfare of Children: immunisation)* [2003] 2 FLR 1095; *LCC v A, B, C and D* [2011] EWHC 4033.
[51] Children Act 1989, s 1(3), factor (f).
[52] Children Act 1989, s 1(3), factor (a).

implications which flow from the UK's agreement to abide by the UN Convention on the Rights of the Child. Article 12(1) states:

> States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Theis J did not apply the *Gillick* competence test, but did articulate reasons for doubting the autonomy of their decisions. Had she decided otherwise, the outcome might have been very different. Whilst the court has the inherent jurisdiction to overrule a competent minor, three factors mitigate against non-consensual inoculation. First, the contentious decision of *Re R*[53] in which Lord Donaldson asserted that parents or the court could consent even where a competent minor withholds consent, related to life-sustaining treatment. It is questionable whether the same principle would apply to preventative medicine. Second, Silber J in *R (Axon) v Secretary of State for Health*[54]suggested that parents lose any rights under Article 8 of the European Convention on Human Rights to control their child's medical treatment once that child becomes competent. This suggests an increased relevance of decisional autonomy of competent minors.[55] Third, it would conflict with Government policy. The NHS advice on the HPV vaccine given to 12-13 year old girls to protect against the two viruses that cause over 70% of cervical cancer, allows competent minors to refuse the vaccination, whatever the reason:

> **What if she doesn't want to have the vaccination?**
>
> She doesn't have to have it, if she doesn't want to.
>
> But it is recommended that she does for the reasons given above. Having the vaccination now will protect her for many years. Suggest she speaks to the nurse or doctor if she wants more information, on her own, or with you, if she'd prefer.[56]

In *F (Mother) v F (Father),* Theis J considered the views of L and M in accordance with Article 12(2) of the UN Convention on the Rights of the Child. However it is less clear that the judgment complies with the Article 12(1) requirement that 'due weight' is given to the view of the children.

The context must not be ignored. L and M's parents separated in 2009 and divorced in 2013. The inoculation dispute might, under different circumstances, have been resolved amicably. Presented with a united front, the daughters might have complied with whatever decision

[53] [1991] 4 All ER 177.
[54] [2006] EWHC 37 (Admin).
[55] And see *Mabon v Mabon* [2005] EWCA Civ 634, per Thorpe J at [26] and [32].
[56] NHS, *The HPV Vaccine*, at http://www.nhs.uk/Planners/vaccinations/Documents/HPV.pdf (2012) at p 8 (last visited 31 October 2013).

their parents made. If this is the full extent of the problem, then Theis J offers a solution. The judicial determination of best interests may be enough to persuade the mother to change her position in which case, assuming the court is right about her level of influence, the daughters will follow suit. Even if the mother maintains her position, L and M, caught in the cross fire of a parental dispute, have the justification they need to accept the father's opinion, free of the guilt that might otherwise accompany this decision.

But, as we saw above, it is also possible that L and M really do have a strong desire not to be inoculated. Theis J decided that both minors' views were insufficiently balanced, did not give sufficient weight to the positive side of immunisation and were swayed by the strong views of their mother.

> The girls' wishes is, of course an important factor, particularly bearing in mind their ages but the court also has to consider their level of understanding of the issues involved and what factors have influenced their views.[57]

The court relied on apparent misconceptions made by L and M as evidence of their lack of understanding. Ms Vivian report relayed the girls' naivety concerning measles:

> When asked by Ms Vivian how they would get better if they became ill with one of the vaccine preventing diseases M responded they would go to the doctor and get medicine and get better. … L wondered whether they would get treated as the doctors may be scared of getting it too. They said they knew people who had had measles and they 'only get a rash'.[58]

If this view is indeed evidence of naivety (a position I will shortly question), it is concerning that the seriousness of the diseases was not explained to L and M in order to give them an opportunity to reflect upon and reconsider their positions. L and M's abilities to reach reasoned decisions regarding inoculation (albeit decisions which did not necessarily bind the court) were not facilitated. Theis J said:

> [Ms Vivian] considers they have had access to information that they have researched themselves and she does not consider they have obtained a full and proper picture … She did not consider they had any rounded appreciation of the pros and cons of the vaccine and as a result there should be some caution before attaching significant weight to their wishes and feelings.[59]

One option would have been to furnish the minors with this information before assessing their views and their relevance. Were L a few months older, an assessor of their capacity would be required to facilitate their decision-making according to section 1(3) of the Mental Capacity Act 2005 which states:

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[57] [2013] EWHC 2683 (Fam), para [22].
[58] Ibid, at [13].
[59] Ibid, at [14]-[15].

> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

The Act does not apply to L and M, who are under the age of 16, but Andrew McFarlane has expressed the desirability of extending the same facilitative approach to minors.[60] Furthermore, Article 13 of the UN Convention on the Rights of the Child respects the child's right 'to freedom of expression … [including] freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers… .' Had the assessment of L and M's understanding been facilitative, their views (whether for or against inoculation) might have taken on additional significance.[61] The fact that the flaws in the minors' understanding might have been remedied is not taken into account in *F (Mother) v F (Father)*.

The supposed naivety of their views is also questionable. First, L and M's focus on the negatives of inoculation is hardly surprising given that the minors rejected inoculation. Had they expressed views both for and against inoculation, would it not have been easy to overrule them on the basis that they were undecided?

Second, L (a vegan) objected to the gelatine content of the vaccine.[62] In an adult this might have been seen as evidence of a thoughtful and considered approach – of an objection to the vaccine which goes beyond the disputed concerns about its safety following the *Lancet* article and press campaign. An absolutist moral stance would not be taken as evidence of incapacity.[63] In the short judgment, the fact that L did not know or enquire as to the ingredients of any *treatments* for measles, mumps and rubella was mentioned 3 times.[64] It was acknowledged that L and M had done some of their own research on the internet. Yet a perusal of the NHS webpages designed to inform the public on the symptoms, treatments and complications associated with measles, mumps and rubella reveal that there is no treatment for these conditions. L was quite right then to assume both that a doctor treating such a contagious condition might be concerned about infection (L of all people knows that not everyone has been inoculated) and that gelatine or other animal products is unlikely to be administered in any necessary treatment, because no such treatment exists. It seems that a higher level of understanding was required than the NHS expect of the readers of their webpages. Whilst Lord Scarman required that in order to be viewed *Gillick* competent, minors should 'understand fully what is proposed',[65] this would take the level of understanding required of L and M beyond that required when an adult consents to or refuses treatment. A similarly high threshold in the much-criticised case of *Re E (A minor) (Wardship: Medical treatment)*[66] resulted in academic criticism.[67]

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[60] A. McFarlane, 'Mental Capacity: One Standard for All Ages' [2011] 41 *Fam Law* 479.
[61] E. Cave, 'Maximisation of a Minors' Capacity' (2011) 4 *Child and Family Law Quarterly* 429.
[62] [2013] EWHC 2683 (Fam), at [13-15],
[63] Mental Capacity Act 2005, ss 1(4) and 2(3).
[64] Ibid, at [13], [15] and [22].
[65] *Gillick v West Norfolk Area Health Authority* [1986] AC 112, [253].
[66] [1993] 1 FLR 386.

Conclusions

Neither party produced expert medical evidence. Arguably it was not needed given the undisputed medical evidence that the vaccine is safe and effective in preventing potentially serious diseases. On the other hand, the mother's dissatisfaction with the lack of evidence of medical benefit is not limited to the (undisputed) risk of side effects and (disputed) safety concerns over the MMR. I have argued that the relevant assessment is not the safety and efficacy of the vaccine, but the balance between the medical benefits of inoculation in L and M's case in particular and welfare considerations which flow from non-consensual inoculation. I have further argued that the court might have made such an assessment without the aid of expert medical evidence. It is therefore arguable that exaggerated prominence was given to the medical benefits of inoculation in this case.

This factor should be considered in conjunction with the arguably unfair presentation of their views as unbalanced and unfocused[68] and the failure to facilitate L and M's capacity to make a decision about inoculation. This is lamentable. Children's rights should be no less relevant because the dispute originated between their parents.

[67] For example, see R. Taylor, 'Reversing the Retreat from Gillick? R (Axon) v Secretary of State for Health' (2007) 19(1) *Child and Family Law Quarterly* 81.
[68] Ibid.