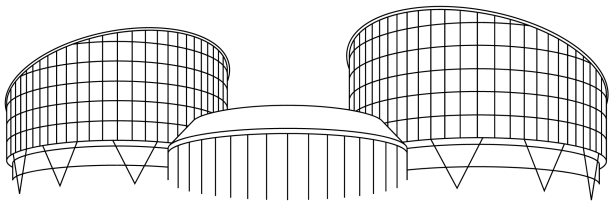

EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FOURTH SECTION

CASE OF MUNJAZ v. THE UNITED KINGDOM

(Application no. 2913/06)

JUDGMENT

STRASBOURG

17 July 2012

FINAL

17/10/2012

This judgment has become final under Article 44 § 2 of the Convention. It may be subject to editorial revision.

In the case of Munjaz v. the United Kingdom,

The European Court of Human Rights (Fourth Section), sitting as a Chamber composed of:

Lech Garlicki, *President,*
David Thór Björgvinsson,
Nicolas Bratza,
George Nicolaou,
Ledi Bianku,
Nebojša Vučinić,
Vincent A. De Gaetano, *judges,*

and Lawrence Early, *Section Registrar*,

Having deliberated in private on 26 June 2012,

Delivers the following judgment, which was adopted on that date:

PROCEDURE

1. The case originated in an application (no. 2913/06) against the United Kingdom of Great Britain and Northern Ireland lodged with the Court under Article 34 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by a British national, Mr C. Munjaz ("the applicant"), on 10 January 2006.

2. The applicant, who had been granted legal aid, was represented by Ms K. Lloyd, a lawyer practising in Merseyside with Hogans Solicitors, assisted by Mr N. Pleming Q.C., Ms F. Morris and Mr A. Ruck Keene, counsel. The United Kingdom Government ("the Government") were represented by their Agents, Mr J. Grainger and Ms H. Moynihan of the Foreign and Commonwealth Office.

3. The applicant alleged that his seclusion at Ashworth Special Hospital, Merseyside, was in violation of Articles 3, 5, 8 and 14 of the Convention.

4. On 25 February 2008 the Acting President of the Fourth Section to which the case had been allocated decided to give notice of the application to the Government. It was also decided to examine the merits of the application at the same time as its admissibility (Article 29 § 3).

5. The applicant and the Government each filed written observations (Rule 59 § 1). In addition, third-party comments were received from the National Association for Mental Health (MIND), which had been given leave by the President to intervene in the written procedure (Article 36 § 2 of the Convention and Rule 44 § 2). The respondent Government replied to those comments (Rule 44 § 5). The Chamber also decided to refuse the applicant's request for a hearing (Rule 59 § 3 *in fine*).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

6. The applicant was born in 1947. After a number of periods in prison and hospital the applicant was admitted to Ashworth Special Hospital ("Ashworth") from prison under sections 47 and 49 of the Mental Health Act 1983 on 19 July 1984. He remained an in-patient until March 1992, when he was discharged by the Mental Health Review Tribunal. About a year later he was arrested and charged with a number of offences and was admitted, from prison, to a medium secure unit in August 1993. In that unit he became increasingly psychotic, aggressive and violent. He was placed in seclusion and transferred to Ashworth on 1 March 1994. While at Ashworth he has been secluded on a number of occasions for the protection of others: between 26–30 May 2001, 2–20 June 2001, 18 December 2001–2 January 2002 and 28 March–5 April 2002. Each period of seclusion involved confinement to his bedroom or another room; however, during each period of seclusion, the applicant was allowed periods of association either with staff or other patients. These periods ranged from five minutes to over eight hours. In the first period of seclusion, he had approximately six and a half hours' association in total; in the second, fifty one hours' association; in the third, twenty-seven hours' association; and in the fourth, twenty-one hours' association. There was only one day, 22 December 2001, when the applicant was not allowed any association at all.

7. Each period of seclusion was made by Ashworth pursuant to its seclusion policy ("the policy": see paragraphs 26–28 below). There is a national Code of Practice, issued by the Secretary of State for Health under the Mental Health Act, which includes a section on seclusion of psychiatric patients (see paragraphs 23–25 below). The applicant maintains that the hospital's seclusion policy differs substantially from the Code, particularly by reducing the number and frequency of reviews of his seclusion by a doctor from that laid down in the Code.

8. The applicant first challenged Ashworth's seclusion policy on this basis in the High Court in 1999. On 10 October 2000, the High Court found that the hospital's policy, by reducing the frequency of review of a patient's seclusion below that provided for in the Code of Practice, was unlawful and was not justified by the fact that the hospital was a maximum secure hospital. In particular, the failure after the third day of seclusion to have twice-daily medical reviews of the continuation of seclusion was not justified.

9. Ashworth did not change its policy and the applicant commenced further judicial review proceedings on 12 July 2001. In December 2002, the hospital adopted a new policy, providing for medical review of the continuation of the use of seclusion twice daily on days 2-7 of the seclusion

and thereafter three reviews a week by a doctor and a weekly multi-disciplinary review. The applicant continued to challenge the legality of the policy on the grounds that from day 8 onwards it did not comply with the review procedures found necessary by the High Court. He also argued that the Code of Practice suggested that there should be medical reviews every four hours. Finally he argued that the hospital's policy was incompatible with Articles 3 and 8 of the Convention.

On 5 July 2002, the High Court ruled that the minimum level of severity required for Article 3 was not met and there was no breach of Article 8. It also found that the Code of Practice was merely guidance. The High Court also accepted the evidence of Ashworth that the applicant had not remained in seclusion for longer than had been necessary, and that there was no evidence that more frequent reviews would have reduced the time spent in seclusion.

A. The Court of Appeal's judgment

10. The applicant appealed to the Court of Appeal and, on 16 July 2003, it allowed his appeal. Relying on *X v. the United Kingdom*, no. 6840/74, Commission decision of 2 May 1997, Decisions and Reports (DR) 10, p. 5 (cited in the judgment as *A. v. the United Kingdom* (1980) 3 EHRR 131), it found that seclusion of a detained psychiatric patient was capable of amounting to a breach of Article 3. On the basis of this Court's ruling in *Keenan v. the United Kingdom*, no. 27229/95, §§ 108-112, ECHR 2001-III, it also found that the Code of Practice, in so far as it regulated seclusion, had to have a status and weight consistent with the State's obligation to avoid ill-treatment of patients detained by the State. Where there was a risk that agents of the State would treat their patients contrary to Article 3, the State should take steps to avoid this through the publication of a Code of Practice, which its agents were obliged to follow unless they had good reason to depart from it.

11. The Court of Appeal also held that seclusion would breach Article 8 of the Convention unless it could be justified under Article 8 § 2. In considering the need for any interference to be "in accordance with law" in terms of Article 8 § 2, it found that the transparency and predictability required by this provision were supplied by the Code of Practice. It found:

> "It would fly in the face of the original purposes of the Code if hospitals or professionals were in fact free not to follow it without a good reason. It is clear that section 118(2) (see para 4 above) cannot have been intended as a 'take it or leave it' provision. In relation to those matters where a patient's human rights are or may be engaged, the arguments for according the Code the greater status are compelling. Where there is a risk that agents of the state will treat its patients in a way which contravenes Article 3, the state should take steps to avoid this through the publication of a Code of Practice which its agents are obliged to follow unless they have good reason to depart from it. Where there is an interference with the rights protected by

> Article 8, the requirement of legality is met through adherence to a Code of Practice again unless there is good reason to depart from it. The same will apply where the Code deals with the deprivation of liberty within the meaning of Article 5.... We conclude that the Code should be observed by all hospitals unless they have a good reason for departing from it in relation to an individual patient. They may identify good reasons for particular departures in relation to groups of patients who share particular well-defined characteristics, so that if the patient falls within that category there will be a good reason for departing from the Code in his case. But they cannot depart from it as a matter of policy and in relation to an arbitrary dividing line which is not properly related to the Code's definition of seclusion and its requirements."

It concluded that the hospital's seclusion policy was unlawful. While the court considered Article 5 of the Convention on its own motion, relying on this Court's rulings in *Bouamar v. Belgium*, judgment of 29 February 1988, Series A no. 129, *Aerts v. Belgium*, judgment of 30 July 1998, *Reports of Judgments and Decisions* 1998-V and *Ashingdane v. the United Kingdom*, judgment of 28 May 1985, Series A no. 93, it found that seclusion did not amount to a further deprivation of liberty.

B. The House of Lords' judgment

12. Ashworth appealed to the House of Lords. On 13 October 2005 the House of Lords (by a majority of three to two) allowed the appeal.

1. The majority

13. In the lead speech, Lord Bingham (with whom Lord Hope and Lord Scott agreed) found that the Code of Practice was only guidance and he was satisfied that the hospital had shown good reasons for departing from it. He stated:

> "21. It is in my view plain that the Code does not have the binding effect which a statutory provision or a statutory instrument would have. It is what it purports to be, guidance and not instruction. But the matters relied on by Mr Munjaz show that the guidance should be given great weight. It is not instruction, but it is much more than mere advice which an addressee is free to follow or not as it chooses. It is guidance which any hospital should consider with great care, and from which it should depart only if it has cogent reasons for doing so. Where, which is not this case, the guidance addresses a matter covered by section 118(2) [of the Mental Health Act 1983 – see paragraph 22 below], any departure would call for even stronger reasons. In reviewing any challenge to a departure from the Code, the court should scrutinise the reasons given by the hospital for departure with the intensity which the importance and sensitivity of the subject matter requires.
>
> 22. The extensive evidence adduced by the Trust makes clear that the Code was very carefully considered. This is indeed evident from the policy itself, which reproduces important parts of the Code and contains cross-references to it. But the policy did depart from the Code in providing for less frequent medical review after Day 7. As the [High Court observed], the Trust 'has explained the justification for the policy in very considerable detail'. ...

23. In considering the frequency of medical review after Day 7 the Trust were in my opinion entitled to take account of three matters in particular. First, as pointed out in the Introduction to the policy, the Code was directed to the generality of mental hospitals and did not address the special problems of high security hospitals, containing as they inevitably do the most potentially dangerous patients in the country. Secondly, the Code did not recognise the special position of patients whom it was necessary to seclude for longer than a very few days. It has been the experience of the Trust that the condition of those secluded for more than a week does not change rapidly, and that it is in any event unsafe to rely on an apparent improvement without allowing enough time to pass to give grounds for confidence that the improvement will endure. Thirdly, the statutory scheme, while providing for the Secretary of State to give guidance, deliberately left the power and responsibility of final decision to those who bear the legal and practical responsibility for detaining, treating, nursing and caring for the patients.

24. The witness statements submitted by the Trust are very strongly challenged in statements and evidence on behalf of Mr Munjaz, Mind and the Mental Health Act Commission. This is a highly controversial subject, on which professional opinions differ. The 7-day divide between short-term and long-term secluded patients is criticised. So is the practice, adopted at Ashworth, of allowing secluded patients to spend periods of time, sometimes lengthy periods, in closely supervised association with other patients. There are differences of practice, not all of them fully explained, between Ashworth, Broadmoor and Rampton. It is not, however, for the courts to resolve debatable issues of professional practice, but to rule on issues of law. If a practice is supported by cogent reasoned justification, the court is not entitled to condemn it as unlawful. In the present case, even with the intense scrutiny called for, I cannot regard the long and detailed statements submitted by the Trust as failing to show good reasons for adopting the policy it has adopted, even though there are many eminent professional experts who take a different view."

14. Lord Bingham found that Article 3 was not breached by the policy. He held as follows:

"29...Despite much learned argument addressed to the House, I do not find it necessary to discuss the extent or probability of the risk or the extent to which it must be foreseen. For I agree with [the High Court] that the policy must be considered as a whole, that the policy, properly operated, will be sufficient to prevent any possible breach of the article 3 rights of a patient secluded for more than 7 days and that there is no evidence to support the proposition that the frequency of medical review provided in the policy risks any breach of those rights. The patient must be the subject of recorded observation by a nurse at least every 15 minutes and of recorded review by two qualified nurses every 2 hours, one of them (where practicable) not involved in the decision to seclude. In the ordinary course of things it is the nurses who know the patient best, and the nurse in charge of the ward can terminate seclusion at any time. There must be a daily review by a ward manager or site manager of a different ward: these, as the evidence shows, are senior and experienced people. There must be 3 medical reviews each week, one of them involving the patient's responsible medical officer. There must in addition be a weekly review by a multi-disciplinary patient care team, including the patient's RMO [Resident Medical Officer]. The seclusion of the patient must be monitored by the hospital's Seclusion Monitoring Group, which includes the medical director, the hospital director, the head of psychology, the senior nurse, the head of social care, 2 nurses, the ward manager and a non-executive director of the Trust, some of whom must have seen the patient. It reports to the hospital's Clinical Governance Committee. The Mental Health Act Commission must

> be informed once a patient has been secluded for 7 days and must thereafter receive regular progress reports: as already noted, it has statutory power to visit and investigate any complaint. The patient may, wherever possible, be visited by a relative. The patient or his representative may appeal to the medical director or his deputy, who must review the case and take account of any representations made. The patient may seek judicial review of the decision to seclude him or continue to seclude him, or to challenge the conditions in which he is secluded. It cannot in my opinion be said, bearing in mind that the standard set must obtain in all member states of the Council of Europe, that a policy containing these safeguards exposes a patient secluded for more than 7 days to any material risk of treatment prohibited by article 3."

15. On Article 5, Lord Bingham endorsed the Court of Appeal's finding that it did not apply and added:

> "The approach to residual liberty which appears to have prevailed in Canada (see *Miller v The Queen* (1985) 24 DLR (4th) 9) does not, as I understand, reflect the jurisprudence of the European Court. I do not for my part regret this conclusion since, as the Court of Appeal pointed out (in para 70 of its judgment), improper use of seclusion may found complaints under article 3 or article 8, and article 5(4) provides that a successful challenge should result in an order that the detainee be released, not in an order that the conditions of his detention be varied. I would not, for example, understand article 5(4) as enabling a prisoner, lawfully detained, to challenge his prison category. In any event, the Ashworth policy, properly applied as one must assume, does not permit a patient to be deprived of any residual liberty to which he is properly entitled: seclusion must be for as short a period and in conditions as benign as will afford reasonable protection to others who have a right to be protected."

16. On Article 8 of the Convention, Lord Bingham doubted that seclusion, when properly used in order to protect others from violence and intimidation and when used for the shortest period necessary, was an interference with a patient's Article 8 rights. He considered that "a detained patient, when in his right mind or during lucid intervals, would not wish to be free to act in such a way [to be violent or intimidating] and would recognise that his best interests were served by his being prevented from doing so." However, for Lord Bingham, if there were an interference then the "in accordance with law" requirement of Article 8 § 2 had not been breached. He found (at paragraph 34 of the judgment):

> "The requirement that any interference with the right guaranteed by article 8(1) be in accordance with the law is important and salutary, but it is directed to substance and not form. It is intended to ensure that any interference is not random and arbitrary but governed by clear pre-existing rules, and that the circumstances and procedures adopted are predictable and foreseeable by those to whom they are applied. This could of course have been achieved by binding statutory provisions or binding ministerial regulations. But that was not the model Parliament adopted. It preferred to require the Secretary of State to give guidance and (in relation to seclusion) to call on hospitals to have clear written guidelines. Given the broad range of institutions in which patients may be treated for mental disorder... it is readily understandable why a single set of rules, binding on all, was thought to be undesirable and perhaps impracticable. It is common ground that the power to seclude a patient within the hospital is implied from the power to detain as a 'necessary ingredient flowing from a power of detention for

treatment' treatment": see Auld LJ in *R v Broadmoor Special Hospital Authority, Ex p S, H and D* (5 February 1998, unreported) and the Court of Appeal judgment in the present case, para 40. The procedure adopted by the Trust does not permit arbitrary or random decision-making. The rules are accessible, foreseeable and predictable. It cannot be said, in my opinion, that they are not in accordance with or prescribed by law."

17. Lord Hope, in agreeing with Lord Bingham, stated:

"In my opinion there is nothing that is arbitrary about the way in which Ashworth has departed from the Code in the framing of its Policy. A careful reading of it shows that it is based very substantially on the Code's guidance, and that where it departs from it – with regard to the frequency of reviews in particular – it does so because of its perception of the way seclusion needs to be used in the special circumstances that obtain at Ashworth. The system that it lays down has been carefully designed to deal with its use for much longer periods than the Code's guidance was designed for. Its purpose is to ensure that its use for these longer periods is not resorted to at random or arbitrarily. Following the Code's example, that is the whole purpose of the Policy.

97. As for the question whether Ashworth was free to depart from the Code as a matter of policy, and not just in relation to individual patients or groups of patients, I do not see why this should be so, provided of course that it can demonstrate that it had a good reason for doing so. The distinction which the Court of Appeal made between a departure in the case of individual patients or groups of patients and a departure which takes the form of a written policy for dealing with a particular form of intervention is elusive, and I do not think that it can be regarded as acceptable. There is an obvious danger that, if the Code could be departed from in the case of individual patients or groups of patients where no written guidance was available, decisions to do this would be open to attack as being arbitrary because their consequences were unregulated and unpredictable. That, precisely, is what Ashworth's Policy seeks to avoid. Good clinical and medical practice dictates that seclusion should only be used in particular situations to protect others and subject to particular conditions to ensure that the patient is not harmed or secluded for any longer than is necessary. The purpose of the Policy is to ensure that the conditions under which it is to be resorted to are clearly understood and carefully observed so that decisions that are taken about the management of this procedure are consistent and not arbitrary.

98. I am in full agreement with all that my noble and learned friend Lord Brown of Eaton-under-Heywood has said about this case except with regard to the issues raised by article 8(2) of the Convention, as to which I have the misfortune to disagree with him. The point that divides us is whether the practice of seclusion carried out at Ashworth in accordance with the Policy is "in accordance with the law." As his quotation from para 39 of the Court's judgment in *Hewitt and Harman v United Kingdom* (1991) 14 EHRR 657 reminds us, it is the quality of the law that matters rather than the form it takes. The touchstones by which its quality is measured are, as Lord Brown says, its transparency, its accessibility, its predictability and its consistency. Where these qualities are present the measure protects against the abuse of power and against conduct which is arbitrary. There is no doubt that the Code satisfied these tests, notwithstanding the fact that there is no statutory obligation to comply with it. In my opinion Ashworth's Policy, which is careful in all these respects to follow the Code's example, does so too. It is, of course, true that Ashworth could alter its Policy. But if it did so every departure from the Code would have to be justified in the same way as the Policy itself has had to be justified. I do not think that the fact that Ashworth has its own Policy opens the door to further departures from the Code that could be described as arbitrary.

> 99. Assuming, of course, that Ashworth has shown - as it has - clearly, logically and convincingly that it had cogent reasons for departing from the Code in these particular respects in favour of its own Policy, I would hold that its decision cannot be said to have been unlawful. Concerns that a departure from the Code in this instance will lead to widespread variations in practice and undermine its status generally or that your Lordships' judgment lowers the protection offered by the law to mentally disordered patients are misplaced, in my opinion. The requirement that cogent reasons must be shown for any departure from it sets a high standard which is not easily satisfied. The protection which the law provides to ensure that any departures are compatible with Convention rights is an additional safeguard. This has been amply demonstrated in practice since the Code was promulgated. Ashworth is the only place where a hospital has departed from what the Code says about seclusion in favour of its own policy. While I would respectfully endorse everything that Lord Brown says in the last paragraph of his speech [paragraph 127, quoted below], I believe that it would be wrong to see this judgment as opening the door to substantial departures from the Code on the part of individual hospitals. The decision of the majority should not be seen as an invitation to other hospitals to do this and resort to their own policies. The status of the Code remains unchanged, and so does the need to show cogent reasons if in any respect it is departed from.

18. Lord Scott, in agreeing that Ashworth's policy was in accordance with the law for the purposes of Article 8, emphasised the duty the hospital owed to protect patients and staff from harm. Once it was accepted that Ashworth had no statutory obligation to have a seclusion policy that conformed in every respect to the Code and that Ashworth's seclusion policy was rational and reasonable in itself despite its divergences from the Code, there could be no room for any suggestion that the implementation of Ashworth's seclusion policy for the safety of other inmates was otherwise than in accordance with the law.

2. Lord Brown

19. Lord Brown concurred in respect of Articles 3 and 5 and dissented in respect of Article 8. He did not find that the hospital's policy was "in accordance with law" for the purposes of Article 8 § 2, since it did not have sufficient "quality of law". In his view, for the requirements of Article 8 § 2 to be met, the Code of Practice had to be given the higher status of the force of law, disentitling individual hospitals to depart from it on policy grounds. He concluded:

> "125. Not without some considerable hesitation I have reached the conclusion that the Code must indeed be given this higher status. Without such a Code the legal position would be this. The only authority for seclusion would be, in the case of patients detained under the 1983 Act, the implied power of control over those lawfully detained; in the case of informal patients, the common law doctrines of necessity and self-defence. The actual use of seclusion in individual cases would not be regulated save insofar as each hospital practising it would be required to adopt, publish and practise a rational policy of its own. That, of course, is precisely what Ashworth does. But by the same token that Ashworth is permitted to adopt its own policy, so too may other hospitals. Much of the factual focus of the appeal was upon those of Ashworth's patients who are detained for over seven days. But Ashworth's policy departs from the

Code much earlier than this: only for the first 12 hours does Ashworth conduct medical reviews at 4 hourly intervals as specified by the Code; from then until the end of the seventh day such reviews occur twice (rather than six times) a day. Other hospitals too may think it unnecessary to conduct reviews as frequently as provided for by the Code. And of course there is nothing to stop Ashworth altering its policy whenever it thinks it right to do so. The policy of an individual hospital can be changed with infinitely greater ease than the Code itself.

...

127.The Secretary of State's Foreword to the 1999 issue of the Code stated that: 'the Code should be followed' until necessary new legislation came into force. It ended:

'The Code provides essential reference guidance for those who apply the Act. Patients and their carers are entitled to expect professionals to use it.'

Under the ruling proposed by the majority of your Lordships, patients and their carers must be reconciled instead to substantial departures from the Code on the part of individual hospitals who may prefer to follow a different policy of their own. It is my reluctant conclusion that not only will these patients and carers be disappointed in their expectations but that the practices in the event adopted by any such hospital (rational though I acknowledge they must certainly be) will not have the necessary legal quality to render them compatible with the rule of law. Unless it is to the Code that one can look for regulation carrying the force of law it is not in my opinion to be found elsewhere. Hospital policies themselves provide too insubstantial a foundation for a practice so potentially harmful and open to abuse as the seclusion of vulnerable mental patients."

3. Lord Steyn

20. Lord Steyn dissented on all three points. On Articles 3 and 8 he approved the reasoning of the Court of Appeal. On the status of the Code of Practice, by section 118(1) of the Mental Health Act 1983 (which directs the Secretary of State to prepare such a code) he found:

"...in section 118(1) Parliament had authorised a Code with some minimum safeguards and a modicum of centralised protection for vulnerable patients. This is inconsistent with a free-for-all in which hospitals are at liberty to depart from the published Code as they consider right. Indeed, it seems unlikely that Parliament would have authorised a regime in which hospitals may as a matter of policy depart from the Code. After all that would result in mentally disordered patients being treated about seclusion in a discriminatory manner, depending on the policy adopted by the managers and clinicians in particular hospitals."

He also found Article 5 to be applicable, stating as follows:

"Under English law a convicted prisoner, sentenced to imprisonment, retains all his civil rights which are not taken away expressly or by necessary implication: *Raymond v Honey* [1983] AC 1, at 10G, per Lord Wilberforce. To that extent the prisoner has a residual liberty. The concept of residual liberty is a logical and useful one as demonstrated by the decision of the Canadian Supreme Court in *Miller v The Queen* (1985) 24 DLR (4th) 9. The reasoning in *Miller* shows that in a case of a prisoner where solitary confinement is unlawfully and unjustly superimposed upon his prison sentence the added solitary confinement can amount to 'prison within a prison': it is capable of constituting a material deprivation of residual liberty

...

It would also be wrong to assume that under the jurisprudence of the ECHR residual liberty is not protected. There is relevant European authority not placed before the Court of Appeal. In *Bollan v United Kingdom,* App No. 42117/98, the European Court of Human Rights, albeit in an admissibility decision, considered the point. The complaint was a comparatively weak one: the prisoner had been confined to her cell, unlawfully it was said, for some two hours. The evidence was that she was a heroin addict who objected to that restriction on her residual liberty. In European terms the case simply did not reach the necessary threshold of severity. The European Court of Human Rights dealt with the legal principles arising under the ECHR as follows:

'It is undisputed in the present case that Angela Bollan was lawfully detained in Corton Vale prison pursuant to a court order remanding her in custody pending sentence for a criminal offence. Nor is it disputed that the prison was an appropriate establishment for that type of detention or that there was anything inappropriate concerning her place of detention within the prison. The principal issue is whether the decision of the prison officers to leave Angela Bollan in her cell until lunchtime - a period of less than two hours - in itself disclosed an unjustified and unlawful deprivation of her liberty within that prison.

The court does not exclude that measures adopted within a prison may disclose interferences with the right to liberty in exceptional circumstances. Generally however, disciplinary steps, imposed formally or informally, which have effects on conditions of detention within a prison, cannot be considered as constituting deprivation of liberty. Such measures must be regarded in normal circumstances as modifications of the conditions of lawful detention and therefore fall outside the scope of Article 5 § 1 of the Convention (see Application no. 7754/77, dec. 9.5.77, D.R. 11, p 216. In appropriate cases, issues may arise however under articles 3 and 8 of the Convention.'

(My emphasis)

Plainly, the ECtHR has not ruled out as a matter of principle the concept of residual liberty. On the contrary, it accepts that there is scope for such a doctrine. It will be noted also that the ECtHR observed that in such cases 'in appropriate cases, issues may arise however under articles 3 and 8 of the Convention'. To that it must be added that, if substantial and unjust seclusion of a mentally disordered patient cannot in our domestic law be protected effectively under articles 3 and 8, the case for protection under article 5 becomes ever stronger. It follows that a substantial period of unnecessary seclusion of a mentally disordered patient, involving total deprivation of any residual liberty that the patient may have within the hospital, is capable of amounting to an unjustified deprivation of liberty."

II. RELEVANT DOMESTIC LAW AND PRACTICE

21. The relevant domestic law and practice are set out in the speech of Lord Bingham in the House of Lords' judgment in the present case (paragraphs 4-17) and may be summarised as follows.

A. Primary legislation

22. Section 118 (1) of the Mental Health Act 1983 provides:

"1) The Secretary of State shall prepare, and from time to time revise, a code of practice—

(a) for the guidance of registered medical practitioners, managers and staff of hospitals and mental nursing homes and approved social workers in relation to the admission of patients to hospitals and mental nursing homes under this Act and to guardianship and after-care under supervision under this Act; and

(b) for the guidance of registered medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder."

Before preparing or altering the Code of Practice the Secretary of State is required to consult such bodies as appear to him to be concerned (subsection (3) of the same section). The Code and any revised Code must be laid before Parliament, and either House may within a specified period require its alteration or withdrawal (subsections (4) and (5)). The Code must be published (subsection (6)).

By section 120(1) of the 1983 Act the Secretary of State is required to keep under review the exercise of the powers and the discharge of the duties conferred or imposed by the Act so far as they relate to the detention of patients under the Act, and is further required to make arrangements for persons authorised by him in that behalf to visit and interview privately patients detained in hospital under the Act and to investigate complaints made by persons who are or have been detained under the Act. By section 121(2) the Secretary of State must direct that these functions shall be performed by the Mental Health Act Commission, an authoritative professional body established under section 11 of the National Health Service Act 1977 and continued by section 121(1) of the 1983 Act.

B. The Code of Practice

23. The Code of Practice was promulgated in March 1999. Chapter 19, entitled "Patients presenting particular management problems", addresses seclusion. Paragraph 19.16 defines seclusion as follows:

"Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.

Seclusion should be used;

• as a last resort

• for the shortest possible time

Seclusion should not be used;

• as a punishment or threat

• as part of a treatment programme

• because of shortage of staff

• where there is any risk of suicide or self- harm."

24. Paragraph 19.17 provides:

"Hospitals should have clear written guidelines on the use of seclusion which:

• ensure the safety and well being of the patient;

• ensure the patient receives the care and support rendered necessary by his or her seclusion both during and after it has taken place;

• distinguish between seclusion and 'time-out' (see paras 18.9-18.10);

• specify a suitable environment taking account of patient's dignity and physical well being;

• set out the roles and responsibilities of staff;

• set requirements for recording, monitoring, reviewing the use of seclusion and any follow-up action."

25. The procedure for seclusion is set out at paragraphs 19.18-19.21:

"19.18 The decision to use seclusion can be made in the first instance by a doctor or the nurse in charge. Where the decision is taken by someone other than a doctor, the RMO or duty doctor should be notified at once and should attend immediately unless the seclusion is only for a very brief period (no more than five minutes).

19.19 A nurse should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient's seclusion, and present at all times with a patient who has been sedated.

19.20 The aim of observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be terminated. The level should be decided on an individual basis and the patient should be observed continuously. A documented report must be made at least every 15 minutes.

19.21 The need to continue seclusion should be reviewed

• every 2 hours by 2 nurses (1 of whom was not involved in the decision to seclude), and

• every 4 hours by a doctor.

A multidisciplinary review should be completed by a consultant or other senior doctor, nurses and other professionals, who were not involved in the incident which led to the seclusion if the seclusion continues for more than:

• 8 hours consecutively; or

• 12 hours intermittently over a period of 48 hours.

If the need for seclusion is disputed by any member of the multidisciplinary team, the matter should be referred to a senior manager."

C. The Ashworth Hospital Policy

26. The policy of Ashworth Hospital applicable to the applicant is as follows. The introduction to the policy states at paragraph 2.4:

> "The Code of Practice provides guidance on how registered mental health practitioners, managers and staff of hospitals should proceed when undertaking duties under the Act. The Code of Practice revised in March 1999 was written to encompass a wide range of mental health services and does not specifically consider the special situation of a high security hospital."

27. The policy repeats verbatim the definition of seclusion in the Code of Practice and the Code's statements on when seclusion should be used and that it should not be used as a punishment or threat or as part of a patient's treatment. Paragraph 6 of the policy addresses the decision to seclude and provides:

> "6.3 The decision to use seclusion will be made usually in the first instance by the nurse in charge of the ward. It must be clear which individual made the decision. The RMO or deputy and the Ward Manager or deputy should be informed immediately.
>
> 6.4 The doctor and Ward Manager or deputy will attend the ward as soon as possible within the hour to assess the situation and review with the nurse in charge whether or not seclusion is required to continue and assess alternative responses. The doctor will record in the notes any agreed level of observation or intervention in excess of the standard seclusion observation."

A nurse is to be readily available within sight and sound of a room in which a person is secluded at all times, and a paper recording of direct visual observation of the patient is to be made at least every 15 minutes (paragraph 7.1). Paragraph 8 provides for the keeping of detailed records and for a detailed plan for management of the ending of seclusion to ensure its ending at the earliest possible time.

28. The review of seclusion and possible challenges to it are set out in paragraphs 9-11 of the policy which provide as follows:

> "9 Review
>
> 9.1 The RMO [Resident Medical Officer] is responsible for the use of seclusion. Regular reviews must take place involving the RMO or deputy and Ward Manager or deputy. The details of these are given below.
>
> 9.2 If a doctor was not present at the time of seclusion, he must initiate a review on arrival within one hour and then at:
>
> 9.2.1 First day - medical review at 4, 8, 12 and 24 hours;
>
> 9.2.2 Day 2 to day 7 - twice per day;
>
> 9.2.3 Day 8 onwards:-
>
> [1] daily review by Ward Manager or Site Manager from different ward;
>
> [ii] three medical reviews every 7 days [one being by the RMO];
>
> [iii] weekly review by multi-disciplinary patient care team to include RMO;

[iv] review by Seclusion Monitoring Group as per paragraph 10 below;

9.3 If at any review at 8 hours or subsequently the doctor is not a consultant psychiatrist the doctor doing the review must consult with the patient's responsible medical officer or the duty consultant and this should be fully documented.

9.4 The senior manager/nurse will conduct a review on arrival on the ward within one hour of the decision to seclude and then in accordance with the agreed review schedule.

9.5 The nurse in charge will ensure that the patient's Consultant Psychiatrist, or their deputy is informed at the earliest opportunity. Others involved in the patient's care should also be informed.

9.6 Two qualified nursing staff will carry out a review of the seclusion every two hours. They will record the outcome in the observation record and they will both sign the entry.

9.7 Where practicable one of the nursing staff who carries out a review of seclusion should not have been involved in the original decision to seclude.

9.8 A Consultant Psychiatrist [who will be the RMO if available or their designated deputy, e g out of hours or during absence from hospital] must see the patient within 72 hours or on the first working day. If waiting until the first working day causes a delay, the duty Registrar must discuss the patient's care with the duty Consultant or RMO and seek agreement to the delay.

9.9 If the patient remains in seclusion for more than 8 hours continuously or for 12 hours intermittently within a period of 48 hours, an independent review of the need to continue seclusion will take place for this purpose. This should involve, where practicable, one or more clinicians who were not directly involved in the decision to seclude the patient as well as members of the Patient Care Team. However, at least one clinician taking part in the review must not have been involved in the decision to seclude the patient.

9.10 There is an appeal process available to all secluded patients, separate from and additional to the procedures set out within this paragraph. This process is set out at paragraph 16.

10 Monitoring arrangements

10.1 All seclusion used within the hospital is reviewed by a multi-disciplinary group known as the Seclusion Monitoring Group (SMG).

10.2 The functions of the group are as follows:

• to monitor the implementation and adherence to the policy and procedure for the use of seclusion

• to monitor and review the use of seclusion throughout the hospital

• to monitor and review patients secluded under conditions of paragraph 8 of the seclusion procedure

• to receive and analyse data relating to seclusion and to monitor overall trends in the use of seclusion

• to review documentation for the collection of information about the use of seclusion and alternative management strategies

• to examine training and educational needs to support staff mechanisms and make recommendations to the Hospital Authority Board

• to prepare and submit reports to Clinical Teams, Executive Directors, Authority Board

• to consider any other matters relating to seclusion that occur

• to share and disseminate good practice, hospital wide.

10.3 The Seclusion Monitoring Group is chaired by the Medical Director and reports to the Clinical Governance Committee.

11 The use of seclusion for patients posing management problems

11.1 Any patient for whom the clinical team has to institute seclusion in excess of seven days, will be individually brought to the attention of the Medical Director or in their absence the Executive Nurse Director, by the chairperson of the patient's clinical team, with a resume of the reasons for the continuing use of seclusion, the care and treatment which the patient will be receiving and what is hoped will be achieved.

11.2 The Medical Director will inform the Chief Executive and request a formal case presentation to the next planned meeting of the SMG.

11.3 The Medical Director and Executive Nurse Director, or two representatives of the Seclusion Monitoring Group acting on their behalf, must see the patient whether or not they are familiar with the case.

11.4 Following the case presentation at 10.2, monitoring arrangements will be agreed between the SMG and the patient's clinical team.

11.7 Each patient's case will be reviewed weekly by the clinical team and a written report sent monthly to the Seclusion Monitoring Group. At the initial review meeting, and with the patient's consent, consideration will be given by the team to notifying the patient's key relative(s).

11.8 After six months, the Medical Director and Executive Nurse Director will participate in a clinical team review. The case will then be discussed at the Executive Team Meeting.

11.9 The Mental Health Act Commission will be informed if seclusion continues beyond 7 days and will receive progress reports on a regular basis."

D. Evidence on the practice of seclusion at Ashworth

29. The Government provided the following information on the nature of Ashworth hospital, and the practice of seclusion there, in the form of witness statements, which had been before the domestic courts in the present case. Those statements were prepared by various senior clinicians at the hospital, including the applicant's Responsible Medical Officer.

30. Ashworth is one of three hospitals in England providing high security accommodation for persons detained under the Mental Health Act. It includes patients who cannot be reached by treatment and whose persistent illness renders them predictably dangerous. The aim of seclusion at Ashworth is to contain severely disturbed behaviour which is likely to cause harm to others. The majority of those secluded go into and come out

of seclusion within seven days. Those who are secluded for more than seven days are likely to be secluded for much longer periods. The common factor in such patients is a danger to others which is not liable to be resolved in the short term, and the decision to terminate seclusion is one to be made over days or even weeks, because of the need to be satisfied of the enduring nature of changes to the patient. Even in such cases, reviews and other safeguards exist to ensure that the patient will not be secluded for longer than necessary, including the possibility of more frequent medical reviews, if necessary.

31. The approach of Ashworth is to allow secluded patients the most liberal regime that was compatible with their presentation. Most patients are secluded in their own rooms and, only if that is not possible, in modified bedrooms or, in the most serious cases, in special seclusion rooms. Staff are always within sight and sound. Meals can be taken in-room or, if the risk permits, on the ward. Secluded patients received regular and frequent visits. Periods are also spent "in association" outside the room, either with staff or other patients, and can last up to several hours. Walks in a secure garden and occupational therapy are also possible.

E. Relevant national reports

1. Statistics on seclusion: Count Me In 2007

32. "Count Me In" is a national census of inpatients in mental health and learning disability services in England and Wales, which is carried out jointly by the Healthcare Commission, the Mental Health Act Commission and the National Institute for Mental Health in England. The 2007 census found that approximately 3% (957 of 31,187 patients surveyed) had experienced one or more episodes of seclusion in their period of admission (or in the previous three months, whichever was shorter).

2. Calls for the statutory regulation of seclusion

33. The Mental Health Act Commission is a statutory body under section 121 of the Mental Health Act 1983 and has the task, *inter alia*, of reviewing the operation of the Act and publishing a biennial report (section 121 (11)). Chapter 11 of the Mental Health Act Commission's Tenth Biennial Report (2001-2003) addressed the legality and practice of seclusion at length. It found that many hospitals failed to comply with the Code of Practice's provisions on seclusion and recommended that it was now appropriate to provide a framework of statutory regulation of seclusion (at paragraphs 11.17 and 11.24 of the report). A similar recommendation was made in its Eleventh Biennial Report (paragraphs 4.224 et seq.).

34. The Parliamentary Joint Select Committee on Human Rights considered seclusion of mental health patients as part of its report entitled

"Deaths in Custody" (Session 2003-2004, Third Report, 14 December 2004. The Committee concluded (at paragraphs 235 and 245):

> "We remain concerned at the evidence we have received, including from the statutory body responsible for review of mental health services, attesting to the low level of compliance with guidelines on the use of seclusion and of physical force against vulnerable people who have been deprived of their liberty. This situation carries a serious risk of breach of rights under Article 2, Article 3 and Article 8 of the Convention.
>
> ...
>
> [W]e remain concerned at the under-enforcement of guidance in this highly human rights-sensitive area. We are not confident that Convention compliance can be effectively and comprehensively ensured without some statutory obligations in this area. This should include statutory obligations on all health authorities to keep comprehensive records of all violent incidents."

35. In its report on the Mental Health Act 2007, during its passage as a Bill, the Joint Committee returned to the issue of seclusion and recommended:

> "We urge the Government to ensure that, whatever method of regulation is adopted, sufficient safeguards are included on the face of the bill to ensure that seclusion is only used when strictly necessary and that individuals subject to it should have access to review at intervals to ensure that it is brought to an end when no longer necessary."

36. The Mental Health Alliance (a coalition of seventy-five organisations working in the field of mental health) also campaigned for an amendment to the Mental Health Act 2007 to provide statutory regulation of seclusion. It adopted the views of the Joint Committee and the Mental Health Act Commission set out above. The proposed amendment was not adopted.

III. OTHER RELEVANT COMPARATIVE AND INTERNATIONAL MATERIALS

A. The United Nations Mental Illness Principles

37. On 17 December 1991, in resolution 46/119, the General Assembly of the United Nations adopted "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care". Principle 11 is entitled "Consent to treatment" and at paragraph 11 it provides:

> "Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified

members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient."

B. Relevant Council of Europe legal texts

38. Recommendation Rec2004 (10) of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder, where relevant provides as follows:

> **"Article 25 – Reviews and appeals concerning the lawfulness of involuntary placement and/or involuntary treatment**
>
> 1. Member states should ensure that persons subject to involuntary placement or involuntary treatment can effectively exercise the right:
>
> i. to appeal against a decision;
>
> ii. to have the lawfulness of the measure, or its continuing application, reviewed by a court at reasonable intervals;
>
> iii. to be heard in person or through a personal advocate or representative at such reviews or appeals.
>
> 2. If the person, or that person's personal advocate or representative, if any, does not request such review, the responsible authority should inform the court and ensure that the continuing lawfulness of the measure is reviewed at reasonable and regular intervals.
>
> ...
>
> **Article 27 – Seclusion and restraint**
>
> 1. Seclusion or restraint should only be used in appropriate facilities, and in compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed.
>
> 2. Such measures should only be used under medical supervision, and should be appropriately documented.
>
> 3. In addition:
>
> i. the person subject to seclusion or restraint should be regularly monitored;
>
> ii. the reasons for, and duration of, such measures should be recorded in the person's medical records and in a register."

39. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) is required to draw up an annual general report on its activities. The substantive sections of those reports are collected in CPT/Inf/E (2002) 1 - Rev. 2006: "the CPT Standards". Chapter V of the CPT standards covers involuntary placement in psychiatric establishments and paragraph 49 provides:

> "Reference should also be made in this context to the seclusion (i.e. confinement alone in a room) of violent or otherwise "unmanageable" patients, a procedure which has a long history in psychiatry.

> There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.
>
> Seclusion should never be used as a punishment."

C. "Residual liberty"

40. In *Miller v The Queen* (1985) 24 DLR (4th) 9), 12 October 1984, the Supreme Court of Canada considered whether a prisoner who had been placed within a "Special Handling Unit" at his normal place of detention could bring habeas corpus proceedings to challenge that placement. In finding that he could, the court stated that a prisoner was not without some rights or residual liberty and that there may be significant degrees of deprivation of liberty within a penal institution. In effect, a prisoner had the right not to be deprived unlawfully of the relative or residual liberty permitted to the general inmate population of an institution (Le Dain J for the Court at paragraph 32).

THE LAW

41. The applicant complained first that Ashworth's policy on seclusion, in departing from the Code of Practice, placed him at real risk of ill-treatment contrary to Article 3 of the Convention.

Second, he alleged that seclusion amounted to a further deprivation of liberty under Article 5 § 1 and was not prescribed by law in terms of that Article. He further alleged that there was no right of review or appeal to an independent body outside the hospital in violation of Article 5 § 4.

Third, under Article 8 he complained that the hospital's policy did not meet the requirement of being "in accordance with the law" since it lacked the necessary foreseeability and procedural safeguards.

Finally, he complained that there was a breach of Article 14 when taken with Articles 3, 5 and 8 of the Convention in that the United Kingdom Government's policy of permitting each hospital to seclude its patients according to its own procedures led to patients being treated differently depending on which hospital they were detained in, even though their conditions might be the same or materially similar. He alleged that this amounted to different treatment which was not justified under Article 14.

The applicable provisions of these Articles of the Convention are as follows.

Article 3 provides:

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

Article 5, where relevant, provides:

"1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

...

(e) the lawful detention of persons ... of unsound mind...

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

Article 8 provides:

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

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

Finally, Article 14 provides:

"The enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

I. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

A. The parties' submissions

1. The Government

42. The Government submitted that the applicant had not alleged that any of his four periods of seclusion had amounted to ill-treatment. Nor could it be suggested that seclusion at Ashworth attained the minimum level of severity required by Article 3.

43. None of the judges in the domestic proceedings had found that the applicant was at real risk of ill-treatment and the applicant's evidence had not established that he was at such a risk. It was also inappropriate in this context to apply the "real risk of ill-treatment" test, when the person concerned was within the jurisdiction of the Contracting State and within the control of the domestic authorities. Instead, it was appropriate to consider first, whether the State had taken general measures to ensure the effective protection of the applicant from Article 3 ill-treatment; second,

whether it had taken reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge (*Z and Others v. the United Kingdom* [GC], no. 29392/95, § 75, ECHR 2001-V); and third, in the present case, whether provision had been made for effective monitoring of the applicant while in seclusion (cf. *Rohde v. Denmark*, no. 69332/01, § 108, 21 July 2005).

44. In any event, the evidence of Ashworth made clear that the safeguards set out in the Policy were adequate and sufficient to prevent a real risk of ill-treatment. These included: the regular reviews provided for in the Policy (and the fact that the frequency of such reviews could be increased if necessary); the need for a nurse to be within sight and sound at all times; the fact that a doctor could be called at any time; and that there was no evidence that the applicant (or any other patient at Ashworth) had remained in seclusion for longer than was necessary. There was no real or immediate risk of ill-treatment in the applicant's case which would have required additional measures to be taken in relation to him.

2. The applicant

45. The applicant submitted that the "real risk of ill-treatment" test was the correct one; it was consistent with the Court's observations in both *Rohde*, cited above, § 97 and *L.C.B. v. the United Kingdom*, 9 June 1998, § 38, *Reports of Judgments and Decisions* 1998-III. It was consistent with the positive obligation under Article 3, as that obligation to take steps to guard against a breach could only arise where there was a risk of such a breach taking place. The risk did not need to come to pass in order for that positive obligation to be imposed on the State. It was therefore appropriate to ask: (i) whether there was a real risk that, but for the steps that the State could take, a person would suffer ill-treatment; and (ii) whether the State had taken steps sufficient to offer effective protection against that risk.

46. In his case, the applicant had adduced sufficient evidence to show that there was a real risk of ill-treatment if domestic law remained unchanged, not least because of the high vulnerability of detained psychiatric patients. This physical and psychological vulnerability increased with seclusion, owing to the range of risks to a patient's well-being that arose during seclusion. These included the need to discontinue the patient's regular treatment regime for the duration of seclusion and the psychological distress inherent in seclusion. These risks had been detailed by the Mental Health Commission in its reports (see paragraph 33 above). The Government were well aware of those risks; indeed, the real risk of harm and abuse in seclusion had provided the basis for the Code of Practice.

47. *Rohde*, cited above, was of limited relevance given that it had been concerned with solitary confinement in prison and not the seclusion of psychiatric patients. *Rohde* was also concerned with whether there was appropriate monitoring of an applicant whom the Court accepted was at risk

of suicide. By contrast, the concern in the present case was not just that there was inadequate monitoring at Ashworth, but also that there should be a positive obligation on the United Kingdom to ensure a uniform, rational and fair national minimum standard in order to protect against unnecessary or inappropriate seclusion.

3. The third party intervener

48. The third party intervener MIND (see paragraph 5 above) recalled that, in *Keenan v. the United Kingdom*, no. 27229/95, § 111, ECHR 2001-III, the Court had found that the authorities were under an obligation to protect the health of persons deprived of liberty, and the assessment of whether treatment or punishment was incompatible with the standard of Article 3 had, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment. Although there had been no alleged ill-treatment in the present case, there was still an obligation to put in place a legislative and administrative framework designed to provide effective deterrence against conduct that would breach the Convention. MIND also stressed the positive obligation to provide effective protection to vulnerable persons and to take reasonable steps to prevent ill-treatment (*Z and others*, cited above, § 73). The reasonable steps required to be taken depended on the particular circumstances of the case, but in the context of seclusion, this included regular views of seclusion backed up by a statement of reasons, which needed to be increasingly detailed and compelling the more time goes by (*Ramirez Sanchez v. France* [GC], no. 59450/00, § 139, ECHR 2006-IX) This was plainly of relevance to the present case where Ashworth's policy provided for fewer reviews as time went by.

B. The Court's assessment

49. The Court observes that the core of the applicant's complaint under Article 3 is that Ashworth's departure from the Code of Practice in respect of the number of reviews provided for during seclusion places him at real risk of ill-treatment contrary to that Article. However, the Court finds no basis for interfering with the finding of Lord Bingham (who spoke for the majority of the House of Lords on this point) that there was no evidence to support the proposition that the frequency of medical review provided in the policy risked any breach of Article 3 (see paragraph 29 of the House of Lords' judgment, quoted at paragraph 14 above).

50. Although the applicant in his submissions to the Court maintains that he adduced sufficient evidence to show that there is a real risk of ill-treatment in any future period of seclusion, the Court notes that all of the evidence which he has adduced was before the House of Lords. Given that it

is primarily for the domestic courts to assess the evidence before them, and that cogent reasons are needed before the Convention organs may depart from the findings of fact of the national courts (*Klaas v. Germany*, 22 September 1993, § 30, Series A no. 269), the Court is unable to reach a different conclusion from that of Lord Bingham.

51. It is also of some significance that the applicant does not allege that he was ill-treated during any of the previous four periods when he was secluded at Ashworth. Nor does he allege that Ashworth's policy was not followed each time. It is not apparent from his submissions why any risk of ill-treatment to him would increase simply because, in the later stages of seclusion, the Ashworth policy provides for less frequent reviews than under the Code of Practice, not least when subsequent reviews are conducted at increasing levels of seniority in the hospital and the policy requires that the Mental Health Act Commission be informed if seclusion continues beyond seven days.

52. Whatever the frequency of review of seclusion, the fact also remains that, under the policy, at all times, a nurse has to be within sight and sound of the seclusion room, periods of association are allowed and the conditions of seclusion can be adjusted according to the patient's condition. These factors significantly minimise the likelihood of any physical or psychological deterioration in a patient who is placed in seclusion.

53. Therefore, even assuming that the "real risk" test is appropriate in this context, there is nothing to indicate that the applicant is at real risk of ill-treatment during any future seclusion at Ashworth. The Court therefore finds that this complaint is manifestly ill-founded and must be rejected pursuant to Article 35 §§ 3(a) and 4 of the Convention.

II. ALLEGED VIOLATION OF ARTICLE 5 OF THE CONVENTION

A. The parties' submissions

1. The Government

54. The Government submitted that the applicant had already been lawfully detained at Ashworth and that his seclusion did not amount to a further deprivation of liberty within the meaning of Article 5. Seclusion at Ashworth was very different from solitary confinement, particularly when it was imposed only for the safety of the patient and others. The hospital's approach was to allow secluded patients the most liberal regime that was compatible with their presentation, for instance by allowing as much association and as many visits as possible (see paragraph 31 above). Moreover, patients at Ashworth were already in conditions of high security; the additional restrictions on secluded patients were not as significant as if the patient were being detained in conditions of medium or low security. In

this respect, the Government also submitted that the applicant's seclusion could be distinguished from *Schneiter v. Switzerland* (dec.), no. 63062/00, 31 March 2005, where the Court had found that Article 5 applied to the applicant's placement in solitary confinement. It appeared from the Court's decision in that case that the Swiss authorities had no rules or procedures in place to mitigate the harshness of the applicant's isolation. There was also nothing to indicate that the applicant in that case had been held in a high security hospital before being placed in isolation.

55. Alternatively the Government submitted that *Schneiter* had been incorrectly decided. It was inconsistent with the Court's prior decisions in *Engel and Others v. the Netherlands*, 8 June 1976, § 58, Series A no. 22 and *Ashingdane v. the United Kingdom*, 28 May 1985, §44 and 49, Series A no. 93. The wording of Article 5 § 1 could not properly bear the interpretation given to it in *Schneiter*: the ordinary meaning of "deprived" made it impermissible to construe Article 5 § 1 in this way. It would also be inconsistent with Article 5 § 4, which required release if detention were unlawful. Article 5 did not need to be extended when Articles 3 and 8 were capable of providing effective protection to secluded patients. Finally, such an extension would be unworkable given the flexibility of the Ashworth seclusion regime, where the precise restrictions imposed as a result of seclusion varied according to the risk a particular patient posed to others. It would be impossible to determine whether seclusion amounted to a deprivation of liberty when the length of periods of seclusion varied, as did the periods of association and time spent outside the seclusion room, especially when any period of association or time spent outside the seclusion room would clearly bring any "deprivation of liberty" to an end.

56. Finally, even if seclusion at Ashworth did amount to a deprivation of liberty, it met the "prescribed by law" requirement of Article 5 § 1. The possibility of bringing an application for judicial review was also sufficient to meet the requirements of Article 5 § 4.

2. The applicant

57. The applicant submitted that *Schneiter*, cited above, had been correctly decided and represented a clear endorsement of the concept of "residual liberty" by the Court (see *Miller v. the Queen* at paragraph 40 above). The Government's submissions to the contrary failed to recognise the heightened importance which people who had been deprived of their liberty felt in respect of any further restrictions upon their little remaining liberty. Moreover, the practice of seclusion was not limited to high security hospitals, but extended to all detained persons and to voluntary patients who had not been detained at all. Therefore it could not logically be said that the deprivation of some liberty by confining a patient to a hospital automatically deprived that person of all of their liberty.

58. *Schneiter* was consistent with the Court's earlier jurisprudence: *Ashingdane*, for instance, had not addressed the question of residual liberty at all. Contrary to the Government's submission, Article 5 § 1 could bear the interpretation placed on it by *Schneiter*: "release" in this context simply meant release from seclusion and return to ordinary conditions of detention. It was necessary to expand Article 5 precisely to afford patients its protection and it was workable to do so; it could be done by making the Code of Practice enforceable or enacting a scheme similar to that which governed solitary confinement of prisoners. The applicant also argued that, if Article 5 applied, then not every period of seclusion would require court review under Article 5 § 4; this could be limited, for instance, to periods of seclusion which lasted longer than seventy-two hours.

59. The applicant submitted that his seclusion had not been lawful under Article 5 § 1. He considered that the submissions made by MIND as to why seclusion was not in accordance with the law for the purposes of Article 8 (see paragraph 86 below) applied with greater force to Article 5.

60. There had also been a breach of Article 5 § 4 in his case. There was no external appeal from any decision by Ashworth to seclude. Although bringing proceedings in the High Court (by way of an application for judicial review or a writ of habeas corpus) was possible, such proceedings would not be an effective remedy. There were formidable practical obstacles to any secluded person bringing such proceedings and, upon any such application, the hospital would only have to show that the person had been lawfully detained and give reasons for the decision to seclude the person. The High Court was also not the appropriate forum for assessment of medical evidence.

B. The Court's assessment

1. Admissibility

61. The Court considers that the primary question it must determine in relation to this complaint is whether any of the applicant's four periods of seclusion amounted to a further deprivation of liberty for the purposes of Article 5 and, therefore, whether Article 5 § 1 applies. It considers that this question is closely linked to the merits of the applicant's complaints. It therefore joins this preliminary issue to the merits.

62. It finds that the case is not inadmissible on any other grounds and it therefore declares it admissible.

2. Merits

63. The Court recalls that in *Bollan*, cited above, where a lawfully detained prisoner, Angela Bollan, had been kept in her cell for less than two hours as an informal disciplinary measure, it found that disciplinary steps

could not be considered as constituting deprivation of liberty. Such measures had to be regarded in normal circumstances as modifications of the conditions of lawful detention and therefore fell outside the scope of Article 5 § 1 of the Convention. On the facts of that case, taking into account the type, duration and manner of implementation of the measure, the Court found that the confinement of Angela Bollan in her cell disclosed a variation in the routine conditions of her detention, the nature and degree of which did not in the circumstances involve a deprivation of liberty.

64. In *Schneiter*, cited, above, the applicant was detained by order of the prefecture in a psychiatric unit. He absconded but later returned of his own accord. He was then placed in solitary confinement and given forced medication. The solitary confinement lasted eleven days. The last nine days of detention had been found by the domestic courts to be unlawful. To determine whether the applicant had been deprived of his liberty for the other two days, as in *Bollan*, the Court considered the type, duration and manner of implementation of the measure. In light of those criteria, it took the view that placement in solitary confinement, which involved the removal of all social contact and lasted for several days, could be interpreted as a deprivation of liberty within the meaning of Article 5 § 1. The Court recalled that, though only two days' detention was at issue before it, the applicant's detention had, in reality, lasted eleven days. The Court distinguished *Bollan*, finding that the circumstances in that case were not comparable to placing in solitary confinement for eleven days a patient who had been confined to a psychiatric institution. Finally, the Court observed that it had been possible for Mr Schneiter to submit further appeals against his solitary confinement; this was an additional factor in favour of the finding that such confinement constituted a further deprivation of liberty. The Court went on to find, however, that the applicant's detention for the two days in question fell within the terms of the general police clause of the Constitution of the Canton of Berne and was not arbitrary within the meaning of Article 5 § 1 of the Convention.

65. Against the unusual factual background of the *Schneiter* case, the Court does not consider that, properly considered, *Schneiter* can be interpreted as laying down a general rule that either solitary confinement or seclusion *per se* can amount to a further deprivation of liberty, nor as having departed from the approach taken in *Bollan*, namely that whether or not there has been a further deprivation of liberty in respect of a person who is already lawfully detained must depend on the circumstances of case.

66. Indeed, as the Grand Chamber has recently reaffirmed (see *Austin and Others v. the United Kingdom* [GC], nos. 39692/09, 40713/09 and 41008/09, § 57, 15 March 2012), in determining whether someone has been deprived of his liberty, the starting point must be the applicant's concrete situation and account must be taken of a whole range of criteria, such as the type, duration, effects and manner of implementation of the measure in

question. The difference between deprivation of and restriction upon liberty is one of degree or intensity, and not of nature or substance.

67. The Court considers that these criteria must apply with greater force when determining whether a person who has already been deprived of his liberty has been subjected to a further deprivation of liberty or merely a further restriction upon their liberty.

68. In applying those criteria in the present case, the Court finds that, for the following reasons, none of the applicant's periods of seclusion at Ashworth amounted to a further deprivation of liberty.

69. First, in considering the applicant's concrete situation, the Court considers some weight must be attached to the fact that, at the time of his seclusion, the applicant was, and remains, a long-term patient in a high security hospital, one of only three such establishments in England and Wales. Thus, even when he was not in seclusion, he would already have been subjected to greater restrictions on his liberty than would normally be the case for a mental health patient.

70. Second, it is clear that seclusion, though coercive, was not imposed on the applicant as a punishment: both Ashworth's policy and the Code of Practice preclude seclusion from being used in this way (see paragraphs 23 and 27 above). Instead, as the information provided by the hospital demonstrates, the very purpose of Ashworth hospital is to house patients who cannot be reached by treatment and whose persistent illness renders them predictably dangerous (see paragraph 30 above) and the aim of seclusion at the hospital is to contain severely disturbed behaviour which is likely to cause harm to others. Moreover, it is not argued by the applicant that any of his periods of seclusion were unnecessary or failed to pursue this aim, nor has he argued that any of the four periods of seclusion had any significant or lasting adverse effects upon him.

71. Third, while the duration of the applicant's seclusion, particularly the latter three periods when he was secluded for 18, 14 and 9 days respectively, would point towards a further deprivation of liberty, the Court considers that this alone is not determinative of the question. The length of the applicant's seclusion was foremost a matter of clinical judgment. Seclusion could only continue for as long as those responsible for the applicant's care judged it necessary. It is true that, in exercising their judgment as to how long to prolong the applicant's seclusion in each of the four periods, the clinicians at Ashworth would have drawn on their experience that patients who were secluded for more than seven days were likely to be secluded for much longer periods, and that the decision to terminate seclusion was one to be made over days or even weeks (see the evidence submitted by the Government as summarised at paragraph 30 above). However, these considerations speak more to the need to ensure that there are proper safeguards in place to protect the rights of patients who are susceptible to long-term seclusion than to whether seclusion – either in itself

or as practised in the applicant's case – is a further deprivation of liberty within the meaning of Article 5 § 1 of the Convention.

72. Finally, of greatest weight to the Court's conclusion that there has been no further deprivation of liberty in the applicant's case is the manner in which his seclusion was implemented. The Court accepts Ashworth's evidence that its approach was to allow secluded patients the most liberal regime that was compatible with their presentation, including seclusion in their own rooms, the continual presence of staff, the opportunity to take meals in the ward, regular visits, and periods of association outside their rooms (see paragraph 31 above). The logs covering the applicant's four periods of seclusion bear this out. They show that, during each period of seclusion, the applicant enjoyed long periods of association and there was only one day when he was not allowed any association at all (see paragraph 6 above). They also demonstrate that seclusion was not applied strictly at Ashworth, but flexibly and with no fixed boundary between periods of confinement and periods of association. For this reason, and for the further reasons given above, the Court is satisfied that the applicant's seclusion did not amount to solitary confinement of the kind experienced by the applicant in *Schneiter*, still less a further deprivation of liberty within the meaning of Article 5 § 1 of the Convention.

73. The Court therefore finds that, since Article 5 is inapplicable, there has been no violation of Article 5 § 1 or Article 5 § 4 in this case.

III. ALLEGED VIOLATION OF ARTICLE 8 OF THE CONVENTION

1. Admissibility

74. The Court notes that this complaint is not manifestly ill-founded within the meaning of Article 35 § 3(a) of the Convention. It further notes that it is not inadmissible on any other grounds. It must therefore be declared admissible.

2. Merits

a. Was there an interference with the applicant's rights under Article 8?

75. The Court will first consider whether the seclusion of the applicant amounted to an interference with his private life.

i. The parties' submissions

76. The Government did not accept that any of the four periods of seclusion of the applicant amounted to an interference with Article 8 § 1 given: the high security conditions at Ashworth to which the applicant would have been subjected even if he were not in seclusion; the fact that he regularly spent periods in association throughout the four periods of

seclusion; and the fact that, under the regime applicable at the hospital, he would have been visited by staff on a regular basis.

77. The applicant contested that submission and adopted the observations of the third party, MIND, which considered that seclusion frequently constituted an interference with a patient's right to respect for his or her private life in that it was very likely to affect adversely his or her physical or psychological integrity, right to personal development and right to establish and develop relationships with other human beings and the outside world. It also interfered with a patient's right to personal autonomy. The Court had already found in *Storck v. Germany*, no. 61603/00, § 143, ECHR 2005-V, that even a minor interference with a person's physical integrity had to be regarded as an interference with private life if carried out against that person's will. MIND accepted that not all interferences with respect for private and family life arising out of lawful detention would engage Article 8 but argued seclusion could not be categorised as a normal restriction on hospital life.

ii. The Court's assessment

78. The notion of private life is a broad concept and covers, *inter alia*, the physical and psychological integrity of a person, the right to personal development and the right to establish and develop relationships with other human beings and the outside world. In addition, the notion of personal autonomy is an important principle underlying the interpretation of the guarantees of Article 8 (see *Pretty v. the United Kingdom*, no. 2346/02, § 61, ECHR 2002-III).

79. In assessing the proper scope of private life for those who are deprived of their liberty, the Court reiterates that, under the Convention system, the presumption is that detained persons "continue to enjoy all the fundamental rights and freedoms guaranteed under the Convention save for the right to liberty, where lawfully imposed detention expressly falls within the scope of Article 5 of the Convention" (*Hirst v. the United Kingdom (no. 2)* [GC], no. 74025/01, § 69, ECHR 2005-IX). Any restriction on those rights must be justified in each individual case (*Dickson v. the United Kingdom* [GC], no. 44362/04, § 68, ECHR 2007-XIII).

80. In applying those principles to the present case, the Court agrees that the compulsory seclusion of the applicant interfered with his physical and psychological integrity and even a minor such interference must be regarded as an interference with the right to respect for private life under Article 8 if it is carried out against the individual's will (*Storck*, § 143, cited above). Moreover, the importance of the notion of personal autonomy to Article 8 and the need for a practical and effective interpretation of private life demand that, when a person's personal autonomy is already restricted, greater scrutiny be given to measures which remove the little personal autonomy that is left.

81. In reaching this conclusion, the Court is mindful of Lord Bingham's doubts as to whether seclusion would amount to an interference with a patient's private life (see paragraph 16 above). There is considerable force in his view that a person would, when in a better mental state, agree that his or her seclusion was necessary to prevent harm to others. However, in the view of the Court, this is more relevant to the question whether seclusion is justified (in the sense of being proportionate to the legitimate aim of protecting the rights and freedoms of others) than to the question whether there has been an interference at all.

82. For similar reasons, the Court is unable to accept the Government's submission that consideration has to be given to the high security conditions at Ashworth to which the applicant would have been subjected even if he were not in seclusion. The Court observes that, as the "Count Me In 2007" census noted (see paragraph 32 above), nationally seclusion had been applied to a limited number of patients: less than three percent of those surveyed. Under the Ashworth policy each case of seclusion required a separate decision by hospital staff. Seclusion was not authorised unless it was considered necessary; for the remainder of the time, the applicant was free to associate under the normal conditions of detention of the hospital and, when each period of seclusion ended, he returned to those conditions of detention. Consequently, the four periods of seclusion must be regarded as additional interferences with the private life of the applicant, which were distinct from the inevitable interference with his private life that arose from his detention in high security conditions at Ashworth.

b. Was the interference "in accordance with law"?

i. The parties' submissions

α. The applicant

83. The applicant submitted that there was a greater need for precision when considering the law governing the circumstances of detained psychiatric patients because such persons were frequently at the mercy of the medical authorities (*Herczegfalvy v. Austria*, 24 September 1992, § 91, Series A no. 244). Procedural safeguards were also necessary in domestic law to prevent arbitrary or mistaken interferences with Convention rights (*T.P. and K.M. v. the United Kingdom* [GC], no. 28945/95, §§ 71-72, 80 and 83, ECHR 2001-V (extracts). Ashworth's policy did not fulfil these requirements because it could be changed whenever the hospital considered it appropriate. Instead, these requirements could only be met by the application of a consistent national standard; therefore, the Code of Practice had to be interpreted as having the force of law. The applicant also adopted the submissions made by the third party, MIND (see paragraph 86 below).

β. The Government

84. The Government submitted that decisions to initiate or continue seclusion were predicated on careful medical judgments, which involved a careful weighing of matters such as the mental well-being of the patient and the chance that he might assault others. In such circumstances, an absolutely certain body of rules would be neither achievable nor desirable. Furthermore, such decisions had to be taken quickly in response to emergency situations, making a relatively wide discretionary power appropriate (*X v. the United Kingdom*, 5 November 1981, § 41, Series A no. 46). The foreseeability of seclusion at Ashworth was guaranteed by the clear written guidelines set out in Ashworth's policy. The requisite protection against arbitrary interference was provided by both the detailed provisions of the Code of Practice, by the hospital's policy and by the availability of judicial review. In addition, under section 139(1) of the Mental Health Act 1983 a patient could bring civil or criminal proceedings in respect of any act purporting to be done in pursuance of the Act where that act was done in bad faith or without reasonable care.

85. In respect of the frequency of reviews provided for in Ashworth's policy, the Government argued that any interference with the applicant's Article 8 rights arose only from the decision to seclude him; no separate or distinct interferences arose from the presence or absence of particular medical reviews of whether the seclusion should continue. Even if this were so, the frequency of medical reviews was clearly foreseeable as this was set out in Ashworth's policy. Article 8 did not impose a requirement that such provisions be contained in a national standard. The House of Lords had authoritatively determined the status of the Code: a hospital had to consider it with "great care" and could only adopt a policy of less frequent reviews if it had "cogent reasons" for doing so (see Lord Bingham at paragraph 13 above). There was no proper basis upon which either the applicant or MIND could ask the Court to reconsider the status of the Code in domestic law. Finally, the applicant had accepted that individual departures from the Code of Practice would, in principle, be permissible in exceptional cases. However, this approach was, in fact, less foreseeable than allowing Ashworth to set out its policy in detail and in advance of its application in any particular case.

γ. The third party intervener

86. MIND submitted that, as a consequence of the House of Lords' judgment, the only law that was applicable to patients at Ashworth in relation to seclusion was the hospital's policy rather than the universal Code of Practice. There was, moreover, no reason why all 181 psychiatric hospitals in England and Wales could not reject the Code of Practice and introduce their own policies, as Lord Steyn had recognised in his dissenting opinion in the House of Lords (see paragraph 20 above). Non-binding

administrative policies were, in practice, likely to be unenforceable and inaccessible to patients and their representatives and therefore did not provide the necessary legal protection. Those policies were theoretically enforceable in judicial review proceedings but this was theoretical and illusory protection. The State could only meet its obligations to protect vulnerable psychiatric patients by promulgating national minimum standards binding on all psychiatric establishments. The Code of Practice was important and ought to have been binding because it had democratic legitimacy; it regulated the imposition of invasive restrictions on patients' lives, which were not regulated by the Mental Health Act 1983; it also provided greater detail as regards powers which were set out only summarily in the Act; it had universal application; it applied equally to public and private hospitals; and it applied to all patients admitted to mental health hospitals.

ii. The Court's assessment

87. The Court notes that the domestic proceedings in the present case turned primarily upon whether the legal basis for the applicant's seclusion could be provided by Ashworth's policy on seclusion or whether it could only be provided by according greater status to the national Code of Practice. However, it is not this Court's task to interpret domestic law or to adjudicate on whether a particular instrument has the force of law in a national legal system (*Kruslin v. France*, 24 April 1990, § 29, Series A no. 76-A; *Campbell v. the United Kingdom*, 25 March 1992, § 37, Series A no. 233). Consequently, the Court cannot accept the submissions of the applicant (and supported by MIND) that it should consider whether or not Article 8 § 2 requires that the Code of Practice be given the status of binding law. In any event, the Court finds that the issue it is required to determine under Article 8 § 2 is not whether the Code of Practice was (or should have been) binding but whether Ashworth's policy on seclusion can meet the requirements of the "quality of law" test as set out in the Court's case-law.

88. According to that case-law, the wording "in accordance with the law" requires the impugned measure both to have some basis in domestic law and to be compatible with the rule of law, which is expressly mentioned in the preamble to the Convention and inherent in the object and purpose of Article 8. The law must thus be adequately accessible and foreseeable, that is, formulated with sufficient precision to enable the individual – if need be with appropriate advice – to regulate his conduct (*S. and Marper v. the United Kingdom* [GC], nos. 30562/04 and 30566/04, § 95, 4 December 2008). It is also well-established in its case-law that the Court recognises the impossibility of attaining absolute certainty in the framing of laws and the risk that the search for certainty may entail excessive rigidity (*Silver and Others v. the United Kingdom*, 25 March 1983, §§ 88, Series A no. 61;

Sunday Times *v. the United Kingdom (no. 1)*, 26 April 1979, § 49, Series A no. 30). Instead, the level of precision required of the domestic legislation depends to a considerable degree on the content of the instrument considered, the field it is designed to cover and the number and status of those to whom it is addressed (*Hasan and Chaush v. Bulgaria* [GC], no. 30985/96, § 84, ECHR 2000-XI, with further references; and *Chorherr v. Austria*, 25 August 1993, § 25, Series A no. 266-B). With respect to the need for foreseeability, what is required is that, where discretionary powers are conferred on authorities, the law must indicate the scope of any such discretion conferred on the competent authorities and the manner of its exercise with sufficient clarity to give the individual adequate protection against arbitrary interference (see, among many authorities, *Liberty and Others v. the United Kingdom*, no. 58243/00, §§ 66-69, 1 July 2008; *Vlasov v. Russia*, no. 78146/01, § 125, 12 June 2008; *C.G. and Others v. Bulgaria*, no. 1365/07, § 39, 24 April 2008; and *Herczegfalvy*, cited above, § 89).

89. In applying those requirements to the applicant's seclusion under Ashworth's policy, the Court observes that the policy was certainly accessible; the real question is whether the discretion conferred on Ashworth to depart from the Code of Practice and to formulate its own seclusion policy met the requirement of foreseeability. In other words, it is necessary to consider whether, at the time of the applicant's four periods of seclusion, there was sufficient indication of the scope of discretion that Ashworth enjoyed and whether the manner of exercise of that discretion was indicated with sufficient clarity such as to protect the applicant against arbitrary interference with his Article 8 rights.

90. In the Court's view, determining the appropriate degree of discretion in this area is essentially one of balance between two competing considerations.

On the one hand, the State must be alive to the fact that people who are detained because they suffer from mental health problems – whether dangerous or not – are particularly vulnerable detainees. Seclusion, even when clinically justified, puts them in an even more vulnerable position than normal since they are, as the applicant has observed, at the mercy of those responsible for their care (see, *mutatis mutandis*, *Herczegfalvy*, cited above, § 91).

On the other hand, there is a need for appropriate deference to be accorded to expert mental health practitioners. At the operational level, it must be for practitioners to decide when seclusion will be the necessary and appropriate form of treatment for a particular patient. At the policy level, there will be a need to take into account the fact that not all hospitals will have the same type of patient or security classification. A degree of flexibility rather than excessive rigidity will be required in such a difficult and sensitive area of public health.

91. The Court considers that the majority of the House of Lords struck the right balance between these considerations. They found that a hospital could depart from the Code of Practice but, for that departure to be lawful, it had to be justified by cogent reasons. For Lord Bingham, this meant that, in reviewing any challenge to the Code, a court should scrutinise the reasons given by the hospital for departure "with the intensity which the importance and sensitivity of the subject matter requires" (paragraph 22 of the House of Lords' judgment quoted at paragraph 13 above). For Lord Hope, the requirement that cogent reasons be shown for any departure from the Code set a "high standard" which was not easily satisfied (paragraph 99, quoted at paragraph 17 above). Lord Scott endorsed the reasons given by Lord Bingham and Lord Hope (see paragraph 18 above).

It is clear therefore that, even though a majority of their Lordships accepted the need for Ashworth to have discretion in deciding whether to depart from the Code, they were anxious to ensure that appropriate limits were placed on that discretion.

92. Having considered all of the expert evidence before it, the majority also concluded that Ashworth had met the test that they had laid down. Lord Bingham was satisfied that Ashworth could legitimately depart from the Code because: (i) the Code was directed to the generality of mental hospitals and did not address the problems of high security hospitals; (ii) it did not recognise the special position of patients whom it was necessary to seclude for longer than a very few days; and (iii) the statutory scheme intended to leave the power and responsibility of decision to those bearing the legal and practical responsibility for detaining, treating, nursing and caring for patients (see paragraph 23 of the House of Lords' judgment, quoted at paragraph 13 above). Lord Hope found that, where Ashworth departed from the Code it did so because of its perception of the way seclusion needed to be used in the special circumstances that obtained at the hospital. He also found that the system set out in the Policy had been "carefully designed" to deal with the use of seclusion for much longer periods than the Code's guidance was designed for (see paragraph 96 of the judgment, quoted at paragraph 17 above).

In the Court's judgment, the very full reasons given by Lord Bingham and Lord Hope demonstrate that they gave intense scrutiny to whether Ashworth should be allowed to depart from the Code and that they were satisfied that Ashworth had provided the cogent reasons for departure which their Lordships required. There is nothing in the submissions of the applicant or MIND that would allow the Court, applying the same standard of intense scrutiny, to reach a different conclusion.

93. The Court recognises that a minority of their Lordships (Lord Steyn and Lord Brown) took the view that allowing Ashworth to depart from the Code would lead to widespread variations in practice, undermine the status of the Code and lower the protection offered by the law to mentally

disordered persons, a position that the applicant has adopted in his submissions to this Court (see paragraph 83 above). Nonetheless, the Court has some doubts as to whether such a submission falls within the scope of the present application, involving as it does questions of broader public policy than are at issue for the applicant who has, at all material times, been detained at Ashworth. In any event, the Court considers that this was answered by Lord Hope's observation that Ashworth was the only hospital to have departed from the Code in favour of its own seclusion policy, that it would be wrong to see the House of Lords' judgment as opening the door to substantial departures from the Code, and that the decision of the majority was not to be seen as an invitation to other hospitals to resort to their own policies (see paragraph 17 above). This Court has not been shown any evidence that the effect of the House of Lords' ruling has in fact been to encourage such widespread variations between mental hospitals in England and Wales.

94. Finally, the Court attaches some significance to the fact that, despite departing from the scheme of review set out in the Code, Ashworth tried to retain many of the Code's other procedural safeguards. For example, in formulating its own policy, Ashworth was meticulous in providing the "clear written guidelines" on its use of seclusion that paragraph 19.17 of the Code required (see paragraph 24 above). The policy was also exemplary in providing for a clear allocation of duties to those who were responsible for the decision to seclude the applicant and to those entrusted with his care during seclusion (see, in particular, paragraphs 6-8 of the policy, summarised at paragraph 27 above).

Lastly, there was a measure of external review of the decision to maintain seclusion beyond seven days. For instance, in addition to the need for weekly reviews by the multi-disciplinary patient care team, reviews had to be conducted by the hospital's Seclusion Monitoring Group, and the Mental Health Act Commission had to be informed and receive progress reports on a regular basis. As Lord Bingham observed, the Commission had the statutory power to visit and investigate any complaint; a secluded patient could, wherever possible, be visited by a relative; and the patient or his representative could appeal internally against seclusion and could seek judicial review of the seclusion or its conditions (see paragraph 14 above). In the Court's opinion, these internal and external safeguards show that Ashworth did not seek, and did not enjoy, unfettered discretion in deciding when to seclude the applicant.

95. For these reasons, the Court finds that, during each of the applicant's periods of seclusion, there was sufficient indication of the scope of discretion that Ashworth enjoyed and that the manner of this discretion was exercised with sufficient clarity to protect the applicant against arbitrary interference with his Article 8 rights. It concludes, therefore, that

Ashworth's policy was foreseeable and thus each period of seclusion was "in accordance with the law" for the purposes of Article 8 § 2.

c. Overall conclusion on Article 8

96. The Court notes that the applicant has not submitted that his seclusion failed to pursue a legitimate aim. Nor has he submitted that his seclusion had been unnecessary in a democratic society. The Court considers that there are no grounds to find that these requirements of Article 8 § 2 were not met. Accordingly, it finds no violation of Article 8.

IV. ALLEGED VIOLATION OF ARTICLE 14 OF THE CONVENTION

97. The Government submitted that, in respect of the complaints made under Article 14 when taken with Articles 3, 5 and 8, the applicant had not exhausted domestic remedies. No claim had been made under Article 14 in the course of the domestic proceedings and it clearly could have been. They relied on the fact that the applicant had been allowed to rely on Article 8 before the Court of Appeal when no formal claim had been made under that Article before the High Court.

98. The applicant made no submissions in reply to this preliminary objection. However, he maintained his original complaint that the Government, in allowing hospitals to depart from the Code of Practice, had created an unjustifiable difference in treatment for patients at different hospitals. He also submitted that there was an unjustifiable difference in treatment between patients who were subjected to seclusion and prisoners who were subjected to solitary confinement, since the latter enjoyed much greater substantive and procedural protection in domestic law.

99. The Court observes that, since it has declared the applicant's Article 3 complaint inadmissible and has found Article 5 to be inapplicable, the only remaining basis for the applicant's Article 14 complaint would be to consider it when read in conjunction with Article 8.

100. However, the Court considers that, particularly in the absence of any submissions from the applicant on the question of non-exhaustion, it must uphold the Government's preliminary objection. The Convention is, by virtue of the Human Rights Act 1998, an integral part of the legal system of England and Wales and thus Article 14 is directly applicable. It would have been open to the applicant to have relied expressly on Article 14 in the course of the domestic proceedings, yet he did not do so. Consequently, none of the domestic courts were able to examine the merits of his complaint under that Article. The Court therefore finds that the applicant has failed to exhaust domestic remedies in respect of this complaint. It is therefore rejected pursuant to Article 35 §§ 1 and 4 of the Convention.

FOR THESE REASONS, THE COURT UNANIMOUSLY

1. *Declares* the applicant's complaints under Articles 5 and 8 admissible and the remainder of the application inadmissible;

2. *Holds* that there has been no violation of Article 5 of the Convention;

3. *Holds* that there has been no violation of Article 8 of the Convention.

Done in English, and notified in writing on 17 July 2012, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

Lawrence Early	Lech Garlicki
Registrar	President