

## Court of Protection: Capacity outside the Court of Protection

Welcome to the November 2016 Newsletters. Highlights this month include:

- (1) In the Health, Welfare and Deprivation of Liberty Newsletter: the new COPDOL 10 form comes into force on 1 December, an *MN*-style case management decision, Baker J on life and death and Strasbourg's latest on deprivation of liberty;
- (2) In the Property and Affairs Newsletter: trusts versus deputies, undue influence and wills, and useful STEP guidance for attorneys and deputies
- (3) In the Practice and Procedure Newsletter: important practice guidance on participation of P and vulnerable witnesses, naming experts and child competence to instruct solicitors;
- (4) In the Capacity outside the COP Newsletter: new guidance from the Royal College of Surgeons and the College of Policing, and an important decision of the German Federal Constitutional Court on forced treatment and the CRPD;
- (5) In the Scotland Newsletter: new guidance on supported decision-making (of relevance also in England and Wales) and problems with MHOs.

We have also updated our [guidance note](#) on judicial deprivation of liberty and are very pleased to announce a new [guidance note](#) (written by Peter Mant) on mental capacity and ordinary residence.

And remember, you can now find all our past issues, our case summaries, and much more on our dedicated sub-site [here](#). 'One-pagers' of the cases in these Newsletters of most relevance to social work professionals will also shortly appear on the SCIE [website](#).

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For all our mental capacity resources, click [here](#).

## England and Wales

### Short Note: Capacity and settlement agreements

In *Glasgow City Council v Dahhan* [2016] UKEAT 0024 15 1105, the EAT has confirmed that it has jurisdiction to consider an argument that a settlement agreement should be set aside on the basis that the claimant lacked the mental capacity to enter into it. Although a Scots case (the law relating to contractual capacity being different in Scotland), as Lady Wise noted:

*20. [...] Once it is accepted that the analysis of Silber J in **Industrious Ltd** is correct to the extent that the obligation on the Tribunal when presented with a proposed settlement agreement is to consider whether it is valid, there is no sound basis for drawing a distinction between invalidity on the ground of, say, misrepresentation on the one hand and invalidity on the ground of lack of capacity to contract on the other. Both sides were agreed that the distinction between Scots and English law rendering contracts entered into through lack of capacity void in the former but voidable in the latter were not material to determination of this issue. It is of course the case that none of the decided cases have required to address the particular question of whether the Employment Tribunal has jurisdiction to set aside an agreement said to have been entered into where one party to the contract lacked legal capacity. However, I agree with the submission made by counsel for the respondent that it would be a strange, even illogical result if a Tribunal was required to decline to give effect to the contract entered into through misrepresentation that was otherwise valid but could not refuse to enforce a contract that was a nullity (at least in Scots law) from the outset.*

### New consent guidance from the Royal College of Surgeons

The Royal College of Surgeons has recently updated its [good practice guidance](#) on consent in light of the *Montgomery* judgment. Its main messages as regards the shift in balance towards recognising doctors as the clinical experts and patients as experts in being themselves are welcome, and clearly and crisply expressed. The explanation of the meaning and the role of capacity under the MCA 2005 is also succinct and to the point. However, as is so often the case, the treatment of Scotland and NI is problematic, failing to make sufficiently clear in relation to Scotland (in particular) that the legal framework is very different.

### New College of Policing mental health guidance

The College of Policing has updated its mental health authorised professional practice (APP). It is a wide-ranging set of documents, including detailed material upon mental capacity. It is important to note for social workers and healthcare professionals that this is likely to be the material that police officers will have been trained upon (if they have indeed received any training at all). Whilst the material is for the most part excellent, and lucidly clear, it is unfortunate that the section on mental capacity repeats the canard that s.4B MCA in some way provides authority to deprive a person of their liberty outside the scope of an application being made to the Court of Protection. Section 4B only applies where an application has been made; it should therefore never be relied upon by police officers to remove a person from their home absent an order having been sought from the Court of Protection.

## Mental Health Act Survey

The Mental Health Alliance, a coalition of over 75 organisations united by a common interest in a fair Mental Health Act, has launched an important survey on the Act. The survey is designed to gather your views on the principles of the Mental Health Act, how people's rights are currently protected, where this is working well and what could be changed. This includes how the Act integrates with the Human Rights Act and the Mental Capacity Act. Your help is needed to ensure the survey represents a range of views, including the legal profession. Over 2,000 people have already completed the survey. This is your opportunity to help us influence the Government and other stakeholders in future reform of the Act. The survey should take around 15 minutes, and is available [here](#).

## Supported decision-making guidance

Although strictly it relates only to Scotland, our readers' attention is directed to the recent guidance on supported decision-making produced by the Mental Welfare Commission and noted in the Scotland section of this Newsletter, as its principles are equally applicable in England and Wales (and indeed further afield).

## Europe

### A major step forward in CRPD compliance by the German Federal Constitutional Court?

#### 1. Introduction

Legislatures and courts worldwide, when they

consider medical treatment and other measures in the context of intellectual disabilities, will require to take account of a decision dated 26<sup>th</sup> July 2016 and published 25<sup>th</sup> August 2016 by the First Senate of the German Federal Constitutional Court (Bundesverfassungsgericht). This decision by eight justices, without any dissenting opinion, has significance beyond the 80,000,000 population within the jurisdiction of that court. The impressive and careful reasoning of the court could well be referred to comparatively if similar issues were to arise in any other jurisdiction. The decision has the potential to contribute significantly to any assessment, in relation to the UN Convention on the Rights of Persons with Disabilities ("the CRPD"), of the role played by the practice of contracting states in the interpretation of international treaties, accorded by Article 31 of the Vienna Convention on the Law of Treaties; and to any assessment of the relative weight to be given to the views of committees which have competence to offer interpretations of human rights treaties, including the UN Committee on the Rights of Persons with Disabilities ("the UN Committee").

At national level, the decision remedies a lacuna in German law by permitting medical treatment of people in the situation of a woman who opposed it. At international level, it is groundbreaking in claiming that her situation fell also within a lacuna in the reports, guidelines and recommendations of the UN Committee, and that the court's decision is accordingly not inconsistent with the position of the UN Committee in terms of those documents. Those of us who have engaged with the UN Committee, and who have benefited from the willing availability of its members to discuss, cannot doubt that the UN Committee regards its published views as explicitly prohibiting an

outcome such as that in this German case. Another view, however, would be that the German court has identified and addressed a blind spot in the Committee's understanding of the realities of some intellectual disabilities. Two opposing and irreconcilable interpretations of the CRPD have now been authoritatively placed in the international public domain.

The decision also gives an insight into the role of a constitutional court in jurisdictions which have one. That insight could form an interesting footnote to the masterly and fascinating exposition by Lord Neuberger, referred to in the Scotland section of this Newsletter, of trends over the last two decades towards *de facto* requirements for the UK Supreme Court to adopt a function which, to a modest extent, could be seen as analogous to that of a formally constituted constitutional court.

The full citation of the decision is "Bundesverfassungsgericht, Beschluss (des ersten Senats) vom 26. Juli 2016 - 1 BvL 8/15". It is available in German [here](#). A press release in English which describes the decision in a helpful degree of detail is available [here](#)<sup>1</sup>.

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<sup>1</sup> In addition to the sources mentioned above, I have been much assisted by a translation of selected parts of the decision and of some other relevant material provided by Professor Sabine Michalowski of the University of Essex. She and other members of the core research group of the Essex Autonomy Three Jurisdictions Project, including Professor Wayne Martin (also of Essex University), have assisted my understanding of various matters addressed in this article. Professor Volker Lipp of Gottingen University has, not only on this occasion, assisted my understanding of German law. Alex's contribution has exceeded the normal responsibilities of an editor. I am grateful for all this generous help, but – as ever – responsibility for each item in the Newsletter, and in particular for any opinions expressed, remains with the identified author. The full report of the Three Jurisdictions Project can be found at

One comment, however, upon the press release is that it uses "custodianship" to translate the German "Betreuung" (and "custodian" for "Betreuer"). It would be wrong to see Betreuung as implying a form of custody, and a more traditional translation would be "guardianship" and "guardian". Thus the title in English of the "Weltkongress Betreuungsrecht", reported on by Alex in the October 2016 Newsletter, was "World Congress on Adult Guardianship". However, the glossary on the Congress website offered "court-appointed legal representative", reflecting an increasing international move away from the sometimes unacceptable connotations of the traditional terminology<sup>2</sup>. In this report I use "Betreuung" and "Betreuer". Some case names and citations are given as they appear in the published decision of the First Senate.

The decision uses the terms "free will" and "natural will". The former is understood to mean an exercise and expression of will by a person with competence in relation to the matter in question, and thus being legally valid where it is capable of having legal significance. The latter is understood to be any wish or will that is consciously and wilfully expressed or made known to others, notwithstanding that it might lack legal validity because it was not capably formulated and communicated. The decision also refers to "original will" and "when necessary supported will". In section 6 of this report I describe further, and comment upon, aspects of the decision as to the description, use and considerable significance of these terms.

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<http://autonomy.essex.ac.uk/eap-three-jurisdictions-report>. The members of the core research group continue to collaborate, as many of the themes from that work continue to generate lives of their own.

<sup>2</sup> Thus the revised Yokohama Declaration (see [Newsletter link, please, Alex]) no longer contains those traditional terms.

## 2. *Facts and procedural history*

The woman concerned in the proceedings suffered from a “schizoaffective psychosis”. In consequence, a Betreuer<sup>3</sup> had been appointed to her in April 2014. In September 2014 she was briefly admitted to a care facility. While there, she declined to take medications prescribed to treat an auto-immune disorder. She refused to eat. She expressed the intent to commit suicide. In accordance with various orders of the court, she was transferred to a closed dementia unit at a clinic, and treated with medication “through coercive medical measures”.

Further examination showed that the woman also suffered from breast cancer. She was described as being by then severely weakened physically, and unable to walk or even to move around with a wheelchair by herself. She was described as being mentally capable of expressing her “natural will”. In response to questions from the court, she repeatedly stated that she did not wish to be treated for her cancer. Her Betreuer then applied to the court to authorise extension of her placement in her current accommodation, and to approve coercive measures, particularly to treat her breast cancer.

The court refused that application. It held that the legal requirements to permit placement in accommodation “associated with the deprivation of liberty” and for coercive medical treatment were not satisfied. The Betreuer appealed unsuccessfully to the regional court, and then on points of law to the Federal Court of Justice. The Federal Court of Justice stayed the proceedings and referred to the Federal Constitutional Court the question of whether relevant legislation was

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<sup>3</sup> See explanation of “Betreuer” above.

compatible with the German Basic Law (Grundgesetz – “GG”).

## 3. *Issues and decision: German law*

The point of law at issue was that the law of Betreuung under the German Civil Code provides that coercive medical treatment may only be given to persons who have a Betreuer if they are accommodated in a closed facility “associated with the deprivation of liberty”. The First Senate described as “constitutionally unobjectionable” the intention of the legislature in establishing a legal basis for coercive medical treatment that is applicable only to persons placed by their Betreuer in a closed facility<sup>4</sup>. Persons, such as the woman at the centre of this case, who have a Betreuer, who are already within in-patient treatment, and who are factually not capable of physically removing themselves, cannot be placed in accommodation “associated with the deprivation of liberty”. In consequence, they cannot be subjected to coercive medical treatment under the provisions described above. Accordingly, even if such persons would otherwise undoubtedly meet all of the substantive conditions for treatment, in that situation they could not be treated coercively. I refer to such persons as “persons in the woman’s situation”.

It was argued, successfully, that this situation contravened the state’s duty of protection under the GG. The GG also contains a general equality and anti-discrimination clause, which was referred to by almost all of the interveners in the case before the First Senate: disability groups, lawyers, charities, psychiatrists and so forth. The

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<sup>4</sup> Or, though not mentioned by the First Senate, persons so placed by an attorney acting under an enduring power of attorney.

Association of Psychiatry Users was an exception. It argued that the problem was that the relevant provisions permitted deprivation of liberty and compulsory medical treatment at all. The court did not address the discrimination point. It determined that there was unconstitutionality based on the state's positive obligation to protect the health of persons in the woman's situation.

The woman to whom the proceedings related was deceased by the time the decision was made. The First Senate held that the referral to the Constitutional Court was not rendered inadmissible by her death. It held that the function of judicial review, directed to clarifying the law and bringing about satisfaction, can in exceptional circumstances justify answering a referred question even after an event that would normally resolve the matter, if a sufficiently weighty and fundamental need for clarification persisted. The First Senate did however sound the warning that the question of when an interest in legal protection survived such an event would depend on the circumstances of each individual case.

The court held that it violated the state's duty of protection under the GG that persons who have a Betreuer, who are not capable of forming a "free will", should be entirely excluded from necessary medical treatment if giving that treatment should conflict with their "natural will", where they cannot be placed in accommodation "associated with the deprivation of liberty" because the requirements for placement in such accommodation are not satisfied, and where such placement is a precondition for giving treatment contrary to the "natural will" of the person. The First Senate ruled that this deficit was unconstitutional. It would be within the discretion of the legislature how to remedy the

deficit, but the court ordered that it must promptly be remedied. It further ordered that in the meantime, because the current legal situation in effect entirely denied the possibility of treatment for persons in the woman's situation even in the face of the threat of serious or life-threatening damage to their health, the existing provisions permitting non-consensual treatment should apply to this group of people. "The state community cannot simply abandon helpless persons to their own devices".

In reaching this decision, the First Senate acknowledged that giving treatment against the "natural will" of a person who has a Betreuer conflicts with the person's right of self-determination, and with the fundamental right to physical integrity. Under the GG, all persons are, as a rule, free to make their own decisions regarding any interferences with their physical integrity, and how to deal with their own health. In deciding whether and to what extent to allow an illness to be diagnosed and treated, they are not required to follow a standard of objective reasonableness. However, the state's duty of protection takes on special weight in the case of a serious threat to the health of a person who is unable to protect himself or herself. The state's duty of protection outweighs the person's right to self-determination and to physical integrity, where the following criteria apply: (a) no special treatment risks are associated with the medical measure necessary to avert the threat to health, and (b) there is no viable reason to believe that the refusal of treatment reflects "the original free will" of the person who has a Betreuer (which I interpret as meaning the competent will of the person, prior to loss of relevant competence).

#### *4. Issues and decision: international obligations*

In a passage commencing at paragraph 90 of the decision, the First Senate concluded that no international obligations conflicted with the state's obligation to provide protection to a person who has a Betreuer and who is vulnerable and unable to form a "free will", in the circumstances addressed in the case. Coercive treatment in such circumstances, the court held, was consistent with the CRPD, the European Convention on Human Rights ("ECHR"), and the case-law of the European Court of Human Rights.

In Germany the CRPD has the force of law, and can be used as an interpretative aid when defining the content and scope of basic rights under the German Constitution. The Federal Constitutional court on 23<sup>rd</sup> March 2011 had held that the CRPD did not suggest a different outcome. The CRPD includes provisions (notably in Article 12) aimed at guaranteeing and strengthening the autonomy of persons with disabilities. However, in the court's understanding of these provisions, they did not impose any general prohibition of measures which are taken against the "natural will" of a person with a disability, where that is done on the basis of the person's limited ability to make decisions, and where that limitation of ability is the result of an illness.

The court had held that: "The context of Art. 12(4) CRPD, which relates to measures which limit the exercise of a person's legal capacity, shows that *the Convention does not impose a general prohibition of such measures*, but rather limits their admissibility, inter alia by requiring the contracting states to develop feasible safeguards against conflicts of interests, abuse, and to guarantee proportionality" (para 88 of the decision, again in informal translation, with emphasis added).

Since the decision of 23<sup>rd</sup> March 2011 had been issued, the UN Committee had promulgated various reports, guidelines and recommendations regarding the interpretation of the CRPD and the legal situation in Germany. As to the effect of such reports, guidelines and recommendations upon the decision of 23<sup>rd</sup> March 2011, the court opined that they "do not lead to a different conclusion". The court pointed out that the views of a committee that has competence to interpret a human rights treaty are to be given significant weight, but they are not binding on international or national courts under international law<sup>5</sup>. On the views under the additional protocol to the ICCPR, the court noted General Comment No 33 of the Human Rights Committee<sup>6</sup>. The court held that such committees do not have the competence to develop international treaties beyond the agreements and practice of the contracting states, having regard to Art. 31 of the Vienna Convention on the Law of Treaties, which codifies customary international law<sup>7</sup>. The court

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<sup>5</sup> The court referred to ICJ, *Ahmadou Sadio Diallo* [Republic of Guinea v Democratic Republic of the Congo], I.C.J. Reports 2010, S. 639, <663-664>, para. 66; Supreme Court of Ireland, *Kavanagh v Governor of Mountjoy Prison and the Attorney General*, [2002] IESC 13 March, S. 14 f.; Tribunal Constitucional [Spain], STC 070/2002, recurso de amparo num. 3787-2001, Decision of 3 April 2002, II. Para. 7 a); Conseil d'état [France], Juge des référés of 11. October 2001, No. 238849, ECLI:FR:CEORD:2001:238849:20011011, S. 4.

<sup>6</sup> UN Doc. CCPR/C/GC/33 of 5 November 2008, para 13, which reads "The views of the [Human Rights] Committee under the Optional Protocol represent an authoritative determination by the organ established under the Covenant itself charged with the interpretation of that instrument. These views derive their character, and the importance which attaches to them, from the integral role of the Committee under both the Covenant and the Optional Protocol".

<sup>7</sup> And ICJ, *LaGrand* [Germany v USA]. I.C.J. Reports 2001. S. 466 <501> para. 99; Mark Villiger, Commentary on the

conceded that it was an open question whether principles which have been developed in the context of other international treaties apply to all declarations of the UN Committee. It is however clear, the court found, that Article 34 of the CRPD does not confer on the UN Committee a mandate to provide a binding interpretation of the CRPD. When interpreting a treaty, the court held that a national court should nevertheless engage in good faith with the views of a competent international treaty body, but it is not obliged to adopt them<sup>8</sup>.

In any event, the court held that, as regards the substance of the views of the UN Committee, those views would not exclude medical treatment without a person's consent where this is required under German constitutional law. The Committee had in its concluding observations of 13 May 2015 on the first German state report (UN Doc. CRPD/C/DEU/CO/1) criticised the provisions of the law on Betreuung in the German Civil Code, by referring to the UN Committee's General Comment No. 1. In particular, in General Comment No. 1 the Committee demanded the abolition of all substitute decision-making, and replacement with a system of supported decision-making. However, the court considered that the UN Committee's criticism "remains unspecific" with regard to the issues in this case concerning medical treatment without consent. In particular, the court considered that the UN Committee remained silent with regard to the question that was relevant in the present case, namely medical emergencies in which the "free

will" of a disabled person is completely absent.

The court took the view that a corresponding approach applied to the guidelines of the Committee regarding the interpretation of Article 14 of the CRPD (of September 2015). In those guidelines the Committee had emphasised that no healthcare measures should be taken in respect of persons with disabilities that are not based on the free and informed consent of the person concerned. The Committee asserted that states should refrain from any form of compulsory treatment. However, the court held that here also the Committee had not provided an answer to the question of what, according to its understanding of the treaty provisions, should happen to persons who cannot form a "free will" and who are in a vulnerable position. The court held that, even taking into account the views of the UN Committee, there were no good reasons under the text and spirit of the CRPD to abandon such persons to their fate, and to conclude that the Convention is opposed to compulsory medical treatment where this is constitutionally required under strictly regulated circumstances. The court held that this was so, in particular, because the requirements of German constitutional law and of the law on Betreuung, in compliance with the CRPD, give precedence to the will of the disabled person, and where necessary to the will to be determined with support.

The court considered relevant provisions of the ECHR, and in particular Article 8, which, according to the jurisprudence of the European Court of Human Rights, guarantees the right to determine for oneself how to live one's life, including the possibility to engage in activities that are physically harmful or dangerous. With reference to these provisions, the court held that the

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1969 Vienna Convention on the Law of Treaties, 2009, Art. 31 Rn. 37.

<sup>8</sup> See – though with reference to decisions of international courts – BverfGE 111, 307 <317 f.>; 128, 326 <366 ff., 370>; Christian Tomuschat, Human Rights Committee, The Max Planck Encyclopaedia of Public International Law, Bd. IV, 2012, S. 1058 <1061> Rn. 14.

medical treatment of competent adult patients against their wishes would amount to an interference with the person's physical integrity, and therefore with their Article 8 rights, even where refusal would lead to the person's death. The court referred to *Lambert v France*<sup>9</sup>; and *Pretty v United Kingdom*<sup>10</sup>. However, also by reference to *Lambert v France*, the court noted that states have a margin of appreciation in this respect.

The court held that it is a prerequisite for the obligation of the state and of society to accept a decision that is objectively unreasonable, and which could result in death, that the decision is based on the "free will" of an adult person who has mental capacity. If, on the other hand, a person does not take a decision voluntarily and with full understanding of the circumstances, the court held that the European Court of Human Rights imposes an obligation on states (under Article 2 of ECHR) to prevent the person from putting his or her life at risk<sup>11</sup>. Where a patient refuses a medically indicated treatment with the consequence that his or her life is put at risk, the European Court of Human Rights imposes on the state the obligation to take adequate precautions to ensure that – in cases where there is reason to believe that the person lacks "free will" – the relevant medical practitioners investigate further the capacity of the person concerned<sup>12</sup>. The court concluded that compulsory treatment required by the German Constitution under the conditions addressed in the decision, of persons who are vulnerable, does not conflict with obligations under Articles 2 or 8 of ECHR.

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<sup>9</sup> [2015] ECHR 545, § 120 ff.

<sup>10</sup> [2002] ECHR 427, § 62 f.

<sup>11</sup> *Lambert v France*, § 140; *Haas v Switzerland* [2011] ECHR 2422, § 54; *Arskaya v Ukraine* [2011] ECHR 1735, § 69 f.

<sup>12</sup> *Arskaya v Ukraine*, §§ 62, 69, 70, 88.

#### 5. *Comment: "free and informed consent"*

In a crucial sentence, the decision of 26<sup>th</sup> July 2016 describes the view of the UN Committee as to the effect of Article 14 of the CRPD thus (in informal translation): "As regards persons with disabilities, no measures for the protection of health may be undertaken unless they rest on the free and informed consent of the person concerned". That could mean two things, in relation to millions of people in the world who, because of their intellectual disabilities, are not capable of "free and informed" consent or dissent. Firstly, it could mean that those people, because they are incapable of "free and informed consent", should not be provided with any healthcare. That however would contravene the right of persons with disabilities under Article 25 of the CRPD "to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability". That cannot therefore be the correct interpretation if another interpretation not inconsistent with the provisions of the CRPD is possible. Secondly, it could mean that the requirement for "free and informed consent" applies only to people capable of giving it. If they are capable of such consent to a proposed "measure for the protection of health" (or refusing it), then that measure may not be imposed without consent. But if they are not so capable, the stipulation does not apply to them.

It is unsurprising that the German court should opt for the latter approach. It is also perhaps unsurprising that this outcome should be identified in the context of German language and usage. In English, the meaning of "free ... consent" is not obvious: not "free from" something specified, simply "free". The meaning identified above (and discussed further below) of

“free will” does point to a clear meaning: “free” means competent, and legally effective. It must surely be common ground that, in the context of the CRPD of all places, a disability preventing a person from giving competent consent to healthcare treatment, or preventing exercise of legal capacity in any other way, should not disqualify that person from receiving healthcare treatment, or from the benefits and protections of any other exercise of legal capacity.

In the CRPD, “free and informed consent” appears not in Article 14, but in Article 25, part of the first sentence of which is quoted above. The particular requirements of Article 25 include that States Parties should “d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent ...”. Here again the method of reasoning of the German court is relevant. Healthcare cannot be provided “of the same quality ... as to others” if people incapable of giving free and informed consent because of their disabilities should be excluded from receiving it. “Others”, if taken to hospital unconscious following an accident or sudden onset of illness, receive treatment notwithstanding their inability at the time to give “free and informed consent”. If that inability is the consequence of a disability, treatment should still be given.

A key word in this discussion is “include” in the second sentence of Article 1 of the CRPD: “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”. People with disabilities across the world still face such barriers, in various ways and

degrees. The sustained energy of the UN Committee in confronting reluctance to remove those barriers – wherever it is encountered – is to be absolutely commended, driven as it is by personal experience of their own disabilities. Those are disabilities, the disadvantages of which could ultimately be removed substantially if not entirely by the elimination of such barriers. That holds good for physical, sensory and many intellectual disabilities. In the legal sphere, the support provisions of Article 12(3) of the CRPD should be applied to the maximum extent to enable as many people with intellectual disabilities, in as many matters, as possible to exercise their legal capacity themselves. There will always be people, however, for whom measures relating to the exercise of legal capacity referred to in Article 12(4), will be necessary if (in the words of the German court, translated): “helpless persons” are not to be abandoned “to their own devices”.

It is here that the word “include” in Article 1 is so significant. Persons with disabilities, for the purposes of the CRPD, are not limited to those whose full and effective participation in society is limited by barriers. It also includes those, albeit a minority, who are in some respects limited by the very nature of their intellectual disabilities. That, for some, means in relation to the exercise of legal capacity. If that were not so, and if they were not included within the provisions of the CRPD, then - as the German court identified – there would be no place for the safeguards in Article 12(4).

#### *6. Comment: The four concepts of “will”*

I return to the four concepts, to be found at various points in the decision, of “free will”, “natural will”, “original free will” and “the when-

necessary-supported-will of the person with a disability". The decision does not set out clear definitions of any of them. It is understood that the core meanings of the first two are however well established in German law, though there is some marginal ambiguity and scope for debate. As indicated above, and put simply, free will means a competent formation and expression of will, sufficient for a legally valid action or transaction. An action could be consent to (or refusal of) healthcare treatment, or making a Will. A transaction could be entering a contract. Also as indicated above, and again put simply, natural will means any wish or will that is consciously and wilfully expressed or made known to others, notwithstanding that it might lack legal validity because it was not capably formulated and communicated. It could be expressed as an acceptance or refusal of healthcare, but might lack validity as such. Likewise, a purported Will or contract could lack validity.

With these two concepts defined with a degree of confidence, one can move forward to suggest, also with some degree of confidence, that "original free will" means a competent formation and expression of will in the past of a person who may no longer retain such competence, but which remains decisive.

Two aspects of the court's treatment and use of these three concepts are significant and fascinating. Firstly, the court appears to accept a reality which has always been readily apparent to anyone with experience of engaging with people with even some of the wide and diverse range of intellectual disabilities. The court appears to accept that humanity does not divide neatly into people capable of "free will", on the one hand, and those incapable of "free will" and able only to

communicate expressions of "natural will", on the other. These concepts are at two ends of a spectrum. The formation and expression of will by different people, by the same person at different times and in different circumstances, or by the same person in relation to different matters, can all be at different points along that spectrum, as well as at one end or the other. Thus, for example, the court refers to "the quality of the natural will": a particular formation and expression of natural will may be at some point closer to, or further from, the "free will" end of the spectrum.

This leads to the even more significant aspect in the decision, which is the apparent synthesising of these different categories of "will" into a single overall concept of "will", particularly in a passage where the court elaborates how the legislature must resolve the question of proportionality and give the highest possible weight to the person's will. My interpretation of that requirement is this. The principle of proportionality must be applied to the question whether, in a particular case, the presumption in favour of a person's expressed will should be applied and should be decisive, or whether – exceptionally – a person's expressed will should be overridden. The requirement is that the legislature should provide methodologies for carefully determining whether a person's "free will" can be identified, or even constructed, so that such "free will" will be decisive.

This echoes the process of "constructing decisions" which I described in the final chapter (Chapter 15: "Constructing Decisions") of *Adult Incapacity*, W Green, 2003. That chapter offered a description of the decision-making process required by the newly enacted Adults with Incapacity (Scotland) Act 2000. I described a

hierarchy of elements ranging from, at one end, an adult's present competent decision, through past competent decisions, decisive or at least significant choices, current wishes and feelings, past wishes and feelings, information about the adult from persons closest to the adult, and widening beyond there to significant personal or professional input about the adult, the shared views and ethos of the adult's family and background, and so forth. Generally, an element earlier in that list should prevail over a later element, unless later elements strongly and persuasively indicate that it would be appropriate for them to prevail. Different aspects of a decision might be derived from different points on the hierarchy. However, while other people may play a role in this process of constructing a decision, the purpose of such a process is to construct the adult's decision in the matter, not to impose a decision made by someone else.

I write "echoes" advisedly. There is a quantum leap from a process of constructing a decision, to transferring a somewhat similar methodology to a process of identifying and perhaps constructing what is a person's will, and assessing the quality of that will, in relation to a particular purpose and at a particular time. Constructing a person's will can be equated with the recommendation in paragraph 21 of General Comment No. 1 that: "Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the 'best interpretation of will and preferences' must replace the 'best interests' determinations". An assessment of the quality of the will thus interpreted or constructed is necessary when there is conflict among a person's rights, will and preferences in the context of the requirement of Article 12(4) of the CRPD that safeguards must "respect the rights, will and preferences of the

person"<sup>13</sup>.

On this view, one could see this decision of the German Federal Constitutional Court as a significantly progressive step in carrying forward the task of implementing and operationalising the key requirement of Article 12(4) to respect a person's rights, will and preferences. If respect for a person's will is to be elevated from "something that is good" to an element actually to be delivered in the world of hard reality, the only way of maximising that respect requires something more than defining ways to travel as far as possible in the direction of identifying or even constructing "will" that in particular circumstances can be categorised as decisive "free will". If we accept that the purpose here is to set the potential boundary of decisive "free will" as widely as possible, and if doing so is to become effective not only in theory but in day-to-day practice, it becomes all the more important that this boundary be clearly defined. It becomes essential to define the boundary up to which "will" is decisive, and beyond which, for a particular purpose and in a particular situation, that "will" is of such a quality that respect for a person's rights, or addressing a situation where there are various incompatible preferences, may require that the person's will be overridden.

It is in the context of this interplay of the flexible concepts of will, and the need to assess whether identified or even constructed will should be

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<sup>13</sup> An exploration of how the drafting committee for the CRPD intended that "will" should be understood in this phrase would be valuable, but is beyond the scope of this report, as it would appear to require further research into the travaux préparatoires. This would appear to be a situation where resort to the travaux would be appropriate in terms of Article 32 of the Vienna Convention on the Law of Treaties (see §2 of the Essex Autonomy Three Jurisdictions Report referred to in footnote 1 above).

decisive, that the court said that the free will of the person needs to be respected even if it can only be determined by reference to previously expressed views of the person, or based on the quality of the natural will. The court went further when (in Sabine’s translation – see above) it said that: “This can, *inter alia*, require differentiation as to how much weight should be given to the natural will of the person, depending on how close it comes to the person’s free (or presumed free) will after providing due support”.

We have only this one tantalising reference to this significant further step forward to the concept of “the when-necessary-supported-will of the person with a disability”. Article 12(3) of the CRPD requires states parties to “take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”. The proper route towards satisfying this requirement has been the topic of considerable discussion. The formula used by the court suggests that the route to providing the support required by Article 12(3) must include strategies for supporting the person’s will. Much work remains to be done to create and operationalise such strategies.

If the above analysis is correct, then the German Federal Constitutional Court is to be congratulated for signposting this significant step forward in the task, shared by the worldwide community, of fulfilling in day-to-day practice the aspirations and promise of the CRPD.

*Adrian D Ward*

## European Parliament Report on Protection of Vulnerable Adults

### Summary

This [study](#), produced by the European Parliamentary Research Service, supports a legislative initiative on the protection of vulnerable adults by the European Parliament.

There is currently no uniform legal framework allowing for a proper protection of vulnerable adults in cross-border situations across the European Union (EU). All EU Member States have their own legal framework, with differing tools for the protection of vulnerable adults. This increases legal uncertainties when it comes to cross-border situations.

In order to react to an increase in international mobility and to an ageing population with a growing number of age-related illnesses, such as Alzheimer’s and other forms of dementia, the World Organisation for Cross-border Co-operation in Civil and Commercial Matters negotiated the Hague Convention on the International Protection of Adults 2000 (“Hague 35”), which was designed to protect vulnerable adults in cross-border situations. In essence, it addresses questions such as which law applies and who may represent a vulnerable adult, and with what power. The Hague Convention provides rules on jurisdiction, applicable law and international recognition and enforcement of protective measures. Furthermore, it establishes mechanisms for cooperation between the authorities of Contracting States. However, only seven EU Member States have ratified Hague 35 (Austria, Czech Republic, Estonia, Finland, France, Germany and the UK (in respect of Scotland only)). Another seven EU countries have signed

Hague 35 but have not yet ratified it (Cyprus, Greece, Ireland, Italy, Luxembourg, Poland and the Netherlands).

In 2008, the European Parliament passed a Resolution which encouraged those EU Member States who had not ratified H to date, to proceed with ratification. It is, of course, one of the fundamental principles of the EU that there is freedom of movement and residence for all EU citizens. The world's population is becoming increasingly mobile especially in retirement. The report identifies a growing trend for northern European wishing to retire in warmer southern European climates. However, adults may become incapacitated or vulnerable at any stage of their lives. Young adults with mental disabilities or injuries, for example, also require protection in cross-border situations whether working, living or holidaying abroad.

This study reinforces the message to all EU Member States to ratify Hague 35 as a crucial preliminary step. It then goes further by supporting legislative action at EU level aimed at improving the protection of vulnerable adults in cross-border situations (beyond Hague 35) within the EU. The authors of the report consider that, even if all Member States ratified the Hague Convention, there would still be seven weaknesses remaining:

(i) The limited geographical scope, especially with a view to recognition and enforcement. Hague 35 provides for recognition and enforcement of measures taken in Contracting States only. It does not apply to the mutual recognition and enforcement of protective measures for the protection of vulnerable adults in non-Contracting States. Only nine States have ratified Hague 35 so far (seven EU Member States plus

Monaco and Switzerland).

(ii) The absence of a supranational court for solving disputes arising from different interpretations of Hague 35. This could lead to different interpretations of the Convention and inconsistent results across the Contracting States.

(iii) The poor cooperation and communication among the authorities of Contracting States. Providing for cooperation mostly channelled through central authorities designed by the Contracting States, Hague 35 makes only a timid suggestion that authorities "may" get in touch for the purpose of discharging duties under the Convention.

(iv) The difficulty in enforcing foreign protective measures. Measures for the protection of vulnerable adult adopted in one Contracting State must first be declared enforceable as a prerequisite to their enforcement in another Contracting State.

(v) The weak means by which evidence of the powers granted a representative of a vulnerable adult are to be provided abroad. Hague 35 establishes a certificate designed to allow the representative of a vulnerable adult to provide their capacity as a representative in another State. According to Hague 35, the individual Contracting States are to determine the procedural rules under which a certificate is to be delivered. In practice, certificates are very rarely issued which contributes to the legal uncertainty in the representation of a vulnerable adult.

(vi) The absence of any possibility for an adult to choose in advance the State whose authorities should have jurisdiction over his or her protection.

(vii) The lack of rules providing for the “continuing jurisdiction” of the authorities of the State of former habitual residence of the adult. Normally, according to the Hague Convention, a change of an adult’s habitual residence from one Contracting State to another involves a change of jurisdiction for the protection of the adult.

This study recommends five legislative measures at EU level aimed at improving the protection of vulnerable adults in cross-border situations by:

(i) Enhancing cooperation and communication among authorities of EU Member States. This should ensure frequent and systematic direct communication among the EU Member States’ authorities. Prompt availability of information is likely to enhance the protection of vulnerable adults.

(ii) Abolishing the need for protective measures to be declared enforceable in an EU Member State. This could be developed with appropriate safeguards for the protection of vulnerable adults and would be based on mutual trust among EU Member States enhancing the effectiveness of protective measures taken in EU Member States.

(iii) Creating a European certificate of powers granted for the protection of an adult. Such a European document would provide a comprehensive legal framework for relevant procedures.

(iv) Enabling the adult to choose the EU Member State whose courts should have jurisdiction to take measures directed at his or her protection. This would allow the authorities of the State of an adult’s former habitual residence to retain jurisdiction for some time following a change in

habitual residence and to modify the existing measures.

The study concludes with a recommendation that the EU should adopt legislative measures based on Article 81 TFEU to address the problems faced by vulnerable adults in cross-border situations and to supplement the framework provided by Hague 35 which does not allow all cases to be dealt with in the best interests of the adult concerned.

### Comment

The recommendations in this study are intended to enhance legal certainty and to harmonise the huge diversity of measures and instructions for the protection of vulnerable adults currently existing across the EU. In order to secure effective and consistent international cooperation, it is often preferable for States to enter into multilateral international instruments rather than individually negotiated bilateral instruments between states. However, like in many other areas of law, the future of the UK’s involvement in European endeavours is looking very uncertain in the wake of Brexit. If the UK ceases to be a member of the EU then it may need to enter into bilateral treaties with each and every other EU Member State to ensure that its decisions would be recognised and enforced in each and every other EU Member State. This could lead to variations across different bilateral instruments for the protection of vulnerable adults and extremely complicated practical matters when multiple instruments apply. It is heartening to see the EU moving towards greater and more consistent protection for vulnerable adults however, quite what the UK’s role will be, is yet to be seen.

In the meantime, whilst the legal implications of Brexit are still being worked out, different regimes of private international law will continue apply in the UK regarding the cross-border protection of adults. Scotland is a Contracting State to Hague 35 which is implemented by Schedule 3 to the Adults with Incapacity (Scotland) Act 2000. Although England and Wales has not ratified Hague 35, Schedule 3 to the Mental Capacity Act 2005 is built on the same principles as the Convention. There is no suggestion that these provisions will change in the foreseeable future.

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## Conferences at which editors/contributors are speaking

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### Scottish Young Lawyers Association

Adrian will be speaking on adults with incapacity at the SSC Library, Parliament House, Edinburgh on 21 November. For more details, and to book, see [here](#).

### Royal Faculty of Procurators in Glasgow

Adrian will be speaking on adults with incapacity at the RFPG Spring Private Law Conference on 1 March 2017. For more details, and to book, see [here](#).

### Scottish Paralegal Association Conference

Adrian will be speaking on adults with incapacity this conference in Glasgow on 20 April 2017. For more details, and to book, see [here](#).

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### Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to Mind in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

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Our next Newsletter will be out in mid-December. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Newsletter in the future please contact [marketing@39essex.com](mailto:marketing@39essex.com).

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