[POSTAL ADDRESS OF RECIPIENT IF NEEDED (not required if only sent by email)]

[DATE (DD.MM.YYYY)]

**FAO: [Relevant person of authority at the University / Workplace / NHS / Placement]**

[By email and post] OR [By email only]:

[Enter email address here]

Dear [First Name of ‘relevant person of authority’]

**Re: Covid-19 Vaccination Exemption for [NAME]**

[NAME] is entitled to [remain employed, undertake a placement, remain a student] without any lawful requirement to have any vaccination beforehand. We kindly ask that you reply to this letter to confirm your understanding and agreement that they are able to complete [his/her/their] [employment/placement/course] without having a vaccination that [he/she/they] [has/have] no wish to take.

[Please find attached two documents (Exhibit A and Exhibit B) contained within the appendices of this letter, which have been provided by [PHYSICIAN’S NAME]. Exhibit A is [EXPLAIN], detailing the reasons as to why [NAME] is exempt from undergoing any Covid-19 vaccination. Exhibit B is [EXPLAIN], Exhibit C is [EXPLAIN], Exhibit D is [EXPLAIN]]

We understand that in [enter date correspondence was sent] you (“**[Employer / University]**”) sent a letter (“**letter**”) to [NAME] stating your intention to require proof of Covid-19 vaccination status (“**vaccination**”) to enable [him/her/they] to [carry on working w/ employer/complete placement/any other reason], which is necessary to complete the course successfully.

By way of background, it became a requirement under The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulation 2021 for those working within the ***regulated care sector*** to undertake the vaccination or prove their exemption status by 11 November 2021. However, such legislation is ***not yet effective for frontline NHS workers***.

You have mentioned, [in correspondence sent to [NAME], in a letter sent to [NAME]], that you are [enter what employer / University are doing]. Because [NAME] may not be able to prove [his/her/their] vaccination exemption status by any other means other than a self-certification, you have a duty to allocate unto [him/her/them] [employment, a placement, a studentship] that does not fall within the scope of the legislation (e.g., outside of the care sector). We remind you that a refusal to make these reasonable adjustments for [NAME] would potentially make you liable in civil law (as it would be in breach of the contract existing between you and [NAME]) and criminal law (undue influence and coercion to take a medical treatment that is currently in clinical trials, and threat of assault contrary to the Offences Against the Person Act 1861).

In your letter you have also indicated that [include extra relevant information here]. However, there is currently no legal duty for [NAME] to undertake a Covid-19 vaccination in order to accept a placement at such an organisation; they cannot declare a medical intervention to be so duly mandatory if there is no specific legal obligation (whether enacted by an Act of Parliament or through common law) to do so. Currently, it is expected that by 1 April 2022, a full course of Covid-19 vaccination will be mandated for all NHS staff, per The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021. Note though that this is [not the case in devolved administrations such as Wales and Scotland](https://www.pulsetoday.co.uk/news/coronavirus/no-plans-for-mandatory-covid-jabs-in-scotland-and-wales-as-ni-announces-consultation/) and the situation may change in England before 1 April 2022.

Clearly, alternatives are available for [NAME]. Therefore, a reasonable alternative may be to [enter reasonable alternative here]. Regardless of this new legislation which may become effective from 1 April, you should be aware of your general legal responsibilities and duties, as following the new legislation may potentially expose you and your staff to well-established civil (e.g., tort and contract) and/or criminal (e.g., prosecution, fines and/or imprisonment), liabilities which are not precluded by the new legislation.

[NAME] has a legal right to give [his/her/their] free and informed consent to undergo (or not undergo) a full course of Covid-19 vaccination which is a medical intervention. Firstly, under section 45E of the Public Health (Control of Disease) Act 1984 persons must not be **required** to undergo medical treatment, which includes vaccination and other prophylactic (preventative) treatment (unless legislation exists to the contrary). Secondly, [NAME] has the right to provide [his/her/their] free and informed consent to medical treatment and reject such treatment if [he/she/they] so chooses; the Supreme Court of the United Kingdom decided as such in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

Lady Hale eloquently surmised at paragraph [108] of the judgment that:

‘[i]t is now well recognised that the interest which the law of negligence protects is a person’s interest in their own physical and psychiatric integrity, an important feature of which is their autonomy, their freedom to decide what shall and shall not be done with their body’.

*Montgomery* established that the test of materiality in the UK consists of an objective standard and a subjective standard (which must not be viewed as a mere ‘gloss’); the test is whether, in the circumstances of the particular case, ***a reasonable person in the patient’s position would likely attach significance to the risk, or the doctor should be reasonably aware that the particular patient would attach significance to it*** (see para [87]). The patient must decide whether or not to run the risk of treatment (because all medical treatment carries an element of risk, however small). Even if that risk is small, in line with the test of materiality, the patient must be informed of it if they subjectively attach significance to the risk. Alternatives must also be considered, as well as the option for no treatment. There are alternatives to the Covid-19 vaccination, even though they may not necessarily be considered prophylactic treatments. Also, given [his/her/their] age, [NAME] is at next to no risk from suffering from any respiratory illness that could be diagnosed as ‘Covid’ where there remains no evidence for asymptomatic transmission.

Where power is asymmetrical in a relationship, a presumption of undue influence exists, e.g., Doctor-Patient relationships and University-Student relationships. By forcing [NAME] to undergo this medical treatment, you are likely to cause psychiatric harm and distress or economic loss (due to the threat of being unable to complete the course). Such behaviour on your part amounts to a breach of contract, and is a criminal offence; applying or attempting to apply a medical intervention without consent amounts to a battery (and potentially assault, ‘the fear of the battery’); it is no defence that you are or were acting under statute or regulation; see *R (on the application of Wilkinson) v Broadmoor Hospital* [2001] EWCA Civ 1545, notably Lady Hale’s comments at paragraph 56:

‘...what was done to the patient, and what it may well be proposed to do again, is an assault unless done with his consent or other lawful justification. The people who carry out such assaults, and in particular the responsible medical officer (RMO) who requires it to be done, may be sued in the ordinary way for the tort of battery. **The fact that those responsible are exercising statutory powers makes no difference.** The analogy with the police and the prison service in the exercise of their powers of arrest and detention is a very helpful one. The fact that they are performing statutory functions which may sometimes be susceptible to judicial review does not relieve them of responsibility in tort for wrongful acts. It is worth remembering that patients may also be detained under the Mental Health Act in private hospitals.’

You are therefore exposing yourselves to potential civil actions in tort and breach of contract, as well as criminal actions for assault.

You must also not subject any individual to inhumane and degrading treatment causing psychiatric harm, or be complicit in doing so. Such treatment would be contrary to Article 3 and Article 8 of the European Convention on Human Rights (ECHR). In relation to ECtHR case law on informed consent to medical treatment and Article 8, see *YF v Turkey* App no 24209/94 (ECtHR, 22 July 2003).

Article 6 of the Universal Declaration on Bioethics and Human Rights 2005 also states, *inter alia* that,

‘[a]ny preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.’

Choosing whether one undergoes or not undergoes medical treatment must be a decision free from external pressures. This important point has been made by the General Medical Council (GMC) in their ‘[**Decision-Making and Consent Guidance 2020**](https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf)’. At clause 69 on page 31, the guidance clearly explains that ‘[m]any factors influence patients’ decision making, but it’s important that nothing influences a patient to such an extent that they can’t exercise free will. If a patient can’t make a decision freely, they won’t be able to consent. At clause 70 on page 31, the guidance further explains that

‘[p]atients may feel pressure to have particular treatment or care. Pressure can come from others – partners, relatives or carers, employers or insurers – or from patients’ beliefs about themselves and society’s expectations’.

Therefore, as a [university, employer, or placement provider] there is no lawful basis for you to enforce mandatory vaccinations for your [students, staff, interns] even if they are undertaking [placements or employment] in a clinical environment. Such a compulsion is completely anathema to public policy.

Furthermore, the Royal College of Nursing (RCN) have made it crystal clear that they object to mandatory vaccinations for NHS staff, stating that they have ‘been clear that making vaccination compulsory could significantly undermine these approaches’. Indeed, the RCN called on the Health Secretary to [delay the implementation of the new law](https://www.rcn.org.uk/news-and-events/news/uk-rcn-calls-for-delay-to-new-law-on-mandatory-covid-19-vaccination-for-nhs-staff-in-england-130122) due to major staffing pressures. The Department of Health and Social Care have also considered in an impact statement that more than [73,000 NHS staff in England](https://www.rcn.org.uk/news-and-events/news/uk-rcn-calls-for-delay-to-new-law-on-mandatory-covid-19-vaccination-for-nhs-staff-in-england-130122) could lose their jobs as a result of the policy. The RCN have also alluded to the fact that there are approximately 40,000 registered nurse vacancies in the NHS, in England:

‘These workforce shortages and the unrelenting pressure nursing staff have been under for nearly two years is compromising patient safety, the RCN warns.’

Therefore, all things considered, there could be over 113,000 vacancies within the NHS (just for registered nurses) which would be hugely detrimental to patient safety and exacerbate the existing staffing pressures that have been causing the NHS severe difficulties over the last two years.

The eloquent words of [Pat Cullen, RCN General Secretary & Chief Executive](https://www.rcn.org.uk/news-and-events/news/uk-rcn-calls-for-delay-to-new-law-on-mandatory-covid-19-vaccination-for-nhs-staff-in-england-130122) are highlighted verbatim below:

“Nothing matters more to a nurse than caring for their patients safely. Right now, our members are telling me they can’t always do that.

We’re calling on the government to recognise this risk and delay a move which, by its own calculations, looks set to backfire. To dismiss valued nursing staff during this crisis would be an act of self-sabotage.

Encouraging people to get vaccinated is the best way to boost vaccine take-up. Nursing staff, who are well-placed to understand people’s concerns and are highly trusted by them, have led the COVID-19 vaccination programme and have a key role to play in addressing any concerns people may have about being vaccinated.”

Please note that Covid-19 vaccinations do not inhibit transmission or infection. This was made clear (and is a statement of public record) by the [Chief Executive Officer of Pfizer](https://www.cnbc.com/2022/01/10/pfizer-ceo-says-two-covid-vaccine-doses-arent-enough-for-omicron.html). Concerns relating to the implementation of mandatory vaccination for NHS staff have also been raised by the Royal College of Midwives (RCM). The [RCM](https://www.rcm.org.uk/media-releases/2021/december/rcm-calls-for-immediate-delay-to-nhs-staff-mandatory-vaccination-plans/) fears a ‘catastrophic’ impact on maternity services. There is currently a shortage of about 2,000 midwives, according to the RCM’s press release. As Gill Walton, Chief Executive of the RCM has explained:

“Since the arrival of the COVID-19 vaccine the RCM has been urging its eligible midwife and maternity support worker members to have the jab to protect themselves, their families and the women and families they care for. We believe that it’s the right thing to do and we believe in the science. However, we do not believe mandatory vaccination is the correct approach, and actively argued against the proposal. Levels of vaccination in the NHS are high and rising and we should be using discussion and education to increase vaccination among NHS staff, not the hammer blow of mandating it.

I appeal to the Health Secretary to reconsider his decision and to delay the implementation. Throughout the pandemic, maternity staff have fought to keep services open and to provide the best care to women and families. It has been unrelenting and so it’s no surprise that staff absence is currently at its highest in the pandemic so far. Moving forward with mandatory vaccination could only see staffing levels fall further. The Government has opened a Pandora’s Box of unforeseen consequences – but there is an opportunity now to close it. We are urging Sajid Javid to do just that.”

All facts considered, and as we anticipate a major exodus of NHS staff in the coming weeks if these regulations come into force, not only is it entirely unreasonable of you to make the Covid-19 vaccination compulsory, but it is also illegal. [NAME], as an adult with capacity to make [his/her/their] own informed medical decisions, has made it clear that [he/she/they] [is/are] unable to take a Covid-19 vaccination, and an exemption must therefore be forthcoming. We are of the understanding that [he/she/they] will not be undertaking [his/her/their] [employment, placement, studentship] in any medical setting that currently requires a full course of Covid-19 vaccination (e.g., in ‘nursing homes’ and the ‘care sector’). Furthermore, it is now highly likely that legislation requiring NHS staff in all other medical settings to have a course of Covid-19 vaccination will be either pushed back to a later date or revoked, as a result of the objections from learned authorities such as the RCN and RCM.

Dr. Joanna Moncrieff (Professor of Critical and Social Psychiatry at University College London), and some of her colleagues, published a [rapid response](https://www.bmj.com/content/375/bmj.n2957/rr-1) on 13 December 2021 agreeing with a [House of Lords Committee](https://committees.parliament.uk/publications/7989/documents/82445/default/) asserting that evidence is insufficient to back mandatory NHS staff vaccination. It is clear that the eloquent and concise opinion of Dr. Moncrieff and her colleagues is that everyone must be able to make a free and fully-informed choice as to whether to have a Covid-19 vaccination course. Here is a summary of the issues set out in Dr. Moncrieff’s rapid response:

* Considerable uncertainty exists as to the efficacy of these vaccines, including issues over short-term complications and a lack of data on long-term harms that may potentially result from having the Covid-19 vaccination.
* It is widely accepted that the only means of providing robust data on the efficacy of medical interventions is through randomised controlled trials, because purely observational data is subject to uncontrolled biases. However, the randomised controlled trials of the Covid-19 vaccination lasted for a very short time and their only objective was to provide definitive statistical evidence on preventing ‘symptomatic infections’, not on preventing infection per se, hospitalisations or death. No data was provided by the trials on whether transmission of infection is reduced by the vaccinations; this is evident by real world evidence such as the rapid spread of the Delta and now Omicron variants.
* Evidence currently available suggests that the vaccines are effective in reducing (by a few weeks) symptomatic infections. Reports alluded to by Dr. Moncrieff in her rapid response demonstrate that either the positive effects of the vaccine wear off quickly, and/or that some bias creeped into the original trial procedures, code-breaks caused by reactions to the vaccine. There may have also been other procedural irregularities. Therefore, the data on ‘the prevention of cases by two vaccinations’ is unreliable which is possibly due to the rapidly waning effects or other factors; because these have not been tested in randomised trials, there is therefore no secure evidence either way.
* No randomised trials have been conducted for the third and fourth ‘booster’ vaccines and there is very little evidence / data on the effectiveness and safety of these. In fact, there have been many studies over the past few years relating to the [dangers of repeatedly being exposed to mRNA technology](https://www.statnews.com/2017/01/10/moderna-trouble-mrna/). Therefore, the cumulative risks of repeated booster shots certainly outweigh the benefits (which are negligible and based on rushed trials).
* In terms of vaccine safety, it is evident that there are rare but serious and potentially fatal adverse reactions, which have been reported in a substantial number of people. [The Government’s MHRA data](https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting#annex-1-vaccine-analysis-print) is applicable in this regard. Some of the most serious adverse reactions are blindness, thrombosis, myocarditis and pericarditis. Dr. Moncrieff notes that these adverse reactions took months to formally identify. Please also note that ‘blood clotting’ is a serious side effect of the AstraZeneca vaccine. During the next few years, the long-term side effects of the Covid-19 vaccinations will become apparent, although such side effects will be even more difficult to detect because of the unduly slapdash way in which the randomised trials were conducted.
* No data is currently available on those groups most at risk of adverse effects of a Covid-19 vaccine, especially those with or at risk of autoimmune disorders.
* Urgent, better-quality research and access to the existing data from the vaccine trials are required to ensure that free and fully informed consent can be given to a Covid-19 vaccination. Mandating the vaccination for, inter alia, certain occupational groups and use of deprivation of livelihoods and careers for non-compliance is not justified. The overall benefits of the Covid-19 vaccinations must be balanced (through a risk-benefit ratio analysis) and currently there exists an unfavourable ratio due to great uncertainty about the vaccination’s overall benefits and the lack of concrete data on long-term harms.

Covid-19 vaccinations are only being used under temporary emergency authorisation and full approval has not yet been granted. Clinical trials are scheduled to end (for the following Covid-19 vaccinations) on these dates:

|  |  |
| --- | --- |
| **Covid-19 Vaccination (Creator)** | **Clinical Trial End Date** |
| [Pfizer / Biontech](https://clinicaltrials.gov/ct2/show/NCT04368728) | 15 May 2023 |
| [Moderna](https://clinicaltrials.gov/ct2/show/NCT04470427) | 27 October 2022 |
| [AstraZeneca](https://clinicaltrials.gov/ct2/show/NCT04516746) | 14 February 2023 |
| [Janssen](https://clinicaltrials.gov/ct2/show/NCT04505722) | 2 January 2023 |

The conclusion of the clinical trials, as demonstrated by the table above, is at least 9-10 months away. These trials have also been compromised by allowing the placebo group to cross over into the treatment arms. No long-term data as to the side effects of these vaccinations is available (novel gene-based mRNA or DNA viral vector technology has not been used before and on such a wide scale). The Nuremberg Code (1947) (see clauses 1-10) and the Declaration of Helsinki (see paragraphs [25]-[32] on informed consent) therefore apply, because the treatment is experimental. As such, the treatment must only be carried out with the fully informed consent of the study participant. These international codes and tenets are [clearly being breached](https://www.ukmedfreedom.org/open-letters/open-letter-to-members-of-the-house-of-lords-re-vaccine-mandates-for-nhs-and-cqc-regulated-healthcare-workers) by those attempting to mandate the Covid-19 vaccinations.

Please also be aware that recently the media and authorities appear to be undertaking a 180-degree about turn on coerced and / or mandatory vaccination. Dr Hilary, appearing on [Good Morning Britain](https://twitter.com/alanvibe/status/1484104606581936128?cxt=HHwWgMCyzdnRzJgpAAAA) on 20 January 2022, mentioned that there is no point in mandating the Covid-19 vaccination for frontline NHS workers. Dr Hilary also agreed that there are huge vacancies in the NHS at the moment and now, people are more likely to transmit Covid outside hospitals, rather than inside hospitals. Dr Hilary would get rid of the mandate because there are so many people who need urgent hospital care and there are not enough NHS staff. Also, leading UK Government advisor Professor Devi Sridhar (chair of global public health at the University of Edinburgh) has also rightly mentioned in her [article](https://www.theguardian.com/commentisfree/2022/jan/19/science-covid-ineradicable-disease-prevention) in the Guardian on 19 January 2022 that “[h]umans are social: we need to hug, dance, sing and recognise each other’s faces and smiles. A sense of community and connection are vital to wellbeing too’ and ‘now is the time to start to recover and heal as a society and move forward, treating this virus like we do other infectious disease threats.”

We again refer you to supporting documents evidencing [NAME]’s medical exemption to Covid-19 vaccinations from [PHYSICIAN’s NAME], who in [his/her/their] professional medical opinion, reasonably believes that it could not be in [NAME]’s best interests to receive any Covid-19 vaccinations. Please see the appendices of this letter, namely Exhibit A and Exhibit B. Exhibit A is [EXPLAIN], detailing the reasons as to why [NAME] is exempt from undergoing any Covid-19 vaccination. Exhibit B is [EXPLAIN].

We kindly request that you allow [NAME] [to complete [his/her/their] placement, to remain in [his/her/their] employment, to complete [his/her/their] education] without requiring a Covid-19 vaccination. We hope the information above, including a full explanation of the legal context, allows you to better understand the important issues involved and to make the right decision for both you and [NAME].

It goes without saying, but [NAME] has invested a lot of [time [and money]] in undertaking this [course, employment, studentship] and if [he/she/they] [is/are] unable to [continue employment, studentship, placement] then [he/she/they] understandably [reserve/reserves] [his/her/their] legal rights to pursue a claim against you related to an unlawful requirement to have a medical procedure that is not wanted or needed by any objective and reasonable standard.

Thank you for your consideration of this important letter.

Yours sincerely,

[NAME]

**Appendices**

The appendices consist of [‘[Exhibit A]’, [AND] ‘[Exhibit B]’], as explained in the letter, supra.

**Exhibit A**

**Exhibit B**