

Judicial recognition of the status of the Code of Practice

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

S v Airedale NHS Trust

Interested Parties: 1) Secretary of State for Health; 2) Mind

[2003] EWCA Civ 1036

Court of Appeal (16th July 2003) Lord Phillips MR, Hale LJ, and Latham LJ

This is the Court of Appeal decision in two cases which raised questions about the status of the Mental Health Act Code of Practice¹. Although both cases concerned the use of seclusion, the judgment is likely to have a significant impact on any matter covered by the Code². At first instance Stanley Burnton J and Sullivan J had each held that the Code was merely guidance to which Trusts should have regard but from which they could depart. Such departure would only be unlawful if it was *Wednesbury*³ unreasonable.

Seclusion and the Code of Practice⁴

The Code of Practice defines seclusion as:

'The supervised confinement 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.'

The Code goes on to expressly state that:

'Seclusion should be used:

- as a last resort;
- for the shortest possible time

Seclusion should not be used:

- as a punishment or threat;
- as part of a treatment programme;
- because of shortage of staff
- where there is any risk of suicide or self harm.'

* Barrister; Legal Unit of Mind (London), an interested party in both cases under review.

1 Mental Health Act 1983 Code of Practice. The Stationery Office (1999)

2 Following the Court's decision, the Department of Health issued a Briefing in which they stated their view that the Court's analysis of the legal status of the Code

is applicable to 'all aspects' of it (i.e. not just 'seclusion').

3 *Associated Provisional Picture Houses Ltd. v Wednesbury Corp.* [1948] 1 KB 223

4 Seclusion is dealt with in Chapter 19 of the Code of Practice

Hospitals are required by the Code to have clear written guidelines on the use of seclusion. A nurse must be within sight and sound of the seclusion room at all times. A documented report must be made at least every 15 minutes. The need to continue seclusion should be reviewed every 2 hours by 2 nurses, one of whom was not involved in the decision to seclude, and every 4 hours by a doctor. A multi-disciplinary review must take place whenever seclusion continues for a period of 8 hours continuously or 12 hours intermittently in any period of 48 hours.

Facts and History

Colonel Munjaz

Colonel Munjaz was a patient in Ashworth hospital. He was regularly nursed in seclusion. Ashworth issued a seclusion policy in 1999, which departed from the Code in a number of respects. In particular, it reduced the number of medical reviews from 4 hourly to twice daily on the second and third days and once daily thereafter. Prior to the first instance hearings in these proceedings, Colonel Munjaz had brought Judicial Review proceedings heard by Jackson J. He decided that departure from the Code would only be lawful if it was justified by a good reason arising from the particular circumstances at Ashworth. The Ashworth policy signified too great a departure from the Code and it was declared to be unlawful⁵.

Ashworth therefore reviewed its policy and produced a new one in 2002. This provided for medical reviews twice daily from days 2 to 7 but after that only provided for 3 per week and a weekly multi-disciplinary review. It is Colonel Munjaz's challenge to the lawfulness of the new policy which is addressed in these proceedings. Sullivan J dismissed the claim saying the mere fact that the policy departed from the Code did not mean that there was a risk of patients' rights under the ECHR being infringed. Read as a whole the policy contained adequate safeguards. The Code of Practice was said to be no more than guidance to which the hospital was obliged to have regard as a material consideration⁶.

Mr S

Mr S was admitted to hospital under section 2 of the Mental Health Act on 11th July 2002. He was aggressive and hostile to staff. He had a history of offending behaviour, he absconded repeatedly and had also attacked another patient. By 18th July his RMO had decided that S required secure accommodation and made efforts to find such a place. In the meantime, due to S's threatening and intimidating behaviour, the decision was made to put him in seclusion. This happened on 21st July. From 28th July S was allowed out of seclusion during the day. On 2nd August S agreed to be transferred to a secure unit in London, where he was treated without the use of seclusion.

S challenged the lawfulness of his seclusion. Dr Grounds, instructed on behalf of the hospital, had accepted that seclusion should normally be used for the shortest possible time to contain acutely disturbed and violent behaviour and that its use in this case was not a normal or ideal use of seclusion. However, it was argued that it was necessary and justifiable as there did not appear to be an effective and safe alternative at the time. Dr Eastman, instructed on behalf of S, had thought

⁵ *R v Ashworth Special Hospital Trust, ex parte Munjaz* [2000] MHLR 183

⁶ *R (Munjaz) v Ashworth Hospital Authority* [2002] EWHC Admin 1521

that the initial decision to seclude had been reasonable but did not think it was necessary to continue the seclusion for so long. Other options such as locking the ward or 1:1 nursing should have been considered.

Stanley Burnton J dismissed the claim and said that in the absence of a secure bed seclusion had been the only way of managing the patient. The exercise of the power to seclude was not made unlawful by reason of it being necessitated by the lack of an available place on a secure ward⁷.

The Appeals

Colonel Munjaz and Mr S appealed these decisions.

The appeal in Munjaz concentrated mainly on whether Ashworth's policy of departing from the Code was unlawful given the risk that seclusion would breach Article 3 (right not to be subject to inhuman or degrading treatment). It was argued that the State had a positive obligation to guard against the risk of a breach of Article 3, and adherence to the Code was one such safeguard.

The appeal in S concentrated on whether the seclusion was in breach of his rights under Article 5 (right not to be unlawfully detained). It was argued that a detained patient had a 'residual liberty' that was taken away by the use of seclusion. Seclusion would be unlawful if it was not justified under Article 5.

Mind intervened to argue that seclusion, and other matters dealt with by the Code, interfered with patients' Article 8 rights (right to respect for private and family life) and would only be lawful if it was justified. Any such interference must be in accordance with law, and the Code provided that legal framework.

Legal Framework

Hale LJ, on behalf of the Court, sought to analyse the questions raised by the use of seclusion under three categories:

1. Domestic private law

Source of the power to seclude

An application under the Mental Health Act is sufficient authority for the hospital managers to detain the patient in hospital (s6(2)). It was common ground that the power to seclude a patient was implied from the power to detain as a necessary ingredient flowing from a power of detention for treatment.⁸

In addition, the Court held that seclusion was capable of being 'medical treatment', authorised under section 63 of the Mental Health Act. Although s63 does not allow the RMO to impose whatever treatment he wishes the broad definition of medical treatment in s145, and the authorities suggesting that it includes various forms of ancillary treatment⁹, meant that seclusion was capable of being categorised as medical treatment¹⁰.

The Court noted that the common law doctrine of necessity might also justify the use of seclusion.

7 *S v Airedale NHS Trust* [2002] EWHC Admin 1780

8 *see R v Broadmoor Special Hospital Authority ex p S, H and D, unreported, 5 February 1998.*

9 *e.g. Reid v Secretary of State for Scotland* [1999] 2 AC 512 and *B v Croydon Health Authority* [1995] Fam 133

10 *Hale LJ, Judgment paras 41–45*

This was said to have two aspects: i) the general power to take such steps as are reasonably necessary and proportionate to protect others from the immediate risk of significant harm; and ii) where the patient lacks capacity, the power to provide whatever treatment or care is necessary in his own best interests¹¹.

Criteria for lawful seclusion

The Court went on to consider in what circumstances seclusion would be lawful in domestic private law. The fact that there existed a power to seclude would not make every use of that power lawful. The criterion was said to be one of reasonable necessity judged against the purpose for which the restraint is employed. “Hence, a detained patient may be kept in the hospital with no more force than is reasonably necessary in the circumstances to achieve this. Any patient may be restrained from doing harm to others with no more force than is reasonably necessary in the circumstances. An incapacitated patient may be given such treatment as is reasonably necessary in his own best interests.”¹²

Hale LJ went on to consider whether the same concept of reasonable necessity applied to treatment given under s63. She noted that the fact that the treatment may be given without consent did not absolve the doctor, or those carrying out his instructions, from their ordinary duties of care towards the patient. In *R (Wilkinson) v Broadmoor Special Hospital Authority*¹³ the Court of Appeal had held that the forcible administration of medical treatment to a protesting patient would contravene Article 3 ECHR unless it was convincingly shown to be a medical necessity. Accordingly, the Court did not find that the criteria for the lawful use of seclusion would be different if the justification were treatment rather than control¹⁴.

Remedies in private law

Confining a patient to a particular room or part of the hospital would not amount to the tort of false imprisonment where a patient had been lawfully detained in the hospital itself. But that did not exclude the possibility of invoking other tortious causes of action if other torts had been committed against him. There might be a claim in negligence if there was a breach of a duty of care which resulted in physical or psychiatric harm.

The use of restraint or the administration of treatment without lawful justification would give rise to a claim for assault and/or battery and would be actionable without proof of harm. There would be no lawful justification for acts which involved excessive force or which were unlawful in public law terms. However, it was accepted that these torts may be difficult to prove. Courts would be slow to criticise decisions of people involved in emergency situations. Section 139 further qualifies the right of detained patients to sue individuals acting under the Mental Health Act – even where actions were not lawfully justified.

In summary, the use of seclusion might involve the commission of a tort for which remedies may be available. However, these remedies would not be triggered by the use of seclusion in itself, nor even every use of seclusion about which legitimate complaint might be made, and certainly not every use of seclusion which did not comply with the Code of Practice¹⁵.

11 *Hale LJ, Judgment para 46*

12 *Hale LJ, Judgment para 47*

13 [2002] 1WLR 419

14 *Hale LJ, Judgment para 48*

15 *Hale LJ, Judgment paras 49–52*

2. European Convention on Human Rights

Article 3

'No-one shall be subjected to torture or inhuman or degrading treatment.'

Treatment must reach a minimum level of severity before this Article will be found to have been breached. The assessment of this minimum is relative, depending on the circumstances of the case. More might be required of the authorities in relation to people who are particularly vulnerable.

It was argued on behalf of the Appellants that the State had obligations not only to refrain from such treatment but also to positively protect the health of people deprived of their liberty. Given that seclusion risked breaching Article 3 the state should take steps to prevent that happening. The Code of Practice was said to be one of those steps and the state should therefore give it some teeth.

By the time of the appeal it was accepted that the treatment of these patients did not reach the minimum threshold level of severity to amount to a breach of Article 3. However, the Court found that there was no doubt that seclusion would be capable of amounting to inhuman and degrading treatment. It was noted that there were important differences between prisoners and compulsory patients. Whereas the detention of criminals was an end in itself, the detention of patients was a means to an end: the assessment and treatment of their mental disorder. Conditions of detention which defeated rather than promoted that end were much more likely to amount to inhuman or degrading treatment.

The Court accepted that it should afford a status and weight to the Code of Practice which was consistent with the State's obligation to avoid ill-treatment of patients detained by or on its authority¹⁶.

Article 8

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

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society ...'

The concept of 'private life' includes the physical and psychological integrity of a person and the right to develop relationships. The concept of personal autonomy has been held to be an important principle underlying the interpretation of the Convention.

On behalf of Mind it was submitted that seclusion was always an interference with Article 8 rights. It involved denial of association with others as well as close and intrusive surveillance. Such interference must therefore be in accordance with law. This required domestic legal justification (see under 'domestic private law' above), but more importantly it required the character of transparency and predictability required by the Convention concept of legality. This was supplied by the Code of Practice.

The Court accepted that seclusion infringed Article 8 unless it could be justified under Article 8(2). The justifications under domestic law were noted to be very broad and, therefore, the Code of Practice had an important role to play in securing that the justification for the interference had the necessary degree of predictability and transparency to comply with Article 8(2)¹⁷.

¹⁶ Hale LJ, *Judgment paras 53–60*

¹⁷ Hale LJ, *Judgment paras 61–65*

Article 5

‘1. Everyone has the right to liberty and security of person. No-one shall be deprived of their liberty save in the following cases and with a procedure prescribed by law ...

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

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

The argument here was that confinement in a ‘prison within a prison’ should amount to deprivation of liberty for the purpose of Article 5. Such detention would therefore require justification on the grounds of the mental disorder and also a ‘speedy review’.

The Court held that the detention itself had to be justified and challengeable in accordance with Article 5. This would be breached if a person was detained in an institution which was inappropriate to meet the purpose of the detention. But provided that the institution was within the appropriate category there would be no breach of Article 5. The conditions of detention were controlled by Articles 3 and 8. Just as the tort of false imprisonment was concerned with all or nothing situations, so was Article 5¹⁸.

3. Public law and the status of the Code of Practice

Section 118 Mental Health Act provides:

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

(a) for the guidance of registered medical practitioners, managers and staff of hospitals, independent hospitals and care homes and approved social workers in relation to the admission of patients to hospitals and registered establishments 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 medical disorder.’

If the guidance on seclusion did not fall within either of these subsections it would be non-statutory guidance; a material consideration but no more.

The court held that seclusion was covered by s118(1)(a) and (b). ‘Admission’ did not end at the hospital door but continued until discharge. The court had already discussed the issue of whether seclusion was capable of being medical treatment and held that it was.

Having made this finding the Court went on to consider the weight that should be given to the Code. It was noted that there was no express statutory obligation to comply with it.

Under Section 7 of the Local Authority Social Services Act 1970 social services have an obligation to act under the general guidance of the Secretary of State. This had been held in the case of *Rixon*¹⁹ to mean that they could only depart from such guidance with good reason.

The Court said that there was a considerable difference between the approach adopted by the first instance judges in the present cases and the *Rixon* approach. Hale LJ stated:

18 *Hale LJ, Judgment paras 66–70*

19 *R v LB Islington ex parte Rixon [1998] 1CCLR 119.*

*“It would fly in the face of the original purposes of the Code if hospitals or professionals were in fact free not to follow it without good reason... In relation to those matters where a patient’s human rights are or may be engaged, the arguments for according the Code a greater status are compelling. Where there is a risk that agents of the state will treat its patients in a way which contravenes Article 3, the state should take steps to avoid this through the publication of a Code of Practice which its agents are obliged to follow unless they have good reason to depart from it. Where there is an interference with the rights protected by Article 8, the requirement of legality is met through adherence to a Code of Practice again unless there is good reason to depart from it. The same will apply where the Code deals with the deprivation of liberty within the meaning of Article 5”.*²⁰

The Court went on to say 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 or groups of patients who share particular well-defined characteristics. However, hospitals cannot depart from the Code as a matter of policy.

The Court considered potential remedies and said that the usual public law remedies would be available if the Code was unlawfully breached. If something was unlawful in public law terms then there could be no defence of lawful excuse for tortious acts and tortious remedies would be available. Finally, if a decision resulted in a breach of an individual’s human rights then the remedies available under the Human Rights Act 1998 would be available.²¹

Ashworth’s policy was declared to be unlawful because the wholesale departure from the Code could not be justified. The seclusion of S, after the point at which it was necessary and proportionate within the meaning of the Code, was also unlawful.

Comment

There are two main aspects of this case which deserve particular attention. First, the case highlights (or, more accurately, fails to highlight) some of the problems regarding the concept of ‘medical treatment’. The Court was of the view that seclusion could be medical treatment and this is a decision that is likely to be controversial.

Secondly, the case clearly elevates and clarifies the status of the Code of Practice. It confirms that patients have the right to challenge practice which is in unlawful breach of the Code. This is a significant and welcome step towards the promotion of the interests of all mental health service users.

I. Medical Treatment

Probably the most controversial aspect of this judgment is the finding that seclusion can be ‘medical treatment’. Although there was some evidence to suggest that some uses of seclusion might be of direct benefit to some patients²², the apparent logic for characterising seclusion as medical treatment was that it protects the patient from the adverse consequences of harming another person. It is difficult to tell whether there are any limits to the concept of treatment in the field of psychiatry where the treatment is of some perceived benefit to anybody at all. It is almost impossible to judge where those limits will lie. This is of massive significance as the Government

20 Hale LJ, judgment para 74

22 Hale LJ, Judgment para 43

21 Judgment para 77

seems likely to continue to pursue the power to use mental health legislation to detain people who are dangerous, and so undermine still further the purpose of hospitalisation.

The view of most people is likely to be that medical treatment must be in the therapeutic interests of the patient. Seclusion itself is a controversial practice, and in these appeals evidence was adduced to show the potential harm that such periods of control and isolation might cause – particularly to a person who was already distressed²³. Nonetheless, it was accepted that there might be occasions when such intervention could be justified in the patient’s own interests. There are almost certainly a significant number of people who would not agree with this view, particularly amongst those who use mental health services. The case highlights the fact that the line between what is in the patient’s interests and what is in the interests of other people can be a difficult one to draw. As Hale LJ stated:

“.....seclusion aimed at addressing the risks to others presented by the behaviour of a patient in the manic phase of a bipolar affective disorder when the behaviour is itself the result of that disorder is treatment ‘for’ the disorder in the same way that force-feeding the anorexic patient was treatment for her disorder²⁴. While her behaviour was purely self destructive, the consequences of allowing Mr S to persist in behaviour which was damaging to others would also have been damaging to him.”²⁵

The implication is that preventing actions that may be damaging to a patient will automatically be of benefit. What is not clear is how the ‘benefit’ to the patient is to be assessed. An outsider’s view of benefit is not the same thing as a patient’s best interests. Allowing someone to act in a violent manner might result in injury to themselves, or it might result in feelings of guilt at a later stage, but the same could be said of anyone who acts violently – regardless of whether they are diagnosed with any mental disorder. The Mental Health Act is concerned with treating people *for* mental disorder and this is very different from the power to treat people *with* such a disorder. There must be evidence of a disorder before seclusion can be medical treatment, and surely there must also be a connection between the disorder and the violent conduct? If so, the seclusion of people who happen to have a mental disorder and are in hospital, but whose violence is unrelated to that disorder, would not be medical treatment and would have to be justified in some other way.

Hospital staff should not assume that the presence of mental disorder and violence mean that seclusion will be justified on the basis of it being medical treatment for the disorder. The identification of the causes of violence may be very difficult but will be important in order for the patient to effectively challenge their treatment, and for the hospital to defend it. The question should be addressed if only for the reason that a failure to do so suggests that any violence committed by a person with mental health problems is as a result of those problems. A failure to consider the question assumes that there is a necessary link between the health and violence of the patient. This is unjustified. Any promotion of the view that there is a connection between mental ill-health and violence causes damage by way of stigma and prejudice to anyone who experiences mental distress. If patients can challenge their seclusion hospitals are going to have to be able to explain why they reached the decision to use it. Common assumptions about mental health and violence should not be sufficient.

23 *Hale LJ Judgment paras 10–13*

24 *In B v Croydon Health Authority [1995] Fam 133* where the Court of Appeal held that treatment addressing symptoms of a disorder, or ancillary

treatment for the symptoms of the disorder, was capable of falling within the definition of ‘medical treatment’ under s145 MHA

25 *Hale LJ, Judgment para 44*

2. Status of the Code

More positively, it is worth emphasising the significance of this decision for people who use mental health services. There can be no doubt that the rights of patients are strengthened considerably by the possibility of bringing legal action when the Code is breached. The Code of Practice identifies a benchmark that patients can now begin to rely on when looking to identify and enforce standards of care. It should be easily accessible so that people know what to expect.

The Code is an important tool for the staff who apply the Mental Health Act. It helps staff awareness of their responsibilities, especially when undertaking some of the more difficult aspects of mental health care. There is no doubt that many mental health practitioners are uncomfortable with some of the things they are asked to do. A requirement to comply with the Code will give staff the basis from which to challenge bad practices. Such an opportunity encourages change from within thereby providing a very significant step towards improving standards.

Compliance with the Code and any positive changes to practice are relatively measurable and so should be welcomed by hospital and social services' managers. The judgment does not mean that compliance with the Code is necessarily enough to prevent practices being unlawful but the judgment does give a message that patients' rights will be taken seriously and provides an avenue for those patients to enforce them.

Since this article was written, the House of Lords has given Mersey Care NHS Trust leave to appeal.
Editor