

One Code to rule them all, one code to bind them: the seclusion of detained patients.

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R v Ashworth Hospital Authority (now Mersey Care NHS Trust) ex parte Munjaz
[2005] UKHL 58 (On appeal from [2003] EWCA Civ 1036)

Introduction

The issue in this appeal was whether a hospital could lawfully implement a seclusion policy which departed from the framework in the Mental Health Act Code of Practice, 1999 revision (“the Code”). However, the significance of the case is much wider, going to the status of the Code as a whole.

The facts

Colonel Munjaz, a man in his late 50s, is a patient at Ashworth high security hospital. In 1999 Ashworth introduced a written policy governing the seclusion of patients detained there which diverged considerably from the framework in the Code, particularly with regard to the frequency of review. Mr Munjaz was subjected to seclusion on a number of occasions. He brought judicial review proceedings, challenging both the decisions to seclude him and the legality of Ashworth’s policy as a whole. The court did not permit the claim in respect of Mr Munjaz’s own seclusion to be pursued, but in 2000 Jackson J ruled that the provisions for review in Ashworth’s policy were not ones which a reasonable authority could adopt: *R v Ashworth Special Hospital Trust ex parte Munjaz* [2000] MHLR 183.

Ashworth revised its seclusion policy. The new policy, which still diverged considerably from that in the Code, was put into effect in December 2002.

In July 2001 Mr Munjaz had brought fresh judicial review proceedings to challenge Ashworth’s failure to amend its policy as required by the judge; the claim was amended to challenge Ashworth’s new policy. Mr Munjaz also initially challenged the use of seclusion in his case but this aspect of his claim was not pursued.

The law

Section 118 of the Mental Health Act 1983 provides:

- (1) The Secretary of State shall prepare, and from time to time revise, a code of practice—
 - (a) for the guidance of registered medical practitioners, managers and staff of hospitals, 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

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- (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.

From the Introduction to the Mental Health Act 1983 Code of Practice (1999 edition), paragraph 1:

“... 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.”

Seclusion in the Code (extracts)

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

Seclusion should be used:

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

Seclusion should not be used:

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

.....
Procedure for seclusion

- 19.18 The decision to use seclusion can be made in the first instance by a doctor or the nurse in charge. Where the decision is taken by someone other than a doctor, the rmo or duty doctor should be notified at once and should attend immediately unless the seclusion is only for a very brief period (no more than five minutes).
- 19.19 A nurse should be readily available within sight and sound of the seclusion room at all times throughout the period of the patient’s seclusion, and present at all times with a patient who has been sedated.
- 19.20 The aim of observation is to monitor the condition and behaviour of the patient and to identify the time at which seclusion can be terminated. The level should be decided on an individual basis and the patient should be observed continuously. A documented report must be made at least every 15 minutes.
- 19.21 The need to continue seclusion should be reviewed:

- every 2 hours by 2 nurses (1 of whom was not involved in the decision to seclude), and
 - every 4 hours by a doctor.
- A multi-disciplinary review should be completed by a consultant or other senior doctor, nurses and other professionals, who were not involved in the incident which led to the seclusion if the seclusion continues for more than:

- 8 hours consecutively; or
- 12 hours intermittently over a period of 48 hours.

Ashworth's 2002 Seclusion Policy (extracts)

2. *Introduction*

2.4 ... 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.

3.1 (Repeats almost verbatim para 19.17 of the Code.)

4.1 ff (Repeats para 19.16 of the Code with regard to the definition of seclusion and when seclusion should be used.)

...

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

...

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.

...

11.7 Each patient's case will be reviewed weekly by the clinical team and a written report sent monthly to the Seclusion Monitoring Group...

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.

The first instance hearing

The Secretary of State for Health submitted a statement to the effect that the Code was guidance only, and that he did not object to Ashworth introducing its own policy on seclusion. In the light of this, Sullivan J dismissed Mr Munjaz's claim: *R (Munjaz) v Ashworth Hospital Authority* [2002] EWHC (Admin) 1521. The judge declared that there was no issue estoppel in judicial review proceedings, so it was open to Ashworth to come to different conclusions from those reached by Jackson J in 2000.

In August 2002, in *S v Airedale NHS Trust* [2002] EWHC Admin 1980, Stanley Burton J dismissed another patient's challenge to seclusion outwith the framework of the Code, on similar grounds to Sullivan J.

Both patients appealed.

The Court of Appeal judgment

The appeals were heard together, with the Secretary of State, Mind and the Mental Health Act Commission (which submitted written evidence only) being joined as interveners. Both appeals were allowed: [2003] EWCA Civ 1036.

Hale LJ made the following findings, inter alia:

- (i) The power to seclude a patient was implied from the power to detain, or possibly from common law necessity. This did not mean that all uses of seclusion were lawful.
- (ii) Seclusion in the Code was within the scope of sections 118(1)(a) and 118(1)(b) of the 1983 Act.
- (iii) Seclusion did not in itself constitute inhuman or degrading treatment, but there was always a risk that it could be in breach of Article 3 ECHR.²
- (iv) Seclusion infringed article 8(1)³ unless it could be justified under article 8(2)⁴.
- (v) Article 5⁵ was not concerned with the conditions of detention: this was left to articles 3 and 8.
- (vi) There was no statutory obligation for hospitals to follow the Code, but where there was a risk that agents of the state would treat their patients in a way which contravened their Convention rights, the state should take steps to prevent it. Thus the Code was not mere guidance, but should be observed by all hospitals unless they had a good reason for departing from it in relation to an individual patient.

Ashworth (but not Airedale Hospital) appealed to the House of Lords. The interveners and arguments were as at the Court of Appeal, except that Mr Munjaz adopted Mind's argument in respect of Article 8.

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

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

4 "There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law as is necessary in a democratic society in the interests of national security, public safety

or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedom of others"

5 "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases, and in accordance with a procedure prescribed by law: ... the lawful detention of persons... of unsound mind...."

The House of Lords judgments

Their Lordships heard the case over three days and delivered their opinions on 13th October 2005. A majority of the House (3:2) allowed the appeal and dismissed Mr Munjaz's application.

Lord Bingham of Cornhill gave the leading judgment.

The first question for consideration was whether the Code (sic) fell within section 118(1) of the 1983 Act. His Lordship accepted the Court of Appeal's conclusion. "Admission" could not sensibly be read as referring only to the process of admission, to the exclusion of all that followed. Similarly, "medical treatment" as defined in section 145(1) of the 1983 Act was wide enough to cover the nursing and caring for a patient in seclusion, even though seclusion could not properly form part of a treatment programme.

The Code described itself as guidance. There was a categorical difference between guidance and instruction. In response Mr Munjaz laid emphasis on the consultation which preceded the drawing up of the Code, on the parliamentary sanction it received, on its issue by the Secretary of State and on the high importance of protecting detained mental patients, a vulnerable and defenceless sector of society, from any risk of abuse.

It was plain that the Code did not have the binding effect which a statutory provision or statutory instrument would have. But the matters relied on by Mr Munjaz showed that the guidance should be given great weight. It was guidance which any hospital should consider with great care, and from which it should depart only if it had cogent reasons for doing so.

The evidence adduced by the Trust made clear that the Code had been carefully considered. It was entitled to take account of three matters in particular. First, the Code was directed to the generality of hospitals and did not address the special problems of high security hospitals. Secondly, it did not recognise the special position of patients whom it was necessary to seclude for longer than a very few days. Thirdly, the statutory scheme deliberately left the final decision to those who bore the responsibility for detaining, treating, nursing and caring for the patients.

There were differences of practice, not all of them fully explained, between Ashworth, Broadmoor and Rampton⁶. It was not, however, for the courts to resolve debatable issues of professional practice but to rule on issues of law. If a practice was supported by cogent reasoned justification, the court was not entitled to condemn it as unlawful.

Ashworth's policy and the European Convention

Mr Munjaz did not contend that his own seclusion had been unlawful. Thus it was necessary to consider the compatibility with the Convention of the policy as a policy. For this purpose the Code was irrelevant: if the policy was incompatible, consistency with the Code would not save it; if it was compatible, it required no support from the Code.

It was to be assumed that the Ashworth policy was followed in the hospital. Seclusion was universally recognised to be an unwelcome necessity of last resort. It was justified only when necessary to protect others, and then for the shortest period necessary for that purpose. The potential injury which seclusion could cause to the psychological and physical well-being of a patient was universally recognised.

⁶ *The three High Security Hospitals*

The internal distribution of powers within member states was not regulated by the Convention. If Parliament chose to establish a framework of binding statutory provision, and to supplement those provisions by a Code which would guide but not bind local managers and healthcare professionals, there was nothing in the Convention which invalidated that decision.

Article 3

The Trust must not subject patients at Ashworth to treatment prohibited by article 3 or adopt a policy which exposed patients to a significant risk of such treatment. The policy, considered as a whole and properly operated, would be sufficient to prevent any possible breach of the article 3 rights of a patient secluded beyond 7 days, and there was no evidence that the frequency of medical reviews provided in the policy risked any breach of those rights.

Article 5

While Article 5 may avail a person detained in an institution of an inappropriate type it could not found a complaint directed to the category of institution within an appropriate system. The approach to residual liberty which appears to have prevailed in Canada (see *Miller v The Queen* (1985) 24 DLR 4th 9) did not reflect the jurisprudence of the European Court. Improper use of seclusion might found complaints under Article 3 or Article 8, and Article 5(4) provided that a successful challenge would result in an order that the detainee should be released, not that the conditions of his detention be varied.

Article 8

It was obvious that seclusion, improperly used, might violate a patient's Article 8 right in a serious and damaging way. This appeal, however, was directed to the compatibility of the Ashworth policy with the Convention. His Lordship had some difficulty in appreciating how seclusion could be said to show any lack of respect for a patient's private and family life, home or correspondence if it was used as the only means of protecting others from violence or intimidation and for the shortest period necessary. A detained patient, when in his right mind or during lucid intervals, would recognise that his best interests were served by his being prevented from acting in such a way.

If it was accepted that seclusion engaged article 8(1), it was necessary to consider justification under article 8(2). It was 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, seclusion would not be disproportionate because it would match the necessity giving rise to it.

Mind had submitted that the interference was not "in accordance with the law" because it was not prescribed by a binding general law. His Lordship could not accept this. The requirement was directed to substance not form. It was intended to ensure that any interference was not random and arbitrary but governed by clear pre-existing rules, and that the circumstances and procedures adopted were predictable and foreseeable by those to whom they were applied. Given the broad range of institutions in which patients may be treated for mental disorder, it was readily understandable why a single set of rules was thought to be undesirable and perhaps impracticable. The procedure adopted by the Trust did not permit arbitrary or random decision-making. The rules were accessible, foreseeable and predictable. It could not be said that they were not in accordance with or prescribed by law.

The Court of Appeal had given the Code a stronger effect than was permissible. Their conclusion gave the Code a weight which Parliament did not give it, which the Secretary of State did not support and which the Convention context did not require.

Lord Steyn, dissenting, said that the Mental Health Act 1983 was out of date. It was left to so-called soft law, in the form of a Code, to fill the gap.

The judgment of the Court of Appeal had demonstrated a thorough understanding of this sensitive and difficult branch of law. He agreed with the Court in respect of Articles 3 and 8 of the ECHR, the status of the Code, and the conclusion that hospitals might not depart from the Code as a matter of policy.

The only part of their judgment which his Lordship would not adopt was in respect of Article 5. Under English law a convicted prisoner retained all his civil rights which were not taken away expressly or by necessary implication. To that extent he had a residual liberty. The reasoning in *Miller v The Queen* (above) showed that where solitary confinement was unlawfully superimposed upon a prison sentence it could amount to a “prison within a prison”. In *R v Deputy Governor of Parkhurst and others ex parte Hague* [1992] 1 AC 58 the House of Lords had ruled out this concept, but *Hague* predated the Human Rights Act 1998 and should no longer be treated as authoritative. A fortiori it should not be applied to mentally disordered patients who were not guilty of any legal or moral culpability.

It would also be wrong to assume that under the jurisprudence of the ECHR residual liberty was not protected. In *Bollan v United Kingdom*, App No 42117/98, 42117/98, the European Court of Human Rights had said:

“...The court does not exclude that measures adopted within a prison may disclose interferences with the right to liberty in exceptional circumstances.”

If substantial and unjust seclusion of a mentally disordered patient could not be protected effectively under Articles 3 and 8, it followed that a substantial period of unnecessary seclusion could amount to an unjustified deprivation of liberty.

It was wrong to focus exclusively or even primarily on the dictionary meaning of “guidance”. The provision in section 118(2), and in the White Paper of 1981, for the Code to specify forms of treatment was inconsistent with a free-for-all in which hospitals were at liberty to depart from the Code as they considered right. Indeed, it seemed unlikely that Parliament would have authorised a regime in which hospitals could as a matter of policy depart from the Code.

The Court of Appeal had applied the dictum of Sedley J in *R v Islington BC ex parte Rixon* [1997] ELR 66, at 71, that local authorities might only depart from the Secretary of State’s guidance for good reason. In the present case fundamental rights were at stake and even before the Human Rights Act 1998, an intense review on principles of proportionality was appropriate.

The Court of Appeal had stated: “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...” Given the manifest dangers inherent in seclusion, and the extreme vulnerability of the patients, this conclusion was sound.

The endorsement of the Code by the Secretary of State made his virtual disowning of the Code in these proceedings difficult to understand. The judgment of the majority of the House lowered

the protection offered by the law to mentally disordered patients.

Lord Hope of Craighead concurred with Lord Bingham. One of the virtues of the Code was that it was able to provide clear standards that were capable of being applied by all hospitals and all healthcare facilities.

In the introduction to its Seclusion Policy, it was noted that Ashworth Hospital admitted patients who were considered to present a grave and immediate risk to the public which could not be managed in conditions of lesser security. It was often the case that all other usual interventions such as psychological interventions and alterations in drug treatment had been tried.

Much of what was in the Policy complied with and elaborated upon the guidance which the Code offered. The departure from that guidance was explained by Ashworth's perception of what was needed for the management of the patients detained there whose behaviour fell outside the normal pattern of that exhibited by mental patients generally. There was a genuine and respectable difference of view among those who were responsible for the formulation of policy in this difficult and highly specialised field.

In a letter to Ashworth's solicitors, the Mental Health Act Commission had said that the Code had perhaps been written on the assumption that seclusion should not normally still be in place after three days, no matter how disturbed the patient might be at the time of seclusion; in that event other methods of management should be resorted to. This dispute was not something on which judges were competent to adjudicate.

Domestic law

With regard to section 118(1) of the 1983 Act, the words "the admission of patients to hospitals" could not be limited to the actual admission process. Seclusion was not part of the patient's treatment, but it fell well within the scope of the phrase "the medical treatment of patients suffering from mental disorder". The statutory basis for the guidance was to be found in section 118(1)(b) of the 1983 Act.

What did "guidance" mean in this context? There was no statutory obligation to comply with it. But it could not be divorced from its statutory background, from the process of consultation and from the Parliamentary procedure that had to be gone through. Statutory guidance of this kind was less than a direction, but more than something to which those to whom it was addressed must "have regard to". He would go further than the Court of Appeal. Those to whom the Code was addressed must give cogent reasons if in any respect they decided not to follow it. Those reasons must be spelt out clearly, logically and convincingly.

There were ample grounds for thinking that good reasons had been demonstrated at Ashworth. There was no doubt the situation there differed greatly from that in the generality of institutions in which mental patients might find themselves. The Code did not address this problem, nor was it designed to do so. Section 118(1) envisaged a single code of practice, not a series of codes designed for different types of hospital. A balance was struck in the Policy between the need for frequent medical reviews in the early stages and group monitoring in the longer term at less frequent intervals, bearing in mind that some patients at Ashworth were dangerous not just for short bursts but also for long periods, and the need to make the most efficient use of medical resources at the hospital.

The Convention rights

The proposition that it was the responsibility of the court to give the Code the weight and status that it needed to secure the patients' Convention rights was undoubtedly sound in principle. The reasons for any departure from the Code must be subjected to particularly intense and careful scrutiny.

No complaint was made about the way the Policy had been implemented at Ashworth, nor that it had been applied to the respondent in a way which had caused harm to him. There was no evidence that any other patient had suffered as a result of the way the Policy had been implemented.

Article 3

Inhuman or degrading treatment must attain a minimum level of severity. In *Osman v United Kingdom* (1998) 29 EHRR 245 the court had recognised that such obligations must be interpreted in a way which did not impose an impossible or disproportionate burden on the authorities. Regard must be had to the particular conditions, the stringency of the measure, its duration, the objective pursued and its effect on the person concerned.

The risk which must be considered was whether a patient might suffer ill-treatment of the required level of severity as a result of having been kept in seclusion under Ashworth's policy for longer than would have been the case under the Code. Dr Davidson's⁷ report concluded that Ashworth's policy of fewer reviews after seven days increased the risk. But the evidence fell well short of demonstrating that the Policy gave rise to a serious risk of ill-treatment of the required level of severity. In view of the safeguards which it contained and the special circumstances that obtained in the hospital it would be disproportionate for Ashworth to be compelled to abandon it in favour of the Code.

Article 5

A person who was of unsound mind must be detained in a place which was appropriate for that purpose: *Aerts v Belgium* (1998) 29 EHRR 50. Beyond that, article 5(1)(e) was not concerned with the patient's treatment or the conditions of his detention. These matters must be dealt with under articles 3 and 8. In *Bollan v United Kingdom* (above) the court had said that disciplinary steps imposed on prisoners could not be considered a deprivation of liberty, but were modifications of the conditions of detention. The seclusion of a patient at Ashworth did not amount to a separate deprivation of liberty which engaged Article 5.

Article 8

Normal restrictions and limitations consequent upon prison life and discipline would not constitute in principle a violation of this Article. The Committee of Ministers had recognised that seclusion might be resorted to in appropriate circumstances.

Clearly there was a risk of a violation if this form of intervention was resorted to improperly or for longer periods than the person's mental condition justified. But there was no evidence that this was happening at Ashworth. The whole purpose of the Policy was to define the standards which must be followed and prevent abuse and arbitrariness. It was hard to see why, in these circumstances, the Policy should itself be thought to be incompatible with Article 8(1).

⁷ *Dr Davidson is a Consultant Forensic Psychiatrist, whose evidence had been adduced by Mr Munjaz in the Court of Appeal*

Assuming nevertheless that the Policy required to be justified under Article 8(2), his Lordship would conclude that it satisfied those tests. The aim was to prevent disorder or crime. Its purpose was to address the special considerations to be applied in a high security hospital, whose patients were considered to present a grave and immediate risk to the public and might do so also to other patients, staff and visitors. It also aimed to ensure that the procedure was resorted to in a way that was proportionate and that, even in long-term cases, it was brought to an end as early as possible.

The main thrust of Mind's argument was that an interference with Article 8(1) could not be justified unless it was "in accordance with the law". "Law" in this context was not limited to statutory enactment or to measures which had their base in a statute. It included the common law. But the measure must be formulated with sufficient precision and be sufficiently accessible to satisfy the criterion of foreseeability.

The Policy satisfied these requirements. Its procedures were spelled out with the same clarity and attention to detail as those in the Code. The Policy was published within the hospital so that it was available to all who needed to see them. The way this form of intervention was managed at Ashworth was entirely foreseeable.

Mind argued that the Code would not have the force of law if it was open to Ashworth to depart from it in formulating its own policy. The patient would not be able to foresee to a degree that was reasonable how this form of intervention might be exercised. His Lordship did not accept this. But the argument missed the point in any event, because the issue was not whether the Code was incompatible or at risk of being so, but was directed to the lawfulness of Ashworth's Policy.

There was no reason why Ashworth was not free to depart from the Code as a matter of policy, and not just in relation to individual patients or groups of patients. There was an obvious danger that, if the Code could be departed from in the case of individual patients or groups of patients, decisions to do this would be open to attack as being arbitrary. That was what Ashworth's Policy sought to avoid.

It was the quality of the law that mattered rather than the form it took. Its qualities were measured by its transparency, its accessibility, its predictability and its consistency. There was no doubt that the Code satisfied these tests, although there was no statutory obligation to comply with it. Ashworth's Policy did so too. It was true that Ashworth could alter its Policy, but every departure from the Code would have to be justified in the same way.

Concerns that a departure from the Code would lead to widespread variations in practice and undermine its status generally or that the House's judgment lowered the protection afforded by the law to mentally disordered patients were misplaced. Ashworth was the only place where a hospital had departed from what the Code said about seclusion in favour of its own policy.

Lord Scott of Foscote agreed with Lords Bingham and Hope. He also agreed with everything that Lord Brown had written, except in relation to article 8, where he concluded that the Ashworth policy did not have the necessary quality to render it compatible with the rule of law. This could not be right. "The law", for Article 8 purposes, did not consist only of statutes, directives, statutory codes etc. It must include, also, the variety of duties and rights arising out of the circumstances in which individuals and institutions found themselves that were imposed by the common law.

Ashworth owed a legal duty to the inmates of the hospital to take reasonable steps to protect him

or her from injury by other inmates. Ashworth could not choose its patients. It had to accept them, detain them and look after them. All of them suffered from some degree of mental disturbance – otherwise they would not be there. Some of them from time to time presented a danger to other inmates. Placing a patient in seclusion where the danger was sufficiently acute was a step that Ashworth's legal duty would require it to take. A dangerous patient's Article 8 rights could not justifiably be pitched at a level that required the hospital to leave other patients in unacceptable danger of harm. Once it was accepted that Ashworth had no statutory obligation to have a seclusion policy that conformed in every respect to the Code and that its policy was rational and reasonable in itself, there could be no room for any suggestion that its implementation for the safety of other inmates was otherwise than in accordance with the law.

Lord Brown, dissenting, said that the Court of Appeal had declared that, in relation to seclusion, the Code might only be departed from if there was good reason for the departure in the case of an individual or a group of individuals sharing the same characteristics. A majority of the House had concluded that the Code was guidance to be departed from only if the hospital had cogent reasons for doing so. The difference between these positions must be that, where the Code embodied one view and a hospital took another, the Court of Appeal would require the hospital to follow the Code but the majority of the House would not.

The case advanced by those who challenged Ashworth's Policy was, 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, section 118 must be construed to give greater weight to the Code; third, once the Code was given this additional weight, Ashworth became disentitled to adopt a different policy of its own.

The Court of Appeal had accepted the appellant's case with regard to articles 3 and 8 but not as to article 5. His Lordship agreed with regard to article 5. There was no evidence that the approach to seclusion up and down the country created so plain a risk of article 3 violations that the Secretary of State was bound to take corrective measures. There was further ground for rejecting the article 3 argument. The Secretary of State was obliged not to act incompatibly with a Convention right, but was not obliged to ensure that other public authorities acted compatibly.

On these issues his Lordship was in full agreement with the majority of the House. The issue revolving around article 8, however, he found altogether more difficult. The first question was whether seclusion engaged article 8 at all. There could surely be only one answer to that question. It was unthinkable that a mental patient could be subjected to seclusion without such interference being "in accordance with the law".

The case therefore turned on article 8(2), and above all on the requirement that any interference be effected "in accordance with the law". Nobody could dispute that seclusion as a practice was necessary. It could be justified under several of the grounds in article 8(2). But that was not a sufficient answer to the complaint of interference with article 8 rights. In *Malone v United Kingdom* (1984) 7 EHRR 14, nobody doubted the justification of phone-tapping but it was held not to have been in accordance with the law. In *Hewitt and Harman v United Kingdom* (1991) 14 EHRR 657, secret surveillance activities were based on a directive from the Home Secretary which did not have the force of law: the European Commission of Human Rights had concluded that the directive did not indicate with sufficient certainty the scope and manner of the authorities' exercise of discretion in carrying out their activities.

More was required by way of legal justification than that there existed a sufficient basis for the practice in domestic law. The phrase ‘in accordance with the law’ also related to the quality of the law, requiring it to be compatible with the rule of law. This encompassed notions of transparency, accessibility, predictability and consistency, to guard against the arbitrary use of power and to afford sufficient legal protection to those at risk of its abuse.

His Lordship had reluctantly concluded that the Code must be given something akin to the force of law with regard to seclusion. Without such a Code seclusion would not be regulated, save insofar as each hospital would be required to adopt, publish and practise a rational policy of its own. This, of course, was precisely what Ashworth had done. But by the same token, other hospitals might think it unnecessary to conduct reviews as frequently as in the Code. And there was nothing to stop Ashworth altering its policy whenever it thought it right to do so.

Although Ashworth ostensibly adopted the Code’s definition of seclusion, at most times about 75% of the long-term secluded patients were being nursed in extended association. This different attitude resulted in widely differing approaches to the practice. One patient had been transferred from Ashworth to Rampton having been in seclusion for the best part of nine years. At Rampton his long-term seclusion had ceased, and although from time to time he had since been secluded, this had never been for as long as eight hours, or a total of twelve hours within any forty-eight hour period.

Under the ruling proposed by the majority of the House, patients and their carers must be reconciled to substantial departures from the Code by individual hospitals. Unless one looked to the Code for regulation carrying the force of law it was not to be found elsewhere. Hospital policies provided too insubstantial a foundation for a practice so potentially harmful and open to abuse as the seclusion of vulnerable patients.

The discordance of views in this case seemed both striking and unfortunate. The Joint Parliamentary Select Committee on Human Rights had recently expressed concerns about the low level of compliance with guidelines on seclusion. His Lordship hoped that it might prove possible to lay down a comprehensive and compulsory scheme for the regulation and review of seclusion which reflected not merely best practice generally but also such special problems as Ashworth experienced. Sooner or later, consensus must be reached upon the proper place of seclusion within mental hospitals. The issue had been a running sore for far too long.

Comment

So, in respect of seclusion at least, the Code of Practice no longer has the enhanced status given it by the Court of Appeal. The majority judgment may be welcomed by those advising Trusts but is likely to alarm patients’ representatives, who have relied upon the Code as a basis for challenging practices they regard as oppressive. As Saimo Chahal points out in *Legal Action* [2006] April, pages 20–22, seclusion “raises significant issues of concern pointing to human rights violations”. It is therefore important to look at the majority judgment in terms of both the legal arguments and also its practical implications.

There is a striking degree of unanimity between the Court of Appeal and their Lordships. Seclusion is justified in domestic law; the framework in the Code derives its authority from the 1983 Act, probably as ‘treatment’ under s.118(1)(b). However, it potentially violates Convention rights, so the court has an obligation to ensure that these are adequately protected. There is no

evidence that seclusion in Ashworth or anywhere else attains a level of severity such as to engage article 3. Article 5(1) is not engaged either (Lord Steyn dissenting), as it concerns the conditions of detention only. Thus the case turns on the application of Article 8.

It is hard to understand why Lords Bingham and Hope struggle to bring seclusion within Article 8(1). Both acknowledge its potential for harm; but Lord Bingham doubts whether Article 8(1) is engaged “if it is used as the only means of protecting others from violence or intimidation and for the shortest period necessary to that end” (para 32). Lord Hope states: “The whole purpose of the Policy ... is to define the standards which must be followed and prevent abuse and arbitrariness” (para 89). The logic is hard to follow. Surely what they say goes to justification under Article 8(2)? Or do they mean that they have such faith in the infallibility of the Ashworth regime that an article 8 violation could never arise? (The cases Lord Hope cites – *Raninen v Finland* (1997) 26 EHRR 563 and *Herczegfalvy v Austria* (1992) 15 EHRR 437 – are both concerned with mechanical restraint, a very different thing from extended seclusion.) Lord Brown is surely correct when he states (para 118): “... as a practice it will inevitably sometimes engage article 8: there are bound to be occasions when the patient’s “personal autonomy” or “moral integrity” ... are undermined ...”

If article 8(1) is engaged, it must be correct that Ashworth’s policy cannot be challenged on grounds of its legitimate aim; and it is not necessary to have as rosy a view of Ashworth as Lords Bingham and Hope to accept that the proportionality of the use of seclusion will inevitably be a matter for the clinical judgement of the staff concerned (i.e. *Bolam* strikes again).

“Accordance with the law” is another matter. Leaving aside Lord Scott, whose argument – ‘Ashworth have a duty to protect other patients, so their policy must be lawful’ – begs too many questions (what if Ashworth said they had no choice but to shackle patients to their beds?), the Lords split 2:2 on the issue. On the one hand, the policy derives its authority from the Code, is accessible and foreseeable; on the other, patients need the certainty of knowing that wherever they are held they are governed by a single document which has been the subject of extensive consultation and endorsed by the Secretary of State.

One’s attitude to this probably depends on whether one accepts, with the majority of their Lordships, that Ashworth is a ‘special case’. Lord Brown is the only one to question why the practice at Ashworth is out of step with Rampton and Broadmoor, which (it might be thought) have broadly similar populations. Lord Bingham says that “it is not for the courts to resolve debatable issues of professional practice...”

But this issue is surely at the heart of the appeal: what are Ashworth in fact doing when they seclude a patient for weeks, months or even years? It is plainly something different from what is envisaged in the Code, which is expressed in terms of hours. Their Lordships agree that seclusion is covered by the definition of ‘treatment’ in s.145 MHA, and yet seem to take at face value Ashworth’s statement, following the Code, that they do not use seclusion as part of a patient’s treatment.

Lord Bingham gives the game away in para 23: “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.” In other words, patients are left in seclusion until they have learned to behave differently. Presumably the periods of extended association referred to by Lord Brown are to test whether they are ready to return to the ward. In

what way is this not 'behaviour modification', i.e. a form of treatment?

This is not to dispute that Ashworth has some very violent and aggressive patients, for whom the framework of seclusion in the Code may be inappropriate. Perhaps such patients indeed require a programme of individual behaviour modification, with its own procedure and review mechanisms. But it would be far more helpful if this could be acknowledged and a full debate held on an appropriate policy for all such patients, who are certainly not limited to Ashworth or even to the high security hospitals.

Lord Hope states (para 99) that the majority decision "should not be seen as an invitation to other hospitals ... to resort to their own policies ..." This seems optimistic. There is no obvious reason why other hospitals should not, if they wish, find 'cogent reasons' based on their unique circumstances to justify departing from the Code with regard to seclusion, or any other aspect of their care of detained patients which is not reinforced by statute. Whether readers think this matters will no doubt depend upon their professional standpoint.