[2006] 4 All ER 736

R (on the application of Munjaz) v Mersey Care NHS Trust

[2005] UKHL 58

HOUSE OF LORDS
LORD BINGHAM OF CORNHILL, LORD STEYN, LORD HOPE OF CRAIGHEAD, LORD SCOTT OF FOSCOTE AND LORD BROWN OF EATON-UNDER-HEYWOOD

John Howell QC and Phillippa Kaufmann (instructed by Capsticks) for the trust.
Nigel Pleming QC and Fenella Morris (instructed by Hogans) for Mr Munjaz.
Richard Gordon QC and Paul Bowen (instructed by MIND Legal Unit) for MIND.
Clive Lewis and Ben Hooper (instructed by the Solicitor to the Department of Health) for the Secretary of State.

13 October 2005. The following opinions were delivered.

LORD BINGHAM OF CORNHILL.

[1]

My Lords, in December 2002 the appellant, the Mersey Care National Health Service Trust (the trust), as managers of Ashworth Hospital, implemented a written policy governing the seclusion of patients detained at the hospital. The issue in this appeal is whether that policy is unlawful, either because it is inconsistent with the domestic law of England and Wales or because it fails to comply with the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in Sch 1 to the Human Rights Act 1998). Sullivan J at first instance held the policy to be lawful in both respects ([2002] EWHC 1521 (Admin)). For reasons given in a judgment of the court delivered by Hale LJ, the Court of Appeal (also including Lord Phillips of Worth Matravers MR and Latham LJ) declared the policy to be unlawful ([2003] EWCA Civ 1036, [2004] QB 395, [2003] 3 WLR 1505). In this appeal the trust challenges that decision. Its legal submissions are supported by the Secretary of State for Health as an interested party. Mr Colonel Munjaz seeks to uphold the Court of Appeal decision. His submissions are supported and elaborated by the National Association for Mental Health (MIND). The Mental Health Act Commission makes written submissions in support of Mr Munjaz.

[2]

Ashworth Hospital is one of three hospitals (the others are Broadmoor and Rampton) which provide high security hospital accommodation and services for persons liable to be detained under the Mental Health Act 1983. The Secretary of State is bound by ss 1 and 4(1) of the National Health Service Act 1977 to provide

such accommodation for persons who 'in his opinion require treatment under conditions of high security on account of their dangerous, violent or criminal propensities'. It is not

in doubt that among those detained at Ashworth there are patients who, for differing periods and in differing degrees, but sometimes to an extreme degree, exhibit such propensities. The trust became the managers responsible for Ashworth with effect from 1 April 2002.

[3]

Mr Munjaz is a man now in his late 50s. After a number of spells in prison and hospital he was admitted to Ashworth from prison under ss 47 and 49 of the 1983 Act on 19 July 1984. He remained an in-patient until March 1992, when he was discharged by a 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. Since then he has been secluded on a number of occasions for the protection of others. In these proceedings he originally complained of four periods of seclusion in the years 2001–2002, the longest of these lasting for 18 days and the shortest for four. But, as will be seen, these complaints are not pursued. His claim now relates solely to the general lawfulness of the policy of the trust with respect to medical reviews of seclusion and its application to patients at Ashworth.

THE LEGISLATIVE BACKGROUND

[4]

The admission, detention and treatment in NHS hospitals of those suffering from mental disorder are largely governed by the 1983 Act. Part II of the Act governs compulsory admission to hospital and guardianship. Patients are ordinarily detained in hospital by the managers of the hospital acting on the authority of medical recommendations. At common law those who have custody of or treat or look after patients owe them a duty of care, but this duty is fortified by s 127 of the 1983 Act which makes it a criminal offence punishable by imprisonment to ill-treat or wilfully neglect a hospital in-patient.

[5]

Section 118(1) of the 1983 Act is central to this appeal and, as amended in 1995, provides:

> '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.'

This is followed by sub-s (2) which makes more particular provision for the code to address forms of treatment not falling within s 57(1)(a) or specified by the Secretary of State in regulations made by him for purposes of s 57(1)(b) but nonetheless calling for

special care in ensuring that the patient consents. Subsection (2) provides:

> 'The code shall, in particular, specify forms of medical treatment in addition to any specified by regulations made for the purposes of section 57 above which in the opinion of the Secretary of State give rise to special concern and which should accordingly not be given by a registered medical practitioner unless the patient has consented to the treatment (or to a plan of

> treatment including that treatment) and a certificate in writing as to the matters mentioned in subsection (2)(a) and (b) of that section has been given by another registered medical practitioner, being a practitioner appointed for the purposes of this section by the Secretary of State.'

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 (sub-s (3)). The code and any revised code must be laid before Parliament, and either House may within a specified period require its alternation or withdrawal (sub-ss (4), (5)). The code must be published (sub-s (6)).

[6]

By s 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 s 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 s 11 of the 1977 Act and continued by s 121(1) of the 1983 Act.

[7]

As is now well known, s 6(1) of the 1998 Act makes it unlawful for a public authority to act in a way which is incompatible with a convention right. It is not in doubt that the trust is a public authority. The victim of an act made unlawful by s 6(1) may bring proceedings under s 7(1) and obtain redress under s 8. The main convention rights here in issue are those provided in art 3, which prohibits the subjection of any person to torture or inhuman or degrading treatment or punishment, and art 8, which guarantees to everyone the right to respect for his private and family life, his home and his correspondence. This guarantee in art 8(1) is supplemented and qualified by para (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 . . . the prevention of disorder or crime, for the protection of health or morals, or for the protection of the

> rights and freedoms of others.'

Reference should also be made to art 5. This guarantees to everyone the right to liberty and security of person, and provides that no one shall be deprived of his liberty save in specified cases and in accordance with a procedure prescribed by law. The relevant case for present purposes is '(e) the lawful detention . . . of persons of unsound mind'. Article 5(4) provides:

> '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.'

[8]

If in any proceedings one of the higher courts determines that any provision of primary legislation is incompatible with a convention right, the court may so declare: see s 4(1), (2) of the 1998 Act. But the courts are subject to an unusual interpretative duty designed to obviate the need for such a declaration save exceptionally. Section 3(1) of the Act provides:

> 'So far as it is possible to do so, primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the Convention rights.'

THE SECRETARY OF STATE'S CODE OF PRACTICE

[9]

Pursuant to his duty under s 118(1) of the 1983 Act, following long and detailed consultation with appropriate bodies including the Mental Health Act Commission, and in accordance with the procedure prescribed by statute, the Secretary of State promulgated in March 1999 the code of practice relevant to this appeal. It was prefaced by a statement of guiding principles to guide interpretation of the code. These included principles that people to whom the 1983 Act applies should 'receive recognition of their basic human rights under the European Convention', should 'have their needs taken fully into account, though it is recognised that, within available resources, it may not always be practicable to meet them in full', and should 'be given any necessary treatment or care in the least controlled and segregated facilities compatible with ensuring their own health or safety or the safety of other people'.

[10]

The code covers a wide field, and most of its contents are irrelevant to this appeal. Chapter 19 covers 'Patients presenting particular management problems'. Part of this section is addressed to seclusion, defined in para 19.16 to mean '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. Thus seclusion should be used as a last resort and for the shortest possible time and should not be used as a punishment or threat, as part of a treatment programme, because of shortage of staff or where there is any risk of suicide or self-harm.

[11]

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.'

[12]

Succeeding paragraphs cover the procedure for seclusion and the frequency of medical reviews. They are in these terms:

> '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.'

There follow paragraphs in which the code addresses the conditions in which patients are to be secluded, the keeping of records and other matters.

THE ASHWORTH POLICY

[13]

In response to para 19.17 of the code (see [11], above), and in the light of an earlier judgment of Jackson J on 28 September 2000 ([2000] MHLR 183), the trust drew up the policy on seclusion which is challenged in these proceedings. The introduction to the policy draws attention to the special problems presented by patients at Ashworth. In para 2.4 it states:

> '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.'

The aims of the policy are set out in para 3 in terms which almost reproduce para 19.17 of the code, quoted in [11], above.

[14]

The policy repeats verbatim the definition of seclusion in the code (para 4.1: see [10], above). It repeats 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 (paras 4.2–4.3). It addresses the risk of self-harm (para 4.4). The aim of the policy is to protect the public, staff, visitors and patients within the hospital (para 4.5). It deals in detail with the conditions of seclusion (paras 5.1–5.6).

[15]

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 (para 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.

[16]

Because of their importance in this appeal, paras 9–11 of the policy must be quoted in full:

'9 Review

9.1 The RMO 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:—

[i] 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, eg 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.

[2006] 4 All ER 736 at 747

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.'

An appendix to the policy provides more detailed guidance on the conduct of the eight-hour review.

[17]

Paragraph 12 lays down a further requirement of record keeping. Paragraph 13 authorises the nurse in charge of the ward to terminate seclusion at any time. Paragraph 14.2.1 provides that visiting relatives should, whenever

possible, be allowed to visit a secluded patient. Paragraphs 15 and 16 are to this effect:

'15 Monitoring of Seclusion in Ashworth Hospital Authority

15.1 Regular performance management information on the use of seclusion will be reviewed daily by the Site Managers, regularly by Service Managers and monthly by Service Management Teams. Information will be reviewed by Executive Team and Ashworth Hospital Authority Board monthly. Review of Seclusion Policy and overall auditing will be the responsibility of the Clinical Governance Committee through the Clinical Audit and Effectiveness Committee. The Executive Nurse will provide regular reports to the Clinical Governance Committee.

16 Appeal

16.1 If a patient or patient's representative want to make any representations they can do so. These representations should be made to the Medical Director, or the Medical Director's nominated deputy, who will conduct a formal review, taking into account all representations as well as all the circumstances before making a decision.

16.2 The procedure is separate from and additional to the review procedure set out at paragraph 9 above, although any representations made by the patient or the patient's representative will be taken into account as part of the procedures set out under paragraph 9. This appeal procedure is to provide a further opportunity for representations to be made.'

IS THE ASHWORTH POLICY UNLAWFUL IN DOMESTIC LAW?

[18]

Mr Munjaz contends that the Ashworth policy is unlawful under the domestic law of England and Wales because it provides for less frequent medical review of seclusion, particularly after day 7, than is laid down in the code. If para 9.2.3 of the policy is compared with para 19.21 of the code it is indeed evident that the frequency of medical

reviews is significantly less under the policy than under the code.

[19]

The first question for consideration is whether the code issued by the Secretary of State falls within s 118(1) of the 1983 Act. The trust suggests that it does not, since it does not relate to 'admission', the subject matter of (a), and does not relate to 'medical treatment', the subject matter of (b). The judge held that the code fell within (1)(b) but not (1)(a): see para [73] of his judgment. The Court of Appeal ([2004] QB 395 at [72]) held that guidance on the use of seclusion can be issued under (1)(a) and (1)(b). I prefer the Court of Appeal's conclusion. 'Admission' cannot sensibly be read as referring only to the process of admission, to the exclusion of all that follows. Similarly, 'medical treatment' as defined in s 145(1) of the 1983 Act, a definition very similar to that considered and explained by my noble and learned friend Lord Hope of Craighead in Reid v Secretary of State for Scotland [1999] 1 All ER 481 at 494–496, [1999] 2 AC 512 at 529–531, is in my opinion an expression wide enough to cover the nursing and caring for a patient in seclusion, even though seclusion cannot properly form part of a treatment programme.

[20]

If, then, the code is issued under s 118(1), what is its legal effect in relation to those to whom it is addressed? The trust insists that it is guidance. That is what s 118 requires. The code itself states in its introduction:

[2006] 4 All ER 736 at 749

> 'The Act does not impose a legal duty to comply with the Code but as it is a statutory document, failure to follow it could be referred to in evidence in legal proceedings.'

It describes itself as guidance. There is a categorical difference between guidance and instruction. In calling (para 19.17) for hospitals to have clear written guidelines on the use of seclusion, the code acknowledges that hospitals are not bound simply to reproduce the terms of the code. The Secretary of State has a power to give binding directions to hospital authorities (see s 17 of the 1977 Act, in any of its recent amended forms) but that was not the power he was exercising when he issued the code. No express obligation was placed on hospitals to follow the guidance, an omission which contrasts with other provisions, discussed in the authorities, where such an obligation is found. In response, Mr Munjaz lays emphasis on the consultation which must (and certainly did) precede the drawing up of the code, on the Parliamentary sanction which it received, on the issue of the code by the Secretary of State as the public officer responsible for the National Health Service and on the high importance of protecting detained mental patients, a vulnerable and defenceless sector of society, from any risk of abuse. These considerations, it is said, show that the code was intended to be very much more than advice which hospital authorities might choose to follow or not to follow.

[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 s 118(2), 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 judge observed (at [36]), the trust 'has explained the justification for the policy in very considerable detail'. Witness statements were made by Dr Collins, who was Mr Munjaz's responsible medical officer, Dr James, a consultant psychiatrist and the medical director of the trust, Dr Finnegan, a consultant psychiatrist and the lead consultant for mental health services at Ashworth, Dr Davenport, consultant psychiatrist and the lead consultant for the women's service at Ashworth, Mr Barwood, the trust's executive director of nursing, and Mr Eley, the deputy director of nursing.

[23]

In considering the frequency of medical review after day seven 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 seven-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.

IS THE ASHWORTH POLICY INCOMPATIBLE WITH THE CONVENTION?

[25]

Mr Munjaz does not contend that it was inappropriate to seclude him on any of the four occasions when he was secluded. He does not contend that he was secluded for longer periods than his mental condition justified or that his periods in seclusion were longer than they would have been had his condition been the subject of medical review at the frequency indicated in the code rather than that in the Ashworth policy. He does not contend that the periods for which he was secluded, or the reduced frequency of medical review as compared with the code, had a deleterious effect on his mental or physical condition. The evidence of Dr Sophie Davison, a consultant forensic psychiatrist, which Mr Munjaz adduced in the Court of Appeal, precludes any of these contentions. Thus it is necessary to consider the compatibility with the convention of the policy as a policy. For this purpose the code is irrelevant: if the policy is incompatible, consistency with the code will not save it; if it is compatible, it requires no support from the code.

[26]

It is furthermore to be assumed for purposes of this discussion that the Ashworth policy is followed in the hospital, or at least that it is followed with that degree of regularity to be expected in a well-ordered and suitably staffed institution. This is a matter of some importance. For seclusion is universally recognised to be an unwelcome necessity of last resort, never a preferred option. It is justified only when used to protect others, and then for the shortest period necessary for that purpose. These restrictions are insisted upon because the potential injury which seclusion can cause to the psychological and physical health and well-being of a patient is, again, universally recognised. It is quite plain that, improperly used or continued, seclusion can violate a patient's convention rights, found claims under ss 6 and 7 of the 1998 Act, and give rise to common law

claims in tort. The focus of this appeal, however, is not on acts or omissions said to give rise to violations of convention rights but on the compatibility of the policy with the convention.

1. Article 3

[27]

As a party to the convention the United Kingdom is bound in international law, by art 1 of the convention, to secure to everyone within its jurisdiction the rights and freedoms with which this appeal is concerned. As a contracting party it is answerable for any failure to do so. But the internal distribution of powers within member states is not regulated by the convention. It is for them to resolve, through the democratic process, what power shall be exercised and by whom to secure the observance of convention rights. If, therefore, as in this case, Parliament chooses to establish a framework of binding statutory provisions, and to supplement those provisions by a code which will guide but not bind local managers and healthcare professionals, leaving the final decision to them, there is nothing in the convention which invalidates that decision. The evidence makes plain that there are those who would favour binding central direction on the use of seclusion, but that is not the choice which Parliament has made and not a course the Secretary of State supports. It is for the trust to secure observance of art 3 at Ashworth.

[28]

The trust must not subject patients at Ashworth to treatment prohibited by art 3. There is no evidence, and it is not suggested, that it has done so.

[29]

The trust must not adopt a policy which exposes patients to a significant risk of treatment prohibited by art 3. 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 judge (at [57]–[58]) that the policy must be considered as a whole, that the policy, properly operated, will be sufficient to prevent any possible breach of the art 3 rights of a patient secluded for more than seven 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 two 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 three 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. 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, two 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 seven 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

[2006] 4 All ER 736 at 752

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 seven days to any material risk of treatment prohibited by art 3.

2. Article 5

[30]

It does not appear that the potential applicability of art 5 was canvassed before the judge, but it was raised in the Court of Appeal. That court concluded ([2004] QB 395 at [69]) that while art 5 may avail a person detained in an institution of an inappropriate type (as in Bouamar v Belgium (1989) 11 EHRR 1 and Aerts v Belgium (1998) 5 BHRC 382) it cannot found a complaint directed to the category of institution within an appropriate system (as in Ashingdane v UK (1985) 7 EHRR 528). The approach to residual liberty which appears to have prevailed in Canada (see Miller v R (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 (at [70]), improper use of seclusion may found complaints under art 3 or art 8, and art 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 art 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.

3. Article 8

[31]

Mr Munjaz placed no reliance on art 8 before the judge, but Mr Gordon QC representing MIND as an interested party addressed argument on it to the Court of Appeal. He repeats that argument to the House, and Mr Pleming QC for Mr Munjaz adopts it.

[32]

It is obvious that seclusion, improperly used, may violate a patient's art 8 right in a serious and damaging way and may found a claim for relief. This appeal, however, is directed to the compatibility of the Ashworth policy with the convention, assuming it to be followed. I have, for my part, some difficulty in appreciating how seclusion can be said to show any lack of respect for a patient's private and family life, home or correspondence, if it is used as the only means of protecting others from violence or intimidation and for the shortest period necessary to that end. A detained patient, when in his right mind or during lucid intervals, would not wish to be free to act in such a way

and would recognise that his best interests were served by his being prevented from doing so.

[33]

If, however, it is accepted that seclusion, properly used in accordance with the policy, involves an interference by a public authority with the exercise of the patient's right under art 8(1), it is necessary to consider justification under art 8(2). Seclusion under the policy is plainly necessary 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. Properly used, the seclusion will not be disproportionate because it will match the necessity giving rise to it.

[2006] 4 All ER 736 at 753

[34]

Mr Gordon, on behalf of MIND, submits that the interference is not 'in accordance with the law' because not prescribed by a binding general law. I cannot for my part accept this. The requirement that any interference with the right guaranteed by art 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, a matter on which Mr Gordon places special emphasis, 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': see R v Broadmoor Special Hospital Authority, ex p S, H and D [1998] CA Transcript 143 per Auld LJ and the Court of Appeal judgment in the present case (at [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.

[35]

Since the trust's policy does not in my view violate any of the convention articles under consideration, there is no warrant for resorting to s 3 of the 1998 Act to give s 118 of the 1983 Act a meaning and effect other than that which Parliament gave to it.

[36]

The Court of Appeal gave the code a stronger effect than is in my view permissible. It said (at [76]):

> 'Hence 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.'

The considered judgment of a strong and experienced Court of Appeal naturally commands great respect. But this conclusion gives the code a weight which Parliament did not give it, which the Secretary of State does not support and which the convention context does not require. It deprives local managers of the judgmental authority they were given and intended to exercise, and so has a strong (and in my opinion impermissible) centralising effect. It elevates the authority of the code in a way for which there is no warrant in the statute or the code.

[37]

I would allow the appeal and, for reasons which are in large measure those given by the judge, dismiss Mr Munjaz's application for judicial review.

[2006] 4 All ER 736 at 754

LORD STEYN.

[38]

My Lords, the advance in the treatment and care of mentally disordered individuals since Victorian times has been great. On the other hand, mental health law has not entirely marched in step with the changing attitudes of society towards treating and caring for mentally disordered patients justly. The Mental Health Act 1983, the controlling statute, is out of date in its approach. Unfortunately, its modernisation in a comprehensive new statute, in conformity with evolving standards, has not yet been accomplished. In respect of the treatment of persons detained in high security mental hospitals, such as Ashworth Hospital, it has been left to so-called soft law, in the form of a code of practice issued by the Secretary of State, to fill in part the gap. The current code was published in March 1999. It addresses, to some extent, the problem of seclusion. It may not be much in terms of modern health law but at least the code is an attempt to set some modern standards. It is the best we have at present. But the present appeal raises the question of the status of the code.

[39]

The appeal concerns the use of seclusion in hospitals where mentally disordered patients are detained. The hospital involved is Ashworth Hospital. It decided not to adhere to the current code but instead to follow its own different policy statement. From the perspective of the individual patient it is probably right to say that Ashworth's policy statement represents a somewhat lesser order of protection of mentally disordered

patients than was contained in the code. That is the reason for the present case.

[40]

In my view the real issues on this appeal are: (1) What is the status of the code of practice (in so far as it covers seclusion) issued under s 118 of the 1983 Act as a matter of domestic and European Convention for the Protection of Human Rights and Fundamental Freedoms (as set out in Sch 1 to the Human Rights Act 1998) law? (2) Upon what basis, as a matter of domestic and convention law, is the seclusion of a patient, already detained under the 1983 Act, lawful?

[41]

The judgment of the Court of Appeal in this case has been reported: see R (Munjaz) v Mersey Care NHS Trust, R (S) v Airedale NHS Trust [2003] EWCA Civ 1036, [2004] QB 395, [2003] 3 WLR 1505. It is a judgment which demonstrates a thorough understanding of this sensitive and difficult branch of mental health law. I would respectfully pay tribute to it. Having had the advantage of testing the reasoning of the Court of Appeal in the light of detailed adversarial argument, I find myself in agreement with the Court of Appeal on essential points and in particular in respect of arts 3 and 8 of the convention the status of the code, and the conclusion reached (at [76]) that the hospitals may not depart from the code as a matter of policy. The minor error involved in the incorrect reference to s 7 of the Local Authority Social Services Act 1970 (at [73]) does not affect the central reasoning of the judgment.

[42]

The only part of the judgment of the Court of Appeal on which I would not adopt the reasoning and conclusion is in respect of seclusion and the applicability of art 5 of the convention. I will explain the point briefly. Under English law a convicted prisoner, sentenced to imprisonment, retains all his civil rights which are not taken away expressly or by necessary implication: see Raymond v Honey [1982] 1 All ER 756 at 759, [1983] 1 AC 1 at 10 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 R (1985) 24 DLR (4th) 9. The reasoning in Miller v R 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 is true that in Hague v Deputy Governor of Parkhurst Prison, Weldon v Home Office [1991] 3 All ER 733, [1992] 1 AC 58 the House of Lords ruled out this concept. Lord Jauncey of Tullichettle summed up the reasoning of the House ([1991] 3 All ER 733 at 755, [1992] 1 AC 58 at 176):

> '[The prisoner] is lawfully committed to a prison and while there is subject to the Prison Act 1952 and the Prison Rules 1964. His whole life is regulated by the regime. He has no freedom to do what he wants, when he wants. His liberty to do anything is governed by the prison regime.

> Placing Weldon in a strip cell and segregating Hague altered the conditions under which they were detained but did not deprive them of any liberty which they had not already lost when initially confined.'

Hague's case predates the 1998 Act. It is cast in the lexicon of the old law. It excluded a remedy for intolerable prison conditions on the basis of false imprisonment and breach of statutory duty. Lord Bridge of Harwich ([1991] 3 All ER 733 at 746, [1992] 1 AC 58 at 165–166) suggested a possible remedy in negligence. But as Feldman Civil Liberties and Human Rights in England and Wales (2nd edn, 2002) p 440, has pointed out:

> 'the remedies depend so heavily on the supply of resources from government that it is hard to imagine that a duty of care in tort would ever be adequate to provide a remedy for those who are condemned to live in [inhuman and degrading] conditions.'

In Hague's case Lord Bridge observed ([1991] 3 All ER 733 at 746, [1992] 1 AC 58 at 166): 'In practice the problem is perhaps not very likely to arise'. It is not to be assumed that in 2005 such conditions do not sometimes occur in our prisons. Under domestic law Hague's case effectively denies prisoners any effective remedy for a breach of their residual liberty. Even in respect of convicted prisoners Hague's case should no longer be treated as authoritative. A fortiori Hague's case should not be applied to the relationship between a detained patient and the managers of the hospital. After all, unlike prisoners who committed crimes of their own volition, mentally disordered patients are not guilty of any legal or moral culpability.

[43]

It would also be wrong to assume that under the jurisprudence of the convention residual liberty is not protected. There is relevant European authority not placed before the Court of Appeal. In Bollan v UK App No 42117/98 (4 May 2000, unreported), 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 dealt with the legal principles arising under the convention 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 art 5(1) of the convention (see X v Switzerland (1977) 11 DR 216). In appropriate cases, issues may arise however under arts 3 and 8 of the convention.' (My emphasis.)

Plainly, the European Court 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 European Court observed that in such cases 'in appropriate cases, issues may arise however under arts 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 arts 3 and 8, the case for protection under art 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.

[44]

In relation to the status of the code, I am in full agreement with the reasoning of the Court of Appeal. The code was plainly issued under s 118(1)(a) and (b) of the 1983 Act. It is a very special type of soft law. It derives its status from the legislative context and the extreme vulnerability of the patients which it serves to protect. In the context of the code the Court of Appeal explained (at [11]), and I accept, that the concern about seclusion lies 'in the combination of the potentially harmful or degrading effects of seclusion upon the patient and its potential for misuse by those looking after him'. This is the contextual scene of s 118(1). It is wrong to focus exclusively or even primarily on the dictionary meaning of 'guidance'. In a careful analysis Mr Pleming QC relied in addition to the reasons given by the Court of Appeal on the fact that s 118(2) provides that 'the code shall, in particular, specify forms of medical treatment' which 'should accordingly not be given by a registered medical practitioner unless the patient has consented to the treatment'. He pointed out that the preceding White Paper of November 1981 observed that the code 'might include references to treatments such as electro-convulsive therapy when used in particular circumstances, long acting drugs, and behaviour therapies': see Reform of the Mental Health Legislation (para 39). These examples reveal that in s 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.

[45]

Another internal aid to the interpretation of s 118 mentioned by Mr Pleming is s 121 which deals with the Mental Health Act Commission. Section 121(4) provides:

> 'The Secretary of State may, at the request of or after consultation with the Commission and after consulting such other bodies as appear to him to be concerned, direct the Commission to keep under review the care and treatment, or any aspect of the care and treatment, in hospitals and mental nursing homes of patients who are not liable to be detained under this Act.'

This provision is in line with the idea of centralised minimum safeguards. It throws light on the dynamic role that a code issued under s 118 was intended to play.

[46]

The Court of Appeal applied the dictum of Sedley J in R v Islington London BC, ex p Rixon (1996) 32 BMLR 136 at 140, that local authorities may only depart from the Secretary of State's guidance for good reason. The Court of Appeal observed that there is a considerable difference between the Wednesbury approach (see Associated Provincial Picture Houses Ltd v Wednesbury Corp [1947] 2 All ER 680, [1948] 1 KB 223) and the Ex p Rixon approach. Counsel for the Secretary of State and the trust challenged this approach. They were mistaken. In the present case fundamental rights are at stake and even before the 1998 Act an intense review on principles of proportionality was appropriate: see R v Secretary of State for the Home Dept, ex p Leech [1993] 4 All ER 539, [1994] QB 198, which was affirmed in R v Secretary of State for the Home Dept, ex p Simms [1999] 3 All ER 400, [2000] 2 AC 115 and in R v Secretary of State for the Home Dept, ex p Daly [2001] UKHL 26, [2001] 3 All ER 433, [2001] 2 AC 532. The concrete differences between the Wednesbury and proportionality approaches was concretely described in Daly's case. In a speech made with the approval of the House I observed (at [27]):

> '. . . First, the doctrine of proportionality may require the reviewing court to assess the balance which the decision maker has struck, not merely whether it is within the range of rational or reasonable decisions. Secondly, the proportionality test may go further than the traditional grounds of review in as much as it may require attention to be directed to the relative weight accorded to interests and considerations . . .'

The application of these established principles, wholly appropriate to the context of fundamental rights, reinforces the conclusion of the Court of Appeal. That conclusion was stated with precision (at [76]) as follows:

> 'Hence 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.'

Given the manifest dangers inherent in seclusion, and the extreme vulnerability of the patients, I regard this conclusion as sound. It is a corner of mental health

law in which a dilution of minimum centrally imposed safeguards, by pragmatic policy decisions from hospital to hospital, is not appropriate.

[47]

In para 40 of the printed case of Mr Munjaz the resultant picture and implications are graphically illustrated:

> '. . . Ashworth, and any detaining hospital, can now substitute 3 (or 4) medical reviews for the 42 required by the Code of Practice during days 8 to 14. [Mr Munjaz's] complaint is not that he can be secluded for one or two more hours without a Code of Practice medical review, but that he could be secluded for 72 hours without such a review. If such wholesale departures from the Code can be made on the basis of the views of the hospital managers, there is no logical reason why Ashworth should not reduce its medical reviews yet further, depending only on its rational view of its needs and its resources. Why not a medical review every week, every month? Certainly, Ashworth cites approvingly [in para 95 of its printed case] in support of its position, cases where monthly review of segregated prisoners has been held to be lawful. A national Code of Practice provides the necessary checks and balances for this otherwise unregulated activity.'

This is a disturbing picture.

[48]

If Ashworth Hospital is permitted in its discretion to reject the code, lock, stock, and barrel, regarding seclusion, it will be open to other hospitals to do so too. The code would then be seriously undermined. For my part the endorsement of the code by the Secretary of State makes his virtual disowning of the code in these proceedings difficult to understand. Compared to the judgment of the Court of Appeal the judgment of the majority of the House permits a lowering of the protection offered by the law to mentally disordered patients. If that is the law, so be it. How society treats mentally disordered people detained in high security hospitals is, however, a measure of how far we have come since the dreadful ways in which such persons were treated in earlier times. For my part, the decision today is a set-back for a modern and just mental health law.

[49]

I would dismiss the appeal of the trust.

LORD HOPE OF CRAIGHEAD.

[50]

My Lords, at the heart of this case there lies a dispute about the proper use and regulation of seclusion as a means of controlling seriously disturbed behaviour on the part of mental patients detained in psychiatric hospitals. There is general agreement that the sole aim of this procedure is to control such behaviour where it is likely to cause harm to others. There is general agreement also as to the nature of the procedure. It consists of the supervised confinement of the patient in a room which may be locked to protect others from significant harm. But opinions differ sharply as to the length of time for which it may be proper to resort to it. This in turn affects the degree to which seclusion in practice interferes with the patient's personal autonomy, the extent to which it is possible for the state by means of a uniform code to regulate this and the way in which the patient's interests are to be safeguarded.

[51]

Section 118(1) of the Mental Health Act 1983, as amended by s 1(2) of and para 16 of Sch 1 to the Mental Health (Patients in the Community) Act 1995 and s 116 of and para 9 of Sch 4 to the Care Standards Act 2000, directs the Secretary of State to 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 approved social workers in relation to 'the admission of patients' to hospitals and

to guardianship and after-care under supervision under the 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'. Section 118(2) provides that the code shall in particular specify forms of medical treatment which give rise to special concern and which should accordingly not be given by a registered medical practitioner unless the patient has consented to the treatment. Seclusion is not a form of treatment that falls within the scope of that subsection, but its provisions have a bearing on the status that should be accorded to the code by the legal system within which it is to operate.

[52]

The code of practice which is currently in issue (the code) was published in March 1999. It contains detailed guidance on various matters of practice, including the admission of mental patients and their treatment and care in hospital. Chapter 19 deals with patients presenting particular management problems who behave in a way that disturbs others or whose behaviour may present a risk to themselves or others around them or those charged with their care. Among the topics covered in this section are general preventative measures, restraint, methods of restraining behaviour and the use of medication, locked wards and secure areas. It has not been suggested that the ways these

topics are dealt with has given rise to difficulty. The dispute which has given rise to this litigation relates to the way the code deals with seclusion. This topic is dealt with in paras 19.16–19.23.

[53]

Paragraph 19.16 defines seclusion in these terms:

> '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.'

It also contains guidance as when this procedure should and should not be used. Paragraph 19.17 provides that hospitals should have clear written guidelines on the use of seclusion which should, among other things, set requirements for recording, monitoring, reviewing the use of seclusion and any follow-up action. But the code was not content to leave these matters entirely to the discretion of each hospital. Detailed guidance is provided in the paragraphs that follow as to the procedure that should be adopted, including the frequency of reviews of the need to continue the procedure, as to the conditions of seclusion and as to record keeping.

[54]

The code applies to the management of all patients admitted to mental hospitals in England and Wales. They include so-called informal patents who are admitted without any application, order or direction as well as those who are liable to be detained in a hospital under s 3 of the 1983 Act. The Secretary of State was obliged by s 118(3) before preparing or altering it to consult with such bodies as appeared to him to be concerned. It had also to be laid before Parliament, where it was subject to the negative resolution procedure of either House, and it had to be published: see s 118(4)–(6). It has the support of the Royal College of Psychiatrists and of the Mental Health Act Commission, among whose functions is to make proposals to the Secretary of State as to what it should contain. The majority of mental patients are informal, and the majority of the institutions in which they are detained are independent of the National Health Service. One of the virtues of the code is that it is able to provide clear standards and practical norms that are capable of being applied by all hospitals and all healthcare facilities.

[55]

Ashworth is one of three hospitals (the others being Rampton and Broadmoor), formerly known as 'special hospitals', that were established to treat only those mental patients who require treatment under conditions of high security on account of their dangerous, violent or criminal propensities. In February 1999 the Ashworth Special Hospital Authority (Ashworth) issued its own Seclusion Procedure which made provision for the frequency of reviews of the need to continue the procedure which departed in several respects from that set out in the version of the Secretary of State's code that was then in issue. This statement of the procedure to be used at Ashworth was the subject of

proceedings for judicial view by the respondent, Mr Colonel Munjaz, in 1999. Following a judgment given by Jackson J on 28 September 2000 ([2000] MHLR 183), who held that the provisions for review which it contained were not ones which a reasonable authority could adopt, a review of Ashworth's seclusion policy was conducted and a new policy was formulated. It was ratified by the Regional Board of the National Health Service on 6 November 2002 and it was put into effect from 6 December 2002 by the appellant, Mersey Care National Health Service Trust, which had assumed responsibility for Ashworth. This is the policy (the policy) which is said in this case to be unlawful.

[56]

In the introduction to the policy it is noted that Ashworth Hospital admits patients with mental disorder who are considered to present a grave and immediate risk to the public and who present a risk to other patients, staff, visitors or the general public which cannot be managed in conditions of lesser security including medium security. Reference is made to particular reasons for referral which include the fashioning of weapons from items in common use such as furniture and cutlery, the taking of hostages, the possession of skills which could lead to serious injury and the use of techniques to plan and commit assaults which involve other patients and general subversion of day to day routines and practices. It is expected that patients will only be referred to Ashworth when conditions of lesser security have exhausted all appropriate management interventions. For such patients it is often the case that all other usual interventions such as psychological interventions and alterations in drug treatment have been tried, and the increased relational procedure and the perimeter security at Ashworth is considered necessary to add to the individual patient's treatment plan.

[57]

It is in the light of this background that the introduction to the policy then explains why it was decided that it was necessary to devise a policy which was specially designed to address the use of seclusion at Ashworth:

> 'Seclusion in this policy is as defined in the Code of Practice [19.6] (sic). 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. This is an intervention which good clinical and professional practices dictate should only be used when other less restrictive interventions are inadequate. Special considerations need to be applied to the use of seclusion in a high secure hospital given that patients have been referred to the hospital because the usual range of interventions available within Mental Health Services have failed to protect others from harm. The policy on seclusion in Ashworth Hospital needs to reflect this.'

The same point is made in para 2.4 of the policy, which states:

> '. . . 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.'

[58]

The policy deals with a variety of matters, many of which are not the subject of criticism. Paragraph 3 sets out its aims, which are taken word for word from the list of items in para 19.17 of the code about which hospitals are told they should have clear written guidance. Paragraph 4 contains a policy statement about the use of seclusion. Here too the guidance in the code is followed word for word. In para 5, which deals with the environment for seclusion and the maintenance of dignity and care and support, the guidance in para 19.22 of the code is adopted and elaborated upon. Paragraph 6 deals with the decision to seclude. In substance it repeats the guidance in para 19.18 of the code, but here too it is elaborated upon. Paragraph 6.2, for example, states that if a member of staff has been threatened or attacked by a patient they should so far as possible not be involved in the decision to seclude—a point not dealt with in the code, which does not mention incidents of this character or offer any advice as to how to deal with them. Details are set out in para 7 of how patients who are in seclusion are to be observed and cared for and in para 8 of the way records are to be kept. Here again the advice given in paras 19.19 and 19.20 of the code is followed and elaborated upon. One such elaboration is the requirement in para 8.4 of the policy that a detailed management plan for management of the ending of seclusion should be prepared in all cases to ensure the earliest possible ending of seclusion. There is an indication here that it was not envisaged that seclusion would be used at Ashworth for a brief period, such as one of no more than five minutes as para 19.18 of the code envisages.

[59]

The point of departure from the code is in para 9 where the policy deals with regular reviews of the use of seclusion. The system of review described in para 19.18 of the code is modified from the first day up to day seven. Thereafter the frequency of regular reviews is reduced very considerably. Paragraph 9.2.3 provides that from day eight onwards there are to be (i) a daily review by the ward manager or a site manager from a different ward, (ii) three medical reviews every seven days (one being by the patient's responsible medical officer (RMO), (iii) a weekly review by a multi-disciplinary patient care team which is to include the RMO and (iv) a review by a multi-disciplinary group known as the Seclusion Monitoring Group whose functions are set out in para 10. Paragraph 11.1 provides that the case of any patient for whom the clinical team has to institute seclusion in excess of seven days will be 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 it is to be hoped will be achieved. Monitoring arrangements are to be agreed between the Seclusion Monitoring Group and the patient's clinical team, the patient's case is to be reviewed weekly by the clinical team and a report sent monthly to the Seclusion Monitoring Group and after six months the medical director and the executive nurse director are to participate in a clinical team review: paras 11.4–11.8. Paragraph 11.9 provides that the Mental Health Act Commission will be informed if seclusion continues beyond seven days and that it will receive progress reports on a regular basis.

[60]

It is important to appreciate that much of what is in the policy complies with and elaborates upon the guidance which the code offers. The departure from that guidance is explained by Ashworth's perception of what is needed for the

management of the patients detained there whose behaviour falls outside the normal pattern of that exhibited by mental patients generally in terms both of the risk it offers and its duration. There is a genuine and respectable difference of view among those who are responsible for the formation of policy in this difficult and highly specialised field as to the parameters within which seclusion may properly be resorted to, including the length of time for which it may continue before it is terminated.

[61]

In a letter to Ashworth's solicitors dated 27 March 2002 the Mental Health Act Commission said that it was perhaps true that the code was written on the assumption that seclusion as a last resort response to dangerous behaviour should not normally still be in place after three days, no matter how disturbed the patient might be at the time of the seclusion. The Commission's view was that in that event other methods of management should be resorted to:

> 'It is arguable, for instance, that, by the time a patient has been secluded for three days, arrangements should have been considered for alternative management of the patient, such as a trial period of one to one (or more intensive) nursing, etc. The Commission takes the view that, where seclusion as defined by the Code of Practice does continue past 72 hours, the need for rigorous monitoring and review of its continuance is a pressing need.'

In para 12.26 of its Tenth Biennial Report 2001–2003 the Commission repeated these observations, adding that it would wish to see such alternatives implemented. Ashworth has however made it clear that it wishes to adhere to the system of monitoring and review set out in its policy.

[62]

This dispute is not something on which judges are competent to adjudicate. But the law is not blind to the importance of the issue in the wider context, as it is in the interests of all mental patients that the use of this highly intrusive procedure should be properly regulated.

THE ISSUES

[63]

The first question then is whether it is lawful under domestic law for Ashworth, for the reasons indicated by these passages in the introduction to the policy, to depart from the

code and devise and apply its own seclusion policy. The status that is to be accorded to the code lies at the heart of this question. This is an important issue of general public importance. The second question is whether, assuming that it was otherwise lawful in domestic law, the relevant parts of the policy are incompatible with the respondent's rights under the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in Sch 1 to the Human Rights Act 1998).

DOMESTIC LAW

[64]

The question for resolution under domestic law is whether it was unlawful for Ashworth's policy to depart from the provisions in the code of practice about the frequency of medical reviews where seclusion is resorted to. Section 118(1) of the 1983 Act provides that the code is to be prepared 'for the guidance' of those to whom it is addressed. The code itself states in para 1 of the introduction that, while the Act does not impose a legal duty to comply with it, as it is a statutory document failure to follow it could be referred to in evidence in legal proceedings. As Mr Lewis for the Secretary of State pointed out in his written case, s 118(1) does not impose an express obligation on anyone to 'have regard' to the code. But he said that it is implicit in the subsection that those to whom it is addressed are under an

obligation to have regard to it in reaching any decisions on matters which fall within its scope.

[65]

This interpretation of its effect, which is subscribed to also by Ashworth, is to be contrasted with the view of its status that the Court of Appeal expressed in its judgment ([2003] EWCA Civ 1036 at [76], [2004] QB 395 at [76], [2003] 3 WLR 1505):

> 'Hence 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.'

[66]

The first point that has to be considered is whether there is a statutory base for the guidance that the code gives on seclusion. Does it fall within the scope of s 118(1) of the 1983 Act? Section 118(1)(a) provides for the giving of guidance 'in relation to the admission of patients to hospitals'. Section 118(1)(b) provides for the giving of guidance 'in relation to the medical treatment of patients suffering from mental disorder'. A narrow

reading of these two phrases might suggest that seclusion falls outside the scope of the matters which are to be dealt with by means of a code of practice prepared by the Secretary of State under this subsection. But the purpose of the statute requires a broader view to be taken. I agree with the Court of Appeal that the words 'the admission of patients to hospitals' cannot in this context be limited to the actual admission process so as not to include anything that happens thereafter while the patient is detained in hospital: see [2004] QB 395 at [72]. The expression 'medical treatment' is defined in s 145(1) of the 1983 Act as including, as well as nursing, care, habilitation and rehabilitation under medical supervision. In my opinion it includes all manner of treatment under medical supervision of those suffering from mental disorders from cure to containment. It includes treatment under medical supervision which is designed to alleviate or prevent a deterioration of the patient's condition, even if it will have no effect on the disorder itself. As para 15.4 of the code puts it, it covers the broad range of activities aimed at alleviating, or preventing a deterioration of, the patient's mental disorder.

[67]

Seclusion is not part of the patient's treatment. Paragraph 19.16 of the code states that it is not to be used as part of a treatment programme. But it aims to contain severely disturbed behaviour, the decision to resort to it is made by a nurse or a doctor and it is supervised by medical staff in the hospital. So it falls well within the scope of the phrase 'the medical treatment of patients suffering from mental disorder' on which the Secretary of State is directed by s 118(1)(b) to give guidance. The fact that the guidance on seclusion appears under the general heading 'Treatment and Care in Hospital' and in a section dealing in particular with patients presenting particular management problems suggests that those who wrote the code had this paragraph of s 118(1) in mind when they were framing it rather than the paragraph that refers to the admission of patients to hospitals. I would hold that the statutory base for its guidance on seclusion is to be found in s 118(1)(b) of the 1983 Act.

[68]

Then there is the question of the code's status. What does 'guidance' mean in this context? There is no statutory obligation to comply with it. But it cannot be

divorced from its statutory background, from the process of consultation and from the parliamentary procedure that must be gone through before it is published under s 118(6) as 'the code as for the time being in force'. Statutory guidance of this kind is less than a direction. But it is more than something to which those to whom it is addressed must 'have regard to'.

[69]

The Court of Appeal said (at [76]) that the code is something that those to whom it is addressed are expected to follow unless they have good reason for not doing so: see R v Islington London BC, ex p Rixon (1996) 32 BMLR 136 at 140 per Sedley J. Like my noble and learned friend Lord Bingham of Cornhill I would go further. They must give

cogent reasons if in any respect they decide not to follow it. These reasons must be spelled out clearly, logically and convincingly. I would emphatically reject any suggestion that they have a discretion to depart from the code as they see fit. Parliament by enacting s 118(1) has made it clear that it expects that the persons to whom the code is addressed will follow it, unless they can demonstrate that they have a cogent reasons for not doing so. This expectation extends to the code as a whole, from its statement of the guiding principles to all the detail that it gives with regard to admission and to treatment and care in hospital, except for those parts of it which specify forms of medical treatment requiring consent falling within s 118(2) where the treatment may not be given at all unless the conditions which it sets out are satisfied.

[70]

If good reasons are required for departing from the system that the code sets out for the monitoring and review of the use of seclusion, there are ample grounds for thinking that they have been well demonstrated at Ashworth. There is no doubt that the situation there differs from that in the generality of institutions in which mental patients who are severely disturbed may find themselves. As the introduction to Ashworth's policy states, special considerations need to be applied to the use of seclusion in a high security hospital, bearing in mind that the very reason why patients are there is because they cannot be dealt with by mental health services elsewhere in a way that will protect others from harm. The code does not address this problem. Nor is it designed to do so, as s 118(1) does not provide for this. The subsection envisages a single code of practice, not a series of codes designed for different types of hospital. The care with which the problem at Ashworth was addressed is evident from the witness statements of those who were responsible for evolving and applying the policy. It is evident too from the policy itself, which sets out a series of additional safeguards that must be applied if seclusion extends beyond seven days. A balance is struck between the need for frequent medical reviews in the early stages and the process of group monitoring in the longer term at less frequent intervals, bearing in mind that some patients at Ashworth suffer from mental conditions that make them dangerous not just for short bursts but also for long periods, and bearing in mind too the need to make the most efficient use of the medical resources at the hospital.

[71]

The point does not end there however. There are further questions that must be addressed. How is the court to judge whether good reason to depart from the code has been demonstrated? Must the code be given a greater status in order to make it compatible with mental patients' convention rights? Was Ashworth free to depart from the code by adopting its own policy for the use of this procedure, or was it free to do so if at all only in regard to individual patients or groups of patients? These were the points to which, while endorsing the Ex p Rixon approach, the Court of Appeal directed its attention (at [74]):

> '. . . 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.'

It was in the light of these observations that the Court of Appeal held (at [76]) that hospitals could depart from the code only in the case of individual patients or groups of patients and that they could not do so as a matter of policy.

[72]

The respondent does not suggest that the code itself fails to respect the patients' convention rights. The Secretary of State is not said to have failed in her duty under s 118(1). She is not a party to these proceedings. His argument is that, given the state's obligation under art 3 of the convention to avoid ill-treatment of patients detained by or on its authority, the code must be given a weight and status which is consistent with that obligation. The same point is made with reference to the state's obligations under arts 5 and 8 of the convention. He submits that it is for the court to achieve this, in its assessment of the weight and status that is to be given to the code.

[73]

There is no doubt that, as it is a public authority, the court has a responsibility in domestic law to do what it can to ensure that legislation is applied compatibly with convention rights: see s 6 of the 1998 Act. It is subject also to the interpretative obligation which s 3(1) of that Act sets out. These provisions reflect the way the obligations of the state in these matters are seen by the court in Strasbourg. In Storck v Germany [2005] ECHR 61603/00 (para 93) the European Court of Human Rights said:

> 'The court recalls that it is not its function to deal with errors of fact or law allegedly committed by the national courts and that it is in the first place for the national authorities, notably the courts, to interpret the national law. However, the court is called to examine whether the effects of such an interpretation are compatible with the convention (see, inter alia, Platakou v Greece App No 38460/97 (11 January 2001, unreported) at para 37). In securing the rights protected by the convention, the contracting states, notably their courts, are obliged to apply the provisions of national law in the spirit of those rights. Failure to do so can amount to a violation of the convention article in question, which is imputable to the state.'

[74]

It is plain that the intensity of review must vary according to the context. The proposition that it is the responsibility of the court to give the code the weight and status that it needs in order to secure the patients' convention rights is undoubtedly sound in principle. It follows that in this context the reasons for any departure from the code which puts the

patients' convention rights at risk must be subjected to particularly careful and intense scrutiny. But the complaint which the respondent makes is directed not at an isolated act or series of acts of departure from the code in violation of his convention rights but to the fact that Ashworth has developed its own policy for the seclusion of patients in its hospital. The argument that the code must be given an enhanced status is a sterile one in this context unless it can be demonstrated that the policy is in itself incompatible with the patients' convention rights. Unless this can be done, the conclusion must be that there are no grounds for declaring that the policy is unlawful in order to ensure that there is compatibility.

[75]

The crucial question then, to which I now turn, is whether the relevant parts of the policy are incompatible with the respondent's convention rights. The rights that have been put in issue are those which are guaranteed by arts 3, 5 and 8 of the convention.

[76]

It must be stressed at the outset that no complaint is made about the way the policy has been implemented by Ashworth. It is not suggested that the staff in the hospital have been anything other than rigorous in their observance of it. Nor is it suggested that it was applied to the respondent on any of the occasions when he was secluded in a way that has caused harm to him. In a summary of her conclusions at the end of a report which she prepared following an interview with him, having had access to his full medical records, Dr Sophie Davison, a consultant forensic psychiatrist, said that the Ashworth policy of fewer reviews than recommended in the code of practice increased the risks associated with seclusion, particularly after seven days. But she also said that the initial decision was appropriate on each of the four occasions of seclusion in his case that she had investigated, that there was no evidence that he had suffered as a result of medical reviews being less frequent than recommended in the code and that there was no evidence that more frequent reviews would have reduced the overall time that he had spent in seclusion. There is no evidence that any other patient has suffered as a result of the way Ashworth's policy on seclusion has been implemented.

a. Article 3

[77]

Article 3 guarantees that no one shall be subjected to torture or to inhuman and degrading treatment or punishment. No one suggests that seclusion is a form of torture or that it is being used as punishment. Paragraph 4.3 of the policy states in terms that seclusion is not used as a punishment. So the parts of this guarantee that are relevant to this case are those that prohibit inhuman or degrading treatment. But, as Dr Davison's report makes clear, it is not suggested in this case that Ashworth has done anything that is directly prohibited by this article. The argument has concentrated instead on its positive effects—what must be done to ensure that patients do not suffer treatment of the

kind that is prohibited.

[78]

The European Court has repeatedly said that ill-treatment must attain a minimum level of severity if it is to fall within the scope of the expression 'inhuman or degrading treatment': see A v UK (1998) 5 BHRC 137 at 141 (para 20). This standard is to be judged in the light of the circumstances, as the court has held that in order for an arrest or detention in connection with court proceedings to be degrading within the meaning of the article it must be of a special level and it must in any event be different from the usual degree of humiliation that is inherent in arrest or detention: see Õcalan v Turkey (2005) 18 BHRC 293 at 345 (para 181). It has also made clear that, while the absolute prohibition is not capable of modification on grounds of proportionality, issues of proportionality will arise where a positive obligation is implied as where positive obligations arise they are not absolute. In Osman v UK (1998) 5 BHRC 293 at 321 (para 116) the court recognised that such obligations must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Nevertheless, as the court said in Z v UK (2002) 34 EHRR 97 at 131 (para 73), states must take measures to provide effective protection of vulnerable persons, and these must include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.

[2006] 4 All ER 736 at 767

[79]

Further guidance is to be found in Van der Ven v Netherlands [2003] ECHR 50901/99. The applicant's complaint was that the detention regime to which he was subjected in a maximum security prison constituted inhuman and/or degrading treatment and infringed his right to respect for his private and family life. The court held that routine strip searches to which he was subjected together with other security measures amounted to inhuman or degrading treatment in violation of art 3. But it made it clear that detention in a high security prison facility could not be said in itself to raise an issue under the article (para 50). The removal from association with other prisoners for security, disciplinary or protective reasons did not in itself amount to inhuman or degrading treatment or punishment (para 51); see also Koskinen v Finland App No 20560/92 (30 August 1994, unreported). In assessing whether a measure may fall within the ambit of art 3 in a given case, regard must be had to the particular conditions, the stringency of the measure, its duration, the objective pursued and its effects on the person concerned: para 51; see also, for a case where the same test was applied to the conditions of detention in solitary confinement in a mental institution, the European Commission of Human Rights' opinion in Dhoest v Belgium (1987) 55 DR 5 at 21 (para 118).

[80]

I would approach this issue therefore by asking myself whether Ashworth's policy gives rise to a significant risk of ill-treatment of the kind that falls within the scope of the article, and if there is any such risk whether it would impose a disproportionate burden on Ashworth for it to be forced to abandon its policy so as to eliminate it.

[81]

The risk which must be considered is whether a patient might suffer ill-treatment of the required level of severity as a result of being kept in seclusion under Ashworth's policy for longer than would have been the case under the code. As Dr Davison makes clear in her report, seclusion does give rise to risks which are both physical and psychological. That is why regular medical reviews are necessary to ensure that the patient's mental and physical health does not deteriorate. Her conclusion is that Ashworth's policy of fewer reviews after seven days increases the risks. But the evidence falls well short of demonstrating that the policy, when read as a whole and if proper weight is given to all its additional safeguards, gives rise to a serious risk of ill-treatment of the required level of severity. The absence of any evidence that any patient has suffered as a result of Ashworth's policy is highly significant. So too is the absence of any evidence that seclusion is being used at Ashworth for reasons that are unacceptable. On the contrary, Dr Davison's opinion is that the initial decision to seclude the respondent was appropriate on each occasion and that there was no evidence that more frequent reviews would have made any difference in his case. The Mental Health Act Commission's suggestion that arrangements should have been considered for the alternative management of such patients has not, so far as the evidence shows, been followed up by any detailed explanation of the alternative options that are available.

[82]

The conclusion must be that the risk of ill-treatment is very low if full effect is given to the policy, and that in view of the safeguards which it contains and the special circumstances that obtain in its hospital it would be disproportionate for Ashworth to be compelled to abandon the policy in favour of the code to eliminate that risk. In my opinion the policy is not incompatible with art 3.

b. Article 5

[83]

Article 5 addresses the right to liberty and security. It provides that no one shall be deprived of his liberty save in the cases that it describes and in accordance with a procedure prescribed by law. The cases that it describes include the lawful

detention of persons of unsound mind: see art 5(1)(e). Everyone who is deprived of his liberty is entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if it is unlawful: see art 5(4).

[84]

The issue in this case however is not directed to the fact that the respondent is being detained as a mental patient at Ashworth. The criteria for the detention of a patient which were laid down in Winterwerp v Netherlands (1979) 2 EHRR 387 at 403 (para 39), are not in issue in this case. Nor is it suggested that Ashworth is an inappropriate institution for the respondent's detention while he is of unsound mind. Seclusion is, of course, a

further form of detention. It involves the patient's supervised confinement in a room, which may be locked to protect others from significant harm. But it is not suggested that the use of seclusion engages art 5 in every case where the use of this procedure is appropriate. The respondent's argument is directed instead to Ashworth's policy for dealing with it.

[85]

A person who is of unsound mind must be detained in a place which is appropriate for that purpose: see Aerts v Belgium (1998) 5 BHRC 382. Beyond that, as Baroness Hale of Richmond pointed out in R (on the application of B) v Ashworth Hospital Authority [2005] UKHL 20 at [34], [2005] 2 All ER 289 at [34], [2005] 2 AC 278, art 5(1)(e) is not concerned with the patient's treatment or the conditions of his detention: see Ashingdane v UK (1985) 7 EHRR 528 at 543 (para 44). The question whether the way these matters are dealt with involves a violation of the patient's convention rights must be dealt with under arts 3 and 8. Moreover, it is to be noted that, following para 19.16 of the code, para 4.2 of the policy states that seclusion should be used as a last resort and for the shortest possible time. Paragraph 8.4 states that a detailed management plan for management of the ending of seclusion should be prepared in all cases to ensure the earliest possible ending of seclusion. In Bollan v UK App No 42117/98 (4 May 2000, unreported), the court said that disciplinary steps imposed formally or informally on prisoners which have an effect on conditions of detention within a prison cannot be considered a deprivation of liberty, but must be regarded in normal circumstances as modifications of the conditions of detention and therefore outside the scope of art 5(1).

[86]

In my opinion the seclusion of a patient who is lawfully detained at Ashworth under the conditions laid down in the policy does not amount to a separate deprivation of liberty which engages art 5.

c. Article 8

[87]

Article 8(1) provides that everyone has the right to respect for his private and family life, his home and his correspondence. An interference with these rights may be justified under art 8(2), but only if it is in accordance with the law and is necessary in a democratic society for, among other things, the prevention of disorder or crime. The argument that the policy is incompatible with this article was introduced in the Court of Appeal by the mental health charity MIND, which was permitted to intervene in these proceedings and whose arguments the respondent now adopts.

[88]

The European jurisprudence tells us that not all interferences with respect for private and family life during lawful detention will engage art 8. What it describes as normal restrictions and limitations consequent on prison life and discipline in these circumstances will not constitute in principle a violation of this article: see Nowicka v Poland [2003] 2 FCR 25 at 35 (para 71). So long as it does not amount to ill-treatment in

violation of art 3, seclusion will not as a general rule result in an interference with the patient's rights under art 8(1): see Herczegfalvy v

Austria (1993) 15 EHRR 437 at 484, 485 (paras 82–84, 86), Raninen v Finland (1998) 26 EHRR 563 at 588–590 (paras 56–59, 64). Recommendation Rec (2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder, adopted by the Committee of Ministers under the terms of art 15.b of the Statute of the Council of Europe on 22 September 2004, recognises that seclusion may be resorted to in appropriate circumstances. Article 27 provides the following guidelines:

> '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 reason for, and duration of, such measures should be recorded in the person's medical records and in a register.
>
> 4. This article does not apply to momentary restraint.'

[89]

Clearly, there is a risk of a violation if this form of intervention is resorted to improperly or for longer periods than the patient's mental condition justifies. But there is no evidence that this is what has been happening at Ashworth. The whole purpose of the policy, which is written down and published within the hospital, is to define the standards that must be followed and prevent abuse and arbitrariness. It is designed to minimise the risk of a violation. It is hard to see why, in these circumstances, the policy should itself be thought to be incompatible with art 8(1).

[90]

Assuming nevertheless that the policy requires to be justified under art 8(2), I would conclude that it satisfies these tests. The aim of seclusion is to prevent disorder or crime, as it is resorted to only as a last resort to protect others from significant harm. The purpose of the policy is to address the special considerations that need to be applied to its use in a high security hospital, whose patients are considered to present a grave and immediate risk to the public and may do so also to other patients, staff and visitors: see the introduction to the policy. It shares the aims of the code in this respect, and its aim is

a legitimate one. It also aims to ensure that the procedure is resorted to in a way that is proportionate, as it is designed to avoid harm to the patient and to ensure that, even in long-term cases, it is brought to an end as early as possible.

[91]

The main thrust of MIND's argument that the conditions of art 8(2) are not satisfied is directed to the requirement that an interference with the art 8(1) rights cannot be justified unless it is 'in accordance with the law.' This phrase has the same meaning as the expression 'prescribed by law' in arts 9, 10 and 11: see Silver v UK (1983) 5 EHRR 347 at 371 (para 85). The interference in question must have some basis in domestic law and be in conformity with it: Silver v UK (at 372 (para 86)). 'Law' in this context is not limited to statutory enactment or to measures, such as the code, that have their base in a statute. It includes the common law: see Sunday Times v UK (1979) 2 EHRR 245 at 270 (para 47). But the measure must be formulated with sufficient precision and be sufficiently accessible to satisfy the criterion of foreseeability: see Sunday Times v UK (at 271 (para 49)); Silver v UK (at 372 (para 87)).

[92]

In my opinion the policy satisfies the requirements of precision and accessibility. The procedures which it lays down are spelled out with the same

clarity and attention to detail as those in the code. They have been reduced to writing, of course, and the policy is published within the hospital so that it is available to all who need to see them. Uniformity of practice is ensured by this process, so the way this form of intervention is being managed at Ashworth is entirely foreseeable. Patients are protected against random or arbitrary interferences with their art 8(1) rights by the fact that the policy sets out standards in the light of which under domestic law judicial review of such interferences is available. The protections that are available to patients under the civil and the criminal law are reinforced by them. I would conclude that the purposes for which the requirement that the interference must be in accordance with the law is set out in art 8(2) are satisfied.

[93]

MIND accepts that the convention does not require an express statutory provision for the use of this procedure. But it argues that the code of practice would not have the force of law if it was open to Ashworth to depart from it in formulating its own policy. The concern is that, if this is so, the patient will not be able to foresee to a degree that is reasonable the circumstances in and the conditions on which this form of intervention may be exercised. If the circumstances in which the code may be departed from cannot be predicted it will fail the tests of foreseeability and certainty.

[94]

I do not accept this argument. The requirement which the law lays down that those to whom the code is addressed are expected to follow it unless they can give a good reason

for not doing so provides a sufficient assurance of certainty and predictability to satisfy the requirements of art 8(2). But the argument misses the point in any event, because the issue in this case is not whether the code is incompatible or is at risk of being held to be incompatible. It is directed to the lawfulness of Ashworth's policy. The question for inquiry is not whether the code is compatible with this article but whether the requirement of compatibility is satisfied by the policy.

CONCLUSION

[95]

In my opinion it has not been shown that Ashworth's policy is incompatible with the respondent's convention rights. It is not necessary therefore to subject it to enhanced scrutiny in order to ensure its compatibility. This has an important bearing on the question whether, bearing in mind that it was expected to follow the code unless it had good reason for not doing so, it was open to Ashworth to depart from the guidance which the code gives on seclusion and to formulate its own policy.

[96]

The Court of Appeal said (at [76]) that Ashworth could not depart from the code as a matter of policy and in relation to an arbitrary dividing line that was not properly related to the code's definition of seclusion and its requirements. As I accept—and indeed would strengthen—the test which they were applying, this is the key point of difference between us. 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 art 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 the court's judgment in Hewitt v UK (1992) 14 EHRR 657 at 665 (para 39) 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, 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.

[100]

For these reasons and those given by my noble and learned friend Lord Bingham of Cornhill, whose speech I have had the opportunity of reading in draft, I would allow the appeal and dismiss the respondent's application.

LORD SCOTT OF FOSCOTE.

[101]

My Lords, I have had the advantage of reading in advance the opinions of my noble and learned friends and find myself in complete agreement with the reasons for allowing this appeal given by Lord Bingham of Cornhill and Lord Hope of Craighead. I can add nothing useful to those reasons. I am in respectful agreement, also, with everything that my noble and learned friend Lord Brown of Eaton-under-Heywood has written save in relation to art 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in Sch 1 to the Human Rights Act 1998). I want to add a few words to explain why I disagree with my noble and learned friend's conclusion that the Ashworth policy on seclusion cannot be described as being 'in accordance with the law' for art 8 purposes.

[102]

Lord Brown (at [117], below) poses the question whether the placing of a mental hospital patient in seclusion engages art 8. He answers the question (at [118]): 'It is unthinkable that a mental patient can be subjected to seclusion, particularly on a long-term basis as is often the case at Ashworth, without good reason and . . . without such interference with his rights being “in accordance with the law”.' I respectfully agree. But my noble and learned friend then examines whether the Ashworth policy on seclusion can be described as being 'in accordance with the law' and concludes that, because of the significant respects in which the provisions of the Ashworth policy are different from the provisions of the Secretary of State's code of practice, the Ashworth policy cannot be so described. Lord Brown (at [127], below) comments that the practices relating to seclusion adopted by any individual hospital, rational and reasonable though those practices might be, would not have 'the necessary legal quality to render them compatible with the rule of law'.

[103]

My Lords, this surely cannot be right. 'The law', for art 8 purposes, does not consist only of statutes, directives, statutory codes and the like. It must include, also, the variety of duties and rights arising out of the circumstances in which individuals and institutions find themselves and their relationship with one another that are imposed by the common law. It cannot be doubted that Ashworth owes a legal duty to each of the inmates of the hospital to take reasonable steps to protect him or her from physical injury by other inmates. Ashworth cannot choose its patients. They are sent to Ashworth by others and Ashworth has to accept them, to detain them and to look after them. All of them suffer

from some degree of mental disturbance—otherwise they would not be there. Some of them from time to time present a physical danger to other inmates. Where the danger appears particularly acute Ashworth's legal duty to the other inmates may well require Ashworth to place the dangerous inmate in seclusion. It is accepted that the only legitimate purpose of placing an inmate in seclusion is the protection of others. Seclusion cannot be used as a punishment nor can it constitute medical treatment, at least in the narrow sense of that expression. And the placing of a patient in seclusion where the apprehended danger that the patient in question may inflict

harm on other inmates is sufficiently acute would, in my opinion, constitute a step that Ashworth's legal duty to the other inmates would require it to take. So the proposition that for Ashworth to do so would not be 'in accordance with the law' for art 8 purposes because of some perceived defect in the written formulation of Ashworth's policy on seclusion must, in my opinion, be rejected. A dangerous patient's art 8 rights could not justifiably be pitched at a level that required the hospital to leave other inmates in unacceptable danger of physical harm. Once it is accepted that Ashworth has no statutory obligation to have a seclusion policy that conforms in every respect to the statutory code and that Ashworth's seclusion policy is rational and reasonable in itself despite its divergences from the code, there can be no room for any suggestion that the implementation of Ashworth's seclusion policy for the safety of other inmates is otherwise than in accordance with the law.

[104]

I would, for the reasons given by Lord Bingham and Lord Hope, allow this appeal.

LORD BROWN OF EATON-UNDER-HEYWOOD.

[105]

My Lords, I have had the advantage of reading in draft the speech of my noble and learned friends Lord Bingham of Cornhill and Lord Hope of Craighead and gratefully adopt their exposition of the facts, the legislation, the Secretary of State's code of practice (the code), and Ashworth's own policy (Ashworth's policy). In what follows I take all that as read.

[106]

This appeal concerns a very sensitive question: the seclusion of mental health patients. Such patients, it need hardly be said, whether detained under s 3 of the Mental Health Act 1983 or admitted to mental hospitals informally (as the great majority are), form a particularly vulnerable group within society. And, of course, seclusion, forcible supervised solitary confinement, is one of the most extreme methods of controlling them.

[107]

The central question raised by the appeal is what status must be given to the code

(properly issued, as I understand all your Lordships to agree, pursuant to s 118 of the 1983 Act) with regard to the use of seclusion in mental hospitals. I use the word status because that was the word used during argument and in heading (g) to the Court of Appeal's conclusions ([2003] EWCA Civ 1036 at [71]–[76], [2004] QB 395 at [71]–[76], [2003] 3 WLR 1505). It is important, however, to understand precisely what is at issue. The Court of Appeal (at [92]) ultimately made a declaration that:

> 'In relation to the use of seclusion, the code of practice issued under section 118 of the [1983 Act] may only be departed from if there is good reason for such departure either in the case of an individual or a group of individuals sharing the same characteristics.'

I understand a majority of your Lordships to conclude that that declaration should be set aside: the code is to be regarded as guidance rather than instruction, albeit guidance which 'should be given great weight' and departed from 'only if [the hospital] has cogent reasons for doing so' (see [21], above).

[108]

The difference between these two positions is not immediately obvious. 'Cogent reasons' for departing from guidance might well be thought to amount equally to 'good reason'. Yet the Court of Appeal ruled in the light of its declaration that Ashworth's policy—a policy described at [80] as 'departing from the Code of Practice on a wholesale basis'—is unlawful, whereas the majority of your Lordships would find it lawful. The critical difference must surely therefore be this: in a case

where two (or more) views as to the appropriate policy to adopt towards seclusion could each be regarded as reasonable and where the code embodies one view and an individual hospital takes another, whereas the Court of Appeal would require the hospital to follow the code, the majority of your Lordships would not; rather they would hold it lawful for the hospital to adopt and apply its own preferred policy.

[109]

This is in many ways an odd appeal. It is not now suggested that Mr Munjaz was subject to seclusion when he should not have been, nor that he was secluded for longer than he should have been. Nor, I think, is it suggested that Ashworth's policy, assuming always, as one must, that it was properly applied, itself gives rise to any direct violations of the European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (as set out in Sch 1 to the Human Rights Act 1998), let alone to any breach of domestic law. Rather what is suggested is that Ashworth is simply not permitted to have its own different policy towards seclusion (being entitled to depart from the code's policy only if in some individual case or group of cases such departure is justified—notably in those cases where it would make no sense to apply the code).

[110]

I agree with the majority of your Lordships that this argument cannot be advanced on

domestic law grounds: on any conventional approach to the construction and application of s 118 of the 1983 Act, the code would clearly permit Ashworth to adopt its own differing policy on seclusion. But what of the arguments centred on the Strasbourg jurisprudence? The real case advanced by those who challenge Ashworth's policy I understand to proceed in three stages: it is said first, that the United Kingdom would be in breach of its obligations under the convention if Ashworth were permitted to adopt a policy of its own; second, to ensure compatibility with convention rights, s 118 must accordingly be construed pursuant to s 3 of the 1998 Act to give greater weight to the code; third, once the code is given this additional weight, Ashworth becomes disentitled to adopt a different policy of its own.

[111]

The articles of the convention on which the arguments have focused are arts 3, 5 and 8. The Court of Appeal accepted the appellant's case (supported as it was by MIND) with regard to arts 3 and 8 but not as to art 5. As to art 5 the court held that provided only that the person concerned is detained in a type of institution appropriate to meet the art 5(1) purpose of his detention, that article is not concerned with the conditions of that detention, only with its justifiability. I agree with the Court of Appeal's decision on this part of the case as expressed in paras [69] and [70].

[112]

As to art 3, the argument which I understand the Court of Appeal to have accepted was essentially this. Unnecessary or unnecessarily prolonged seclusion can, in extreme circumstances, constitute inhuman or degrading treatment such as to amount to a violation of art 3. The state is under an implied positive obligation to take steps to guard against such breaches. The code of practice, if given the enhanced status contended for by the appellants, satisfies this positive obligation. Otherwise it is breached.

[113]

For my part I find this argument unconvincing. In the extended part of its judgment refusing permission to appeal, the Court of Appeal said (at [91]):

> 'We did not lay down a general principle that where there is a risk that a public authority may act incompatibly with a Convention right there must be a Code of Practice promulgated by the state.'

[2006] 4 All ER 736 at 775

I confess to some difficulty in reconciling this with a number of earlier passages in the judgment. Take this (at [60]):

> 'The argument before us is that the court should afford a status and weight to the Code of Practice which is consistent with the state's obligation to avoid ill-treatment of patients detained by or on the authority of the state. We accept that argument . . .'

And this (at [74]):

> '. . . 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 . . .'

[114]

Reconcilable or not, however, the Court of Appeal's final thoughts on the issue must surely be right: there can be no principle that the state is obliged to promulgate a code whenever the risk arises of a public authority acting incompatibly with a convention right. The Strasbourg jurisprudence goes nowhere near supporting such a principle. Even in an art 2 case the positive obligation arises only in cases where the state knows or ought to know of a real and immediate risk to life. There is no evidence in the present case that the approach to seclusion being taken up and down the country (let alone by Ashworth itself) creates so plain a risk of art 3 violations that the Secretary of State is bound to take corrective measures.

[115]

There is, moreover, to my mind a further ground for rejecting the art 3 argument here. As I observed in my judgment in the Court of Appeal in R (Adlard) v Secretary of State for the Environment, Transport and the Regions [2002] EWCA Civ 735 at [36], [2002] 1 WLR 2515 at [36]:

> '. . . the Secretary of State's obligation under section 6 of the Human Rights Act 1998 is not himself to act incompatibly with a Convention right; he is not obliged to ensure that other public authorities themselves act compatibly . . .'

True it is, as observed by the court below (at [59]), that this was said in the context of an argument that the Secretary of State should have called in a planning application so as to avoid the risk of the local planning authority acting incompatibly with art 6. I see no reason, however, why that same principle should not apply equally in the present context. The Secretary of State is entitled to place the responsibility for acting compatibly with art 3 upon another public authority, here the hospital trust.

[116]

On these issues, therefore, I am in full agreement with the majority of your Lordships. The remaining issue, however, that revolving around art 8, I confess to having found altogether more difficult.

[117]

The first question to arise under art 8 is, of course, whether seclusion pursuant to Ashworth's policy engages art 8 at all—whether, that is, it falls within the scope of art 8(1): 'Everyone has the right to respect for his private and family life, his home and his correspondence.' In placing a patient in seclusion, is Ashworth interfering with the

exercise of the patient's private life so as to require, pursuant to art 8(2), both a substantial factual justification for seclusion and, additionally, a sound legal basis for it?

[118]

There can surely be only one answer to this question. It is unthinkable that a mental patient can be subjected to seclusion, particularly on a long-term basis as is often the case at Ashworth, without good reason and, in the language of

[2006] 4 All ER 736 at 776

art 8(2), without such interference with his rights being 'in accordance with the law'. It is unnecessary to go so far as Mr Gordon QC appears to have submitted below on behalf of MIND, that seclusion is always an interference with the patient's right to private life, to conclude that as a practice it will inevitably sometimes engage art 8: there are bound to be occasions when the patient's 'personal autonomy' or 'moral integrity' (art 8 concepts well recognised and enshrined in the Strasbourg case law) are undermined, occasions when his 'human dignity' (and, indeed, important elements also of his residual 'human freedom') are compromised. The Court of Appeal's analysis (at [61] and [62]) on this part of the art 8 argument is in my opinion correct.

[119]

To my mind therefore, the case turns on art 8(2), and above all on the requirement that any interference with private life involved in the practice of seclusion be effected 'in accordance with the law'. Nobody could dispute that seclusion as a practice is necessary. It can, indeed, be justified under several of the specified grounds provided for by art 8(2): 'in the interests of . . . public safety', 'for the prevention of disorder or crime', 'for the protection of health', and 'for the protection of the rights and freedoms of others'.

[120]

But that is not a sufficient answer to the complaint of interference with art 8 rights. This is illustrated by in Malone v UK (1985) 7 EHRR 14, a complaint about telephone-tapping. Nobody doubted the justification of the practice but it was held to be contrary to art 8 for not being 'in accordance with the law'—a deficiency in the legislation cured by the Interception of Communications Act 1985.

[121]

Hewitt v UK (1992) 14 EHRR 657 provides another illustration of the principle in the context of secret surveillance activities carried out by the Security Service. These activities, an undoubted interference with the applicants' private lives, were based on a non-binding and unpublished directive from the Home Secretary to the Director General of the Security Service. The directive did not have the force of the law, nor did its contents constitute legally enforceable rules governing the operation of the Security Service. In those circumstances the European Commission of Human Rights concluded that the directive did not provide a framework indicating with the requisite degree of certainty the scope and manner of the exercise of discretion by the authorities in the carrying out of their activities. This want of legal support for the practice in turn had to

be cured by further legislation, the Security Service Act 1989.

[122]

What is clear from these and other Strasbourg authorities is that more is required by way of legal justification for an interference with private rights merely than that there exists a sufficient basis for the practice in domestic law. In its judgment in Hewitt v UK (at 665 (para 39)) the Commission referred back to the court's judgment in Malone v UK as having 'elucidated the concept of foreseeability and highlighted its importance as a safeguard against the arbitrary application of measures of secret surveillance', quoting from the court's judgment in Malone v UK (at 40 (para 67)):

> 'The Court would reiterate its opinion that the phrase "in accordance with the law" does not merely refer back to domestic law but also relates to the quality of the law, requiring it to be compatible with the rule of law . . .'

'The quality of the law' there referred to encompasses notions of transparency, accessibility, predictability and consistency, features of a legal regime designed to guard against the arbitrary use of power and to afford sufficient legal protection to those at risk of its abuse.

[2006] 4 All ER 736 at 777

[123]

It was just such considerations which recently led the European Court of Human Rights in HL v UK (2004) 17 BHRC 418 (the complaint to Strasbourg which followed on from your Lordships' decision in R v Bournewood Community and Mental Health NHS Trust, ex p L (Secretary of State for Health intervening) [1998] 3 All ER 289, [1999] AC 458) to hold that the absence of procedural safeguards to protect informal mental patients against the arbitrary deprivation of liberty on grounds of necessity violates art 5(1): the court was struck by the lack of any fixed procedural rules governing the admission and detention of compliant incapacitated persons, contrasting this dearth of regulation with the extensive network of safeguards applicable to psychiatric committals under the 1983 Act.

[124]

What view then should be taken of the seclusion of mental patients? Is this a form of control where regulation can satisfactorily be left to the individual hospitals who practise it or must it be subject to more constraining central direction? In short, for the practice to be compliant with the convention, must the Secretary of State's code have something akin to the force of law? Must it therefore be given the status for which the appellants contend, a status disentitling individual hospitals to depart from it on policy grounds (rather than on the ground that it would be unreasonable to apply the code to particular patients or groups of patients)?

[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 in so far 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 four-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.

[126]

Under Ashworth's approach, moreover, seclusion as a concept loses something of its clarity. Although Ashworth ostensibly adopts the code's definition of seclusion—'the supervised confinement of a patient in a room, which may be locked to provide others from significant harm'—Dr Finnegan's evidence (para 58) is that 'at most times about 75% of the long term secluded patients are being nursed in extended association, despite being defined as “secluded”'. These patients are said to be 'up in the public areas of the ward interacting with staff and patients'. Small wonder that this different attitude to the very concept of seclusion results in what seem to be widely differing approaches to the practice. A startling example of this appears from the written intervention helpfully submitted to the House by the Mental Health Act Commission. In October 2002 one particular patient was transferred from Ashworth to Rampton having been in seclusion at Ashworth for the best part of nine years. At Rampton his long-term seclusion ceased and

although from time to time since he has been subject to seclusion this has never been for as long as eight hours (or a total of 12 hours within any 48-hour period) such as to trigger Rampton's independent review process (the process provided for by para 19.21 of the code).

[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 referenced 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.

[128]

On this limited basis I for my part would uphold the judgment of the Court of Appeal and declare Ashworth's policy to be unlawful.

[129]

I add only this. The discordance of view revealed in this case between on the one hand the hospital trust and the Secretary of State, and on the other hand the Mental Health Act Commission (the statutory body charged with keeping under review the exercise of the powers and duties contained in the 1983 Act) and MIND (the leading mental health charity in this country), seems to me both striking and unfortunate. It is noteworthy too that, as recently as December 2004, the Joint Parliamentary Select Committee on Human Rights expressed itself concerned about 'the low level of compliance with guidelines on the use of seclusion' as attested to by the Mental Health Act Commission (see para 242 of its report). The new Mental Health Bill, just as the 1983 Act, makes provision for a code of practice. The present code, I readily accept, appears on its face to be altogether more obviously directed to short-term than to comparatively long-term periods of seclusion. I would express the hope that with a proper degree of co-operation on the part of all those concerned in this sensitive area of public administration, it may prove possible to lay down a comprehensive and compulsory scheme for the regulation of seclusion and its periodic review such as properly reflects not merely best practice generally but also such special problems as Ashworth (although apparently not the other high security hospitals) experiences. Sooner or later, consensus must be reached upon the proper place of seclusion within our mental hospitals. This issue has been a running sore for far too long.

Appeal allowed.
Kate O'Hanlon Barrister.