Neutral Citation Number: [2019] EWHC 3565 (Admin)

Case No: CO/941/2019

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 20 December 2019

Before :

THE HONOURABLE MR JUSTICE SUPPERSTONE

- -

Between :

THE QUEEN **(on the application of KK)**	**Claimant**
- and -	
TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST	**Defendant**
- and -	
NHS ENGLAND	**Interested Party**

- -
- -

David Lock QC and Michelle Brewer (instructed by **Leigh Day**) for the **Claimant**
Jenni Richards QC and Jack Anderson (instructed by **Hempsons**) for the **Defendant**
The Interested Party was not represented

Hearing date: 28 November 2019

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Approved Judgment

Mr Justice Supperstone :

Introduction

1. The Claimant, now aged 60, is a transgender woman who seeks a referral for NHS-funded gender reassignment surgery ("GRS"). She is a serving prisoner. In September 2006 she was convicted and sentenced, as a man, for making indecent photographs of children. She is subject to an indefinite sentence for public protection with a tariff of 30 months less 317 days. She lives in open prison conditions, having been recommended for open prison conditions by the Parole Board at a review in August 2017.

2. By a Claim Form filed on 25 February 2019 the Claimant challenges "The Defendant's Protocol which bars transgender prisoners including the Claimant (save those with no possibility of release) from being referred for [GRS]" (Section 3). The Claimant seeks, inter alia, (1) a declaration that the Protocol is unlawful; and (2) an order quashing the Protocol (Section 7).

3. The Claimant in her detailed grounds for judicial review contends that the Defendant, the Tavistock and Portman NHS Foundation Trust ("the Trust"), has acted unlawfully in respect of the Protocol in six respects:

    i) The Trust breached its duties under s.242 of the National Health Service Act 2006 ("the 2006 Act") and/or its duties under s.2 of the Health Act 2009 ("the 2009 Act") and/or acted in breach of the NHS Constitution in adopting the Protocol without any patient involvement or engagement whatsoever and/or without publishing or otherwise informing patients of the existence of the Protocol (until it adversely affected them);

    ii) The Protocol is unlawful by reason of departing from the World Professional Association for Transgender Health ("WPATH") Guidance, which the Trust claims to be following, and is endorsed by both the Secretary of State for Health and NHS England. The WPATH Guidance explicitly provides that prisoners should not be discriminated against, including in relation to their access to GRS on the grounds that they are in prison;

    iii) The Protocol is unlawful because it is irrational for the reasons set out below. It seeks to treat all transgender prisoners as having the same risk of complications or regret on the basis of their status as serving prisoners due to an unidentified number of transgender prisoners who underwent GRS and later experienced complications or regrets when: (a) there is no peer-reviewed evidence to support such an approach; (b) that approach is directly contrary to the WPATH Guidance and the peer-reviewed evidence that underpinned that Guidance; (c) the evidence of the factors or categories of persons where there is a higher level of complication or regret does not identify serving prisoners as a higher-risk category; and (d) the commitment to autonomy in the policies means that the risk of complications or regret should be a matter for the patient, not a filter applied by Trust clinicians;

    iv) Further, the Protocol or the way in which the Protocol has been operated by the Trust is unlawful in that it appears to permit no exceptions and unlawfully

fetters the discretion of the decision maker. This is illustrated by the fact that there has been no assessment as to whether the Claimant had a higher than usual (i.e. about 3%) chance of complications or regret and/or what the chance of such factors was in her case and thus whether the Claimant was a suitable patient to be referred for GRS;

v) The Protocol is unlawful in that it is an unlawful interference with the Claimant's Article 8 rights read with Article 14 ECHR; and

vi) Decisions made not to refer the Claimant for GRS made under the Protocol are unlawful because those decisions have been based on an unlawful Protocol and/or have breached the duty of transparency.

4. The Trust response is that there was no such Protocol. In its Summary Grounds of Defence (at para 4) the Trust states that the challenge is not arguable "because the Trust does not operate any such Protocol. As explained in the Trust's response to pre-action correspondence, the decision about whether to make a referral for GRS is based on an individual clinical assessment as to whether a referral is appropriate in light of the circumstances of the particular patient".

5. On 23 July 2019 Waksman J granted permission to challenge the Protocol, observing:

> "Despite the Defendant's claim that there was and is in fact no protocol preventing clinical recommendations for gender reassignment surgery where the applicant is serving a prison sentence (unless that person has no prospect of ever being released) it is arguable from the correspondence that there was and if so that was unlawful in one or more of the ways set out in sub-grounds 1-6 of the Detailed Grounds."

6. In his skeleton argument dated 14 November 2019 Mr David Lock QC, who appears for the Claimant, raised a new ground of challenge (referred to as "New Ground 1"). At paragraph 3 of his skeleton argument Mr Lock stated:

> "The crucial legal issue in this case is whether it is lawful for clinicians to refuse to make a referral to a surgeon for an appropriate medical procedure for a patient because the clinicians are concerned about the risk of the medical procedure being later seen by the patient themselves as being inappropriate. It is the Claimant's case that, where there is a medical procedure that has potential benefits for a patient and also potential risks, the decision maker concerning this risk is, in law, the patient and not the clinicians." (See also paras 43-48 of the skeleton argument).

7. In *R (Talpada) v Secretary of State for the Home Department* [2018] EWCA Civ 841, Singh LJ emphasised (at para 69) that public law proceedings must be conducted with appropriate procedural rigour and "Courts should be prepared to take robust decisions and not permit grounds to be advanced if they have not been properly pleaded or where permission has not been granted to raise them. Otherwise there is a risk that

there will be unfairness, not only to the other party to the case, but potentially to the wider public interest, which is an important facet of public law litigation".

8. Ms Jenni Richards QC, for the Trust, opposed the grant of permission to pursue "New Ground 1" on the basis that the argument now advanced by the Claimant has an entirely different focus from the challenge to a (non-existent) protocol; there is no good reason why it was not pleaded before if it was to be argued at all; it is substantially out of time; and the Trust has not had a proper opportunity to file evidence or grounds in response to it. In any event Ms Richards submits, for the reasons summarised at paragraph 4 of the Trust's skeleton argument, it is without merit.

9. I heard submissions from Mr Lock and Ms Richards as to whether the Claimant should be permitted to advance the new ground. In circumstances where the new ground had not even then been properly pleaded I indicated to Mr Lock that pursuit of the new ground will necessitate an adjournment. Having had an opportunity to consider the matter further with those instructing him, Mr Lock informed me that the new ground would not be pursued. Accordingly, I refused the Claimant permission to challenge the Trust's decision on New Ground 1.

The Legal Framework

Gender Recognition Act 2004

10. The Gender Recognition Act 2004 ("GRA") enables a person to apply for legal recognition of their acquired gender. A person wishing to acquire a gender recognition certificate ("GRC") must apply to the Gender Recognition Panel ("the Panel"). Section 1 of GRA provides:

> "(1) A person of either gender who is aged at least 18 may make an application for a gender recognition certificate on the basis of—
>
> (a) living in the other gender, or…"

11. Section 2 of GRA provides:

> "(1) In the case of an application under section 1(1)(a), the Panel must grant the application if satisfied that the applicant—
>
> (a) has or has had gender dysphoria,
>
> (b) has lived in the acquired gender throughout the period of two years ending with the date on which the application is made,
>
> (c) intends to continue to live in the acquired gender until death, and
>
> (d) complies with the requirements imposed by and under section 3."

12. Section 3 provides:

> "(1) An application under section 1(1)(a) must include either—
>
> (a) a report made by a registered medical practitioner practising in the field of gender dysphoria and a report made by another registered medical practitioner (who may, but need not, practise in that field), or
>
> (b) a report made by a registered psychologist practising in that field and a report made by a registered medical practitioner (who may, but need not, practise in that field).
>
> (2) But sub-section (1) is not complied with unless a report required by that sub-section and made by—
>
> (a) a registered medical practitioner, or
>
> (b) a registered psychologist,
>
> practising in the field of gender dysphoria includes details of the diagnosis of the applicant's gender dysphoria.
>
> (3) And sub-section (1) is not complied with in a case where—
>
> (a) the applicant has undergone or is undergoing treatment for the purpose of modifying sexual characteristics, or
>
> (b) treatment for that purpose has been prescribed or planned for the applicant, unless at least one of the reports required by that sub-section includes details of it. …"

Responsibilities within the NHS

13. The statutory responsibility of commissioning "Gender identity disorder services" lies with NHS England (see National Health Service Commissioning Board and Clinical Commissioning Group (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations"), paragraph 57 of Schedule 4).

14. Regulation 10 provides:

> "Where a person is detained in prison or in other accommodation described in paragraph (2), the Board must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision to that person as part of the health service of—
>
> (a) community services (including mandatory dental services and sedation services);
>
> (b) secondary care services; and

(c) the services specified in Schedule 4."

15. Schedule 4 of the 2012 Regulations sets out a series of services for rare and very rare conditions. Paragraph 57 of Schedule 4 provides that NHS England is responsible for commissioning "Gender identity disorder services".

16. NHS England has selected to discharge that responsibility by entering into contractual arrangements with specific NHS trusts (including the Trust) to provide those services. The services which the Trust is commissioned to provide by NHS England include (amongst other matters) the making of a referral for GRS in an appropriate case.

Relevant guidance

17. Service specification No.170086S covers the provision of surgical interventions for individuals on the NHS pathway of care for the treatment of gender dysphoria. It provides at Appendix B (Referral for surgical intervention):

> "Referrals for surgical intervention must be made by a Lead Clinician from a specialist Gender Dysphoria Clinic that is commissioned by NHS England, with necessary accompanying clinical opinions as described in this service specification.
>
> A decision about an individual's suitability for surgical interventions to alleviate gender dysphoria requires careful assessment and support from a specialist multi-disciplinary team, taking into account medical, psychological, emotional and social issues in combination. As such, and given the potential range of complexities that may be experienced by individuals on the NHS pathway of care and the potential treatments, referrals to the specialist surgical team will not be accepted from other providers or health professionals…"

18. Appendix D (Criteria for initiation of surgical treatments) provides, so far as is material:

> "**Criteria for genital surgery (requires two letters of referral: one from a Lead Professional, the other a similarly qualified and experienced professional not directly involved in the individual's care and able to form an independent opinion; at least one letter of referral must be from a Registered Medical Practitioner with expertise in gender dysphoria)**
>
> *Feminising genital surgery*
>
> - Persistent, well documented gender dysphoria;
> - Capacity to make a fully informed decision and to consent for treatment;
> - Age 17 years or older;

- If significant medical or mental health concerns are present, they must be well-controlled;

- 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

- 12 continuous months of living in a gender role that is congruent with their gender identity; this must not entail a requirement for the individual to perform to externally imposed or arbitrary preconceptions about gender identity and presentation; this requirement is not about qualifying for surgery, but rather preparing and supporting the individual to cope with the profound personal and social consequences of surgery; where individuals can demonstrate that they have been living in their gender role before the referral to the Provider, this must be taken into account."

The WPATH Guidance

19. The WPATH Guidance provides, so far as is material:

> "**I. Purpose and use of the Standards of Care**
>
> … One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transexual, Transgender, and Gender Nonconforming People.* …
>
> **The Standards of Care are Flexible Clinical Guidelines**
>
> The SOC are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria…
>
> As for all previous versions of the SOC, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programmes may modify them. Clinical departures from the SOC may come about because of a patient's unique anatomic, social or psychological situation; …
>
> **VII. Mental Health**
>
> **Tasks Related to Assessment and Referral**

5. **If applicable, assess eligibility, prepare, and refer for surgery**.

The SOC also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged after care). …

It is important for mental health professionals to recognise that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding health care. However, mental health professionals have a responsibility to encourage, guide and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for the decision with the surgeon.

- One referral from a mental health professional is needed for breast/chest surgery…

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery…

The recommended content of referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counselling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for co-ordination of care and welcomes a phone call to establish this. …

XI. Surgery

Sex Reassignment Surgery is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria… For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective wellbeing, cosmesis, and sexual function… Additional information on the outcomes of surgical treatments are summarised in Appendix D.

…

Criteria for Surgeries

Criteria for genital surgery (two referrals)

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns at present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity; …

Rationale for a preoperative, 12 month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation…

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, the patient should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., school, work other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

…

XIV Applicability of the Standards of Care to People Living in Institutional Environments

The SOC in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the SOC can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalisation or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialised area of health care. …

…

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the SOC, if such accommodations do not jeopardise the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the SOC (Brown 2010).

> **Appendix D**
>
> **Evidence for Clinical Outcomes of Therapeutic Approaches**
>
> … Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. …
>
> Similar improvements were found in a Swedish study in which 'almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow up as stable or improved in global functioning' …
>
> … Fewer than 2% of patients expressed regret after therapy…"

Royal College of Psychiatrists, Good Practice guidelines for the assessment and treatment of adults with gender dysphoria (October 2013)

20. In October 2013 the Royal College of Psychiatrists produced a report "Good Practice guidelines for the assessment and treatment of adults with gender dysphoria". The report recognises that some patients may be in prison at the time of referral. It says (at page 18): "Those in prison should have access to both local mental health services for non-gender care and a gender identity specialist". The document continues.

Good practice

> *Availability and accessibility of services*
>
> "Gender consultants and specialists should recognise the expertise and opinion of colleagues in othr gender identity services when a person transfers from one gender identity service provider and another. The patient may, of course, seek a separate, independent opinion".
>
> **Overview of recommended procedure**
>
> **The Change of Gender Role**
>
> "… A verifiable period of time, usually at least 12 months, living in a gender role that is congruent with the gender identity is a requirement for those who seek genital surgery…
>
> The quality of life in the new role is assessed through discussions about the patient's ability to function in areas such as employment, voluntary work, education and training or some other stable, social and domestic lifestyle, and to adopt a gender-appropriate first name …
>
> **Surgical interventions**
>
> Genital Reconstructive Surgery

> … It is the surgeon's responsibility to determine that a referred patient's physical and mental wellbeing is sufficiently robust to undergo such a major irreversible procedure…"

General Medical Council Guidance

21. The General Medical Council ("GMC")'s "Good medical practice" guidance to doctors states (at page 8): "In providing clinical care you must (a) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs".

22. The GMC's guidance on "Consent: patients and doctors making decisions together" states (at pages 7-8):

> "**5**. If patients have capacity to make decisions for themselves, a basic model applies:
>
> a. The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
>
> b. The doctor uses specialist knowledge and experience and clinical judgment, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient. The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice.
>
> …
>
> d. If the patient asks for a treatment the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request. If, after discussion, the doctor still considers that the treatment will not be of overall benefit to the patient, they do not have to provide the treatment. But they should explain their reasons to the patient, and explain any other options that are available, including the option to seek a second opinion."

23. A doctor cannot be compelled to provide treatment which he does not consider to be in a patient's best interests (*R (YZ) v Oxleas NHS Foundation Trust* [2017] 1 WLR 3518 at para 91, per Lord Thomas CJ).

The Factual Background

24. The Claimant first raised the matter of her gender identity in prison. On 26 April 2011 she was referred by a Consultant Forensic Psychiatrist, Dr Rami El-Shirbiny, to the London Gender Identity Clinic ("the Clinic").

25. In his referral letter Dr El-Shirbiny noted that the Claimant has a number of convictions for possessing or downloading indecent images of children, starting through the 1980s. She also has a conviction of sexual assault of a child. This occurred with a girl over a four-year period during which she was aged between 12 and 16 years and the Claimant was aged 28 to 32 years. The Claimant pleaded guilty to this, serving one-year of a two-year sentence in custody over 1992-93. Dr El-Shirbiny noted that the Claimant's index offence is that of downloading indecent images of children, for which the Claimant was convicted in September 2006.

26. Dr El-Shirbiny wrote:

> "[The Claimant] stated that he believed that if he was given the chance to change his gender all his offending behaviour would stop. I challenged this, suggesting that he had missed 51 years of his life of being a girl, including the very important period of childhood, and if some explanation of his pull towards images of children (rather than adult women) was related to this, then there may be a risk for future offending in that he might potential want to relive his childhood as a girl, even after gender reassignment. [The Claimant] agreed emphatically that this was the case, "*that's so true*", …[The Claimant] amended his statement by saying that if his gender was reassigned, he believes that he would be happier "*being me*", that he "*could cope with being me later*", and therefore that his risk would be reduced if he was female, as he would not need to resort to his offending in order to vicariously experience womanhood. Nevertheless, we agreed that it would not be appropriate to place all emphasis on gender re-assignment, and it was important for him to continue his therapy."

27. On 18 April 2012 the Claimant was seen by Dr James Barrett at the Clinic. Dr Barrett is past President of the British Association of Gender Identity Specialists. He remains the lead clinician with responsibility for the Claimant's care. Dr Sally Hodges, the Chief Clinical Operating Officer for the Trust describes the Clinic in her witness statement (at paragraph 9) as "the biggest provider of gender services in the UK and possibly the world".

28. Following the consultation on 18 April 2012, Dr Barrett wrote:

> "In terms of assessment, it was always difficult to assess prisoners particularly those with sexual offences as there are a variety of motivations behind seeking a social change of gender role in prison, quite apart from the straightforward one of a gender identity disorder. In this case this patient clearly has paraphilia as well and the connection between this and the gender identity disorder, although strongly made by the patient, it isn't something which is seen in the majority of other

> patients, certainly not in terms of convictions or by their report. I think that this patient is keen for things to move forward but I wouldn't wish to do so until we have had, certainly our customary second part of our usual two-part assessment, but probably also a panel meeting as well as seems usually to be the case with patients who are in prison."

29. In September 2012 the Claimant saw Dr Stewart Lorimer, Consultant Psychiatrist at the Clinic specialising in the treatment of gender dysphoria. Following that consultation Dr Lorimer wrote on 24 September 2012:

> "I reflected that it was not unheard of for male to female transitioners to have masochistic fantasies, but that they tended to involve imagining themselves as adult females rather than children. [The Claimant] found it difficult to say for sure why his sexual fantasies were different."

30. Dr Lorimer expressed his opinion in the following terms:

> "On the basis of this assessment of the previous correspondence available to me, I would agree that there is perhaps an element of gender dysphoria in [the Claimant's] account of growing up and identifying with female peers. He also maintains the cross-dressing did not include an erotic component. As my colleague Dr Barrett points out however, paraphilia seems also to be present, and I think it is by no means straightforward teasing out the gender identity factors from a sort of fetishization of pre-teen girlhood and a degree of sexual masochism."

31. For reasons that are not entirely clear the Claimant's case was not further considered until she was seen again by Dr Lorimer at the Clinic on 2 April 2015. The Claimant told Dr Lorimer that she would like to start hormone treatment. In his letter dated 7 May 2015 Dr Lorimer wrote:

> "I'm weakly supportive of [the Claimant] starting on hormones but I would wish to have the support of my colleagues, including perhaps one further opinion."

Dr Lorimer copied his letter to Dr Barrett.

32. On 17 August 2015 Dr Barrett saw the Claimant. In a letter dated 2 October 2015 Dr Barrett wrote:

> "... This patient next has a parole review in 2017 having had one in January this year and interestingly reports that she wasn't requesting release or a move to a category D prison as she has a considerable amount of anxiety about being released from prison and in some senses feels that she is at least in a stable circumstance where she is at the moment.

> … From our point of view the thing that matters most now is whether this patient can sustain a female role in an environment other than prison. There have been many prisoners who have done quite well in prison only for things to fall apart quite badly after release and so it is my view that if this patient can be in circumstances where there is what used to be called "town leave" or anything like it, it would be immensely informative both for us and also for the patient. Essentially, it is one thing to manage in a female role in the middle of the afternoon on a prison wing and another thing to manage on a High Street, particularly in circumstances where others do not receive any penalty if they behave in an adverse way.
>
> At this stage it does seem reasonable for a mild amount of androgen blockade to be prescribed for this patient…"

33. The Claimant was prescribed a low dose of oestrogen in January 2016 and further medication to supress testosterone. In a letter dated 25 October 2016, following a review of the Claimant on 22 September 2016, Dr Lorimer wrote:

> "She quite reasonably asked about processes within this clinic and where things might go in the future, given that she wants all interventions in order to feminise her body. I explained that, before surgery, individuals are expected to live for a sustained period of time (two years) as a female in all areas of their lives, including socially. It is arguable whether being in prison equates to presenting as female in a wider sense, and every set of circumstances has to be considered individually."

34. In a letter dated 7 November 2016 to HMP Whatton Dr Barrett stated that he was supportive of the Claimant being prescribed additional hormonal injections.

35. On 23 January 2017 Dr Barrett, responding to a letter from the Claimant's previous representatives, wrote:

> "I am pleased to be able to advise you that as things stand anybody in England can be referred to any Gender Identity Clinic in England entirely as they wish and it would seem that this right pertains just as much to prisoners as it does to anybody else. You are indeed correct in saying that this patient has attracted a diagnosis of gender dysphoria from this clinic."

36. By letter dated 22 March 2017, the Claimant's previous representatives wrote to the Clinic stating that the Claimant wished to apply for a GRC, and required a medical report to do so. The Clinic replied on 21 June 2017 in the following terms:

> "I can confirm that Dr Barrett would not be able to provide a report to [the Claimant] for her to apply for a GRC. However, [the Claimant] is free to approach another clinician either at this clinic, or another NHS or private Gender Specialist provider."

37. The Claimant complained about her experience at the Clinic. By letter dated 7 July 2017 Mr Paul Jenkins, Chief Executive of the Trust, replied:

> "… With regard to the progress of your treatment through the clinic, I can confirm that the care pathways of patients who are subject to imprisonment or long-term hospitalisation do differ from the care pathways of other patients. This is due to the diagnostic and therapeutic complexities because of patients' environs, and for this reason surgical referrals are rarely made. Taking this into account, your care pathway has been entirely in line with the clinic's protocol. I can confirm, however, that following your last appointment with Dr Lorimer the use of hormones has been authorised."

38. On 23 August 2017 the Claimant was seen by Dr Bhatia, a Consultant Psychiatrist at the Clinic who also specialises in the treatment of gender dysphoria. Dr Bhatia noted that the Claimant had been granted open conditions and would be transferring to an open prison. Dr Bhatia wrote:

> "In future, plan will be to access escorted town visits and then unescorted town visits. Will also be looking at future work outside the prison environment."

Under the heading "Mood/Mental Health", Dr Bhatia wrote:

> "Generally well, in the review today, no evidence of any psychopathology and no DSH thoughts or intent were present."

39. On 29 August 2017, the Claimant submitted a written complaint to NHS England. She stated that she wanted "to progress at the clinic to having reassignment surgery without going through the RLE [Real Life Experience]". Mr Jenkins replied on 5 October 2017:

> "... As has already been stated in my previous letter, the care pathways of patients who are subject to imprisonment do differ from those of other patients due to the diagnostic and therapeutic complexities because of patients' environs, and for this reason surgical referrals are rarely made. Taking this into account your care pathway has been entirely in line with the clinical protocol.
>
> WPATH (World Professional Association for Transgender Health) guidelines make it absolutely clear that at least one year's life in the new gender role must be completed before any genital surgery can be contemplated.
>
> Dr J Barrett, Consultant Psychiatrist/Lead Clinician, confirms that the only circumstances referral for surgery could be considered would be a prisoner's circumstances were such that there was no possibility of their being released. This is not so in your case; indeed, you mention that it has been

> recommended you move to a more open prison in due course, with a view to being released in the future."

40. By letter dated 28 November 2017 NHS England rejected the Claimant's complaint. Ms Joanne Murfitt, Regional Director of Specialised Commissioning, NHS England (London Region) wrote:

> "A copy of your complaint, the provider response and your clinical records were considered by our Specialised Commissioning Department. Having reviewed all of the relevant documentation related to this complaint, they are satisfied that the Provider has carried out a thorough investigation and are satisfied that the Provider has provided explanations and information that are reasonable and appropriate."

41. In December 2017 the Claimant made a complaint to the Parliamentary and Health Service Ombudsman ("the Ombudsman").

42. On 12 June 2018 the Claimant was seen again at the Clinic by Dr Lorimer. Following a discussion of the Claimant's case in the multi-disciplinary team ("MDT") meeting on 18 June 2018 Dr Lorimer dictated a letter to the Prison on 20 June (which was transcribed on 7 September 2018) in which he said:

> "… I explained that, where both surgery and a GRC were concerned, our own worry as clinicians is that individuals in prison are in an artificial environment and it is difficult to say with authority that they are living as themselves/female in the wider world. We have had patients who did so quite comfortably when in prison and, on release, detransitioned back to male. I brought the question up again in the MDT and this remained the consensus.
>
> ...
>
> I would be in favour of [the Claimant's] hormones being optimised. The next step would be to arrange a blood test for serum, lipids, liver function, prolactin, oestradiol and testosterone.
>
> …
>
> A further appointment has been or will be arranged for some months' time, this time with Dr Barrett to whom she is known."

43. By letter dated 26 November 2018 the Ombudsman wrote in response to the Claimant's complaint, informing her that no action would be taken. The letter stated:

> "… As part of our assessment of your complaint, we have sought the advice of an independent adviser with experience in gender reassignment/gender dysphoria.

> Our adviser says that the Trust's decision not to accept that you had been through the RLE whilst in prison was appropriate and in line with these clinical standards.
>
> Our adviser says that it is completely different living within a community than it is in a protective environment like a prison. You would need to live in the preferred role 24 hours a day, continuously for at least one year before the Trust could be confident to refer you for gender reassignment surgery, in line with WPATH's – *Standards of Care*. This would involve telling relatives, friends, work colleagues and experiencing different life events which may occur throughout the year. Our adviser says that this can be stressful and traumatic, can cause low mood and anxiety, especially the older the person is. Our adviser says that a prison wing does not replicate this sort of environment, as it is a regimental and controlled place. Within prison, a person would not see regularly their friends, family, attend and experience different life events that you would experience outside of prison. Outside of prison is an uncontrolled environment, which prison is not.
>
> Our adviser says that the concerns of a clinician in making a decision for gender reassignment surgery would be whether a person could cope outside of the prison setting for a prolonged period of time. Our advisor says there are cases where people have lived in their preferred gender role in prison (prior to surgery), but when released they have not coped and become depressed, stressed and decided to no longer live in their preferred gender role. This would be taken into consideration by clinicians before referral for irreversible surgery.
>
> Our adviser says this decision by the Trust not to accept that you had been through RLE whilst in prison is not only in line with present clinical standards, but is in keeping with other clinics and peer specialists.
>
> Our adviser also says that the Trust appropriately considered … that the limited circumstances in which referral for surgery could be considered. In your case, our adviser says there is a possibility that you could be released in the foreseeable future.
>
> …
>
> We are also of the view that the Trust appropriately considered circumstances where RLE could be accepted within a prison setting, i.e. if there was no likelihood of release…"

44. On 25 February 2019 these proceedings were instituted (see para 2 above).

45. On 20 March 2019 the Claimant was seen again in the Clinic and was assessed by Sophie Quinney under the supervision of Dr Andrew Davies. Following the review Dr Davies wrote to the Prison:

> "She enjoys stable mental health, is resilient, and while thriving in a fully female role for almost a decade, has every intention of doing so, (and is doing so albeit in a restricted way) outside of prison too. It would appear that she has done well with the escorted leave that she has had from prison and we are pleased to hear that in the near future she will be commencing periods of unescorted leave which is likely to give her a fuller insight into the experience of being outside the prison environment whilst in the female role."

Dr Davies stated the plan for the Claimant included "Review again in clinic and for assessment of readiness and eligibility for genital reconstruction surgery to occur when she is living outside of prison as per the MDT discussion".

46. On 1 April 2019 the Claimant's request for a referral for GRS was considered again by the MDT. The notes of the discussion at the meeting record:

> "[The Claimant's] case was taken for discussion with the multi-disciplinary team. There was acknowledgment of the frustration [the Claimant] has felt being on an IPP and how she feels that it has been difficult to progress towards prison release and life in turn has impacted upon progression with a gender role transition. We appreciate that she is doing everything she can within the confines of prison to be in the female gender role and it was encouraging to see that she has recently been having escorted leave into the town and this appears to be going well. It was noted that while she has been in prison for a number of years now there is likelihood over the coming months that she will have unescorted town leave followed by a parole board hearing in September 2019 after which she is hoping to have test home leave. The MDT reflected that it does seem as if [the Claimant] is robustly in the female gender role within her current environment and living circumstances and indeed is likely that this will continue … into the future. However the MDT is mindful of the importance of there being a different set of pressures and stresses upon an individual on release from prison and living on the outside. Whilst it is to be hoped that she will be able to negotiate these pressures and remain living in the female gender role and consequently continue to pursue having the invasive and irreversible procedure of genital reconstruction surgery the clinic is aware of instances where the transition into living outside of prison has not been an easy one to the extent that the individual feels unable to remain in the female gender role. We respect that this may well not be the case for [the Claimant] and she may well remain in the female gender role and thrive, however to try and ensure that she is ready and eligible for gender reconstruction surgery

> identity we would wish to see her living outside of the prison environment for a minimum of 12 months period and for there to be two assessments at this clinic in that time. If at that stage the transition has remained robust then she [can] be deemed as eligible for genital reconstruction surgery. Furthermore it appears that she is indeed doing well within prison at this stage it would be very helpful to have information from her offender manager as to how he/she feels things are progressing for her and what the plan is over the coming months with regard to leave and any potential longer term plans for her at the time of release."

The Parties Submission's and Discussion:

47. The Claimant's pleaded case is that the decision by the Trust to refuse to recommend her for gender reassignment surgery, was made pursuant to an unlawful protocol (see paras 2-3 above).

48. In letters dated 7 July 2017 and 5 October 2017, Mr Jenkins referred to "the Clinic's protocol" (see paras 37 and 39 above). In his witness statement dated 3 September 2019 (at para 5) Mr Jenkins explains his use of the word "protocol" in those letters. He states:

> "When I use the word protocol in my letters, I was relying on what we were told by the clinicians, in this case principally Dr James Barrett. I did not know whether there was written protocol: I thought the pathway of care was a description of a collective view, of a pattern of events, taking account of what the clinicians thought were the salient factors in this case."

49. There is now unchallenged evidence from the Trust that there was no such protocol. Dr Barrett in his evidence makes clear that there is no written or unwritten "protocol" regarding the treatment of prisoners. However, he states that it would be right to say that his decisions are influenced by and resonate with the set of clinical knowledge and experience which he shares with clinical colleagues. Dr Barrett explains why the fact that a patient is in prison is indeed relevant to their care pathway. (See his witness statement dated 2 September 2019 at paras 26-32; and also see witness statements of Andrew Davies, Consultant Psychiatrist at the Clinic, dated 4 September 2019 at para 21, and Dr Sally Hodges, Chief Clinical Operating Officer for the Trust, dated 3 September 2019 at paras 12-15).

50. In the light of this evidence Mr Lock submits, in the alternative, that even if there was no protocol which, in its operation, *de facto* bars transgendered prisoners (save for those with no possibility of release) from being referred for GRS while they are serving prisoners, the Trust and/or the Trust clinicians have adopted and applied a policy or approach to the same effect.

51. It is common ground that the WPATH Standards of Care constitute formal Guidance for decision making by the Trust in relation to treatment options for gender dysphoria patients. Mr Lock submits that the Trust acted in breach of that guidance. The referral letter for surgery should include "4. an explanation that the criteria for surgery have

been met, and a brief description of the clinical rationale for supporting the patient's request for surgery" (see para 19 above). Of the six criteria for surgery the only one in issue is the sixth ("12 continuous months of living in a gender role that is congruent with their gender identity") which, Mr Lock submits, is satisfied. In support of this submission, Mr Lock refers to the rationale given for that criterion (see para 19 above); and Mr Lock emphasises the section in the Guidance dealing with the applicability of the Standards of Care to persons living in institutional environments. The Guidance makes it clear, Mr Lock submits, that time spent in prison has the potential for amounting to RLE.

52. Mr Lock submits that the conclusions of the MDT meeting held on 1 April 2019 recognised that the proposed surgery would more than likely benefit the Claimant, but it appears the MDT were not prepared to make the GRS referral at that point because they had concerns that there was a possibility that the Claimant may not wish to continue to live as a woman following her release from prison and thus may later come to regret having the surgery. However, the WPATH Guidance note in Appendix D (see para 19 above) that since the Guidance has been in place, "there has been a steady increase in patient satisfaction and a decrease in dissatisfaction with the outcome of sex-reassignment surgery". There is, Mr Lock submits, no objective evidence of any greater level of regret amongst those who underwent surgery when in an institutional environment. Mr Lock observes that the Royal College of Psychiatrists "Good practise guidelines for the assessment and treatment of adults with gender dysphoria", (see para 20 above) are consistent with the WPATH guidance and do not suggest that the period of 12 months, living in a gender role that is congruent with the gender identity, should be discounted because of a lesser experience in prison by reason of social exclusion or for other reasons.

53. The first point made by Ms Richards is that it is clear on the evidence that there was and is no protocol, permission having been granted on the basis that there arguably was one, and that therefore should be an end to the claim.

54. As for Mr Lock's alternative submission (see para 50 above), Ms Richards submits that the process of decision making in relation to referral for GRS is comprehensively explained in the Trust's evidence. A referral for GRS will only be made on the recommendation of an appropriately qualified professional, with a second opinion. The decision whether a patient should be referred for GRS is a clinical decision. At the Trust, complex cases will be considered by a MDT. Dr Barrett explains how decisions are taken by clinicians on a case-by-case basis. There is not, he states, a standard gender dysphoria treatment pathway in the sense that there would be, for example, for most forms of surgery.

55. On the importance of RLE in the acquired gender as recognised in the WPATH Guidance and in the Royal Society of Physiatrists guidelines, Dr Barrett in his witness statement (at para 8) states:

> "Even where a person has a clear diagnosis of gender dysphoria or incongruence and has responded well to hormone treatment, they may find that upon undergoing the experience of life in their acquired gender they do not want surgery. The need for "real life experience" is not just about the passage of time. There is a qualitative dimension to the requirement for real-life

> experience in order to ensure that surgery is appropriate: see page 61 of the WPATH Guidance. For example, we would not refer for surgery somebody who was outside prison who had spent a year stuck in her bedroom, with only an online social life and little contact with the outside world."

56. Dr Barrett goes on to explain some important differences between experience in prison and experience in the outside world. He states (at pp.12-15):

> "**12** Prison is unquestionably a complicating factor. This does not mean we are discriminating against those who are referred from prison: it means that in delivering advice and a service that is appropriate to their needs we have to be more careful in making our assessment because we know that things are likely to be less straightforward for them. …
>
> **13**… there are several reasons for being very cautious about people who are already in prison when they make a declaration of gender dysphoria for the first time. The first reason is that life in prison is highly regulated and leads to specific adaptions that will be abandoned after their release. … The challenges to which someone is subjected when they are in prison are significant, but they are very different from the challenges and opportunities that present themselves outside and someone who has adapted well in prison may well find it difficult to do so outside. …
>
> **Sexual Offences**
>
> **20**
>
> Those who are in prison as a result of a sexual offence are additionally complicated and indeed I think they can be some of the most challenging cases we encounter…"

57. Dr Barrett gives the example (at para 19.2), in June 2019, of Dr Davies and himself jointly referring a patient for genital reconstructive surgery notwithstanding that she was still a prisoner. He said that what made the difference in her case is that she was coming towards the end of her sentence, and spending considerable time outside prison by the time the referral was made. She had lived as a woman in the male estate successfully for some years and also spent time successfully in the female estate. They felt sufficiently confident to endorse her wishes, but this was, Dr Barrett said, "a quite exceptional case".

58. In Part II of his witness statement Dr Barrett considers the Claimant's case. His analysis includes the following:

> "**20** The claimant in this case presented (and continues to present) with a number of complicating factors… First and most obvious she was and is living in prison. As I say, that has meant her experience of living in the female role is artificial.

> Her experience did not predict the sort of experience that she would encounter outside. But over and above this there were a number of other factors which have made me much more wary. She has had no family with whom she has been in contact for many years and no supportive partner, so that she may well be socially isolated at discharge. She may well find it difficult to get a job. She had come to this view of herself relatively late in life…
>
> …
>
> **22** The fact that she had a history of sexual offences was a seriously complicating factor. People with gender dysphoria feel imprisoned in the wrong body, convinced they are a woman living in a man's body. Women who are living in female bodies do not normally groom children, still less perform oral sexual acts on 12-year-old girls. It is unusual and it made it much harder to accept her history at face value."

59. Dr Barrett continues (para 36):

> "… I have never yet referred a patient for surgery whilst they were full time in prison without real life experience in the community and I do not think I would do so unless the circumstances were exceptional or uncomplicated… This is not because of any written or unwritten protocol operated by the Trust or the clinic, but because it reflects my views (shared, as I understand it, by my colleagues) as to what is likely be the appropriate clinical course. Certainly, I would not have made such a referral in the case of KK because I think the nature of her previous offence and the index offence, as well as the particular characteristics of her condition and circumstances are complications that challenge the opinion that she would derive any benefit."

60. In his second witness statement dated 21 November 2019 Dr Barrett refers (at para 3) to a meeting on 11 April 2014 of all of the gender identity clinics in England, held at the Nottingham Gender Identity Clinic, specifically to discuss the issue of patients who are in prison. Dr Barrett states:

> "Significantly, all of the clinics started out with broadly similar views and these where somewhat refined at that meeting. None of the clinicians present felt that "time served" was all that mattered and everybody agreed that prisoners were particularly complicated and that time in prison would not often constitute proper lived experience. As far as I know, everybody is still proceeding on exactly the same principles. Certainly in the very much more coordinated meetings that we have after the creation of the Association [British Association of Gender Identity Specialists] nobody has expressed a contrary view and all discussion of prisoners continues to have the same worried,

> cautious theme and emphasis on experience in the real world rather than within a prison setting."

61. Ms Richards submits that it is clear from the evidence that Dr Barrett and other Trust clinicians who dealt with the Claimant did not adopt any rigid policy or approach to whether or not to make a referral in her case. The evidence supports, Ms Richards submits, what Dr Barrett states in his witness statement (at para 37):

> "We have consistently approached [KK's] case in a constructive fashion responding appropriately to her needs as we see them and trying to help her. We have, for example, advised that she should have episodes of town leave. ... From our point of view, matters would benefit if she had experience of living in the community which is why we suggested that periods of escorted and unescorted leave would assist her. We have also, more cautiously, advised that she should have hormonal treatment and that this should be increased. All of these are cautious steps that we have felt able to take. The fact that we have not gone further and recommended her for irreversible surgery is a purely clinical judgment made in her interests as we see them."

62. The Claimant has been informed that she may obtain a separate, independent opinion (see para 36 above). This is in accordance with the Good Practise Guidelines of the Royal College of Psychiatrists (see para 20 above). Despite being informed that she may seek treatment at an alternative clinic if she wished to do so, the Claimant has not taken up this option.

63. I turn finally to consider the specific grounds of challenge. Mr Lock took grounds 1 and 6 together. He submits that whatever decision-making process was adopted it lacked transparency. He submits that s.242 of the 2006 Act prohibits NHS bodies from developing and applying secret policies, in this instance a policy that permitted the treatment of one group of patients (prisoners) from another group of patients (patients not in prison). The s.242 duty is reinforced, Ms Lock submits, by the duty in the NHS Constitution. The right of patients to be included in processes runs throughout the Constitution (see, for example, the following principles that guide the NHS: 4 (the patient will be the heart of everything the NHS does), and 7 (the NHS is accountable to the public, communities and patients that it serves), and NHS values ("Working together for patients" and "Everyone counts").

64. I agree with Ms Richards that there is nothing in s.242 of the 2006 Act, or in the NHS Constitution, that would require clinicians to consult with patients to establish what factors are clinically relevant to recommend GRS. Further, I am satisfied that there has been no lack of transparency. In pre-action correspondence and in evidence in these proceedings the Trust has explained that there was no protocol.

65. Ground 2 of the challenge, as advanced by Mr Lock, involves two contentions. First, that the Trust and Trust clinicians failed to understand that the WPATH guidance, in particular in relation to the sixth criterion for surgery required a pre-operative, 12-month experience of living in an identity-congruent gender role, or if there was no misunderstanding, they misapplied it. None of the relevant guidance is consistent with

an approach that seeks to discount the benefits of RLE simply because the patient has been in a prison environment. Second, they breached the principles of autonomy contained within the WPATH guidance (and all other relevant pieces of guidance) by putting decision making in the hands of doctors when decisions ought to be made by patients about the medical treatment to be provided to them.

66. I do not accept that the Trust or the Trust clinicians misunderstood or departed from the WPATH guidance or any other guidance to which the Claimant has referred. None of the guidance referred to addresses the question whether RLE acquired in prison should be treated the same as RLE acquired outside of that context, in respect of prisoners for whom prison is not intended to be their permanent place of residence. In any event guidance is just that. The expert clinical opinion in this case (including that of the independent advisor to the Ombudsman) is that a referral should not be made. The Claimant has produced no evidence to the contrary. There is, in my view, no basis for the contention that the expert clinicians, having unanimously formed the view on medical grounds that a referral should not be made should nevertheless have decided to refer because the Claimant wished them to do so.

67. Mr Lock acknowledges, as I understand it, that grounds 3 and 4 add nothing to the Claimant's case.

68. As for Ground 5, in my view there has been no unlawful interference with the Claimant's rights under Article 8 and/or 14 ECHR. The same clinical guidelines apply to patients in prison as to those outside of prison. In so far as she is treated differently from how she would be treated were she released and living in the community, that is because the difference in environment is clinically relevant to the question whether to make a referral for GRS. I agree with Ms Richards that even if it were considered that there had been differential treatment, such difference in treatment is justified on the basis that the reason why regard is had to the fact that the Claimant's RLE has been acquired in prison is that it is relevant to the determination of the question of whether surgery is appropriate for her in her present circumstances.

Conclusion

69. For the reasons I have given, none of the grounds of challenge are made out. Accordingly, this claim is dismissed.