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IN THE FAMILY COURT
AT HAMILTON

I TE KŌTI WHĀNAU
KI KIRIKIRIROA

FAM-2017-019-000292
[2022] NZFC 2773

IN THE MATTER OF	THE CARE OF CHILDREN ACT 2004
BETWEEN	[ALEX TOWNSEND] Applicant
AND	[AMBER POOLE] Respondent

Hearing:	25 March 2022
Appearances:	R Sporle for the Applicant Respondent appears in Person T Gunn as Lawyer for the Children
Judgment:	25 March 2022

ORAL JUDGMENT 1 OF JUDGE G S COLLIN

Introduction

[1] [Alex Townsend] and [Amber Poole] are the parents of [Cerys Townsend], aged nine, and [Elliot Townsend], aged eight. The children are in their shared care.

Issue for determination

[2] [Cerys] and [Elliot] are both healthy children, to date they have had all their recommended paediatric vaccinations and have suffered no adverse reactions. Neither [Cerys], or [Elliot], have any pre-existing conditions. There is no reason why they should not have vaccinations, and no known reason why they should not have the Pfizer vaccination.

[3] Mr [Townsend] proposes [Cerys] and [Elliot] be given the Pfizer vaccination for COVID-19. Ms [Poole] does not absolutely oppose [Cerys] and [Elliot] having the vaccination but considers that it should not be administered until the children reach the age of 12 and can make their own decision, or until the clinical trials for the vaccination have been completed.

[4] The issue for determination is should [Cerys] and [Elliot] be given the Pfizer vaccination now, or later as proposed by Ms [Poole].

The hearing

[5] The hearing proceeded by submission-only with both Mr [Townsend] and Ms [Poole] providing written submissions and drawing the Court's attention to the affidavit evidence, articles and research relevant to their case, decisions of courts about vaccinations generally, and the Pfizer vaccination specifically.

[6] Mr [Townsend]'s case for vaccination can be summarised as follows:

(a) If vaccinated, the children will be better protected from being infected from COVID-19;

(b) If the children were to get COVID-19 they are less likely to suffer adverse consequences if they are vaccinated;

(c) If the children are vaccinated there would be less risk to other family members. Mr [Townsend] is concerned for his mother's well-being because she has recently had cancer, and for the children's younger siblings: [Roberta], aged two, and [Victoria], aged one. Further, he notes that his wife, [Nicole], is a specialist nurse working with vulnerable people.

[7] Ms [Poole]'s case against vaccination can be summarised as follows:

(a) The children have said they do not want to be vaccinated;

(b) That to force a child to have the Pfizer vaccination is a breach of their s 10 New Zealand Bill of Rights 1990 entitlement, not to be exposed to experimental scientific or medical treatment;

(c) That there are safety risks because the clinical trials have not yet been completed and data about the long-term impacts of the Pfizer vaccination remain unknown;

(d) That the vaccination is unnecessary because most children only suffer mild symptoms when infected by COVID-19;

(e) That having the vaccination does not prevent a child passing COVID-19 to others.

The children's views

[8] Section 6 of the Care of Children Act 2004 requires that a child must be given reasonable opportunities to express his or her views, and that all views expressed must be taken into account by the Court. Section 6 is not age-restricted, with the youngest child being entitled to an opportunity to have their views made known and considered.

[9] The importance of children's views is emphasised in Article 12 of the United Nations Convention on the Rights of a Child, which states that a child who is capable of forming his or her own views has the right to express those freely in all

matters which affect him or her. Those views are to be given due weight in accordance with the age and maturity of the child. Article 12 refers to the opportunity to be heard in judicial proceedings which affect a child. This can be done either directly or through a representative.

[10] Although the reference to age and maturity in Article 12 is not mirrored in s 6, the weight given to views expressed by children still have regard to their age and maturity. This is reflected in their capacity to understand the issues and any influences that may act on them in the formation of those views.

[11] As a general principle, the younger the child the less likely their views will be determinative, and the less weight that will be given to their views. There comes a point where a child's view may be determinative of the outcome.[1]

[12] In *Long v Steine*,[2] Judge Coyle found that a 12-year-old child was Gillick-competent,[3] with his views being determinative of the outcome. The child was not required to have the Pfizer vaccination on the grounds that to require him to do so would be a breach of his right not to be subject to medical treatment that he opposed.[4]

[13] During the hearing a discussion occurred as to whether [Cerys] and [Elliot] were Gillick-competent, and if so whether any views expressed by them should be determinative of the outcome. The parties were unable to refer me to a case in which children of eight or nine were found to be Gillick-competent, nor did my brief database search locate any such case. On the contrary, I found cases in which children of that age were determined not to be.[5]

[14] Even if a child is not Gillick-competent, that does not mean that their views should not be considered or given weight. This is evident from s 6 which makes no reference to age and maturity. The views of younger children have been given weight

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[1] *Hawthorne v Cox* [2008] 1 NZLR 409.
[2] *Long v Steine* [2022] NZFC 251.
[3] *Gillick v West Northwick & Wisbech Health Authority* [1986] AC 112.
[4] Section 11 New Zealand Bill of Rights 1990.
[5] *S v N* Manukau FC, CRI-2007-055-000321, 30 April 2018 (decision about a 10 year old child); and *Moore v Moore* [2014] NZHC 3213 (a decision of Brown J about children 10 and 18. These are noted only as examples of cases involving children of a similar age to [Cerys] and [Elliot].

to the point of being determinative in care and contact cases where reasonable and strongly-held views have been expressed, and in Hague child objection defence cases where the views of eight and nine year-old children have been given significant or determinative weight.[6]

How does this apply to [Cerys] and [Elliot]'s views?

[15] [Cerys] and [Elliot]'s views have been expressed via their lawyer, Ms Gunn, who, following a meeting with them, reported that her parents had talked to her about the issue of immunisation, but that:

> Dad didn't really say much, neither did Mum, I must have forgotten.[7]
>
> [Cerys] thought that none of her friends had been vaccinated. She said that she knows a little bit about COVID and said there is a few cases in [location A] and a lot in Hamilton.

[16] Ms Gunn reported that [Cerys] understood that the purpose of a vaccination was to stop someone from contracting a disease:

> [Cerys] was aware that friends' parents had talked about the issue and didn't think that children should be vaccinated. Her view was that she doesn't wish to be vaccinated. She thought that her friends' parents talk about it quite a lot, but Mum and Dad don't talk about it too much. Then she said: 'Well Mum kind of did, and Mum thinks it's bad'. [Cerys] was aware that her father thinks it is to protect Grandma, Granddad, [Roberta], and [Victoria].

[17] Ms Gunn summarised [Cerys]'s views as not wanting to be vaccinated.

[18] [Elliot] told Ms Gunn he did not know much about COVID and Omicron.

> He could remember getting injections when he was younger. He was not sure what his dad thinks and had no idea what his mum thinks either. [Elliot]'s view was: 'I don't want to'. [Elliot] did not have any particular views as to why he did not wish to get the injection.

[19] Up until the time Ms Gunn met with [Cerys] and [Elliot], I am satisfied that the children had been talked to about the Pfizer vaccination, but had not been unduly

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[6] *S v S* HC Nelson M 12/94 28 July 1994; *SL v SLN* [2012] NZFC 7195, [2013] NZFLR 1000; *Coates v Bowden* (2007) 26 FRNZ 210.

[7] Memorandum of Ms Gunn of 17 February 2022.

exposed to the opposing views of Mr [Townsend] and Ms [Poole]. This is evident from the discussions Ms Gunn had with them.

[20] In submission, Ms [Poole] suggested that [Cerys] and [Elliot]'s views had changed since they met with Ms Gunn and that they were now more opposed to receiving the vaccination than they had been at the time of the meeting.

[21] I decided not to meet with the children on the basis that Ms Gunn is an experienced Lawyer for Child whose meeting with the children occurred only a few weeks prior to the hearing. I am satisfied that her report represents the reasonably uninfluenced views of the children.

[22] I propose to proceed on the basis that the children do not want to be vaccinated, however I conclude that they are not Gillick-competent and do so for the following reasons:

(a) They are normal children aged eight and nine. Neither has reached the age where children have been considered Gillick-competent;

(b) [Elliot] did not express views to Ms Gunn that indicated any awareness of the issues;

(c) Although [Cerys] had a greater understanding, this did not extend to an ability to understand the arguments for or against the vaccination. Indeed, her knowledge appeared to be limited to an understanding that there had been a few cases in [location A] and a lot in Hamilton, and that the purpose of the vaccination was to stop someone from contracting a disease. Although [Cerys] had an understanding of the views of her parents, she but did not articulate anything other than that;

(d) The views expressed by both did not appear to be strongly held.

[23] Although neither [Cerys] or [Elliot] are Gillick-competent, their views must be considered, however the weight accorded to those views must reflect their welfare and best interests, of which views is but one component.

[24] In summary, I am generally satisfied that [Cerys] and [Elliot] have been given an opportunity to express their views and have done so through their lawyer, that neither is Gillick-competent, and for that reason their views are not determinative. I note that they both prefer not to have the vaccination, but conclude their views were not strongly held at the time they were met by Ms Gunn. I conclude that weight should be given to their views, but must be considered in light of their overall welfare and best interests.

New Zealand Bill of Rights Act 1990

[25] Ms [Poole] refers to s 10 of the New Zealand Bill of Rights Act 1990 which states that: "Every person has the right not to be subjected to medical or scientific experimentation without that person's consent." Ms [Poole] noted that s 10 is not age-restricted, and that [Elliot] and [Cerys] are "persons" as referred to in s 10. Therefore, if the Court respects their Bill of Rights entitlements, and they do not want to be vaccinated, they should not be so.

[26] Section 10 relates specifically to medical or scientific experimentation, rather than to approved medical procedures. For reasons which will be set out in this judgment, I conclude that the Pfizer vaccination is neither a medical or scientific experiment, and that accordingly the s 10 caveat does not apply to the administration of the Pfizer vaccination.

[27] Ms [Poole] did not refer to s 11 of the New Zealand Bill of Rights, which notes that: "Everyone has the right to refuse to undergo any medical treatment." Section 11 was referred to in Judge Coyle's decision,[8] and was largely determinative in his finding that the child should not be vaccinated.

[28] I consider both s 10 and 11 and reject the argument that the rights of the children have been infringed and do so on the grounds:

(a) That [Cerys] and [Elliot], because of their ages, lack Gillick-competency;

[8] *Long v Steine,* ibid at 1.

(b) That the Care of Children Act 2004 gives parents the right to make guardianship decisions on important matters which include medical treatment.[9] Guardians may make those decisions until a child is 16.[10] Section 46R provides the mechanism for resolving disputes where agreement cannot be reached.

[29] The Care of Children Act presupposes that the Bill of Rights entitlements of a child are to be exercised by his or her guardians, or failing agreement, by a Court. I find that this is particularly so for children aged eight and nine. Although their views must be considered, they do not have the absolute right either to consent or refuse consent. Both ss 10 and 11 are limited to that extent.

[30] Although Government policy and health advice recommends the Pfizer vaccination for five to 11-year-olds, it is not mandated for children of that age. Whether a child of five to 11 is vaccinated is therefore a decision of each parent, or if they cannot agree, for the Court, which must exercise the guardianship right having regard to the paramount consideration of the child's welfare and best interests.[11]

[31] Accordingly, I find that although the New Zealand Bill of Rights applies to all "persons" and "everyone", there are limitations which I am satisfied include [Cerys] and [Elliot]'s absolute right to self-determination.

Cases about vaccination

[32] I am satisfied that in determining whether children should have the Pfizer vaccination, principles from other cases are relevant to the administering of the Pfizer vaccination.

[33] The courts have been regularly called upon to deal with vaccination cases. Common themes which have emerged are summarized by Judge Binns in *Oranga Tamariki – Ministry for Children v AW and LC*.[12] Attached to her judgment

[9] Section 16(2)(c) of the Care of Children Act 2004.
[10] Section 36 of the Care of Children Act 2004.
[11] Section 4(1) Care of Children Act 2004.
[12] *Oranga Tamariki – Ministry for Children v AW and LC* [2020] NZFC 4629.

is a table of 16 cases which considered vaccination applications. Although most of the cases resulted in orders being made for immunisation, there are some that did not. Judge Binns summarized the Court's findings as follows:

> [15] The courts are generally reluctant to direct that immunisation should not occur. This is primarily because "the best evidence before the Court of protection of the children from disease is by way of the Ministry of Health recommended immunisation schedule.
>
> [16] Most of the cases relate to s 46R of the Care of Children Act 2004 ("COCA") and in these, the weight of case law appears to be that, in terms of s 4 and s 5 of the Act, there is a need to satisfy the Court with credible evidence, against the benefits of vaccination, in guardian disputes about whether to immunise their child.
>
> [17] The court must adopt an individualised assessment of the child or children, which are the subject of the dispute between the parents, when determining whether they should be immunised or not…
>
> [18] …whether or not to vaccinate a child was related to the best interests of the individual child in its own circumstances.

[34] Factors highlighted in judgments of the Court are that:

(a) Where mainstream medical evidence and Ministry of Health immunisation schedules recommends and advocates for immunisations to be received, in most cases Court orders are made authorising immunisation to occur;

(b) Immunisation protects the wider community;

(c) It is irresponsible for the Court to do anything other than make directions which reflect mainstream medical advice and thinking;

(d) The Court must be satisfied that there is credible evidence against the benefit of immunisation when deciding not to immunise;

(e) The risks of being harmed by contracting a disease are more serious than those associated with vaccination;

(f) Although there is an emphasis on individualised assessment, the starting point is Ministry of Health guidelines. Consequently, medical

evidence regarding the particular needs of a child would need to be provided before the Court ignored Ministry of Health or mainstream medical advice and thinking.

The cases about Pfizer vaccination

[35] In respect of the Pfizer vaccination I have been referred to cases involving children of 12 to 17, including to a case from the Provincial Court of British Columbia, *RSL v AC.*[13]

[36] In that case the Honourable Judge Gouge referred to a decision of the Ontario Superior Court of Justice, which said:[14]

> [5] …The responsible government authorities have all concluded that the COVID-19 vaccination is safe and effective for children ages 12-17 to prevent severe illness from COVID-19 and have encouraged eligible children to get vaccinated. These government and public health authorities are in a better position than the courts to consider the health benefits and risks to children of receiving the COVID-19 vaccination. Absent compelling evidence to the contrary, it is in the best interest of an eligible child to be vaccinated…

[37] In *Holloway v Parsons*, Judge Flatley was dealing with an application in respect of a 12-year-old child. He said that:[15]

> [13] A vaccine to protect against the COVID-19 virus and all of its variants has been developed by leading scientific and medical experts from around the world. It has been tested by independent drug testing agencies and has therefore been subject to rigorous and standardised testing regimes, albeit fast-tracked providing results as to efficacy and safety.

[38] Neither the parties, nor Ms Gunn, were able to refer to any case in which the Court had determined whether a child of 5-11 should be vaccinated, but very relevantly referred to *MKD v Minister of Health,* the High Court judicial review of the rollout of the vaccination to children of that age.[16] The concerns raised by Ms [Poole] largely reflect the issues considered by Ellis J in that case that the:[17]

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[13] *R.S.L. v A.C.L.* 2022 BCPC 9 (January 24, 2022).
[14] *A.C. v L.L.* [2021] OJ NO 4992; 2021 ONSc 6530, para 28.
[15] *Holloway v Parsons* [2022] NZFC 805, at para [13].
[16] *MKD v Ministry of Health* [2022] NZHC 67.
[17] at para [3].

(a) Paediatric vaccination carries few benefits because children aged five to 11 suffer mild symptoms and the vaccination does not prevent transmission;

(b) Paediatric vaccination presents material risks and that the safety data about the vaccination is inadequate;

(c) Granting of consent for the rollout of the vaccination failed to take into account Article 3 of the *United Nations Convention on the Rights of the Child* which makes the best interests of the child a primary consideration;

(d) Vaccination rollout was motivated by irrelevant considerations, namely that children five to 11 would assist in preventing community spread, protecting older or vulnerable adults, and enabling schools to remain open;

(e) The decision to roll-out was made for an improper purpose, namely, to prevent the transmission of COVID-19 and protect older or vulnerable adults when the best interests of children should be the "first", paramount, and only" consideration.

[39] The High Court received detailed scientific and medical information and examined the underlying reasons for the roll-out, the process by which consent was given for the roll-out, and the medical and health benefits and risks of paediatric vaccinations.

[40] Although the decision deals with the roll-out of the paediatric vaccination, the comments made by Ellis J are highly relevant to the individualised assessment that this Court must consider in determining if [Cerys] and [Elliot], as children aged between 5 to 11, should receive the Pfizer vaccination. Her findings were that the scientific evidence justifying the roll-out was bona fides and supported the position taken by the Director General. She concluded that:

> …what is equally clear is that there is a wealth of legitimate scientific opinion supporting the conclusions reached by the Minister.[18]

[41] In dealing with specific concerns Ellis J noted that:[19]

(a) The trial had been conducted using 44,000 participants;

(b) The paediatric trial included 5,500 participants, 3,100 of whom received the paediatric vaccination;

(c) That the trials took place over a number of months;

(d) That there is a significant scientific understanding of how the vaccination works because it is not based on new technology, but technology which is well-known and has been previously used;

(e) That while children aged five to 11 typically suffer mild symptoms, the disease can cause serious complications like respiratory failure, myocarditis, and multi-organ failure;

(f) The paediatric trials indicate the vaccination has a 91 per cent efficacy rate against symptomatic COVID-19;

(g) In terms of health risk, an analysis by the United States' Centre for Disease Control of adverse reports following 8.7 million doses of the paediatric vaccination, found just 100 reported serious adverse effects, (a rate of 0.0000011 per cent), which included only 12 reported cases of myocarditis;

(h) In terms of the impact of the vaccination, that "…it is difficult to see how the best interests of children can be assessed only through the narrow lens suggested by the applicants. Namely, that it is only the child's interests that must be considered". She said: "In particular, it

[18] at para [59].
[19] see para [60] (a)-(e).

> can hardly be in the best interests of children whose whānau include vulnerable adults for those adults to be put at risk of serious disease and death unnecessarily". This finding is particularly relevant to Mr [Townsend]'s case.[20]

[42] Finally, Ellis J notes that:[21]

> [63] The short point is that notwithstanding sincerely held views (of both laypersons and experts) to the contrary, there appears to have been ample, cogent, information that supported the decision to approve the paediatric vaccine. Given the high threshold (discussed earlier) it is not possible to conclude that the applicants' case for a merits-based review of that decision is strongly arguable. My own interim view is that it is barely arguable at all.

Ministry of Health guidelines and Pfizer safety concerns

[43] The Ministry of Health has published guidelines for vaccination for children aged 12 to 15,[22] and five to 11.[23] I refer to both.

[44] In the guidelines for ages 12 to 15, it indicates that real-world data shows the vaccination is safe and effective in younger populations. It notes that the Pfizer vaccine is highly effective, and that immunised young adults who develop COVID-19 are far less likely to fall seriously ill, and less likely to transmit the virus to others.

[45] Their advice on safety is that:

> Medsafe is responsible for approving the use of all medicines and vaccines in New Zealand. They only approve a vaccine in Aotearoa once they are satisfied it has met strict standards for safety, efficacy and quality.
>
> The trials in 12 to 15-year-olds showed the vaccine was safe, and side effects were generally mild.
>
> Millions of people aged 12 to 15 have now been vaccinated around the world, and no additional safety concerns have been raised.

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[20] para [61].
[21] para [63].
[22] Ministry of Health COVID-19 Vaccine: Ages 12 to 15 https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-ages-12-15.
[23] Ministry of Health COVID-19 Vaccine: Ages 12 to 15 https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-ages-5-11.

> The Ministry of Health also receives regular advice from science experts in the COVID-19 Vaccine Technical Advisory Group (CV TAG) which recommends the use of COVID-19 vaccines in different age groups. CV TAG have considered all scientific and technical data in recommending the use of vaccination in this age group and will continue to monitor safety data from the real-world rollout internationally and in Aotearoa New Zealand.

[46] In respect for children five to 11, they note that:

(a) The child formulation of the Pfizer vaccine is a lower dose and smaller volume compared to the adult formulation.

(b) The trials in 5 to 11-year-olds with a paediatric Pfizer vaccine showed it was safe and side effects were generally mild.

(c) The vaccine is highly effective, and that children aged five to 11 are far less likely to fall seriously ill and less likely to transmit the virus to others. For children aged 5 to 11, clinical trial results showed the Pfizer vaccine was 90.7% effective against getting COVID-19 symptoms, and no participants developed severe COVID-19.

(d) The COVID-19 generally has mild effects in children and is rarely severe or fatal. They note that:

> Children who have COVID-19 will commonly have no symptoms or only mild respiratory symptoms – similar to a cold. However, some can become very sick and require hospitalisation. Rare complications can include Multisystem Inflammatory Syndrome (MIS-C) that may require intensive care. Children can also suffer long-term side effects (known as long COVID), even after mild cases of COVID-19.

(e) Young children with COVID-19 can transmit the virus to other people, and immunising young children helps protect whānau members whose health makes them more vulnerable to COVID-19.

(f) That the vaccine has been provisionally approved or authorised and is being rolled out across the US, Canada, Europe, and Australia.

[47] The information provided by the Ministry of Health,[24] is supported by Starship in a paper titled *Covid-19 Vaccination in Children*, which states that data from both the 12-18- and 5-11-year age group trials showed no serious adverse events, and with only minimal risks existing.

[48] Children aged five to 11 have been vaccinated in New Zealand since 17 January 2022. As at 14 March 2022, 53 per cent of children aged five to 11,

[24] See Starship. Covid-19 Vaccination in Children. 8 February 2022.

254,654, had received their first dose.[25] Despite the number, I have not been referred to any material evidencing cases of children suffering adverse consequences. Mrs [Poole] argues this is because of non-reporting, under-reporting, information being withheld, or there being an as-yet undetected long-term dormant impact, the nature of which remains unknown. I consider this unlikely as there has been research and publication of reports about adverse consequences, public reports of rare but adverse consequences in adults, and a recently publicised incident of children being administered an incorrect dose.[26] This suggests that there has not been an overt attempt to hide unknown adverse consequences.

[49] In an article by Nora Colburn,[27] she looks at the known history of vaccinations and notes that going back at least as far as the polio vaccination in 1960 there has never been a vaccination with known long-term side-effects, meaning side-effects that occur several months or years after the injection. All known effects of vaccinations have developed within six to eight weeks of the injection. She says that the known incidences of adverse events of the Pfizer vaccination are extremely rare and are in the region of three to eight cases per million doses. She says:[28]

> COVID-19 vaccines have been studied in humans for more than a year now, and more than 174 million people have been fully vaccinated in the United States alone. The vaccines have been shown to be extremely safe. There are several robust safety monitoring systems in place for these vaccines that can detect the very rare adverse events….

[50] The article examines the technology involved in the creation of both the Pfizer and Moderna vaccines and notes that mRNA vaccines have been studied for decades before COVID-19 emerged, with the technology being studied in vaccinations against other viruses. For that reason, scientists know very well how the mRNA functions in a vaccine, and therefore has considerable knowledge regarding the Pfizer vaccination and any likely adverse outcome. The conclusion is that there is highly unlikely to be any long-term side-effects.

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[25] COVID-10 vaccine data 16 March 2022. https://www.health.govt.nz/covid-10-novel-coronavirus/covid-19-vaccine-data.
[26] Reported in the NZ Herald 25 March 2022.
[27] Nora Colburn: *How can we know the COVID-19 vaccine won't have long-term side-effects*? 14 September 2021 https://wexnermedical.osm.edu/blog/covid-19-vaccine-long-term-side-effect.
[28] at page 2.

The risk of long-term harm of COVID-19 in children

[51] There are known risks from COVID-19, the full extent of which are not yet known, with infected children at best being asymptomatic, and at worst being hospitalised. There are known deaths of children outside of New Zealand. The risk of death and hospitalisation is statistically very low, but some studies suggest that a quarter of those infected develop lingering problems. The most serious risk arises from post-acute effects which are those not part of the original infective illness. These are what might be referred to as dormant effects. An example is rheumatic fever, which is a post-acute complication of streptococcal infection of the throat or skin, and multiple sclerosis which can emerge years after Epstein-Barr infection, or glandular fever.[29]

[52] Long-term post-acute effects have been noted 15 years after initial infection from SARS-CoV-2 from 2002 and MERS-CoV from 2012. The full extent of post-acute effects from COVID-19 remains unknown, however, long COVID – the most common features of which are fatigue, breathlessness, cognitive dysfunction, loss of taste and smell, and evidence of multiple organ system involvement, are likely to occur in some children, and may occur following severe, mild or even asymptomatic infection. Data from the United Kingdom indicates that long COVID may make children feel unwell for months, with some not having recovered for two years after infection.[30] Chronic conditions may have serious and long-life effects, the extent of which remains unknown. Studies suggest that vaccinations protect against the impact of long COVID in adults, and there is nothing to suggest that it will not do so in children.[31]

[53] Although research indicates that serious effects are less common in children than in adults, nevertheless effects can be life-changing or limiting, and are

[29] University of Otago 9 March 2022. Public Health Expert. Longer-term harm from COVID-19 in children; The evidence suggests greater efforts are needed to protect children in Aotearoa NZ from infection. https://blogs.otago.ac.nz/publichealthexpert/longer-term-harm-from-Covid-19-in-children-the-evidence-suggests-greater-efforts-are-needed-to-protect-children-in-Aotearoa-NZ.

[30] Moleteni.E etal; October 2021. Illness duration and symptom profile in symptomatic UK school-aged children tested for SARS-CoV2. www.thelancet.com/child-adolescent Vol 5 October 2021.

[31] University of Otago 9 March 2022, ibid at 29. Page 4/6.

significantly higher in areas where vaccine coverage is lower and COVID rates are higher.[32]

[54] Research concludes that vaccination can reduce risk and should be actively promoted for children. They note that: "Because Omicron has been mis-portrayed as a "mild" variant, families and consultants may be unaware of the symptoms of post-acute effects."[33] It is suggested that the prevalence of post-acute effects indicate the issue requires serious attention and response by both prevention and management.

Arguments advanced by Ms [Poole]

[55] I have considered the arguments of Ms [Poole], and I do not find that she has added anything of relevance to the information provided to Ellis J on the review, nor contained in the Ministry of Health or research documentation to which I have been referred and have noted.

[56] Ms [Poole] sought proof of isolation and purification of SARS-CoV-2. As attached to her affidavit, various official information requests have been made to institutions to provide evidence. She relies on the failure to provide that evidence in support of her application. However, most have replied that they do not have the information, or that the information they have is not relevant to the enquiries made. Furthermore, neither the absence of information, or the failure to reply, proves the proposition that there is something wrong with the vaccination or a cover-up.

[57] In an article published by Reuters they say there are numerous examples of scientists isolating SARS-CoV-2, the virus that causes the COVID-19. The argument about purification, they maintain, relates to 19th Century micro-biological theory that does not apply to viruses. They say that the coronavirus has been proven to exist and has caused millions of deaths worldwide and has infected millions of other people with both short- and long-term impacts.[34]

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[32] University of Otago 9 March 2022, ibid at 29. Page 4/6.
[33] University of Otago 9 March 2022, ibid at 29. Page 5/6.
[34] Reuters Fact Check 31 March 2021. Fact Check-SARS-CoV-2 has been isolated, and its complete genome has been sequenced.

[58] Ms [Poole] argues that the Pfizer vaccine is still in clinical trial. Ellis J dealt with this issue. Clinical trials have occurred in relation to the Pfizer vaccine, and as previously noted the way in which the vaccine is made up has been known for a long time and has been studied over many years. Millions of doses have been administered, and the impacts have been observed first-hand, with very minor risks known to exist.

[59] Another Reuters article concludes that it is untrue that clinical trials have not been done, with the suggestion that trials have not been completed stemming from misinformation which has been shared. Although ongoing trials will occur and clinical data will continue to be analysed, this does not mean that the vaccination is either unsafe, or that clinical trials were not completed prior to its roll-out.[35]

[60] The reality is that the vaccine has been approved by the Ministry of Health following standard practice within the industry. COVID vaccinations are authorised for use in most developed countries and are not experimental.

[61] Ms [Poole] states that she cannot make an informed decision without access to the contract between Pfizer and the New Zealand Government. This has been withheld due to commercial sensitivity. I reject the argument the withholding details of the commercial arrangements is relevant as it does not impact the scientific efficacy of the vaccination.

[62] In almost all medical procedures there are acknowledged risks. The Ministry of Health accepts this. It is for that reason that informed consent is required before medical treatment occurs. In documentation related to vaccinations, and in almost all medical procedures undertaken, any possible side-effects are set out, often in writing, and generally explained by the practitioner providing the medical intervention.

[63] In the case of the Pfizer vaccine, the Ministry of Health indicate the potential side-effects in a paper headed "*Protecting your tamariki from COVID-19*". The side-effects described are documented in reports that have been written following clinical trials and include both short-term and long-term impacts.[36]

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[35] Reuters Fact Check 14 April 2021. Corrected-Fact Check-Covid-19 vaccines are not experimental and they have not skipped trial stages.
[36] Ministry of Health. Protecting your Tamariki from COVID-19.

[64] Ms [Poole] refers to the risk of myocarditis and pericarditis and provides material setting out the Pfizer vaccination side-effects. Although there are acknowledged risks, these are low. The risks were carefully considered by Ellis J, who noted the risks as low and referred to those. Other reports note that the risks of myocarditis and pericarditis are higher in people who are unvaccinated and get COVID-19, than they are in those that have been vaccinated.[37]

[65] Attached to Ms [Poole]'s affidavit,[38] as annexure H, is a list which she says are possible side-effects to the vaccination. However, I conclude that the list, which is long, identifies a list of potential impacts that should be looked for during clinical trials, not impacts that have been identified as having yet occurred, nor that are even likely to occur. Furthermore, the overall recommendation of the report is that there is a favourable benefit/risk balance.[39]

Should [Cerys] and [Elliot] be vaccinated

[66] In every decision made by the Court, the welfare and best interests of a child in his or her circumstances is the Court's paramount consideration. The individualised nature of the assessment means that a different outcome is possible for [Cerys] than for [Elliot]. However, neither party suggested that [Elliot] should be treated differently than [Cerys]. I am satisfied that other than [Cerys] knowing more about the vaccination than [Elliot], there is nothing that would require a different decision to be made for one than for the other.

[67] Both Mr [Townsend] and Ms [Poole] obtained letters from [the children's medical practitioner]. The letter obtained by Mr [Townsend] says there is nothing that would prevent the children having the Pfizer vaccination. The letter obtained by Ms [Poole] says that the possibility of side effect of the Pfizer vaccination cannot be excluded. I do not consider that the letters are contradictory. The children have had their childhood paediatric vaccinations without adverse consequence. There are known risks from vaccinations, these are addressed by Ellis J and referred to in

[37] Ibid at 27 at 2/6.
[38] Affidavit of [Amber Poole] 15 March 2022 Exhibit H. Cumulative Analysis of Post-Authorisation Adverse Event Reports of PF-O7302048 (BNT 162 B2). 28 February 2021. Page 30.
[39] at page 29.

Ministry of Health guidelines. The letters produced by [the doctor] are therefore reconcilable.

[68] Having considered the matter, I conclude:

(a) There are no known reasons why [Cerys] or [Elliot] should not be vaccinated; both are normal, healthy children;

(b) The children's views must be considered in the context of their welfare and best interests which includes their health and the health of others. Their views are not strongly expressed, nor are they expressed with any knowledge of the impact of either COVID or vaccinations. Given their ages, this is unsurprising;

(c) That the Pfizer vaccination is not a medical or scientific experiment and that s 10 of the Bill of Rights Act does not apply;

(d) That the s 11 provisions of the Bill of Rights Act are to be exercised by the children's parents and in the absence of agreement, by the Court;

(e) That the mainstream medical evidence, together with the Ministry of Health guidelines, must be the starting point in any decision made. These strongly recommend that children five to 11 be vaccinated;

(f) That in New Zealand there has been a high rate of vaccination with a very low risk of harm detected. Accordingly, I am satisfied that any risk that arises from being vaccinated is low;

(g) Worldwide millions of children aged 5-11 have been vaccinated, with a very low adverse consequence;

(h) That the risks the children might be exposed to harm by getting COVID are considerably higher than the risks that exist from vaccination;

(i) That there is community interest in vaccination, and community protection occurs if all those eligible are vaccinated. This is true both on a macro, or herd immunity basis, but also at a micro or whanau level. This is a legitimate welfare and best interests consideration. I agree that a narrow view, which looks only at a child in isolation from his or her family, should not be adopted. Accordingly, the risks to other people can be considered and Mr [Townsend]'s family circumstances are therefore relevant and can be taken into account.

(j) It is appropriate to consider the potential for long COVID and the dormant risks which may become evident years after a child has had a disease, even if they were asymptomatic at the time;

(k) That there is no credible evidence which would tell against the benefit of immunisation or delaying the giving of the vaccination. On the contrary, the trials indicate that the risks of immunisation are very low, and that the benefits of immunisation outweigh any minor risks that exist.

[69] Looking at it on an individualised basis, there is no reason why [Elliot] and [Cerys] should not receive the Pfizer vaccination. There are valid reasons why they should. Accordingly, I conclude it is in the welfare and best interests of [Elliot] and [Cerys] to receive the Pfizer vaccination and conclude that it should be administered immediately.

Orders

[70] I now make an order pursuant to s 46R of the Care of Children Act 2004 that [Cerys] and [Elliot] be immunised with the Pfizer vaccination, with this to occur immediately.

[71] Mr [Townsend] seeks costs. Costs are reserved. Submissions are to be filed within 21 days by Mr [Townsend]. Ms [Poole] is to respond within 21 days thereafter. The application for costs to be referred to me for consideration.

[72] Cost contribution orders may be payable, these are to be dealt with in the normal way.

[73] As indicated earlier, I reserve the right to correct and amend this judgment.

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Judge GS Collin
Family Court Judge | Kaiwhakawā o te Kōti Whānau
Date of authentication | Rā motuhēhēnga: 12/04/2022